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THE CANADA MEDICAL RECORD.

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CONTENTS.

Original Communications.

REPORT OF A FATAL CASE OF "GUNSHOT" WOUND OF THE HEAD.

By Dr. CASSELS, Three Rivers, P.Q.

The interest of the following case lies principally in the terrible effect produced by a comparatively small force when applied to a peculiarly fatal spot by accident or otherwise, and in the length of time required to destroy vital action, the injury being of such an exceptionally severe nature.

At about 8 o'clock on the evening of December 26th, 1879, I was called to Mr. B., who had shot himself about an hour and a half previously.

Upon arrival at the house I found the patient lying on the floor of his dining room, on the spot where he had fallen after firing the shot, his symptoms as follows: Pulse 45, full and intermitting, one beat in four; respiration 17, stertorous; pupils equally and much dilated, quite insensible to light, muscles relaxed, skin warm, complete loss of consciousness and sensibility, and in fact all the symptoms of compression of the brain.

The wound was situated in the right temporal fossa, less than a quarter of an inch behind the posterior branch of the temporal artery and close above its junction with its anterior branch, and was a perfectly circular hole of about one eighth of an inch in diameter (as if punched out), the hair was singed, and the orifice of the wound was ingrained with powder; very little blood had been lost.

The pistol used by the unfortunate man, was the smallest size Smith & Wesson seven chamber revolver, and one cartridge only had been fired. On subsequent examination of a cartridge similar to the one which had been used, I found that it weighed exactly forty (40) grains, distributed as follows: bullet, twenty-five (25) grains; copper case, ten (10) grains; powder (including the fulminate), five (5) grains.

I was told by his wife that some ten or fifteen minutes after receiving the wound, the patient, in answer to her question, "if he thought he was going to die," had replied, "No, I am going to get well." These were his last words, unconsciousness rapidly supervening.

His regular medical attendant, who saw him within a few minutes after it happened, had applied cold to the head, a mustard sinapism to the heart, hot bottles, etc., to the extremities, but could not rouse him to swallow any stimulant.

I was unable with a probe to trace the wound more than half an inch into the muscles, and failed, after minute and careful examination, to detect any fracture or depression of the skull.

I had made up my mind to cut down, enlarge the wound, and try and ascertain the amount of injury, but, while waiting the arrival of some of my confrères, I observed that the symptoms of compression were lessening, the breathing became regular and calm, the pulse softer and more frequent, about 64, but still intermitting, the pupils more contracted and slightly sensible

to light, moderate sensibility of the limbs, as they twitched slightly when pricked with a needle, and the patient was more easy although still unconscious, but in a less degree. Taking into consideration this amelioration of the symptoms, also, as I then supposed, the small power of the projectile, and again that most probably the bullet had taken an upward and forward course (judging from the way in which a right-handed man would most naturally perform the act, the muzzle of pistol higher than his hand, and his head turned slightly to the left), I began to hope that, perhaps, the ball had not penetrated the skull, but might have glanced off the bone and be lodged in the scalp. With this idea I again carefully examined the patient, but could find no evidence in support of this supposition. This comparatively improved condition lasted for about two hours, during which time all the usual remedies were tried to restore consciousness, but although the insensibility lessened to a considerable degree, he never recovered sufficiently to swallow or speak. Between 11 o'clock and midnight, without any apparent reason, the coma increased very rapidly, and became so deep in such a short time that I saw I was mistaken as to the amount of injury done, and that it was very much more extensive than I had supposed, and I therefore considered it certain that a severe and copious hemorrhage had suddenly taken place from some large vessel which had been wounded by the shot, and temporarily plugged by a coagulum which had given way under the reaction, and that trephining would not be of the slightest use, or indeed give the most distant hope of success. The post mortem justified my prognosis. Death took place at a few minutes before 7 o'clock a.m., of the 27th instant.

At the request of the Coroner, I made a post-mortem examination of the head of the deceased the same day, eight hours after death. Rigor mortis well developed. On removal of the calvaria, I found that the bullet had passed through the anterior inferior angle of the right parietal bone, cutting the anterior branch of the middle meningeal artery below its division. The hole in the outside of the bone was quite round and clean, but on the inside it was five or six times larger and very irregular, pieces of the inner table being splintered off, many of which I found imbedded in the brain substance. There was a clot as large as a man's closed fist from the meningeal artery, and an enormous effusion of serum both outside and inside of the membranes, the dura mater being detached from a large surface of the bone. At the base of the brain, in front of the crura cerebri, was another clot as large as a small orange, and in this clot, close to the optic commissure, I found the bullet. I was unable to ascertain from which artery this clot came, probably the middle or anterior cerebral. I am sorry to say that, as the Coroner's jury were waiting for me, I cut away somewhat hastily in my anxiety to get the ball, and it was too late to make a more careful examination when I found the second clot, as the parts were so much broken up.

