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THE
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CANADA MEDICAL RECORD

JANUARY, 1897.

Original Communications.

NURSING THE INSANE.

By J. V. ANGLIN, B.A., M.D.

Late Assistant Physician at the Protestant Hospital for Insane, Verdun, and Western Pennsylvania Hospital. Professor of Psychiatry, University of Bishop's College. Physician Montreal Dispensary, &c.

I appreciate the honor conferred in the invitation to tell you something of what the nurse has to do in the care of insane patients, a subject long neglected, for only within the past few years have attendants on the insane been specially instructed in their duties, and risen above the level of mere "keepers." Yet, there is no class of cases in which the role of the nurse is of greater importance.

I shall assume that modesty alone did not prompt the confession that you know nothing about this branch of nursing. Nothing shall therefore be passed over because it seems too elementary.

It will be a pleasure to disabuse your minds of misconceptions, to raise the cloud of calumny from the sick in mind, for certainly those can have no idea of how interesting and satisfactory the work is, who have told me with a suggestive gesture they would not take charge of the insane for anything, as if it were similar to caring for some wild beast instead of our own flesh and blood.

To make my words valuable, I shall have to tell you something of what insanity is, or at least acquaint you with some of the evidences of mental diseases with which you will have to deal if you nurse such cases, so that a fitting title for these remarks might be "the insane and their care."

I shall not attempt that wherein so many able men have failed, viz., to give you a definition of insanity. It is hard to define, because what indicates insanity in one man may be perfectly consistent with sanity in another. So variable are its manifestations, that it is simply impossible to give a brief description of it that will include all the insane and exclude all who are sane. But fortunately for practical purposes it matters little if you do not carry a definition away with you.

Nor shall I venture to discuss what mind is. Suffice it to say that a man's mind, whatever it be, is revealed to us through his conduct, through what he says and does. We can diagnose the mind diseased only by observation of the speech and actions. We speak of the "mind diseased." This is not quite true, as it is the brain, the organ of the mind, that is affected, whence arises disturbed mental action. It is only for convenience we say insanity is a disease. It is really only a symptom of a disordered bodily state.

It may be difficult to detect any difference between your patient and sane people. The essential thing in insanity is the change in the man. To see that, he is not to be compared with others, but with his former self. It may be so slight that only his intimates will note it, or so marked as to attract everybody's attention. Those who knew him all his life may observe his departure from health more than will you. The insane are not all fashioned in one mould. Just as there are no two faces alike, so no two minds are quite alike in disease or health. But when a man goes crazy there is always a change in him, a change from his natural way of thinking, feeling or acting—the modest becoming obscene, the villain religious.

The lunatic of the popular mind, of the story book, you will seldom see, that raving madman who is supposed to be chained, beaten and otherwise ill-treated by the credulous world, which world will sympathize with the maniac in all his rashness till in his blind fury some day he commit murder, of which act he is perhaps unconscious, when with one accord it will turn and cry "Hang him! Hang him!"

Insanity is not one but a number of diseases. The classifications of mental disorders are puzzlingly numerous but you need not freight your brains with them. For prac-

tical purposes, insane cases may nearly all be grouped in a simple way under a few general mental states, one of which being present gives the character and name to the disease. The faculties of the mind are said to be feeling, thinking and the will. The term feeling must not be confounded with the sensation arising from the special sense of touch. What it means cannot well be put in words, but we all know what is meant by pleasurable or painful feelings. According as the feelings are unnaturally painful or pleasurable we classify many cases of insanity.

So we will make three grand divisions of the insane :

1st, There is the melancholy class, whose minds are in a depressed state ; 2nd, the maniacal, whose minds are in an elated state ; and 3rd, the demented, whose minds are in a state of enfeeblement. The melancholy are the most numerous, although not so according to hospital figures, for more of them are kept at home for treatment. You may often tell from the patient's face that the characteristic of the disease is depressed feeling. His head may be bowed, or his eyes cast down, and every feature indicate unhappiness. He talks little, or may refuse to speak. The mind seems to act slowly, the memory dazed. In some cases you can detect little else wrong. He may be able to talk like others about his symptoms. Indeed that is the trouble, the patient thinks of nothing but himself, his unworthiness, etc. Self is the prominent characteristic. He interests himself in nothing else. But all are not quiet. The patient may groan, or cry (for he can shed tears), pacing the floor and wringing his hands. His thoughts may plainly show disorder, his mind being full of painful delusions of which he may talk much. Tortured with fear, he may be as frenzied and violent as any maniac. The melancholiac is often suicidal.

In mania we find the opposite condition. The feelings of the maniac are exalted, often excited. Thus the fundamental difference between the two is in the state of the feelings. They may have other symptoms in common. The maniacal patient's mind is usually overactive, unbridled. His thoughts come too rapidly for utterance, and his speech may be a jumble of words. He talks rapidly, and his loquaciousness is often trying. His memory is acute, his imagination

fired. There may be constant restlessness, or his excitement may come in spells with periods of comparative mental quiet between. He may wander up and down like a tiger in a cage, or laugh, sing, dance or cry, or all in turn. He tends to excess in all things. He may drink heavily in the beginning of his illness, and this is often set down wrongly as the cause. He is often irritable, unreasonable, perhaps threatening, and grows violent when interfered with. His self control may be altogether gone, and he becomes the raving maniac. If, in addition to his feeling of well-being, there are delusions, they are mostly of self-exaltation. He thinks of himself more highly than he ought. He is a Pope, or king, or God himself. Mania is commonest in young subjects. Sometimes there is an acute delirium, the patient recognizes nothing about him, the temperature rises, and the patient is prone to become rapidly exhausted. But mania may be of all degrees. Some patients may be so slightly touched that we cannot say more than that they are on the borderland. In popular language, all the insane are maniacs. Your newspaper will tell even of *suicidal* mania. But you will now see that mania and insanity are not synonymous terms.

Dementia, or the state of mental enfeeblement, usually results from mania or melancholia. It is the goal of all chronic insanity. It comes on often in old age without antecedent mental disease,—an exaggerated second childhood. All the dement's mental powers are impaired almost completely or only slightly. His mind may be so blank that he remembers not yesterday. He is careless as to the necessities and decencies of life, and may need care like a child. He differs from the *imbecile* often only in that he once possessed a developed mind.

The paralytic dement or general paretic is generally put in a class by himself, and is a most interesting patient. In his case, in addition to the mental weakness, there are signs of partial paralysis, and often delusions of enormous power and wealth possessed. He is usually happy, and on his inevitable death-bed will insist he is "first rate." In the beginning he may seem more maniacal than demented.

But you may meet with cases that will not come under the above divisions. There is alternating insanity, in which

the mind is one time maniacal, at another, depressed. There are some in whom the feelings do not seem to be disordered so much as the thoughts, in whom the mind is never free from delusions, especially of persecution, of whom, beware! There are yet others whose wills seem mainly affected, in whom loss of self-control is the prominent feature. Such patients may talk very cleverly, and so the public will say they are sane.

That terrible calamity which attacks the new-made mother, puerperal insanity, may at any time fall to your lot to nurse, whether you desire to undertake it or not, in which emergency you may be a perfect God-send. The form it usually takes is mania, akin to that already referred to, qualified by the lying-in condition.

But it is foreign to our purpose to deal further with the forms insanity takes, especially as doctors differ about them considerably. We will pass on to consider symptoms, the things insane patients say and do, by which they are adjudged of unsound mind. It seems to me very necessary that you should be familiar with at least the ordinary signs of insanity, so that you may be able to look for and recognize them and properly report them. For in no other disease may so much depend on the nurse, who, being constantly with the patient, may elicit symptoms that are never revealed to the doctor in charge. I shall try to be practical, and tell you how to deal with them when they are met with.

It may be well for you to know, especially in obstetric cases, in what way insanity begins. As a rule, insanity comes on gradually. It may *seem* to come on all at once, but when one looks back in such cases, many unheeded warnings that pointed to the disease can generally be noted. It may be weeks coming on before there is anything thought serious enough to consult a doctor about. In nearly every incipient case sleeplessness exists, and the bodily health declines. There is little dread of insanity in any one who sleeps well and holds his own in weight. In puerperal cases it begins more suddenly than usual. Although here again this is more apparent than real. Generally within a fortnight of the confinement, you will note some day as the first sign the patient's self-absorption and neglect of her babe. Then, after a bad,

sleepless night, she is restless. Soon she begins to talk ceaselessly, foolishly, and becomes violent, when you have a fully developed case of mania. Such is the typical picture.

The first, most interesting and common symptoms we shall take up are the delusions of the insane. These may be simply defined as false beliefs due to disease. It is needful to say due to disease, because there are thousands of false beliefs in the world due rather to faulty education. These errors may be called delusions, but not insane ones, because disease does not cause them. Such, for example, is the belief in witches, Mohammedanism, and homœopathy from our way of thinking. You cannot always tell errors from insane delusions. Indeed, the only difference may be in their causes and consequences. The millionaire who fancies himself a pauper, and the pauper who counts himself a millionaire, have both insane delusions.

A delusion is a new belief in the patient's mind, something he did not hold formerly, nor was he taught it in youth, whereas the errors of the sane are usually things they have held all their lives. A delusion is a belief usually in which the patient only is concerned, which refers only to himself, and which affects his conduct, whereas sane errors are held by many men in common, they pertain to other things than themselves, and may not interfere with their conduct to any extent. Delusions are errors that those of the patient's own set do not and cannot endorse, so they isolate him from his fellows. Much depends on the character of the patient whether you suspect he is delusional or not. Thus you would doubt a philosopher's sanity more than an illiterate man's if they both believed in witches. Don't imagine delusions are always silly and impossible. Oftener they are not essentially so, but are contrary to fact in the mouth of the patient uttering them. One says his head is glass, and treads gently lest it break; one, that he is made of butter, and keeps out of the sun; and yet another that he is dead. Such delusions are absurd enough. But suppose a man believes poverty is impending. There is nothing impossible about that. You must see that it has no foundation in fact before it is called a delusion. Such beliefs in possibilities are delusions only when they have no other reason for their existence than that they

are caused by disease. Sometimes injustice is done patients by classing true statements as delusions. You should not without investigation set down every strange thing the patient tells you as a delusion. There are more wonderful things in real life than in fiction. He may tell you true stories his friends would like to hide, stories he would never tell if he were himself; and it is very easy for his family to attribute them all to fancy. Delusions are of all kinds. You may hear a new one every day in a hospital. Some are called dangerous, because they lead the lunatic to harm others. Some are fixed, and cling to the man unchanged through life. Others are fleeting, never two days alike, which is the better omen. They may prate about them continually or they may suppress them so that you can know they have them only from their actions. You must not expect to find delusions in every insane case. They are not essential to it, but are most important corroborative evidence, as our "learned friends" will tell you. On the other hand, it is doubtful if you will find delusions in any case in which other symptoms do not co-exist. The feelings are more or less altered even before delusions indicate derangement of the thought.

When your patient has delusions and talks about them, simply say, if you say anything, that you cannot see as he does, and then change the subject. Be frank with him, but don't antagonize. Patients should not only be discouraged in talking about their delusions, but about all their symptoms. The melancholy especially want to talk a great deal about themselves and their horrible, unprecedented case. The only time discussion of delusions may be advisable is when a patient is on the mend, and the mental cloud is lifting, then something may be done to reason away the fancies that still hover about. Above all, they should never be ridiculed, nor should a patient be nicknamed after his delusion, as the Queen, or President, or the like, for that would only serve to keep it in mind. Neither argument, nor ridicule, nor flat contradiction will show him his error. They will only annoy him. Experience will soon teach that his fancies are as real to him as is your existence to you. Ignore them as much as you can. Try to divert his mind with other thoughts, and get him to act as if the delusions did not exist. You

will find that he does not follow them out to logical conclusions; thus a patient may declare himself a king, and yet he will obey you and do any work you wish. Encourage him in this, and thus ignore his delusion. In home treatment it is always better to select some room other than the one he is used to for the patient while he is sick, as his accustomed room may be associated with his delusions. Also when you wish the assistance of any of the household, you should call on those who irritate him least, those who are not involved in his delusions. Often those nearest to the patient and whom he loved most are the ones on whom he vents the greatest dislike. Keep them out of sight. Don't let the friends try to overcome this by argument. Explain to them it is a symptom of his illness, which will pass off with the others.

Hallucinations and illusions are also often symptomatic of insanity, and demand attention. We say a patient has an hallucination when he hears something when all is still, and there is nothing but his disordered brain to account for the sound. Firmly as he believes in its reality, it is a creation of his mind.

The poet depicts them in the lines

“ I hear a voice you cannot hear which says I must not stay ;
“ I see a hand you cannot see which beckons me away .”

Any of us may have hallucinations, especially in the time between sleeping and waking; but once aroused we do not believe in the reality of our dreams, hence they do not indicate insanity. Lincoln used to see a sailing ship at critical periods of his life. Scott at times saw phantoms of the dead Byron. Dr. Johnson says he often heard his dead mother calling him.

Hallucinations occur in many forms of insanity. There are as many varieties of them as there are senses. Hallucinations of hearing are the ones commonly met with, and are of grave import, for patients having them are often dangerous, and should be closely watched. They are often accompanied by delusions of persecution, and patients hear their enemies threatening, and may retaliate. At first your patient may hear only confused noises, but these are apt soon to become articulate, and, to use the terms of the patient, “he hears voices.” Sometimes, however, the sounds may be of music

groaning or crying. These voices may be strange or foreign even, or recognized as those of friends. They may be ones unfamiliar to him, and ascribed to God, the devil or animals. The voices may say pleasant things, but usually not. Some are incensed at hearing their innermost thoughts repeated aloud. They may come from any distance, and the patient is usually definite about it. One man in Ottawa wrote a threatening letter to Dr. Burgess, because of voices he heard from Verdun. They may come from any direction, even from the patient's own body, giving rise to the idea in his mind that there are two of him. They are so natural that the most intelligent patient cannot be argued out of his belief in their existence, though he may explain them as due to telephones, etc. Patients that converse with these imaginary persons have a characteristic look. You may notice them laughing at something heard, or frowning, or making reply aloud, or moving the lips. I have gone thus minutely into hallucinations of hearing, for it is important to recognize them, patients entertaining them being liable to do sudden, dangerous deeds. Thus one man who attempted murder said: "I do not want to do this, but when God whispers in my ear it must be done, I must obey, and even sacrifice my whole family." Don't be less cautious because they may talk as reasonably as yourself on other topics.

Hallucinations of sight are less common and less serious. You have a familiar example of them in delirium tremens, when the imaginary objects are of a terrifying character; but the insane may fancy they see pleasing things. The patient who tells you he sees flies in the pure milk you offer has hallucinations of seeing, and may refuse food on that account.

Hallucinations of smell and taste are the least common, and are often combined with delusions of poisoning. Sometimes they fancy their own skins emit foul odors, and hence live apart from their friends.

Hallucinations of touch are frequent, consisting in sensations of electric shocks, irritation of the skin by powders, etc. Only last week I had a woman of 50, who firmly believed she was frequently violated by certain men, distorting God's promise to be a husband to the fatherless. She claimed that

a machine was used which could be operated from any distance. Here was an hallucination of the genital sense. That woman is liable to do harm to her imaginary persecutors.

Illusions differ somewhat from hallucinations, and are more frequent in the sane. When a person hears a bell and believes it a voice, he has an illusion. His mind does not correctly perceive what the ear hears. He is mistaken. If for a moment seeing yourself in a mirror, you think it is someone else, that is an illusion. If you persisted in saying it was not your reflection, one would doubt your sanity. An illusion then is based on truth, but the man is deceived, whereas we saw an hallucination is a pure invention of the mind; there is no truth in it. Illusions are common in insanity, but are not so serious as hallucinations, being often seen in curable cases. Those of sight are the most frequent, but they may be connected with any of the senses. A patient may misinterpret sensations coming from the stomach so as to believe some animal is being entertained in his abdomen. One thin woman feeling the pulsations of the aorta assured me a lizard was growing within her.

The term insane delusion is sometimes used to cover both hallucinations and illusions. Once these cannot be corrected by the mind they may be called delusions, and indicate insanity. Insane patients cannot be argued out of their belief in them, however absurd they be. Hallucinations and illusions are to be dealt with in the same way as delusions.

Among the acts of the insane, suicide should have a place in your thoughts, that every precaution may be taken to avert so dire a calamity. It may occur in any case of insanity, no matter what the form. But melancholic patients especially have suicidal tendencies. With some of them death seems the one idea of life, so miserable does their intense mental pain make them. There are few depressed patients in whom suicide does not at some time have a place either in wish, intention or act. The determination to end life is sometimes arrived at in a logical way. The poor wretch argues, "I am utterly miserable, I shan't get well; why should I continue thus?" A patient may have the greatest fear of death, and yet constantly woo it. He suicides from seemingly illogical

motives, as the desire to escape from fancied plots woven to destroy him. Many who fancy they are to be poisoned, or are being hounded, anticipate death by suicide. Have care, therefore, that you are not deceived, thinking that because they live in dread of others they will not injure themselves. Soldiers have fallen by their own hands in battle. Self-destruction is often the outcome of delusions: one dies that he may save others; another, in obedience to God's command; some, because they fancy they are taking their children's bread; others have at times an intense longing to die, and may run to you imploring protection from themselves till it passes off. It may come on as a sudden impulse in a patient who has shown no tendency to it.

Patients may talk of it freely, but some of the most determined cases say the least about it and make us most anxious. They may even assume cheerfulness to throw you off the scent, and profess recovery to get you to relax your watchfulness. Many have the keenest inclination to suicide in the earliest stages of their disease, perhaps it may be committed before any other symptoms have been observed. But while the chronics seem to think less about it, make it a rule to trust no melancholic.

The *methods* of committing suicide are as varied as mind can conceive. The unexpected often happens. Some will swallow pins, stones, or glass, or use braces, garters or torn linen to choke themselves. They will take steel from their corsets, or break dishes or glass to get something to cut their throats. Patients have suicided by keeping their faces beneath water in a basin, so a river is not needed. They will hang by anything,—by towels or sheets from the windows, by yarn from the gas fixtures. I remember one man in Dixmont, Pa., who carried it out successfully in the daytime by tying his handkerchief in the wire screen on the balcony, his toes almost touching the floor. They may try to starve to death, or save up their medicine till they get a fatal quantity. Precipitation is a frequent resort of those weary of life, so that you must be careful with some outdoors, to avoid heights or bridges, or the neighborhood of cars, before which they may cast themselves, and in the house have special care on staircases and all dangerous elevations.

The suicide's ways are often peculiar. He may repeatedly attempt suicide by one method, eschewing all others. He may avoid sure methods, and choose the one least suspected and which does not offer the best chance of success. Thus he may hang from a picture nail so low that he has to bend to keep off the ground.

One of your most important duties then will be to frustrate suicidal attempts. Whenever the propensity is even suspected in a patient he should be under supervision constant but unobtrusive as can be. When you are busy, say getting his meal, that is the time he is most apt to seize on as favorable. Few, however, are constantly meditating it. The opportunity offered often prompts the desire, as the sight of water or a knife. Remember he may need but a moment to finish himself, as when the throat is cut. See to it, then, that the bath-room, fire-places and other risky places are secured and the use of matches restricted. Look with care after everything that may cut, as scissors, knives and broken glass. Medicines should be kept in a safe place; but while putting such things out of reach, avoid doing it in a way to attract attention, and perhaps suggest the suicidal idea for the first time. While outdoors, see that he picks up nothing harmful, and search the bedding and clothing frequently to see that nothing suspicious is hidden there. Suicides are commonest at dawn or at dusk. Patients are often most depressed in the morning before they breakfast, after which they grow brighter, and may even be cheerful when the lamps are lit. A hot drink, as of coffee, given on waking may be helpful in dissipating the gloom of such patients. Your suicidal patient should have his day well occupied. By night there should be some one near by. At no time should he be shut alone in his room. In hospitals the dormitory is a great precautionary measure, for rarely will the suicidal try to destroy themselves before witnesses. Yet extreme measures should seldom be used to save the trouble of close watching. A patient should not be tied up, for example. Better indeed to take some chances than to resort to such treatment as would stand in the way of recovery. If you and I were given a choice in the matter, we would certainly choose to take some risk of suicide to avoid the living death of the

dement, who must drag out long years of useless animal existence in asylum corridors. I cannot impress on you too earnestly the importance of practising eternal vigilance with those supposed to be suicidal. Their care is the greatest responsibility you can have. You can't tell when the suggestion may come from without or within. Suicide is the most terrible thing that can happen to your patient. It hurts your reputation and shocks the community. It puts our consciences on the rack, and we ask, "Have we done our best to anticipate this calamity? Have we been blind to warnings that showed the lurking tendency?" Bitter remorse may come on finding we neglected to observe the straws that indicated the mind's direction.

Another symptom at times displayed by the insane, and which it may tax your skill to combat, is a *disposition to violence*. But it is probably not as common as you expect. Violence usually consists of wanton outbreaks of noise, tearing clothing, breaking glass and furniture, biting, scratching, striking, hair pulling, kicking, or attacking with weapons. Maniacs are most given to it, but not always, and insane epileptics are subject to it, especially in the dazed condition after the fits. Indeed many hospital nurses dread the epileptic more than any other class. To manage such patients successfully, study each one, his habits and delusions, the way he shows violence, and what is apt to provoke it. Each violent one has his own way of manifesting it. By ascertaining the cause, you may remove it; or by watching, you may see its approach, and thus avoid a paroxysm. The irritation which gives rise to the outbreak may often be removed by a word or a joke, or by letting the patient alone, or by a firm show of authority. Most are subject to firm, kind control. Few are continuously violent. Many may be employed in some way, especially in the open air, and thus become calmer. When force is needed, do not tackle the patient single-handed, unless it be to prevent some calamity. He will often meekly submit on seeing resistance is useless against superior numbers, and if he does struggle he can then be mastered so as to run little risk of injury in the scuffle. Three persons should be able to take care of the most violent, if they go about it properly. Inexperienced nurses sometimes fancy it is a weak act to summon

help. This is a great mistake, and leads to personal struggles, often dangerous to both, and creates bad feelings, and your influence is thus lost. Sometimes, when a patient can be safely left alone, it is wiser to get out of his way, if he's aching for a fight, and let him cool off. Force may be necessary to oblige some patients to go to bed, to get up, to dress and undress, or to take a bath, obstinacy being once in a while a leading insane symptom. Force may be dispensed with in such a patient sometimes by letting him alone. The whim may wear off speedily, or he may do your bidding when next requested. A nurse's capacity is well shown in the way she manages such cases. There is here grand scope for tact. When force must be used, be as gentle as you can, and keep your temper. You can more easily do this when you recollect that his fury or stubbornness is a symptom of disease. Fear is the lowest motive to govern the insane by, though much thought of when poor King George was in a tyrannical keeper's care. After the brunt of a violent storm has passed, though the patient continues scolding, let him alone as soon as you can. Don't stop his noise, as it often replaces the violence and lets the steam thus escape, as it were. Mere noise and a certain amount of activity are not harmful, so unless there is some good reason, they need not be repressed. The more patients are restricted and confined, the less exercise they have, the more violence is intensified. Indeed you can thus create unruly patients, if you wish. When a lad, I remember one patient particularly who used to appear to me the devil incarnate. She was in Rockwood Asylum, where under the old regime it was thought proper to keep her arms continually buckled in a leather muff, her body fastened to a wooden bench. Even thus restrained she sent terror to my youthful heart, and I gave her always a wide berth. When the more merciful days came, I was surprised to see this same patient quiet, neatly clad, and working industriously. And this transformation from the wild, noisy demon of former days was solely brought about by the removal of the cruel shackles and the substitution of employment and the watchfulness of improved nurses.

If the violent patient is in his room, and you must go to him, and an attack is feared, after unlocking the door put the

key in your pocket, that both hands may be free, then open it slowly, holding the knob so that it can be quickly closed. He will generally make an attack at once, and before ready for a second he can be overpowered. If needed, a mattress is the best protection by which to crowd him back. As good assistants are necessary in such cases, the persistently violent can seldom be treated at home, but you may have to deal with such an outbreak before he can be got to a hospital.

A more alarming symptom is the *homicidal* tendency that exists in some. Patients may be homicidal from mere frenzy, committing murder by chance rather than design. Maniacs who are full of energy, and perhaps violent, are rarely dangerous in reality. This, again, is in opposition to the popular belief. They may break things, but do not often deliberately injure anyone. As is said of the mad dog, if you keep out of his track, he will not turn aside to harm you. Much more to be dreaded are those who have certain delusions, and secretly harbor murderous intentions. One deluded mortal will kill others to protect himself from fancied assaults, another from ideas of conspiracy. It is safe to assume that any man with delusions of persecution is dangerous. Certain they are wronged, they take to defending themselves. Of such stuff are the assassins of Presidents and Royalty often made. Some hear voices telling them to act; a father, Abraham-like, to offer up his son; a mother, her children to save them from sin. Some think they are God, and so have a right to take the life they gave. All inspired patients are dangerous. Often these are the quietest of cases, and you are deceived. They will lay careful plans, and make the attempt only when they are sure it will succeed. Dr. Metcalfe received a fatal stab from a weakly old man, who was privileged to go in and out as he pleased at Rockwood, and of whom a city doctor had said he was not more insane than many who walk the streets. Yet this patient carefully made ready a knife to slay the doctor, because he imagined him one of a gang of persecutors.

Homicide may also result from a patient's having a morbid desire to kill, or during an attempt to escape, or it may be an impulsive act. Homicidal assaults are best guarded against by having your patient suitably occupied, by judicious super-

vision, and plenty of help at hand to control. All dangerous tools should be kept out of his way. He should sleep by himself. When such patients are at their worst, you had better keep anything out of their way that could serve as a weapon. Even chamber utensils may have to be withdrawn. There was a dent of thrilling depth on a door in Dixmont, when I left there, made by a ragged-edged fragment of crockery at a spot which my head stood in the way of but a second before it was hurled by an irate woman. The circumstance also made some impression on me, hence this warning. Again we say, learn all you can about each patient so as to be on the alert if homicidal tendencies exist. Vigilance is the best preventative. Be sure to warn all against whom the patient has dislikes or delusions. When unusually irritable, it may be well to have the patient remain in bed away from others. You may break up a quarrel by taking one of the participants off to help you at something, or other artifice.