Remarks.—My idea of how the shot was fired, certainly the most natural way, was just the opposite of the fact, for the pistol must have been held in exactly the reverse way, to direct the bullet inwards to the base of the brain; that is to say, hand higher than the muzzle, and head turned slightly to the right, "*and more than that, he must have pulled the trigger with his thumb, as, from the direction of the wound, he could not have reached the trigger with his fore-finger without straining the hand very much, in fact I doubt its possibility.*"

During the past fifteen years I have performed or assisted at a large number of post-mortems of persons killed by brain injuries of all kinds, and the above is the first case in which I ever saw two such large and distinct clots.

CASE OF SPINAL APOPLEXY.

By GEORGE WILKINS, M.D., M.R.C.S., Eng., Professor of Pathology and Lecturer on Practical Physiology, University of Bishop's College, Physician to the Montreal General Hospital.

(Read before the Medico-Chirurgical Society, Dec. 12, 1878.)

J. G., æt. 40, married, a carpenter, was admitted into hospital on 8th September, 1879, in a condition of paraplegia. His history is as follows:—For some years past he has been a hard drinker at times; on the morning previous to admission into hospital, being Sunday, he took four or five glasses of spirit, and lay down on the floor of his room, where he fell asleep: he lay there five or six hours, when he

awakened, and on attempting to rise, found he was completely paralyzed. He says he felt no pain whatever, and that up to a week previous to this attack he was perfectly healthy, and that he worked at his trade until the day before.

Although able to work during the week previous to the paralysis, he complained of having had during that time slight shivering attacks, that he had been a little feverish and had had slight pains in his legs and shoulders, but he considered them only trifling, and attributed his present trouble to his having strained himself, he thought, in carrying home a bag of potatoes the previous night. In reply to leading questions put to him, he thought he had not quite as much power over his limbs, although it did not attract his attention, nor did he perceive any alteration in sensation. He had no trouble in urination, but for a month or so had been restless at night, and would rise two or three times and walk about the room, complaining of the bed being too hard.

He denies ever having had venereal disease of any sort, but appears to have been excessive in the gratification of his sexual desires.

Symptoms on Admission.—Patient has the appearance of a well-nourished, strong, muscular man, and as he lies in bed complains of no pain whatever. He lies perfectly motionless, but is able to move his head and neck.

On percussing spine, tenderness is felt over fourth and fifth cervical vertebræ. There is complete loss of power and sensation in body and limbs below line of nipples; also loss of muscular power in the arms except flexors of forearms, and loss of sensation except over radial side of forearm, in which region, although able to recognize handle of penknife and piece of money, he cannot differentiate heat and cold.

There is complete absence of reflex excitability in paralyzed parts; almost complete absence of Faradic irritability on applying current to legs. It was not considered advisable to test electric excitability of arms on account of reflex centre of those parts being near supposed site of lesion. There was no expansion whatever of chest, breathing being entirely diaphragmatic. Heart sounds normal. Bladder distended, reaching half-way to umbilicus; 34 oz. of urine were drawn off, being the amount secreted since the occurrence of paraplegia. Pupils contracted to size of pin head, fixed and immovable. Temperature on admission, 103.2°.

His chest, abdomen, and back were covered with a lichenous eruption, which, he said, had made its appearance during the past week.

Progress of Case.—Temperature, which on admission was 103·2°, rose on the following morning to 104·3°, falling same night to 99·2°, and the next morning to 96°, at which it remained, with a variation of 0·2° on one day, up to his death, which occurred on the tenth day.

About forty-eight hours after onset of paralysis a bulla 2·5 cm. in diameter formed on internal aspect of right foot, over scaphoid bone, and twenty-four hours subsequently two much smaller ones appeared over eighth dorsal vertebra. Bowels moved involuntarily and unconsciously, regularly once a day, on two occasions twice, after admission. Urine was withdrawn twice a day. Priapism was occasionally present, sometimes the erection being complete, at other times only partially so.

Respirations, which during the first two days were twenty-four per minute, fell to eighteen on the third day, gradually increasing in number until the sixth day of illness, when they were thirty-two per minute, about which number they remained up to death. Pulse 84 on admission, fell on second day to 52, gradually rising to 72, at which it remained to the last, keeping regular during the whole time.

On the fourth day patient complained of the mucus râles, which had been gradually making their appearance, and which, from his inability to cough and expectorate, continued to accumulate, thereby interfering with respiration to such an extent that on the sixth day the lips were blue and countenance presented a dusky hue; which condition increased until complete asphyxia was produced.

The urine, which was occasionally examined for albumen during the first few days of his illness, was found to contain none. On the sixth day it was ammoniacal, sp. gr. 1030, and highly coloured. The bullæ which made their appearance on the second and third days, remained *in statu quo;* there were no indications of bedsores about nates.

Pupils remained tightly contracted up to his death, and when examined a few minutes after death had undergone no alteration.

At the *post-mortem* examination, on opening

the spinal canal, the plexus of veins covering the dura mater contained more than the normal quantity of dark blood, the dura mater itself presented a normal appearance; a longitudinal incision was made through it, permitting the escape of a small quantity of cerebro-spinal fluid. On passing the finger along the cord it was felt to be of slightly softer consistency between the origin of the first and third dorsal nerves; below that firm: above not quite so firm as normal, and slightly enlarged opposite sixth cervical nerve; pia mater congested for the whole length of chord. The spinal nerves were now severed external to the dura mater; the cord and its membranes divided immediately below medulla and removed *en masse*. In the median line of the posterior surface, between the origin of the fifth and sixth cervical nerves, a bluish-black spot, about the size of a pin head, was observed lying beneath the pia mater, which is perfectly intact. On making a transverse incision through this spot, the knife cuts through a dark red clot of a caseous consistence, which at this point is twelve by five millimetres in transverse diameter, the white substance of the cord forming a thin, ragged wall around it, except at this small spot, which is seen superficially. Transverse incisions were made through the substance of cord, one centimetre apart, along its entire length; on examining these cut ends, the clot can be traced with the naked eye as far down as the fourth dorsal nerve, and upward to the second cervical, but that portion between the fifth and eighth cervicals is somewhat cone-shaped, the larger extremity of the cone being opposite the origin of the fifth cervical nerve, where it is twelve by five millimetres in diameter, dwindling down to about two millimetres in diameter opposite eighth cervical nerve, below which it is continued as a mere trace to lower limits first mentioned; at lower fibres of origin of fifth cervical it becomes suddenly smaller (1·5 millimetres in diameter), gradually diminishing in size to upper limit first mentioned. The clot occupies the centre of the cord, and where small enough appears to the naked eye to be limited to the grey matter. The various sections present a pale appearance, except through the clot, which is of a chocolate colour. In the softened portion, the cord swells slightly above the edges of the cut surface.

For microscopical examination, sections were taken in the fresh state, and also after hardening in bichromate of ammonia. Sections were made in a freezing microtome, stained with eosine and hæmatoxylin, and mounted in damar. Sections for examination were taken from the cervical, dorsal, and lumbar regions of the cord. The sections from the cervical region were but very slightly increased in vascularity.

On examining with a hand lens sections opposite origin of fourth cervical nerve, the clot, which is here a little over one millimetre in diameter, is seen to occupy the whole of the grey commissure extending on both sides almost, but not quite, to the lateral columns, and nearly as far as the ganglion-cells of the anterior cornua; it does not invade the white commissure, but encroaches slightly on the posterior columns lower down, considerably so. In all the sections made by me of this portion of the cord, on examining with a higher power the anterior cornua are not at all encroached upon by clot, and are but little increased in vascularity; indeed, the vascularity in this portion of cord is very much less than in any sections of the dorsal or lumbar region.

The white columns in some of these sections contain numerous corpora amylacea, which are especially abundant in the external zone of the most posterior portion of the antero-lateral columns; the posterior columns contain a few much smaller corpora.

Several sections of different portions of the dorsal and lumbar region were also examined, in all of which the vascularity was much increased, the upper dorsal portion being much the most vascular, many of its vessels having aneurismal dilatations and several of the sections showing capillary extravasations—these dilatations and extravasations being seen only in the grey matter; the vascularity of the white substance, although much increased, was not nearly so much so, relatively to normal, as that of the grey matter; the central veins of the grey matter have their coats very much thickened and in a state of corpuscular degeneration. The vascularity of the grey matter in the vicinity of the ganglion-cells of the posterior cornua of the superior dorsal region is very much greater than in the anterior cornua. The

ganglion-cells of the posterior cornua in all the sections appear to have undergone changes. Through the entire length of the cord many of them have lost their prolongations. In the upper dorsal region they are much larger; they have a bulged and swollen appearance, and several can be seen with their nuclei in a state of division—some in the act of dividing, others with two separate nuclei. In many of them no trace of nuclei or nucleoli can be discovered; further down in the dorsal portion of the cord the cells present a somewhat atrophied appearance, and the posterior cornua of the grey matter are thin and translucent, a small segment in the region of the ganglion-cells being much atrophied, and not taking the hæmatoxylin staining.

In the lumbar region of the cord the ganglion-cells of the posterior cornua are very much diminished, both in size and in number, in some of the sections only two or three small and imperfect cells can be seen; the cells of the anterior cornua seem to be perfectly normal. This portion of cord is very much more vascular than the lower dorsal region, some of the vessels presenting a peculiar knotted, or rather double looped appearance.

In all the sections of the dorsal region of the cord the central canal is completely obliterated, owing to its being plugged with epithelial cells and granular matter. In the lumbar region it is pervious, and almost rectangular in shape.

The nerve fibres of the white matter in the anterior dorsal region are in a state of granular degeneration, their axis cylinders are but faintly seen—can only be occasionally distinguished from the cells and nuclei which, with granular matter, swell the neuroglia.

The white columns in the lumbar region present no abnormal appearance.

In referring to the pathology of this case, the first questions are:—Is this a case of spontaneous spinal apoplexy, analogous to frequently recurring cases of cerebral apoplexy, in which no lesion of the nervous centre itself exists before the escape of blood into its substance? Or, is it the result of previously existing inflammatory action in these centres? That blood vessels can spontaneously rupture into the substance of the healthy cord, as in some forms of cerebral apoplexy, is proved by a few carefully reported cases, more especially one by Goltdamer in a recent number of Virchow's Archives.