Some patients who stop short of violence may be constantly restless. In the insanity of old age this is often the case, and combined with bodily frailty, they are exposed to accidents. This restlessness may exhaust them so that they should be kept as quiet as can be. The night care of these senile cases which are often treated at home is troublesome, for they are poor sleepers, and apt to wander at night. Rather than struggle with them, let them get up occasionally and go about, if you can keep them warm.

In the violent, the suicidal, and others, the question of mechanical restraint may arise. By that is meant the use of some sort of apparatus to inhibit muscular movements. In days not yet olden it was thought necessary to use, on slight provocation very often, cribs, leather belts and muffs, buckles and irons. Occupation, improved environment, and above all the educated nurse have so done away with it, that to-day in progressive hospitals it is conspicuous by its absence. There are volumes of proof that patients do better without it. The mortality from acute insanity has been lessened, and the comfort of those who survive promoted. I am proud to say that Canadian Asylums are in the van on this continent as regards the non-restraint system of treatment. Cases may crop up when it cannot be dispensed with in a mild form,

especially if the patient be treated at home ; but they grow fewer daily. It would be better to send such cases to the hospital, where there is more help, and they are more likely to get along without resorting to its use. Patients fume and fret so under mechanical restraint that it increases exhaustion and they are as apt to get injured with it as without. The effect on ourselves is also bad. When we tie a man up like an animal it is harder to regard him as a patient. Our finer feelings are benumbed by such practices.

Manual restraint, the laying on of hands, is preferable when some forcible control is necessary, as it may be at times to protect a patient from himself or others from him, to prevent improper acts or wearing restlessness. In hospitals a nurse may sit by an unruly patient for hours. If you employ this judiciously without anger or irritation, a patient needing it will rarely harbor a grudge against you, and good may result. Acute excited cases that must be held a great deal do not usually continue long in this way. They go on either to recovery or exhaustion.

Seclusion is another form of restraint, and means shutting up a patient in a room by himself for his own or others' good. The need for it cannot occur often in cases that may be kept at home, though in hospitals it is occasionally resorted to on account of disorderly conduct, etc. The objections to seclusion are the dangers of suicide and of increasing waywardness.

The question of restraint, of any kind is quite a live one and most hospitals now boast of having reduced it to a minimum. But you must remember that it has not been altogether banished, nor can it be. All asylum restriction is restraint. Custodial care is one of the advantages of insane hospitals. You will be called to a case of insanity partly for the same purpose. Your presence will mean that the patient is deprived of at least some of his liberty, for not many can be left to do as they like in all things. However, no more restraint should be applied than is absolutely needful. It is a harsh measure at best, and whatever form it takes it must be used with a single eye to the patient's benefit, and never to save your own exertions. Many patients feel it keenly, for over-sensitiveness is another symptom you may encounter.

While patients should have all the liberty possible, you must be watchful to prevent escapes which may mean a suicide or horrible crime. Most new patients want to get away from a hospital, but some are also as prone to get away from home prompted by delusion or dislike.

No form of punishment should be tolerated with the insane, and restraint should never be so abused. Punishment is the infliction of pain for a crime or fault. The words and deeds of the insane are due to disease, and are therefore not faults. Partially responsible they may be at times for their conduct, but none but God can judge in how far they are responsible.

Moreover, punishment would have no control over most patients. You may sometimes use with discretion such motives to self-control as the denial of some luxury as tobacco for petty offences. But necessities, such as food, should never be withheld. Trifling rewards may be justifiable.

(To be continued.)

AFEBRILE TYPHOID FEVER.*

By ROBERT WILSON, M.D.,

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Montreal.

"Cases of typhoid fever which run an afebrile course are reported. I myself have not seen such a case."—W. Osler. In the face of the guarded statement of the eminent authority quoted, it behooves one to be extremely cautious, and to collect all the collateral evidence available, in dealing with a case of supposed afebrile typhoid. Yet at the outset I have to admit that the scientific proof is wanting in three important particulars: first, Ehrlich's test of the urine was not used; for the reason that my sulphanilic acid was finished, and I neglected to obtain more; second, Widal's serum test had not been brought to my attention at that time; and third, the stools were not examined microscopically—three omissions that would not have occurred in hospital practice. The case, however, presented such a

* Read before the Montreal Clinical Society, November, 1896.

clinical picture of a typical typhoid attack of moderate severity, that I am tempted to report it.

E. W., aged 30, brass finisher; first seen Oct. 13, 1896, complaining of pain in right hypogastrium and left side. Present illness commenced nine days previous to my visit (*i.e.*, Oct. 4), with headache, lassitude, pains in the back and side, stomach felt upset, appetite failed, and sight of food was repulsive. Slept well,—in fact, was drowsy all day, but sleep brought no refreshment. Took some opening medicine, but frontal headache and pain in left side persisted, and finally had to give up work on the 13th. He thought he must have caught cold, and tried to get a good sweat, but failed.

When seen on the 13th Oct., the appearance was typically typhoid. Face dull, eyes heavy, forehead drawn, tongue coated white with raw red edges, but large and moist. Abdomen tympanitic on right side, duller on left side, gurgling distinct in right iliac fossa, with marked tenderness on pressure with flat hand. Spleen enlarged and felt at margin of ribs, dullness extending up to 8th rib, axillary line tender to pressure. There was a profuse eruption of raised papules discreet, from a mere point to a little larger than a pin head, bright rose-red, inclined in places to be semi-pustular, disappearing on pressure (except latter), coming out in successive crops (marked). Patient says they were there two days previous to my first call (*i.e.*, October 11th, 1896). Particularly profuse on abdomen, tapering off towards flanks and upper chest. Temperature 98 $\frac{3}{4}$ (two thermometers), pulse 64, respiration not counted, but apparently normal. Examination of lungs and heart negative, no cough, never felt feverish or hot, but simply dull and stupid, with the pains in right iliac region and left side. Bowels constipated. I placed the patient on liquid diet for four days, and gave no medication, anxious to watch the case. The temperature and pulse did not vary a fifth of a degree. On the 5th day, the tongue becoming very foul, gave a teaspoonful of Epsom salts well diluted. Movement very free and offensive—repeated for three days till movements became loose and yellow. At the same time ordered a mixture containing dilute nitro-muriatic acid and nux vomica. On the 21st October the spots had practically all gone, and on the 25th had improved

sufficiently to be allowed up. On November 1st was allowed soda biscuits in milk, and on 4th began light food, returning to work on the 10th of November,—four weeks and six days from onset. At no time did the temperature vary more than $\frac{1}{2}$ of a degree F., although at one time three thermometers were used as controls. Whether the case was one of genuine typhoid, or one of those obscure cases of gastro-intestinal disturbances associated with obstinate constipation, in the absence of bacteriological proof, is hard to say; the clinical condition was that of typhoid, whether induced by the poison of Eberth's bacillus, is another matter. Absence of proof does not necessarily negative the possibility, though it undoubtedly invalidates it for statistical use.

PECULIAR TEMPERATURE IN A PARTURIANT.*

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I submit the following case, not so much because there is an unusually low temperature to report, as to emphasize the importance of bacteriological examination whenever there is a rise of temperature in the puerperal patient at all resembling septic infection.

I was engaged early in June of this year to confine Mrs. J. H., a healthy primipara of 24. Accouchement due about the 26th of August. At 11.30 p.m., July 31, was called by the husband, who stated his wife had been very ill all afternoon. At 12 p.m. reached the house, and examined the patient, having taken the usual precautions as to asepsis, etc., and found the head well down on the perineum, preceded by the intact membranes! At 12.30 p.m. delivered a well-formed healthy female child of about six pounds. Placenta expressed by Credé's method in twenty minutes, complete, without hemorrhage, and perfectly normal. For the next four days the case progressed well, temperature exactly 98.2-5 pulse 80, respirations 24, no pain, no tympanites, breasts in good condition, milk appearing the 3rd day; bowels moving freely, no tear of cervix or perineum; lochia abundant, and

* Read before the Montreal Clinical Society, November, 1896.

normal ; patient feeling well, and anxious to be up. I did not visit on the 5th, 6th and 7th days, convinced that things were progressing favorably. On the 8th day was hastily summoned by husband, wife said to be very sick. When seen, the patient was suffering no pain, but complaining of weakness and prostration, and great heat (it was the commencement of the hot spell for which the first two weeks in August will be remembered). Her temperature was 101 4-5 F., pulse 150, resp. 26, lochia almost stopped. Hot poultices and hot creolin douches ordered. Ninth day, the temperature was 104 3-5, pulse 155, fairly good, compressible, regular. Patient apparently very weak, no tenderness or pain, no chill, lochia returning slightly, urine acid, 1028, no sugar or albumin. A rigid examination of patient, bedroom, cellar, yard, etc., revealed nothing unhygienic. Patient extremely nervous and irritable. On the same afternoon (9th day) made a vaginal examination with the speculum ; found a virgin os, and everything normal. Took four smear cultures with a sterile glass rod from the internal os, and then curetted with the sharp curette. It brought nothing away, and obtained the characteristic hard grating sound all over the uterine cavity. On the 10th day, temperature still 104 2-5, pulse 155, resp. 26, lochia scanty ; poultices continued. The slides examined by Dr. A. J. Richer showed a few scattered staphylococci, and some diplococci, but no streptococci. Douches continued. Evening temperature 101 2-5, pulse 150, resp. 24. Next day (11th) consultation with Sir W. Hingston, and changed nurses. Result of consultation negative, but the patient steadily improved until the 13th day, when the temperature registered 96 1-5° F. Thinking it an error of nurse, verified it myself. Patient up on the 16th day, feeling a little weak, temperature still 96 1 5. Twenty-six days later, temperature 97°. F., pulse 82, resp. 20, feeling well, eating well, assisting in housework (temperature always taken in mouth under the tongue). Have not seen patient since, but hear she is well. Points of interest are :—(a) rise of temperature without appreciable cause ; (b) absence of rigors, and appearance of temperature chart assuming the bacteriological examination to be in error ; (c) persistent high temperature, without much bodily discomfort ; (d) drop by crisis in 48 hours to subnormal ; (e)

and persistence for 26 days of a temperature from 14.5° to 1° below normal. Three explanations might be offered: (1) that it was a septic intoxication; (2) that it was due to the great heat prevailing, and partaking of the nature of heat-stroke; (3) that it was nervous in origin. Reviewing the facts of the case, I am inclined to the latter view. I attach temp. chart.

Progress of Medical Science.

MEDICINE AND NEUROLOGY.

IN CHARGE OF

J. BRADFORD McCONNELL, M.D.

Associate Professor of Medicine and Neurology University of Bishop's College,
Physician Western Hospital.

THE MEDICAL TREATMENT OF TIC DOLOUREUX IN CONNECTION WITH THE QUESTION AS TO OPERATION.

This interesting paper by William Ewart, M.D., F.R.C.P., appears in the *British Medical Journal*, Nov. 21st, 1896.

He first speaks of the tendency to at once resort to operation in this disease, rather than trust to medical treatment, which would be right if all cases were due to mechanical pressure or overgrowth of fibrous tissues; but some constitutional cause exists apart from these. Surgery has shown that the pain is in the peripheral sensory function as much as with the central, and that the gasserian ganglion is the bridge, the cutting of which permanently arrests the pain, hence it is not mainly central.

The constitutional cause is, he thinks, of a gouty nature. He classifies cases into: 1st, those obviously gouty; 2nd, those in which the gouty association is rendered probable by the family as well as the personal history; 3rd, those in which the family history is unknown, but the previous history includes visceral affections analogous to those we recognize as gouty, and in which the personal aspect also speaks of gout. These three groups probably make up a large proportion of cases; a 4th group contains cases not obviously connected with gout, except those due to syphilis and growths.

It is the exception for articular symptoms to be associated with the neuralgia. There is present rather a gouty tendency recognized by the healthy and ruddy complexion, the presence of Heberden's nodules, or of tophi in the ears, a pre-

MRS. J. H.

Confined July 31, 1896, 12.30 p.m. (GIRL)

Nurse—M. BULLOCK.

JULY AUG.

Day of Month	31	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31						
Day of Sickness	1	2	3	4	5	6	7	8	0	10	11	12	13	14	15	16	17	18	44																			
107									Curette																													
106									Phenaet gr X																													
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P.	82	86	84	84	86				150	155	155	150	130	82	82	80	82	80	82	80	82	80	82	80	82	80	82	80	82	80	82	80	82	80	82	80	82	80
P.	24								26	24	24	24	24	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	
Def.	0	0	3	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
									Oil.	Oil.	Oil.	Oil.	Oil.	Oil.	Oil.	Oil.	Oil.	Oil.	Oil.	Oil.	Oil.	Oil.	Oil.	Oil.	Oil.	Oil.	Oil.	Oil.	Oil.	Oil.	Oil.	Oil.	Oil.	Oil.	Oil.	Oil.	Oil.	