Writing in 1876, he says, that but thirty cases of spinal apoplexy are recorded, of which at least twenty showed symptoms of previously existing myelitis. The case just reported must, I think, be considered one of this class, although the indications were ill-defined. The symptoms present pointing to the probable existence of myelitis before the occurrence of paralysis were:—A lichenous eruption on the body, flushes of heat, chills, slight pains in the limbs, and a feeling of not being quite so well able to work as usual, although he managed to follow his trade as a carpenter up to the day previous to the paralysis. To these may be added two at least of the symptoms which were present when he entered Hospital—abolition of reflex action and almost complete loss of electric excitability of the muscles; the latter symptom especially, I look upon as important, since without it the former would lose its significance at this early stage of the disease. In animals reflex action is abolished for a certain length of time after division of the spinal cord, varying with the species; thus in the frog only two or three minutes, whilst in the rabbit as many or more hours frequently will elapse before the reflex irritability returns—this condition being due to shock.

In the cases of injuries to the spinal cord in man, which most nearly approach the conditions experimentally produced in animals, the length of time that has elapsed after occurence of injury before appearance of reflex action is very varied; in some of the reported cases it has been observed within a couple of hours, in others, three or four days, sometimes more, have elapsed before the cord recovers from the shock and reflex action appears. Cases of injury are also frequently recorded, some of them in the cervical region, in which at no time during the progress of the case were there any manifestations of reflex action; in these its continued absence might, I think, be fairly ascribed to changes extending to the ganglion-cells of the cord below the lesion, as they have been for the most part cases in which inflammatory softening had been produced at site of injury by a dislocated or fractured vertebra. At no time during the progress

of my case were there any manifestations whatever of reflex action; he lived long enough to allow the effect of shock to pass away, and no symptoms that could be attributed to shock appeared at any time while under observation. I regard the absence of reflex action as due to changes having already taken place in the grey matter of the cord. Microscopical examination showed the lumbar region of the cord to be abnormally vascular, more so than some portions of the dorsal region. The genito-urinary centre is situated in this part of the cord, and from these facts I infer that the continued and unrestrained sexual excesses caused a hyperæmic state of that region, which extended upwards; myelitis set in, lessening the resistance of the cord, thus permitting the capillary extravasations, as well as the greater rupture. The inflammatory state, by interfering with the function of the ganglion-cells, would thus explain the absence of reflex excitability. It would also account for the apparent early absence of Faradic contractility, supposing it to be due to degeneration of muscle, one of the most constant changes occurring in consequence of irritative lesions of the spinal cord. As this seldom makes its appearnce before the fifth day (between the fifth and fourteenth days, according to Charcot), its presence within forty-eight hours after paralysis would point to an abnormal condition of the nervous centres previous to the occurrence of hæmorrhage. The same inflammatory, and consequently irritative, condition of the spinal cord, would account for the presence of the lichenous eruption, which had made its appearance before entering Hospital; this being one of the many forms of skin affections which are so often seen in *irritative* lesions both of the spinal cord and nerves. Of course, similar cutaneous eruptions may occur and no lesion of the nervous system be found, but its occurrence in this case, coupled with the other symptoms then and subsequently present, point to its being of spinal origin. The bullæ which made their appearance in the course of the disease are among the commonest symptoms accompanying affections of the substance of the cord; this was pointed out fifty years ago by Bright, but it remained for Charcot to define the nature of the lesion. When these symptoms are associated with disease of the spinal cord, he claims that the diseased portion of the cord has been the seat of *inflammatory* mischief. The lichen and other cutaneous affections which appear in the course of the disease, he says, depend upon irritative lesions occupying either the central and posterior portions of the grey matter, or the white posterior fasiculi. The microscope shows unmistakable evidences of such a condition having existed in my patient.

It further enables us to account for another very interesting fact—that while tactile sensation was present in a certain part of the arm, the patient could not recognize heat or cold when applied to same part. According to views advanced by Brown-Sequard, and supported by many observers, the path for temperature impressions in the cervical and dorsal regions is by the central grey matter, while tactile impressions travel chiefly by the anterior parts.

Patient was able to flex his forearms, thus showing that some, if not all, of the motor fibres in the musculo-cutaneous nerve were not implicated in the lesion in the cord, and as the portion of the forearm in which sensation was present corresponded to the cutaneous distribution of the same nerve, it follows, as a matter of course, adopting Brown-Sequard's views, that the anterior cornu of the grey matter which is connected with this nerve was perfect, or that some, at least, of its ganglion-cells had uninterrupted communication with the brain and the peripheral extremities of the nerve; and further, from the fact of temperature sensation being absent, that the central grey matter which is in relation with the same nerve was destroyed, or its communication with the brain interrupted.

On examining the brachial plexus, it will be seen that the musculo-cutaneous nerve arises from its outer cord, and that it is the uppermost of the divisions of that cord; for this reason, I think, it is quite probable that in the spinal cord it has the highest origin of the branches of the plexus. Indeed, the situation of the clot, and exemption from paralysis of the flexor muscles of the forearm, as well as the tactile impression of the portion of the forearm supplied by that nerve, I think fully justifies the conclusion. The section of the spinal cord opposite third cervical nerve is at least five millimetres above the entrance into the grey matter of the uppermost fibres of the fifth cervical nerve (the first nerve forming brachial plexus). In the microscopic

sections of this region, the greater portion of the central grey matter is destroyed; lower down it is completely so. According to Brown-Sequard, this is the path by which sensations of heat and cold ascend. The posterior white columns are encroached upon transversly by clot to a slight extent only, so that the great majority of the fibres have their conducting qualities intact. If Schiff's theory is correct, that these latter columns alone conduct sensations of heat and cold, then the tactile impression being conveyed to the brain temperature impressions should also have been transmitted.

This case, I think, supports Brown-Sequard's views.

The facts and theories connected with this particular nerve in this case are, I should say, these:—When patient endeavoured to move his arm, impulses were directed from the cerebrum to the sensory ganglia at base of brain, and there excited motor influence, which was transmitted long the motor tract of medulla oblongata and the antero-lateral columns of the spinal cord to the large ganglion-cells in the anterior cornua of the grey matter, then by the anterior columns and anterior roots of fifth cervical nerve, through brachial plexus and external cutaneous nerve to flexor muscles. Sensation was conveyed from radial side of forearm, by same nerve, through posterior root of fifth cervical, passing both upwards and downwards in the posterior columns to posterior cornua, the external fibres of which run forward to ganglion-cells in anterior cornua, and are then transmitted to brain as tactile impressions. The fibres which are connected with and partly form the central portion of the grey matter and which should by that path, transmit temperature impressions to brain, have their communication with it shut off by the complete destruction by clot of the central grey matter above these fibres.

It is unnecessary to refer to the well-known respiratory symptoms occurring with lesions immediately below origin of phrenic nerve which were present in this case.

With reference to the pupillary symptoms which were present, the seat of lesion afforded no more information than that it was in the path of the fibres which formed part of the cervical sympathetic, the dilator fibres of the pupil being supplied by this nerve.

Budge calls by the name of "Centrum Cilio-Spinale Inferius" that portion of the cord between the sixth cervical and second dorsal, which corresponds very closely with the seat of lesion in this case; other observers have, however, placed it much higher, and have had their views supported by physiological experiments and also by pathological observations.

A very interesting problem in connection with this case is the cause of the continued low temperature, quickly following an ordinary febrile temperature. It will have been noticed that during the progress of the case, on the second day after admission into Hospital, temperature was over 104°, subsequently falling to 96°, a bulla having previously made its appearance on foot. According to most observers, the variation of temperature in this case would be accounted for in this way: the same lesion in the cord that caused paralysis of motion would also cause vaso-motor paralysis in consequence of which the blood vessels of the paralysed part were dilated to about twice their size, thereby admitting a larger volume of blood into the cutaneous vessels; this would account for the primary elevation of temperature. Under continued exposure of this larger quantity of blood to the cooling effect of the atmosphere, together with diminished combustion in the anatomical elements of the paralysed parts (the vaso-motor system being the great regulator of nutritive activity), rapid cooling of the parts will ensue. It must be remembered that it is now well established that the spinal cord itself contains vaso-motor centres along its entire length, and it is probable that the same condition that causes abolition of reflex would also keep these centres paralysed. Goltz would say, "actively dilated." Other observers would argue that the increased heat production would be better explained by irritation of the grey matter, quoting in this case, with some show of reason, the coincident appearance of bullæ which in spinal lesions are only seen when these lesions are of an irritative character; for it will have been observed that no bullæ or other cutaneous affection came on after the fall of temperature, nor was there any other appearance of bed-sore. The frequently observed fact of extraordinarily high temperature following spinal injury has been mentioned in support of this view, and also that, in these cases, some

time elapsed after the receipt of injury before the rise in temperature took place; the question of time affording additional support, since the inflammation consequent on injury would not immediately be sufficiently intense to act as an irritant.

After the third day, when the temperature fell, there were no symptoms indicative of an irritation to any portion of spinal cord. The non-apppearance of bedsore over nates, such sore frequently occurring in such cases, or of fresh bullæ after that period, would tend to support that opinion.

Without attempting to offer any explanation for these temperature phenomena, an objection to the adoption of the latter theory is the presence of the clot, which was likely to continue to act as an irritant, and, if so, the temperature should also have remained high.

Microscopical sections of the cord in this case, illustrating the various morbid conditions described in the paper, were exhibited at the meeting; also, for the purpose of comparison normal preparations of human spinal cord and cord of cat.

Correspondence.

OUR LONDON LETTER.

London, England, May 1st, 1880.