12.30 p.m., confined

(twenty-six days later)

PHENACETINE—(GRS. X. T I D on 10th and 11th days. Hot ercolin douches on 9th, 10th and 11th days, t. 4. h., then twice daily till 16th day.

vious history of gravel or stone, a long history of gastric intestinal and hepatic disturbances of a nervous type; the abiding strength of the pulse, which strikes us no less remarkable than the resistance of the patient to the effects of long continued pain and insomnia; the adverse influence of alcohol and of certain forms of diet; the presence of uric acid sand in the urine; the distant influence of gout is evidenced in the inherited irritability of the nervous system and perversion of the juices.

In regard to treatment, tic is not benefited by the remedies found to be beneficial in neuralgia, regard must be directed to the following indications: sedative, restorative, alterative and tonic.

Sleep is to be procured by chloral and morphine, rest in bed, and alimentation, in which a vegetarian diet, with moderate nitrogenous additions, is recommended; alcohol is to be avoided. The alterative treatment consists of such remedies as the salicylates, benzoates, sulphur, chloride of ammonium and taraxacum, and the salts of iodine and mercury, especially the combination of 20 to 30 m. of solution of per-chloride of mercury with 6 to 10 grains of iodide of potassium, or the iodide alone, with 15 to 30 min. tincture of iodine which promotes its action. Guaiacum is also recommended. Tonic measures are the vegetable tonics, and especially muscular exercise. Massage should succeed the first long rest in bed, then resistance and Swedish movements, also salt baths and climatic treatment. All his cases improved under this treatment, and operative measures were rendered unnecessary, which may be permanent, or, in the case of relapse, a similar course may again succeed.

THE PSYCHICAL NERVE CELL IN HEALTH AND IN DISEASE.

Dr. H. J. Berkley in the *Johns Hopkins Bulletin* (No. 65) publishes a paper on this subject. The psychical cells in the cortex of all mammals are of two varieties, small and large; the primordial process branches like a tree towards the surface, and an extension from the basal portion resembles the roots. The uppermost branches communicate with the numerous nerve fibres that arise from the medullated masses at the foot of the convolution. The dendritic branches of the neurons have lateral gemmule resembling a round-headed pin. The mass of branching nerve fibres around these end in little bulbs, which come into very close approximation with the globular ending of the gemmules; external impressions pass from the former to the latter, creating thought or motion.

The axon from the basal end also gives off collateral branches, which return toward the cortex and connect the

bulbar endings of one cortical psychical neuron with a number of others, and thus the whole cortex becomes intricately united. Dr. Berkley has studied the action of certain poisons on these cells, especially alcohol, ricin and bacterial toxins which develop in hydrophobia; all lead to loss of function and parenchymatous degeneration. The protoplasmic changes are first observed in its bulbous endings of the dendrites, the gemmules fall off, and then the branches disappear, and finally the corpus and axon of the cell; the axon is the most resistant portion, the nuclear substance and nucleolus also become altered, and the cell can thus no longer communicate with others, or properly perform its functions, and inco-ordinate motor impulses will result.

These changes explain the dementia and mental obtundities which follow infectious fevers. In chronic insanities, dementia and idiocy, fewness and atrophy of the branches and gemmules was found by him to be present.

THE BLOOD IN CHOREA.

Dr. Charles W. Burr reports in the *University Medical Magazine*, December, 1896, the results of the examination of the blood in thirty-six cases of Sydenham's chorea.

The percentage of hæmoglobin and the number of red corpuscles only are given. This investigation would be of more value if other characters of the blood had also been observed, such as the enumeration and character of the leucocytes, percentage of fibrin, etc.

In summarizing, he states that patients are often assumed to be anæmic, because pale and scant of fat, sensitive and precocious; but this is not sufficient evidence of anæmia,—an examination of the blood is necessary.

He gives the following conclusions:—

The blood is rarely absolutely normal in amount of coloring matter and number of red corpuscles during an attack of chorea. There is usually a moderate diminution in the hæmoglobin, and a relatively still smaller decrease in the number of red corpuscles. The anæmia is therefore chlorotic in type. There is no relation between the severity of the chorea and the severity of the anæmia. When the anæmia is severe there is usually some complication competent to explain it. All things considered, we feel justified in believing that anæmia is not an immediate, direct, exciting cause of chorea, and but infrequently a predisposing cause. In the great mass of choreas with very moderate anæmia, it most probably is a result of the chorea, a secondary condition. As to the mechanism of its production, we know no more than we do of the method of action of other profound functional nervous disturbances, for example, emotional shock in reducing the

blood count,—namely, nothing. In the cases caused by bacterial poisoning, which so far have not been proven to be numerous, it is possible that the anæmia is toxic.

There is one form of anæmia the existence of which cannot be shown by any means at present at clinical command,—namely, the condition in which there is an equal decrease in all the elements of the blood, solid and liquid, a quantitative anæmia. This may exist and be the cause of some cases of chorea, but it is not susceptible of proof. Against the probability of such causation is the fact that hemorrhage due, for example, to trauma (which, of course, causes a temporary quantitative anæmia) is not followed by chorea, and the improbability that a quantitative anæmia due to congenital or internal causes would be cured by rest in bed for a few weeks, regulation of diet, and the administration of a small amount of arsenic, a method of treatment of chorea which so often is followed by recovery.

IS THERE A URIC ACID DIATHESIS?

In spite of multitudinous researches into the nature and causation of gout and allied manifestations, so much obscurity remains, that inquirers on fresh lines are welcome, even when one is unable altogether to acquiesce in their "statement of claim." To Dr. Haig, we believe, is due the credit of having been the first to call attention to the fact that large quantities of uric acid are directly introduced with and in the ordinary food of man. This may be eliminated in the urine, failing which, over-saturation of the blood is followed by the deposition of the acid in the tissues. This is a distinct advance in our knowledge of the pathology of gout, and what may be termed uric acid manifestations; but Dr. Haig proclaims that virtually *all* the mischief-making uric acid is thus introduced, the quantities produced in the normal healthy human body being inadequate to the production of morbid symptoms. He admits, however, that uric acid may be, and indeed is, normally produced in the normal organism, in the proportion of 1 part to 33 of urea. He believes the ratio to be unalterable, but this can only be proved by prolonged observation by independent observers. In any event, the fact that uric acid can be elaborated in the human body renders it possible, if not probable, that under particular conditions the output may be so increased as to constitute a pathological condition. We are not concerned to deny the importance of discarding any avoidable addition to the proportion of uric acid already present in a given case, but it has not yet been conclusively proved that it is impossible, even in the absence of alimentary uric acid, for sufficient quantities to be formed to give rise to a deviation from

health. All animal tissues contain uric acid or substances of the xanthin group, and the alkaloids of tea, coffee, and cocoa are also xanthins, and therefore to be avoided. The ideal diet of a person who would still be currently described as suffering from the effects of the uric acid diathesis would have to be restricted to milk and cheese, bread stuffs and cereal foods and the pulses, such as peas, beans, lentils and the like. The exclusion of articles of food containing uric acid, in association with the administration of drugs which are recognized to facilitate the solution of this intractable substance, allows of the excretion of arrears of uric acid, and when the surplus has been disposed of the effects disappear. *Sublatâ causâ tollitur effectus.* There are, however, a number of facts which do not fit in with Dr. Haig's hypothesis. Stone, for instance, is very common in certain parts of India, where the natives nevertheless live exclusively on just such a diet as that recommended by him by reason of its freedom from uric acid constituents. Then, again, certain subjects, especially children, continue to excrete large quantities of uric acid in spite of the most careful dieting, and in certain diseases, such as leucocytnæmia for instance, the excretion is always largely in excess, whatever the diet. The first thing to do in elaborating such a hypothesis is to obtain a general agreement as to the facts on which it is based, and sufficient time has not yet elapsed since these ideas were promulgated for this to have been accomplished in respect of the conditions under which uric acid production is modified by diet. It is quite possible, as suggested by one of the speakers during the recent discussion at the Medical Society of London, that there are two distinct conditions which have as a common factor an excessive excretion of uric acid, one in which the over-production is the result of dietetic errors, and is consequently readily amenable to dietetic measures, and a second in which the over-production is due to a hereditary defect in tissue metabolism, and is only modified by diet to a limited and variable extent. If this be so, the term diathesis will have to be restricted to cases coming into the second group.—*Medical Press*, Dec., 1896.

THE ESTIMATION OF THE SIZE AND SHAPE OF THE HEART BY THE ROENTGEN RAYS.

H. Campbell Thomson, M.D., M.R.C.P. London, Medical Registrar to the Middlesex Hospital, in the *London Lancet*, says :

It has now become an accepted fact that the outline of the heart, and to some extent its movements, can be seen by the aid of the Roentgen rays and fluorescent screen. A shadow of the heart may be photographed, but this does not

so readily lend itself to clinical purposes, on account of the time which is necessarily taken up with the exposure and development of the picture. It may be said that with the method of percussion at the disposal of the physician it is not necessary to use anything else, but one has only to read the literature on the Schott treatment, and it will at once be understood how various are the discrepancies which arise between those who, it must be acknowledged, have both skill and experience. It is on account of these differences of opinion, which must always occur, owing to the numerous personal factors which enter into percussion, that any further means of corroboration must be welcomed, not necessarily to be held up dogmatically as superior to everything else, but merely to be regarded as an additional clinical fact, which may be weighed with the others in judging of the total aspect of the case. Sir William Broadent, in criticizing auscultatory percussion, says: "To ascertain the position and dimensions of the heart, we must continue to employ the sober method of carefully collating the evidence afforded by palpation, percussion and auscultation." To these methods I would now venture to add that of vision. The difficulties in many cases of irregular outlines, of dullness produced by cardiac aneurisms, aneurisms of the first part of the aorta, etc., cannot fail in many cases to be cleared up by a view of the shape of the organ, and certainly thus take the place of surmises. A little practice will enable a permanent tracing of the cardiac outline to be easily taken, and as the ribs can, of course, be seen, a few extra lines will give any relations that may be required. If desirable, a metallic button may be fixed over the nipple, so as to afford a further landmark. The method that I have at present is as follows: A piece of white paper is fixed to the back of the fluorescent screen. This, of course, in no way affects the rays, which pass through it and are seen as usual on the screen. The screen is then put in such a position that a clear outline of the heart is seen, and this outline is then traced on the paper (which is fixed to the back of the screen) by a pin introduced between the screen and the chest of the subject. A metallic pen or pencil should be used for tracing purposes, as it shows up well, and its position can easily be seen as to whether it is on the edge of the shadow or not. Also the marker should be of a flat shape, as it is then more easily introduced between the screen and the chest without shifting either. I hope shortly to be able to produce some tracings of diseased conditions taken by this method, as hitherto my attention has been chiefly given to normal hearts, as it is necessary to become acquainted with the little technical difficulties which must always arise in a subject like this. In concluding this preliminary communication, I must express my best thanks to Dr. Sidney Coupland for kind suggestions and help in my experiments.—*Medical Examiner*.

THE TREATMENT OF RESPIRATORY DISEASES BY WARM BATHS.

Dr. E. LEMOINE makes use of baths of a temperature of 95.8° to 100.4° F. The tub should be large enough for the child to be immersed to his neck, in order that local chilling may be avoided. To prevent congestion of the face and head, which is readily produced during a warm bath, especially in those suffering from fever, a folded napkin, wet in cold water, is placed upon the head, and renewed as often as it becomes warm. The duration of the bath should be about ten minutes, rarely more. If the child is feeble, its pulse should be carefully watched in order to avoid syncope. If necessary, a tea-spoonful of stimulant or a dose of caffeine may be administered before the bath. As soon as it is finished the patient is wrapped in a woollen blanket, rapidly rubbed, and left to sleep well wrapped up in bed for a half-hour. After this a woollen shirt is put on, in which he remains until the next bath. Baths with mustard are valuable on account of their revulsive action, and are prepared by placing eight ounces of powdered mustard in cold water in the tub, which is subsequently filled with warm water. The cold compresses to the head are, in these baths, imperatively necessary. The bath should be continued until the skin is rose-tinted. An inconvenience is the painful nasal and ocular irritation of both patient and assistants, which may be obviated by placing a sheet, through which the head of the patient emerges, over the tub. During eight years, sixty-three patients have been treated without a death—fifty-five children and eight adults. Of the children there were of simple bronchitis, 9; capillary bronchitis, 5; lobar pneumonia, 3; broncho pneumonia, 38. Of the adults there were of pneumonia, 3; severe grippal congestion, 3; general bronchitis, 2 cases. From these baths the revulsion which is obtained affects the whole body, carrying the blood to the surface far more effectually than any local application. Auscultation shows that the râles are larger, more plentiful, and the mucus becomes more fluid, and in the case of pneumonia, the affected lobules more permeable to air.—*Journal des Praticiens*, 1896, No. 39, p. 612. *American Journal of Medical Sciences*.

GOUTY HEART.