Another accident at a Music Hall, at one of those senseless exhibitions on the trapeze, this time at the Temple Opera House, Bolton, owing to the fall from a height of upwards of 20 feet of two performers, one missing his grasp of the other. "No bones were broken, but both men were stunned for a time." This makes another to be added to a long series of accidents occurring at those places of entertainment in a few weeks. How much longer will a paternal government allow these dangerous and worse than useless exhibitions to take place. The rage for sensational athleticism in the present day is something appalling, and I suppose we have yet to learn what the "human form divine" is to be made capable of enduring.

I am afraid I was somewhat premature in announcing that the dispute at "Guys' respecting the nurses was about being settled; matters still appear to remain in *statu quo* there. In private practice a skilled nurse is put in charge of the patient, and has written instructions from the physician which, if she does not obey, she is speedily replaced by one who will, the patient's life frequently depending upon the physician's orders being faithfully carried out. Nurses and sisters at an hospital ought most certainly to be made directly responsible to the medical officers.

A very pretty quarrel between a late physician to St. John's Hospital for skin diseases in Leicester Square and the authorities connected with that institution culminated to-day in the appearance at Bow Street on a charge of libel of the physician in question and the Editor of the *Medical Press and Circular*. The physician charges the management "with receiving large sums of money from the out patients and not accounting for them," to the extent of upwards of £2,000,—a very serious charge, and one which, I should have thought, if untrue, could be easily refuted. The defendants were both formally committed for trial, which, when it comes off, may possibly result in some interesting disclosures.

The following paragraph is copied from the *Kensington News*, a paper enjoying rather a large circulation in and around the suburb of that name. I have not seen or heard of any account of the interesting and unusual event in any other paper, medical or otherwise:

"That fact is stranger than fiction is a proverb well known to us all, but perhaps it has never been better exemplified than during the past week. On March the 15th, 1880, the wife of a barrister, residing in Hampshire, gave birth to a fine boy, and, at the end of the fourth week, was churched, received, and returned visits. On the 21st of April she astonished her friends with the news that she had presented her husband with a second son. At the present time mother and child are doing well."

Chian turpentine has been lately brought into prominence as a cure, or at all events a palliative, for cancer, chiefly in uterine cases. I have a case in which I am now trying it, and will not fail to let your readers know the result. I am writing from memory, but think it is to Dr. Clay of Manchester that we are indebted for this remedy which, if successful, will be an incalculable boon to sufferers from that most painful and distressing of all maladies. Chian turpentine was formerly used as a remedy for

chronic mucous discharges, but it is most difficult to get the genuine article, it being extremely scarce.

The following is another of one of those wonderful accounts which reach us from time to time of the power that the native mesmerists of India possess: In crossing last month from Dieppe I met a gentleman who had been some years in India, and he assured me that on two occasions, he had been instantly cured of two very severe sprains of the ankle accompanied with great swelling and inflammation, and which had existed for several hours, but were instantly cured by a native by a few mesmeric passes, wonderful but incomprehensible, at least to me. A native mesmeriser, named Buni, whose magnetic power would appear to be found quite irresistible by the lower animals, upon which he exclusively exerts it, gives séances, to which the public are invited to bring all manner of ferocious and untamable wild beasts, and, like the Ancient Mariner, holds them with his glittering eye. In a few seconds they subside into a condition of cataleptic stiffness, from which they can only be revived by certain "passes" which he solemnly executes with his right hand. An account of one of these séances states that a snake in a state of violent irritation was brought to Buni by a menagerie proprietor, enclosed in a wooden cage. When deposited on the platform it was writhing and hissing fiercely. Buni bent over the cage, and fixed his eye upon its occupant, gently waving his hand over the serpent's restless head. In less than a minute the snake stretched itself out, stiffened, and lay apparently dead. Buni took it up, and thrust several needles into its body, but it gave no sign of life. A few "passes" then restored it to its former angry activity. Subsequently a savage dog, held in a leash by its owner, was brought in, and at Buni's command, let loose upon him. As it was rushing towards him, bristling with fury, he raised his hand, and, in a second, the fierce brute dropped upon its belly as though stricken by lightning. It seemed absolutely paralysed by some unknown agency, and was unable to move a muscle until released from the magnetiser's spell by a majestic wave of his hand.

Is the following new to your readers? I am quite satisfied with my own proboscis and, singularly enough, find all my friends so, or at least so much so, as to be quite disinclined to allow me to try the operation, which is a pity:

Probably few persons know what a "nasal extensor" is, though it is said that the manufacture of such articles has become a regular part of the business of fashionable dentists in America and on the Continent of Europe. Persons who are dissatisfied with their noses will be glad to hear that a "nasal extensor" is a silver lining for each nostril, the two metal forms being connected together by a yoke at the base if necessary, and the interior covered with red enamel; and by the constant use of extensors, a pug nose, or, to put it more delicately, a nose that is "tip-tilted like the petal of a flower," may be transformed to any shape that its owner and her adviser consider desirable. The New York correspondent of a Cincinnati newspaper describes these inventions, and solemnly asserts that the use of nasal extensors is very common among the ladies of that city, and particularly affected by women to whom Nature has denied the elegant Grecian contour. It has long been understood that a determined person, who is dissatisfied with his or her nose, can alter the shape, though the operation is disagreeable; but, in the cause of vanity, men—and women—will suffer much. A deep transverse incision has to be made across the offending pug about three-quarters of an inch above its tip, cutting through the skin, cartilage, and septum with a single clean stroke of the knife, until the edge of the instrument is on a level with the face. This done, the half-severed tip must be depressed to the proper level, leaving a triangular gap between it and the firm upper portion sustained by the nasal bones. Small, but deeply-incised flaps are next dissected out on either side of the gap, in such a manner as to fill the vacant space and to meet each other at the top. A nasal extensor is fitted in, the nose is trained to the desired shape, and, when the scars are healed, the patient is happy. Of course, all who use extensors do not undergo this operation, but without it the training of an obstinate nose in the way it should go is a tedious business. Whether extensors are used in England the writer from whom we quote omits to say. If persons observe the shape of their friends' noses changing they will guess the reason.