TH. SCHOTT (*Berlin. klin. Wochenschrift*, 1896, Nos. 21 und 23) (*American Journal of the Medical Sciences*) is a firm believer in the existence of gouty affections of the heart though admitting that these are less rarely observed in pure cases of gout than in the irregular forms. In the concretions in sclerosed aortic valves, urates can sometimes be demon-

strated by the murexid-reaction, along with calcium phosphate and carbonate. More frequently gout causes valvular lesions indirectly as the result of sclerotic changes, but in this process other factors, such as abuse of alcohol or tobacco, lues, or over-eating, assist. Gout is more prone to cause motor and sensory cardiac neuroses. Beginning with palpitation, soon followed by tachycardia, dilatation of the ventricles develops with all its consequences. The sensory disturbances vary from mild, pricking pain in the region of the apex or more severe radiating pains to paroxysmal pain, with tenderness on pressure over the sternum or the base of the heart. The latter condition is often associated with symptoms of heart-weakness, and can lead to angina pectoris. The prognosis in pure cases, not too far advanced, is good under proper treatment.

THE BLOOD IN TUBERCULOSIS OF THE BONES.

The *Boston Medical & Surgical Journal* contains a paper on this subject by Dr. John Dane, of Boston; the following are his conclusions:—

(1) Most cases of tuberculosis of the bones and joints do not decrease the number of the red corpuscles in the blood. (2) They do, however, affect the percentage of hæmoglobin, giving rise, in fact, to a mild degree of chlorosis. (3) The leucocyte count seems to bear no direct relation to the temperature. (4) High counts, especially in hip disease, point to the probability that there is or shortly will be an abscess formation; but low counts do not preclude the presence of abscess, especially in cases of long standing. (5) When, in connection with a low leucocyte count, an abscess is found to exist, the pus from it is sterile, and the case is generally one of long standing. (6) In the presence of an abscess, a low leucocyte count generally indicates the absence, and a high count the presence, of a secondary infection with pyogenic organisms. (7) Cases in which, at the primary operation, the pus has proved sterile, show an increase in the leucocyte count when the wound becomes infected with pyogenic organisms. (8) High leucocyte counts do not always affect the differential count. (9) Cases with a traumatic origin are generally accompanied by a high leucocyte count, and run a more severe course. This is especially shown in cases of hip disease. That more of the cases which entered with a developed abscess did not give a definite history of trauma is due no doubt to the fact that the length of time the disease had been progressing had caused a lack of accurate detail at the beginning being remembered.

GYNÆCOLOGY.

IN CHARGE OF

A. LAPHORN SMITH, B.A., M.D., M.R.C.S. England.

Fellow of the American Gynæcological Society, and of the London Obstetrical Society ;
Gynæcologist to the Montreal Dispensary, and to the Western Hospital ;
Surgeon in Chief of the Samaritan Hospital for Women ; Professor
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THE TREATMENT OF DYSMENORRHŒA.*

Taking it for granted that we all recognize the fact that dysmenorrhœa is not a disease, but rather a symptom, of many and varied pathological conditions, it follows that the treatment will depend entirely upon the diagnosis of the disease. On looking over my records of three thousand three hundred cases, of whom one thousand and thirty were seen at my private office, and two thousand two hundred and seventy came to the Montreal Dispensary, I find that dysmenorrhœa is a very common symptom, almost one-fourth of all the patients complaining of it. It appears most frequently among unmarried girls, and a little less so among married women who have not had a child. Next to these in order of frequency come married women, who have had one child, and who have a scanty flow at the period ; while it is also met with, but still less frequently, among married women who have had several children, and who lose profusely, and during a prolonged period of time.

These observations, which I presume correspond with the experience of others engaged in this department, are, I think, important, because they throw a good deal of light on the causation, and consequently upon the treatment of the symptom. Why do unmarried girls suffer in the greatest number from menstrual pain ? Evidently because there are more of them than of any other who are suffering from stenosis of the os uteri. When these same girls become married women, the majority of them become pregnant, then menstruation ceases for at least nine, but often for eighteen or twenty-four, months, and when at the end of that time it reappears, it flows through a widely opened uterine canal. There is another reason, however, why unmarried girls suffer more than married women who become pregnant, and I mention it, as it has an important bearing upon treatment, namely, because at each menstrual period a congestion of the ovaries, tubes and uterus takes place, which is generally relieved by the flow ; but in many women a little congestion remains over unrelieved, to be

* Read before the Medicô-Chirurgical Society of Montreal, Dec. 18, 1896.

added to the next monthly one, until little by little the external layers of the ovary become thickened, and the mucous membrane lining the uterus becomes swollen, so that the canal becomes blocked up. In married women who are childless, either because their husbands are sterile, or because they resort to measures for the prevention of pregnancy, this congestion becomes still greater than in single women, because there is added the more frequently repeated congestions of intercourse. Pregnancy cures the majority of cases not only of stenosis of the uterus but also of congestive dysmenorrhœa, because as a rule it puts a stop alike to menstruation and the repeated congestions accompanying it and intercourse. Pregnancy therefore may be called nature's remedy for dysmenorrhœa, because it both dilates the uterine canal, and gives the ovaries a more or less complete rest. Remember, I do not say that marriage is a cure for dysmenorrhœa; on the contrary, marriage without pregnancy often makes it worse. We now come to those women who, though married, and mothers of children, still continue to suffer at their periods. What is their dysmenorrhœa a symptom of? Many of these women I find by my records have never suffered before their marriage, but only since their first child; in many of these cases a careful examination of their histories will reveal the fact that at their marriage or at their confinement, or soon afterwards, they acquired an acute septic or gonorrhœal endometritis, which subsequently has become chronic, leaving the mucous membrane of the cervical canal swollen with distended glands which block it up, or the tubes and ovaries become diseased enough to make menstruation painful without in every case preventing conception. The fourth and smallest class of cases losing profusely and suffering severely, if less acutely than the former, will generally be found on examination to be affected with some form of displacement, generally a backward one, which seriously interferes with the circulation of the uterus. The blood is pumped into it by the arteries, but cannot get out of it by the veins, and so the generative organs become swollen and sensitive, the cervical canal becomes blocked, and in these cases the discharge, which is pure blood instead of debris of mucous membrane, coagulates, the clots having to be expelled by means of what might almost be termed labor pains.

Besides these four large classes, I find many scattered cases, in which the pain was due to other causes, such as fibroid tumors blocking up the internal os, and the closure of either the uterine end or the fimbriated extremity of the fallopian tube, or both, not without interest, and of the treatment of which I shall speak later on.

What is the best treatment of obstructive dysmenorrhœa

due to stenosis of the cervical canal? Shall we open it up by means of laminaria or tupelo tents? Or shall we place the patient under an anæsthetic, and rapidly dilate the cervix with Hegar's or Hank's graduated sounds, or with Wylie's or Goodell's dilators? Or shall we resort to the relaxing and dilating effects of the negative pole of the galvanic current in order to make a free passage for the ovarian, tubal and uterine secretions? Or should we first try the effects of drugs, especially in the case of young girls?

My own procedure in cases of dysmenorrhœa is generally as follows: 1st. To improve the circulation of the uterus by curing constipation, and ordering exercise in the open air and sunshine, at the same time correcting errors in diet and dress. In addition to these hygienic measures, I have found great satisfaction from the use of iron, strychnine and phosphoric acid. In my experience, about half the cases of dysmenorrhœa are cured without any surgical treatment or any other local treatment whatever. As many of the patients are virgins, I do not even make an examination until the above treatment continued faithfully for a couple of months has failed. It seems to make no difference whether the patients lose very scantily or very profusely; in both cases they have been either cured or greatly relieved. I have often asked myself the question: How does this treatment cure the pain? And my explanation is that a toned up, well fed uterus, well fed both as regards its nerves and its muscles, will be less liable to suffer from obstructing flexures, while the starved ovaries will be less likely to suffer at the menstrual flow from neuralgia, which I define as the cry of the nerves for better nourishment. 2nd. To relieve the spasmodic contraction of the sphincter of the internal os by ten grain doses of acetanilid repeated three times a day for one or two days, although sometimes a single powder is all that is required. In employing this drug, it is advisable either to administer it in strong coffee or weak whiskey and water, or to combine citrate of caffeine with it, as I have occasionally witnessed some alarming effects on the circulation when this precaution had not been taken. Although acetanilid does not cure, I cannot recollect a case in which it has failed to relieve, although I have employed it in over a hundred cases. There are other drugs of considerable value, although they sometimes fail even to relieve; among these, the best, because quite harmless, I consider *viburnum prunifolium*. In the form of liquor sedans prepared by Parke Davis, I have found it to help about half of the cases; the same may be said of Hayden's *viburnum* compound, the cost of which, however, is prohibitive. But in speaking of the medical treatment of dysmenorrhœa, I wish to warn my

brethren against two drugs of surpassing danger, namely, opium and alcohol. I have seen some sad cases of shipwrecked homes and blasted futures, in which the drink or opium habits were acquired by the thoughtless though well meant prescription of opium or morphine, or the advice to take a glass of alcoholic liquor. These cases rarely consult the doctor again until when it is often too late to save them from the thralldom of these drugs, except by incarcerating their victims in an asylum for inebriates and opium eaters. Compared with the treatment by opium or alcohol, I consider that by surgical operation to be immeasurably to be preferred. There is another means of relaxing spasm which at least deserves mention, namely, sitting in a bath of very hot water for half an hour, and splashing the water on the lower abdomen. I have learned this some years ago, like many other good things, from our Nestor, Sir William Hingston, since which I have often employed it with advantage. Hot douches and rest in bed have helped a few cases, but I have not known this alone to cure any. 3rd. If these measures fail, we must turn, although in the case of unmarried girls with reluctance, to some treatment which entails examination of the uterus. The most effective, although the simplest and least dangerous among them, I have found to be the negative pole of the galvanic current. Five years ago I published in the *American Journal of Obstetrics* a report of nine cases of severe dysmenorrhœa cured by this means, which excited considerable comment throughout the United States, as was evinced by the large number of letters I received asking for further details in carrying out the treatment.

As some of these patients had been treated in vain by many other methods, including rapid dilatation, which in one case was repeated twice, and as three of them subsequently bore children after periods of sterility as long as ten years after marriage, doubts were freely raised as to the accuracy of my observations. Since then, however, many other independent observers, including Dr. William Gardner of Montreal, have assured me that their results had been equally surprising. It is due to Dr. Gardner to say that he was obtaining these results before I knew anything about electricity for dysmenorrhœa, although I am not aware of his having reported them. Since reporting those nine cases I have treated nearly a hundred others by this means, which, with a few exceptions, were equally satisfactory. I will not occupy your time in describing the method now, as I have done so in minute detail in my article on "Disorders of Menstruation" in the International System of Electro-Therapeutics, which was published three years ago by Davis of Philadelphia. I will only say that it is marvellous to see how easily a sound will

glide into the uterus when the negative wire is made to touch it, when that same sound cannot be made to enter even by force before the electrical connection was made. If there is anyone who doubts it, I will gladly demonstrate it for him at my office, if he will provide me with a patient into whose uterus he will admit that he could not pass the sound. In the majority of cases the second or third period following the treatment comes on without the patient's knowing it, while in the cases in which it fails there probably exists some disease of the appendages, as I was able to demonstrate in several of them in whom I eventually had to open the abdomen when the tubes were found occluded at one or both ends, and the ovaries diseased.

4th. For those who are not conversant with the electrical treatment, or who are not supplied with the simple outfit necessary for its use, rapid dilatation comes next in value after therapeutic measures have failed. I will probably prepare a list of cases I have so treated, with their results, for the British Medical Meeting; but until I have collected all the cases, I can only estimate approximately that I have treated about three hundred in this way, with about 100 failures. With the exception of five or six of them, in which Hegar's conical dilators or bougies were used, all were dilated first with Wylie's and afterwards with Goodell's dilator. This is not the safe and simple operation that one might suppose it to be. The patient must be profoundly narcotized in order to paralyze the circular muscles in the cervix; and unless you are in a position to carry out absolute asepsis in the minutest details, it were better not to attempt it at all. Among the untoward results I have seen are general peritonitis and death; one perforation of the posterior wall of the uterus, which, thanks to asepsis and subsequent laparotomy and suture, caused no ill effects; several considerable lacerations of the cervix, and quite a number of cases of quiescent pelvic peritonitis relighted by the manipulations. The rather common practice of using the dilator in the office without antiseptic precautions cannot be too severely condemned. When dilatation is performed it must be done thoroughly, at least half an hour being spent in separating the blades to a width of an inch and a half, and all the while a stream of sterilized water should be allowed to flow over the field of operation. Dilatation should in every case, in my opinion, be followed by curetting, especially of the thickened mucous membrane around the internal os, which acts like a valve over the opening and prevents the exit of the menstrual flow. The whole inside of the uterus is then to be coated liberally with a mixture of equal parts of Churchill's iodine and carbolic acid, partly as an antiseptic, and partly because it helps to cure

the endometritis which so often co-exists with and perhaps may be one of the causes of the pain.

Sometimes the dilatation and curetting either fail completely, or only relieve for the immediately succeeding period. What shall we do in these cases? My custom is to repeat it at least once more; some repeat dilatation twice. If the cervix is very long and conical, I have occasionally amputated it by Schroeder's method, and with good results. Should we employ a stem pessary in order to keep the canal open? I am entirely opposed to its use; if they are employed it must be only with the greatest precautions, the patient being kept in bed, and carefully watched for symptoms of peritonitis.