A case tried in the Court of Queen's Bench

here last month, resulting in a verdict for the defendants on all points, and which verdict has since then been refused by the judges to be disturbed, is of interest to the medical profession, and shows the lengths to which some people will allow, what? Their temper? to carry them. The plaintiff a medical man places his son with the head master at Epson college. The boy contracts scarlet fever, is removed to the infirmary, and dies: an action is forthwith brought against the head master and the medical attendant of the college which, if it meant anything at all, meant directly to contend that they were guilty of the boy's death; the ground of the action being that the plaintiff said the head master had agreed to keep the boy in his house *under any circumstances*, and that the infirmary was not in a fit state to receive him. A more ill-advised and ill-judged action has never been brought, and yet it is said the plaintiff is about to carry it to the Court of Appeal!

I must apologize for not sending you my usual contribution last month, but I was in Paris for a fortnight and in bed for ten days soon after my return, having been violently expelled from a hansom, (shot out like rubbish, a friend said) and left with one side of my face like Joseph's coat and the other like a rainbow. Handsome is as hansom does was not true in this case, fortunately it couldn't spoil my beauty, and did not my nose.

R.

Progress of Medical Science.

ROSACEA OF THE FACE.

Dr. Hillairet, in *Annales de Dermatologie*, recommends the following, which he has used with excellent success:

Wash the face several times with very warm water, then—

℞. Sulphuris sublim..... ʒ j.
Tinct. camphoræ..... ʒ ij-iv.
Etheris sulphurici..... ʒ j.
Aquæ.....ad ʒ viij. M.

Bathe the face at night with this and let it dry on. In the morning wash, and apply—

℞. Zinci oxidi..... ..... ʒ ss-j.
Unguenti petrolei..... ʒ j.

Improvement begins in a week, but the treatment should be continued several months.

SLIPPERY ELM SUPPOSITORIES IN PILES.

These are recommended in the *Medical Herald*, by Dr. E. J. Kempff. He observes that suppositories made of powdered slippery-elm bark and warm water (sufficient of the latter to make a sticky mass), medicated with fluid extract of belladonna or ergot, recommend themselves in rectal diseases and for piles, enlargement of the prostate gland or uterine fibroids. They become slimy, dissolve gradually, and medicate very slowly.

TO REMOVE PLASTER-OF-PARIS FROM THE HANDS.

A very effectual way of removing plaster-of-Paris from the hands is mentioned by a correspondent of the *Boston Medical and Surgical Journal* as being employed in St. Thomas's Hospital. It consists merely in the use of white of egg, instead of soap, in washing the hands The fact will interest those who have much to do with plaster dressings.

BORACIC ACID IN SKIN DISEASES.

Neuman prescribes an aqueous solution in parasitic skin diseases, an alcoholic solution in itching due to urticaria and pruritus, an ointment in all forms of eczema. It may be also dusted over a part in powder. The ointment is of the strength of 10 parts in 50; the solution, of 10-20 parts in 300.—*Der Pratische Arzt.*

PREVENTION OF RELAPSES IN TYPHOID FEVER.

Immermann is of opinion (*Centralbl.*, No. 1, 1879) that relapses in cases of typhoid fever are due to the presence of the typhoid poison in the system, except in instances where the patient has committed some error in diet. The latter occurrence can of course be prevented by watching the patient carefully, and the author has endeavored to prevent the former by putting the convalescent through a systematic process of disinfection. The process consisted in giving the patients daily from 4 to 6 grammes of salicylate of soda for ten or twelve days, beginning from the first day the temperature assumes its normal state. Fifty-one patients were treated in this way, and only two suffered from relapses; one owing to something she had eaten in secret, and the other because, owing to a mistake, the drug had not been given to him immediately after the fever had left him. Fifteen out of sixty-seven patients who had not been treated with salicylate of soda had relapses. The author concludes from these observations, that salicylate of soda is not only a powerful preventive of relapses in cases of typhoid fever, but that it also would prove very useful in procuring im-

munity from the disease for the nurses and attendants.

Immermann has also observed that patients who had been treated exclusively with cold water showed a greater tendency to relapse than others who had undergone a combined water and quinine, or salicylate of soda treatment.—*London Med. Record*, May 15, 1879.