What should be our course in those rare cases which after all this treatment still remain unrelieved? My experience has been that in nearly every case which has been carefully treated during a year's time with these various measures unsuccessfully, there is some incurable disease of the ovaries and tubes which will demand their removal. I place the duration of treatment somewhat arbitrarily at a year, because on the one hand I am opposed to removing the ovaries until ample time has been devoted to other measures of treatment, and on the other I like to give my patients some definite promise of cure, as without some hope being held out they will become discouraged, and abandon treatment altogether. In only five per cent. of my cases, or about forty times, have I been compelled to fall back upon this *dernier ressort*, when on opening the abdomen I have found more than enough to explain why the case resisted all ordinary measures of treatment. In most of them the tubes were found to be bound down with adhesions, and closed at one or both ends.

In eight cases I have found a hydrosalpinx of one or both sides, and in about twenty the ovaries were sclerotic, so that the follicles were unable to rupture without great pressure. The result in all the operative cases has been very satisfactory; care was taken to tie the pedicle close to the corner of the uterus, and to remove all of the ovarian tissue, as neglect of these precautions would have caused the operation to fail to attain its object, namely, the immediate and complete arrest of menstruation. I must not forget to mention a remarkable little group of six cases of severe dysmenorrhœa, due to retroversion with fixation, the ovaries being buried in adhesions and the fimbriated ends of the tubes closed. At the urgent request of the patients who were married, not to remove the ovaries, I have in these cases carefully freed the uterus, then dug the ovaries and tubes out of Douglas' cul-de-sac, in some cases lacerating them in the process, then tearing the pavillion of the tube off the ovary and opening it up, and finally fastened the uterus to the abdominal

wall. One of these was done at the Samaritan only a week ago, in the presence of several members of this Society, who can testify to the number and density of the adhesions which were binding the ovaries down; but five of them date back from six months to two years, and are now menstruating without pain. This method has, I think, a good future, as we are coming more and more to realize that the ovaries should never be sacrificed if it is possible to save them.

To sum up my experience:—

50 per cent. were cured by therapeutic and hygienic measures, including pregnancy.

25 per cent. were cured by rapid dilatation and curetting.

12½ per cent. were cured by electricity negative pole.

5 per cent. were cured by removal of appendages.

7½ per cent. being impatient went to other institutions, where eventually most of them had the appendages removed.

Medical Society Proceedings.

MONTREAL MEDICO-CHIRURGICAL SOCIETY.

Stated Meeting, Oct. 16th, 1896.

GEORGE WILKINS, M.D., President, in the Chair.

MALFORMATION OF THE HANDS AND FEET.

Dr. A. E. GARROW exhibited a child with malformation of the hands and feet, and showed an excellent skiagraph of the hands taken by Professor Callendar, of McGill University.

Dr. JAS. BELL pointed out the fact that here the usual history of heredity was wanting. No other members of the family or of former generations had been similarly affected. He contrasted this with a case exhibited by himself on a previous occasion, in which several members of one family had a similar malformation.

MOUTH CONCRETION.

Dr. JAS. BELL exhibited a large mass of calcareous matter which he had removed from the mouth of a patient under his care.

A CASE OF ACUTE HODGKIN'S DISEASE.

Dr. J. T. ARGUE read for Dr. G. D. Robins and himself a paper on a case of this disease.

Dr. H. A. LAFLEUR thought that we had been attaching too much importance to the microscopic appearances of the blood in such cases; and judging of the disease by the state of the white corpuscles, leukæmia might exist without much increase of the leucocytes, and at times where the patient had been under treatment, as far as the blood examination went, it was no longer eukæmic blood, though the other signs of the disease are present, such as enlargement of the spleen, liver and lymphatic glands.

SYPHILITIC NEPHRITIS—FATAL.

Dr. N. D. GUNN reported the following case :—

J. L., aged 25, traveller, consulted me on July 17th 1896, for swelling of the face and fullness of the abdomen, which he had noticed four days before, for the first time.

His family history was good, and his personal history revealed nothing bearing on the case, save that he had contracted syphilis six months previously, and had been under treatment ever since, taking large doses of bichloride of mercury with good results so far as secondaries were concerned, as the rash and sore throat were of the mildest type.

On examination I found general anasarca, temperature $99\frac{2}{3}^{\circ}$ pulse 92, slight accentuation of the second sound of the heart. The liver seemed slightly enlarged, but was difficult to palpate owing to tension in the abdomen. The urine was acid, in consistence like thin linseed tea, of S. G. 1022, and solid on boiling.

The patient was put to bed on a milk diet with the administration of citrate of potash and digitalis. The urine in 24 hours was in amount 10 ounces of S. G. 1020, and albumin over the line marked 12 on Esbach's albuminometer ; it contained no blood but plenty of epithelial casts.

4th day. Urine 20 oz., no change in albumin.

6th day. The œdema was greatly increased. Temperature $102\frac{1}{2}^{\circ}$, pain and tenderness in both groins, slight diarrhoea, urine 10 oz. Hot baths every six hours with hot abdominal compresses in the intervals were ordered.

7th day. Urine increased to 24 oz., temperature 100° , some delirium and twitching of the eyelids present.

8th day. Temperature normal, pulse 88, no pain, great distension of the abdomen, slight tenderness over the liver, bowels active, urine 27 oz., S. G. 1010, no change in the amount of albumin.

It is not necessary to give daily details after this, but only the marked changes in the case.

On the 12th day mercury was given, and the digitalis stopped ; by the 20th day urine was 40 oz., albumin down to line 4 (Esbach).

30th day. Urine 80 oz. Albumin again increased even above line 12, S. G. 1006.

32nd day. Urine 18 oz. No chemical or microscopic changes.

The mercury was suspended, and digitalis and strychnine supplied instead, hot packs and hot air baths were continued as before. From this to the death of the patient on the 12th of October there was a gradual decline. Great ascites developed, with liver tenderness pointing to organic disease of liver ; the urine varied between 25 and 50 oz., S. G. never above 1008. Casts were numerous.

The damage to the kidneys was evidently irreparable. No uræmic symptoms developed until 3 days before death, when a semi-coma, which gradually deepened, came on ; there were no convulsions. Death resulted from heart failure.

The interesting points about this case are :

1st. Could this nephritis have been induced by the large doses of bichloride of mercury which this man was taking at the time it developed ?

2nd. The treatment hinged on whether this complication was a medicinal irritation or a manifestation of the original disease. Should I have increased the dose of mercury above $\frac{1}{2}$ grain a day, which he was taking when the disease developed? I stopped it for two weeks, then began again with the small doses, which seemed to do some good for a few days, then a change for the worse came, and I stopped it again. I believe I should have continued with mercury from the beginning in doses sufficient to produce the ordinary constitutional symptoms.

POISONING BY A BELLADONNA OINTMENT.

Dr. F. W. CAMPBELL related the following case in practice: An acute rash is sometimes difficult to decide as to its character, especially in a defective or artificial light.

The other night he was called to a woman who had been confined three or four days previously. On examination he found a slight rash, universal all over the body, which had the appearance of measles, and somewhat crescentic in its character. Her temperature was a little over 101° . He forgot the exact figure, and the pulse was somewhat quickened. The patient was being treated with a view of getting rid of her milk. On enquiry he learned that an ointment containing extract of belladonna was being used on the breasts. All was then clear to him. He had a belladonna rash to deal with. Dr. Campbell also mentioned several cases of belladonna poisoning from the local application of belladonna liniment in small quantity.

Stated Meeting, Oct. 30th, 1896.

GEORGE WILKINS, M.D., President, in the Chair.

GANGRENE OF THE FOOT.

Dr. G. E. ARMSTRONG showed a young woman 24 years of age with spots of gangrene on the dorsum and inner and outer border of the left foot. These spots were seven in number, and varied from the size of a 5 cent piece to an area $2\frac{1}{2}$ inches in diameter.

He said: the patient was admitted to the Montreal General Hospital ten days before.

Four years ago she suffered from typhoid fever, and during convalescence her left leg became painful and swollen, and remained so for several weeks, ultimately returning to its normal shape and size. This is the fourth time that spots of gangrene have appeared on the left foot and leg during the past two years. One patch occurred just behind and a little below the left knee joint.

About six months ago the patient had been under Dr. Kirkpatrick's care in the Montreal General Hospital for a similar condition.

Her father, mother, and several brothers and sisters are living and well.

The onset occurred suddenly without any recognizable symptoms, and, so far as I can ascertain, without any probable exciting cause. She denies having worn tight shoes, or having received any injury to the foot, and says she has not been taking medicine of any kind.

Her heart and lungs are normal. Urine high colored, sp. gr. 1030, acid, and contains no albumin or sugar. Microscope shows amorphous urate and crystals of uric acid.

It is as yet impossible to say how deep these sloughs will prove to be. At any rate, it is quite evident that they involve the whole of the true skin.

I am inclined to think that quite possibly the phlebitis or endarteritis following the typhoid may have had an etiological influence. It may also be of the nature of Raynaud's disease. It has been suggested that the condition is self-inflicted. I don't know how she could have produced this condition if she had tried. I am quite sure that I could not do it. I don't know what I could use to gain this result. This is the fourth time that she had suffered from a similar condition, and always on the same foot and leg. There is not, so far as I know, any other evidence of hysteria about her.

These patches do not all lie within the area supplied by any one artery or any one nerve.

Dr. R. C. KIRKPATRICK said that the patient had been under his care some months before, and the leg was then in a much less marked but somewhat similar condition. There were two or three spots of gangrene on the foot, which were quite superficial, and his impression had been that they were self-inflicted.

As bearing on this case he had brought another patient somewhat similarly affected, the condition in this case being undoubtedly due to a burn from a hot water can. He thought that a lesion was more likely to have been produced by the patient than due to an arrest of the arterial circulation.

Dr. F. J. SHEPHERD had come to the same conclusion after seeing the case, and referred to several other cases that he had met with, notably one in which a series of rings of gangrene appeared, following each other at short intervals. As soon as a watch was set upon this patient and her hands kept tied, the eruption ceased appearing.

Dr. D. F. GURD referred to a case which had come under his notice. A slough appeared on the skin of the leg in a child during convalescence from scarlet fever, although no hot applications could have been the cause.

Dr. JAS. STEWART asked if the patient showed any evidence of hysterical stigmata. He did not know of any means either from heart or irritants that could induce such a condition. He considered it neurotic in origin.

Dr. ARMSTRONG replied, that so far as known the patient showed no evidence of hysteria, and he agreed with Dr. Stewart that no artificial means that he knew of could produce deep sloughs of such a character.

ANEURISM OF THE ASCENDING PORTION OF THE AORTIC ARCH, LEADING TO EXTERNAL RUPTURE.

Dr. JAS. STEWART and Dr. J. G. ADAMI reported this case.

LIMITATIONS OF THE VISUAL FIELD OF INTRA-CRANIAL ORIGIN.

Dr. J. W. STIRLING read a paper on this subject.

Dr. JAS. STEWART referred to one of the cases mentioned by Dr. Stirling as showing the great value of a thorough examination

of the eyes and ocular muscles in determining the nature of intracranial disease.

HÆMORRHAGE OF THE BOWELS IN A VERY YOUNG TYPHOID PATIENT.

Dr. D. F. GURD read the following case report : Typhoid fever is seen in persons of all ages, but is much less frequent at the extremes of life. Authentic cases have been reported at the ages of 70, 80 and even 90, and Dr. Murchison exhibited the specific lesion in the intestines of an infant of six months. Previous to 1840 it was thought that young children were exempt from this disease, but Ribbot and Tampin demonstrated conclusively that they were not, and that most of the cases previously known as infantile remittent were typhoid fever.

Hæmorrhage of the bowels is a rare complaint in young children. This fact is my apology for calling your attention to a case which occurred in my practice.

On Nov. 8, 1895, I was called to see Lizzie H., aged 27 months, who was suffering with fever and slight tickling cough. From the history of the case, as obtained from her mother, an intelligent lady, I judged she was then in her sixth day of fever. The case ran a mild course till the evening of the twelfth day, when she had a bloody stool; this made me anxious, and I got a trained nurse in attendance. At 8 a.m. the next day she had another, which the nurse said contained about 2 oz. of blood. At 2.30 the following morning, *i.e.*, the 14th day of fever, she had a small stool, having about an ounce of blood in it. From this time on the temperature rapidly declined, so that it reached normal on the 21st day, and never again went above it. The blood in the stools was bright.

A CASE OF CEPHALHÆMATOMA CAUSING BONY DEFORMITY; GRADUAL ABSORPTION.

On Sept. 16, 1895, G. H. was born with the aid of forceps after a fairly tedious labor. No excessive force was needed. The child had what looked like an ordinary caput succedaneum, the size of a large orange.

Next day the nurse called my attention to baby's head, which I examined, and found over the left parieto-occipital region the commonest form of hæmatoma, that is, a blood tumor between the periosteum and the bone. I assured the anxious mother that it might take some weeks, but that it would entirely disappear.

After about three weeks, flakes or plates of bone could be felt over the tumor, and those slowly grew larger. When pressure was made over them they would bend inwards, giving a peculiar crackling sound and feel. These plates, perhaps four or five in number, gradually united, and finally completely covered the tumor, which by this time had lessened by absorption to about three-quarters of its original size. The child's head at three months was very unsightly, having this large, firm, bony prominence. I saw the child this week, and found the deformity much lessened, owing to the greatly increased size of the head during the past ten months, and this, with a fair growth of hair, has masked almost all appearance of anything wrong in the shape of the little fellow's

head. I might have removed the contents of the tumor when I found that it was being absorbed so slowly, either by aspiration or excision, but I think the already greatly diminished deformity has justified my leaving the case severely alone.

This condition is said to occur once in 250 new-born infants. I have seen several, but never one before which had a firm bony covering form over it.

RESECTION OF THE BOWEL.

Dr. R. C. KIRKPATRICK read the following report, to which is appended the pathological report of Dr. W. H. JAMIESON, who exhibited the specimen.

J. C., aged 63, was admitted to the Montreal General Hospital on Sept. 18, 1896. He said that for three weeks he had not had a motion of the bowels, and that for a week before that he had been much constipated. Previous to this time (four weeks before the date of his admission) he had been well. He had been treated by all sorts of purgatives and injections before he came to the hospital.

The abdomen was evenly distended (37 inches in circumference at umbilicus), and tympanitic throughout. Liver dullness present (1½ inches on mammary line). No tenderness. Digital examination of the rectum revealed nothing abnormal. The case being urgent, the abdomen was opened in the middle line. The small intestines presented and were distended.

On drawing over the sigmoid flexure it was found to be distended until the lower part was reached, where a constriction was found. This was resected, and the ends of the bowel united by a double row of silk sutures. As soon as the rubber tubing (which had been tied round the bowel above and below the field of operation, to prevent the escape of fæces) was removed, the bowels commenced to act. A large rubber tube was inserted into the rectum, and a copious motion was passed, I should think a couple of quarts of fluid fæces. This line of union being apparently tight, the abdominal wound was closed. The patient died forty-nine hours after the operation, the highest temperature being 100° and the pulse 100. The abdomen remained soft and flaccid throughout. He had a slight bronchitis before the operation, and the ether made this worse, so that I was inclined to look on the pulmonary condition as the cause of death. However, the pathologist has another story to tell, namely, leakage from the line of the re-section, and septic peritonitis.

How should such cases be treated? Looking back on this case, I feel strongly that the best treatment would be a temporary inguinal colotomy. Then, when the enormous collection in the bowels had been got rid of, a resection could be done with much greater prospect of success. The bowel could be opened at once, or if the patient's condition would permit of it, after twenty-four or forty-eight hours, when there would be no danger of infecting the peritoneum by the discharges.

The strain put upon the line of union by the contents of the bowel is very apt to be too much for the sutures or whatever device is used to approximate the cut-ends, especially as there is a chronic

inflammation going on, and consequently leakage takes place. Again, such patients have very little resisting power, the absorption from the bowel having already depressed the vital powers.

Pathologist's report.—On opening the abdomen there was evidence of fibrino-purulent peritonitis. The abdominal cavity contained about 5viii of greyish-yellow purulent fluid with fecal odor. In the region of the sigmoid flexure of the colon a line of sutures extends around the circumference, a portion evidently having been removed. The omentum is stitched to this at one point. The contents of the bowel escape here. On opening the bowel the edges are found in apposition. No leakage taking place anywhere except from a small spot corresponding to where the omentum is attached; the edges of the wound here are un-united and gangrenous. A perforation, through which a good sized probe can be passed, leads through a mass of omental tissue between the sutured edges, and allows the escape of the contents of the bowel.

Anatomical diagnosis.—Resection of bowel for adenocarcinoma. Incomplete union of edges with escape of bowel contents into peritoneal cavity. General septic peritonitis. Broncho-pneumonia. Brown atrophy of the heart, and some fatty change. Chronic interstitial nephritis. Fatty degeneration of the liver. Infection by streptococcus and colon bacillus.

MONTREAL BRANCH OF THE BRITISH MEDICAL ASSOCIATION.

The annual meeting of this branch was held on the 2nd December, at 9 o'clock, in the rooms of the Association, Dr. Roddick in the chair. We take the report of the meeting from the *Montreal Medical Journal*, December, 1896. There were present Drs. J. A. Hutchison, Wm. Gardner, James Perrigo, G. G. Campbell, K. Cameron, Morrow, E. P. Blackader, J. G. Adami, Kirkpatrick, Proudfoot, G. T. Ross, Birkett.

The President reviewed the work of the past year as follows:

The year about to terminate has been an eventful one in the history of this Branch. Your Council has been called to meet many times during the year. Quarterly meetings have been regularly held, and we are indebted to Drs. Adami, Johnson, Macphail, and Martin for pathological specimens shown at each meeting. We are also indebted to the following gentlemen for contributions towards the programme of each meeting: Drs. Armstrong, Kirkpatrick, Evans, Alloway, James Stewart and others, for many interesting specimens shown.

During the past year, By-law No. 4 was amended so that five instead of three ordinary members are in future to be elected to Council.

The following new members were elected during the year: Drs. Edward Semple, G. A. Berwick, H. B. W. Carmichael, F. J. Hackett, R. C. Kirkpatrick, George Fisk, S. F. Wilson, and J. A. Henderson, making 85 present members.

On January the 18th, the British Medical Association was invited unanimously by the Branch to hold its Annual Meeting for 1896 here, provided Carlisle would forego her claim. The invitation was cabled to England, but it was found to be impossible, as

arrangements had already been made in that city. However, at the next meeting, April the 15th, a further invitation was tendered the Council in London to meet here in 1897, and at a meeting on June 26th following, Drs. Armstrong and Adami were elected delegates to the annual meeting at Carlisle, to further press the matter, the result being that the invitation was accepted, and Dr. T. G. Roddick, President of this Branch, was elected to the distinguished position of President-elect. As a consequence of this, your Council immediately set to work to organize for the coming event, and at a meeting on September 14th, presented a representative list of names that might constitute desirable committees to carry on the various branches of such an organization.

The following have applied for membership: Drs. R. F. Rorke, South Woodside, Ont.; Charles F. Martin, Montreal; George A. Dickinson, Port Hope, Ont.; William McDermid, Vankleek Hill, Que.; Robert B. Martin, Cleveland, Ohio; W. B. Nesbitt, Toronto, Ont.; John A. Hutchinson, Westmount; George E. Josephs, Pembroke, Ont.; J. V. Clemesha, Port Hope, Ont.; Joachim Guinane, Toronto, Ont.; James Ross, Dundas, Ont.; T. P. Shaw, Montreal; Henry Lunan, Campbellton, N.B.; A. L. DeMartigny, Montreal; William Burnett, Montreal; A. G. Morphy, Lachine; H. J. Harrison, Cornwall, Ont.; Grosvenor Hayes, Barre, Vermont; William Mason, Montreal; George Villeneuve, Montreal; Ridley Mackenzie, Montreal; H. D. Hamilton, Montreal; Ahern, Quebec; David A. Hart, St. Lambert's, Que.; W. H. Jamieson, Montreal; J. C. Webster, Montreal; Jas. Warburton, Charlottetown, P.E.I.; A. F. Garrow, Montreal; Henry Beaumonte Small, Ottawa. These 29 new members were elected.

Dr. Hutchison, the Treasurer, then read his report, which was duly adopted, and showed a balance of \$37.03 on hand. Drs. E. P. Blackader and K. Cameron were nominated auditors by the chairman.

The question then came up as to what should be the annual fee to this Branch, including the subscription to the *Journal*, and after much discussion it was moved by Dr. Hutchison, and seconded by Dr. Kirkpatrick, that the sum of \$5.25 be the fee for 1897 for new members living outside the city and its suburbs.—Carried.

The election of officers for the ensuing year was then proceeded with. It having been suggested by the meeting, that in view of the fact that the present officers having already in hand the preparations for the coming meeting here next August, it would be advisable that the same officers be elected again for the ensuing year. This was adopted by the meeting. President, Dr. T. G. Roddick; Vice-President, Dr. E. P. Lachapelle; Treasurer Dr. J. Alex. Hutchison; Secretary, Dr. J. A. Springle. Council—, Drs. F. J. Shepherd, James Perrigo, Sir William Hingston, George E. Armstrong and J. George Adami.

In view of the fact that a large number of members would be elected for the ensuing year, and it would be impossible to call together the Branch for such elections, it was moved by Dr. Gardner, seconded by Dr. G. G. Campbell, that the Council be empowered to elect such members for the present year and 1897.—Carried.

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Editorial.

THE TWENTY-FIFTH VOLUME OF THE CANADA MEDICAL RECORD.

In order that the business year of the publishers may end with each volume in December, it has been decided to continue this volume until December next, thus giving to our subscribers this year fifteen numbers instead of twelve.

While making the announcement, we would take the opportunity of urging the claims of the RECORD among our readers for their influence in helping towards a more extended circulation. As heretofore the various departments will reflect the general progress made, and a resumé of the papers and discussions at the Medico-Chirurgical Society and British Medical Association branch in Montreal will be given, which represents the work done at the different English hospitals here.

There will be much of interest to record during this present year, owing to the meeting of the British Medical Association in this city, and as we trust to keep our readers fully posted, medical men throughout Canada and the United States should subscribe now for the RECORD, which has been placed at a nominal subscription price in order that its constituency may be enlarged.

THE TALLERMAN SHEFFIELD PATENT LOCALIZED HOT AIR APPARATUS.

Through the kindness of Dr. James Stewart, the members of the profession in Montréal and its vicinity had an opportunity of witnessing at the Royal Victoria Hospital an exhibition of the application of this method to cases of chronic rheumatism and gonorrhœal arthritis. The condition of the patients was described by Dr. Stewart. Mr. Tallerman, the inventor of the apparatus, who is a retired merchant from England, then explained the mechanism of, and method of using the invention. There are two pieces, one a cylindrical oven for single limbs, the other similar to a cot with a half cylinder top enclosure over the central part. The joints were covered with strips of lint, and lightly bandaged, and the body wrapped in sheets and blankets. The gas jets were lit, and a thermometer at the top registered the temperature of the air surrounding it. It registered as high as 240° F, the patient remained some 40 to 50 minutes. Little change occurred in the body temperature as taken in the mouth, the volume of the pulse was increased and the patients perspired freely. After removal, the patients admitted feeling a decided relief in the affected joints. We understand that Mr. Tallerman is giving exhibitions of this kind in the chief cities of Canada and the United States, the object being to induce hospitals and practitioners to use the method and his patented apparatus, for which a somewhat exorbitant price is asked. Mr. Tallerman has not given any very scientific explanation as to how this local application of dry heat cures these chronic affections. We understand that fairly good results followed the use of the method here. We must feel grateful to the authorities at the Royal Victoria Hospital for the privilege of witnessing a demonstration of this method of treating a class of affections which respond but poorly to medicinal treatment, and feel assured that much benefit will accrue from indicating a line of therapy which has been somewhat neglected by the profession, and suggesting a thorough scientific examination of the action of the local application of superheated air. But we do not see anything very striking about this patented apparatus in distinguishing it from somewhat similar methods which have

been in vogue for centuries. It is but a modification of the Turkish bath, where the temperature of the air ranges from 210° to 300° , and a still slighter modification of the old household remedies of raising the bed clothes by a few barrel hoops, and using a spirit lamp for heating the air; or using a cane-bottomed chair, and surrounding the patient with blankets. We do not object to this plan of treatment being modified and developed to the full extent of the benefit that may be possibly obtained from it, but we hope that the patent will not prevent the use of hot air by the numerous contrivances which may suggest themselves to any physician of a mechanical turn of mind; if so, we should be sorry to encourage the introduction of this expensive so called invention any further than its mechanical worth as a piece of convenient apparatus.

For some months back, without any knowledge of Mr. Tallerman's apparatus or methods, a somewhat similar method has been in use at the Western Hospital here in the medical wards. A number of cases of chronic rheumatism having been but little benefited by the ordinary methods, an attempt was made to imitate the Turkish bath by using the large ward bath tub. The patient is surrounded with a sheet and blanket, and placed in a semi-prone position in the tub, which is covered with blankets and rubber sheeting, the body being entirely covered in except the head; a Bunsen's burner enclosed in a wire basket was used to heat the air, and temperatures of 200° to 285° were obtained. Very free perspiration is induced, and surprising results have been obtained in some stubborn articular cases, which we hope to publish shortly in detail.

OUR SELF-PRESCRIBING PATIENTS.

At no time in the history of Medicine has it become so imperative for the members of our profession to take into serious consideration matters which affect their financial interests; more especially the general practitioner, who has so many difficulties to contend with, which all tend to lessen his income. Specialism takes from him some of his most remunerative cases, many of which he could take care of as successfully as the specialist. The surgeons connected with

our Hospitals become prominent by success in some brilliant surgical operation, but they all practise medicine as well, and hence handicap the general and medical practitioners.

The multiplicity of drug stores, which occupy every prominent corner in the city, are most of them depots for numerous patent medicines and cure-alls; these, owing to crafty advertising, are the resource of hosts.

Druggists not only recommend these to their patrons, but even prescribe the preparations of drugs learned from the prescriptions of physicians. Our patients, learning the value of certain prescriptions or methods of treatment, repeat them when like conditions arise, and even recommend them to their friends. The community at large is gradually becoming divided up into benefit societies, employing physicians at mere nominal fees, and creating a condition of bondage and subserviency among those holding the appointments which is not creditable to the profession. Nor would the slight advantage to the young and struggling practitioner be at all missed were the custom entirely abolished, and all practitioners in good standing prohibited from holding such position, which, on the whole, means cheapening of medical services, and in most cases where the recipients are not in need of medical charity. Then again the abuse of our Hospitals is a constant menace to the interests of the young practitioner, owing to the numbers who throng to the wards and out-door clinics for advice and medicine who are in a position to adequately remunerate a physician.

When these facts are placed beside that of the ever increasing numbers of those entering the ranks of the profession, and depending for an existence upon the support of the community in which they reside, it becomes a subject worthy of consideration in the interest of the practitioner, as well as of the members of the community, to consider the best means of mitigating the effects of the evils above indicated. The following editorial in the *MEDICAL RECORD*, September, 1896, under the above heading, which suggested these comments, is very *apropos* :—

To such as have studied the causes of the present decline in professional work, it becomes a serious question whether there are not other elements than those attributable

to stringent business relations that explain the condition. While the science of medicine has made great progress in the methods of diagnosis and treatment, the physician finds that his vocation, although more honorable and useful, is really less remunerative, and his legitimate practice is proportionately curtailed. There is no less sickness in the world, but the number of patients has markedly decreased. In fact, the sick ones are inclined to get the better of the doctor, and to act more or less independently of his direct ministrations. It is not difficult to understand why this is so, when we consider the vast number of persons who willingly yield to the growing habit of prescribing for themselves. This tendency is fostered by the belief, in the majority of cases, that such prescribing is tacitly sanctioned by the profession itself by the use of many of the legitimate remedies so frequently ordered for the relief of the more common ailments. There is a very reasonable foundation for this conviction, and its responsibility rests more or less on the prescriber himself. At the bottom of the whole business is the prevailing practice of delivering private clinical lectures to the patient on the nature, extent, progress, and outlook of his malady, and the indications for the use of special drugs in the treatment of certain conditions. While this may give evidence of remarkable learning on the part of the medical adviser, and may help for the time being to establish his methods in the confidence of his client, it too often educates the recipient into the presumption of thinking and acting for himself. The most superficial knowledge is all that is necessary to this end, and, easily persuading himself that he has a repetition of the malady of which he has had such an authoritative opinion, he either repeats the prescription at will or purchases his former remedy in open market at the counter of the obliging pharmacist. Quinine, phenacetin, salol, morphine, pepsin, the mineral laxatives, and a host of other much-used medicines are given the currency of indispensable household articles. To such persons a diagnosis is a useless refinement, it being sufficient for their special purpose that their physician has given explicit directions how to use the supposed harmless remedies under what the patient believes to be similar circumstances. Not only this, but the remedy is freely prescribed to all his friends who are willing to trust to the blind chances of having a like ailment.

With shame be it said, that very many of the pharmacists, far from discouraging such practices, not only willingly abet them, but offer special inducements to purchasers by peddling the favorite prescriptions of well-known physicians. These drug sellers, for they deserve no more dignified title, do not prescribe themselves, but are willing to

recommend the prescription of another, charging a round price for the trouble of dispensing it. When it is understood that the physician knows of this, it is not difficult to explain why so few prescriptions are written and why so many prescribers deal out their own medicines.

Aside from the purely business aspects of the question, this inconsiderate self-prescribing is in the highest degree detrimental to the community at large in stimulating an unnecessary consumption of drugs, in the formation of habits which eventually undermine health, and in directly jeopardizing life by the loss of valuable time in the prompt recognition and scientific treatment of many of the dangerous and insidious maladies of which the ordinary patient has no possible knowledge. The profession should always be ready with any information tending toward the prevention of disease, but any attempt directly or indirectly to teach therapeutics is fraught with untold evil to the giver and the receiver. The more the patient is kept in ignorance of the remedies prescribed, the better for him, and certainly, under the circumstances already named, the better for the prescriber. The physician is never called in consultation with his patient, as the very nature of the case precludes the necessity of more than one opinion. The moment any argument is allowed on this point all proper respect for purely professional opinion is lost. This is one of the results of selling the birthright for a mess of pottage. The lesson is one which many of the too-obliging practitioners can take to heart.

ANOMALIES AND CURIOSITIES OF MEDICINE.

This is the title of what promises to be one of the most important works of the present year. It will be published by W. B. Saunders, who has, during the last few years, enriched our medical libraries with such a large variety of valuable works. It will be an encyclopædic collection of rare and extraordinary cases and of the most striking instances of abnormality in all branches of medicine and surgery, derived from an exhaustive research of medical literature from its origin to the present day, abstracted, classified, annotated and indexed by George M. Gould, A.M., M.D., and Walter L. Pyle, A.M., M.D. Several years of exhaustive research have been spent by the authors in the great medical libraries of the United States and Europe in collecting the material for the work. The work, it is said, will be of general interest, outside the profession, to all who

are interested in general scientific, sociologic and medico-legal topics. It will be sold by subscription, and will be issued during the present month.

Book Reviews.

A System of Gynæcology. By many writers. Edited by Thomas Clifford Allbutt, M.A., M.D., LL.D., F.R.C.P., F.R.S., F.L.S., F.S.A., Regius Professor of Physics in the University of Cambridge; Fellow of Gonville and Caius College; and W. L. Playfair, M.D., LL.D., F.R.C.P., Professor of Obstetric Medicine in King's College, and Obstetric Physician to King's College Hospital. London: McMillan & Company, Ltd. New York: The McMillan Co., 1896.

This is a volume of nearly one thousand pages, being a part of the New System of Medicine. We must begin by congratulating Dr. Playfair, who had the choosing of the contributors, upon the excellence of his choice. Anyone familiar with the names of leading gynæcological writers of the day will at once recognize such names as Berry Hart, Freeland Barbour, Milne Murray, Halliday Croome, Armand Routh, George Hermann, Bland Sutton, Haultain, Cullingworth, Priestly, Knowsley-Thornton, Alban Doran, and Greig Smith; indeed, many of these gentlemen, including Playfair, are authors of text-books which are recognized as standard ones throughout the world. The whole subject of gynæcology is one of recent development. Even the work of its pioneers is within the recollection of the oldest among us, while works written twenty years ago are absolutely useless as guides to the practice of to-day, not containing even a reference to the burning gynæcological questions of the hour. On the other hand, many opinions and methods of treatment then largely taught and practised have justly passed into oblivion. Much of this great progress is undoubtedly on the surgical aspect of the subject. The increasing frequency of abdominal sections has directed attention to the diseased states thus revealed, and to methods of treating them, previously quite unknown. Owing to the greater conservatism of the gynæcologists of Great Britain, they have been considered by their American and Continental brethren as being rather backward in recent advances. This volume has been the means of quite changing the reviewer's opinions at least on this point, for it contains full and frequent references to all the most recent work in this department, and shows that they not only preach but themselves practise the same line of treatment as is advocated by the majority of the gynæcologists of this continent. They are opposed, but not more so than we are, to the wholesale removal of organs without first having exhausted all hygienic and medicinal treatment, and in this they cannot be too highly commended. A good many years have passed since any complete work on Gynæcology has appeared in England, so that we had no means of knowing what progress that art and science had made there; but from a careful perusal of the volume before us, we can safely say that British gynæcology will compare favorably with

European or American. We do not agree with all the statements of the various authors, neither does the editor, neither do all the authors' opinions coincide with each other; but this is not objectionable; it is surely better that in vexed and disputed questions, both sides should be fairly considered. Among the finest and most interesting chapters are: The Etiology of the Diseases of the Female Genital Organs, by Balls-Headly; The Nervous System in Relation to Gynæcology, by W. S. Playfair; Disorders of Menstruation, by Halliday Croome; and Ovariectomy, by Greig Smith. It is impossible in our limited space to notice all of the many excellencies of the work, we must content ourselves by saying that the type, paper and binding are unusually good, while all the writers have presented their material in such clear and graphic manner that it is a pleasure to take it up to read it. We can confidently recommend it to practitioners of medicine as one of the safest guides for them that has appeared since several years.

Remsen's Theoretical Chemistry.—New (fifth) edition. Principles of Theoretical Chemistry, with special reference to the Constitution of Chemical Compounds. By Ira Remsen, M.D., Ph.D., Professor of Chemistry in the Johns Hopkins University, Baltimore. New (fifth) and thoroughly revised edition. In one royal 12mo. vol. of 328 pages. Cloth, \$2.00. Lea Brothers & Co., Publishers, Philadelphia and New York.

No book hitherto published has given a more clear and comprehensive explanation of the fundamental principles of chemistry as they are accepted now than this. Mr. Remsen, than whom no one is better known in this country in connection with the study of chemistry, has endeavored to make clear in this treatise those facts and speculations that have to deal especially with the problem of the constitution of chemical compounds. In his introduction the author says his object has been and is to help students to get clear ideas in regard to the foundations of chemistry. Many students go through their courses in chemistry, merely learning the formulæ, equations, etc., by rote, without any definite idea about the principles; now this book read well will bridge over that difficulty. Its having gone through 5 editions, besides being translated into German and Italian, shows how warmly it has been received, and is a good criterion of its worth.

PUBLISHERS DEPARTMENT

THE POPULAR ÆSTHETICS OF COLOR.

While *blue* is pre-eminently and overwhelmingly the masculine favorite, it is by no means so general a feminine favorite. The favorite woman's color, standing at the head of the female list, is *red*. Roughly speaking, of every *thirty* masculine votes, *ten* would be for *blue*, and *three* for *red*; while of every *thirty* feminine votes, *four* would be for *blue*, and *five* for *red*. Red and blue are thus much more nearly equally popular among women than among men. Other relatively marked masculine preferences are for the colors related to blue (blue violet and violet), and other feminine preferences are for lighter red (or pink), and, to a less extent, for green and yellow. Further, men confine their selections to relatively fewer colors than do women; and finally, while all men and

women alike are much more apt to choose a normal than a transitional color and a darker than a lighter shade, yet the tendency to do so (about the same in the former direction) is markedly different in the latter respect; of a *dozen* men, *ten* would choose among the darker colors and only *two* among the lighter for the most pleasing color; while of a *dozen* women, *seven* would choose among the darker and *five* among the lighter shades. This feminine fondness for the lighter and daintier shades appears also in other respects, to be noted presently.

Passing next to the discussion of the preferences among the combinations of colors enumerated above, the first noteworthy result is that no combination of colors occupies the position of a decided favorite as did blue among the single colors; but that preferences for the several combinations vary gradually from the most to the least favorite. The two most frequently (and about equally) preferred combinations are *red with violet* and *red with blue*, which are somewhat similar in effect (the violet being very dark in appearance); more than *one-fifth* of all the persons contributing to the results choose one or the other of these combinations. —Prof. JOSEPH JASTROW, in *Appletons' Popular Science Monthly for January*.

THE UNTOWARD EFFECT OF SUBSTITUTES.

A. M. Collins, A.M., M.D., of Shelbyville, Ills., writes under date of November 2nd, 1896: "I never realized the vast difference between genuine antikamnia and the various substitutes that are being palmed off, until within the past few days; and the realization was all the more pronounced because I myself was the patient.

"For four weeks I had been suffering with neuralgia of a very severe type, and attended with considerable febrile movement. I tried the various compounds and other preparations, lauded as 'just as good,' but with no real advantage and with no little heart disturbance.

"On Saturday, I went to Arcola, and while there was taken very sick with one of my neuralgic attacks. I sent to the drug store for some genuine antikamnia, and to be certain about it, procured an unbroken original package. I took it in eight to ten grain doses at intervals of two hours. The effect was magical, the first dose relieved the severity of the pain, while the second quieted it entirely, and I went to bed, sleeping all night with one awakening of a few moments only, a thing I had not done in four weeks. This experience on my own person has thoroughly convinced me of the superiority of the genuine antikamnia."

SANMETTO IN GONORRHOEA.

Dr. A. G. McCormick, Richmond, P.Q., Canada, writing, says: "I prescribed Sanmetto in a recent severe case of gonorrhœa with the greatest satisfaction. I never prescribed any remedy in such cases that acted so well. The case was one of simple gonorrhœa, of a severe type—pain, burning and scalding, with a profuse discharge. By the use of Sanmetto my patient made a rapid and satisfactory recovery. Sanmetto is a sovereign remedy in such cases. I used it two years ago in a like case with a similar result. I am well satisfied that Sanmetto is by far the surest, speediest, and safest, as well as the most pleasant and most satisfactory remedy we have for gonorrhœa."

ADHESION OF PLACENTA, WITH HEMORRHAGE.

I had a bad case of adhesion of placenta, with dangerous hemorrhage. With ergot and Sanmetto the danger was at once removed, and by continued use of Sanmetto, patient, although very weak from loss of blood, improved rapidly, and is now up and about the house helping about her work. In sixty years practice, with an attendance upon more than three thousand child births, I have used no medicine that seemed to hit the case better than Sanmetto in this instance. I am now in my eighty-seventh year, and have practised since 1832.