CLINICAL LECTURE ON THE RETENTION OF FECES.

[By J. Matthews Duncan, M.D., LL.D., in *Medical Times and Gazette.*]

Incontinence of feces is a disease of importance not only because the feces pass involuntarily, but because also this imperfection leads in a peculiar way to depravation of the general health. How long the feces take to pass is a subject that I do not intend to enter upon to-day; but when they pass too slowly and accumulate they may lie in any part of the great gut. The most frequent seat of accumulation is the rectum and sigmoid flexure but you have cases of enormous accumulation taking place when the sigmoid flexure and the rectum are emptied by cathartics or by enemata. In some rare cases of this kind, where, when the case comes to a happy termination, a potful of feces is evacuated, you may, before the evacuation, feel the accumulation, as I have already said, in any part of the course of the colon. I have seen enormous masses of this kind, which were for a time suspected to be malignant masses, in the right flank; and the worst case I have ever seen presented the accumulation in the epigastric region; an immense accumulation of feces could be felt, forming a hard tumor in the region of the stomach.

I shall now read to you a case illustrating a common form of accumulation which implies retention of feces. Indeed, cases are recorded —though I do not ask you to believe them implicitly—where a woman only defecated every three months. The case which I am about to read is in "Martha," on account of phlegmatia dolens of a peculiar kind. On palpating her belly we could perceive a peculiar pultaceous fulness of the abdomen, without resonance or with very limited resonance. This condition led us to inquire into the state of this woman's bowels, and I will read you the particulars in this respect of her case: L. B., aged thirty-three; seven children; last child born six weeks ago in an easy labor; has never been well since; phlegmatia dolens of left leg began a fortnight after delivery. Her symptoms indicate the probable existence of abscess in the thigh, but locally no sign of it can be discovered in the swollen limb. During the first fortnight after confinement the bowels were opened once or twice; for four weeks previous to admission they were not opened at all. Abdomen presents little tumefaction; no tympanites, but some resonance every where; has a doughy, pultaceous feeling. Castor oil and turpentine were administered four nights in succession, producing three or four large evacuations. The first three evacuations were very large and hard, the rest more nearly liquid. The abdomen is softer and more resonant on percussion, and the woman feels better.

There is a kind of retention the very opposite of this—retention in the rectum of little bits of feces. These little bits may not be scybala. Sometimes they are very black and peculiarly irritating, but this is not a necessary quality. The rectum, on examination, is found not to be a tube of moderate and nearly uniform dimensions, but a semi-paralyzed tube, dilated and pouched. In this kind of rectum the bearing-down pressure does not evacuate the bowel completely, and little bits are left which may give rise to intense irritation. A case of this irritation I saw a few days ago. This woman, after the evacuation of the bowels, which she effects by an aloetic purgative, has to use and always does use an enema to wash out the pouched semi-paralyzed bowel. If she does not use an enema, or if the enema does not succeed, she has irritation far worse than tickling, which she can not forget, and which prevents her from sleeping. I have said, "if the enema does not succeed;" and in her it generally does not succeed, and then she always has to put in her finger and get hold of the very little bit or bits and pull them out, and until she does she can get no rest. This condition is important on account of the annoyance it causes.

A semi-paralyzed pouched rectum is in potential dimensions equal to the whole pelvis. It is necessarily an inactive rectum, and the feces are often accumulated and very difficult to get out. In such cases it frequently happens that no kind of purgative is efficient, and the bowel must be washed out. This washing by an enema consists in dissolving the feces and in filling the rectum with a fluid which carries away the feces in its gush through the anus when the woman stools. Sometimes the enema does not succeed; and I have known women—generally women exhausted by excessive child-bearing, who had long suffered from this condition—who had to dig out with their fingers the feces from the rectum; not a little bit left which irritated the rectum, but the mass of feces, the whole stool.

There is a kind of this pouching which is peculiar to women that occurs in women who have vaginal rectocele. The fecal mass is projected into the pouch of the vaginal rectocele. It does not make the turn downward as it ought to do in order to emerge at the anus, but passes forward, and with the rectocele pushes through the os vaginæ. If the woman has no

disease but this vaginal rectocele she can be taught to assist herself. When defecation is going on she presses firmly against the orifice of the vagina, and pushes back this pouch so as to restore the proper shape to the rectum, and then the feces are evacuated naturally in other respects.

Retention of feces is sometimes caused by congenital smallness of the anus. The most common cause of reteniton from smallness of the anus is a too thorough operation for piles. Cases of this kind are not very rare where the anus gets too much closed, generally by the contraction of the cicatrix, so that the woman can not effectually defecate. In some cases the evil is temporary, and arises from spasms of the sphincter.

Now I come to another kind of retention which introduces me to the word scybalum. A scybalum is a rounded or oval mass of feces the size of a hazelnut or of a hen's egg, or larger, which, long retained, has become partly decolorized, hardened, and sometimes incrusted with salts of lime, producing a rough shell resembling a hen's egg. Such scybala may be in any part of the great gut. They are not always the cause of retention of feces. The further up the gut they occur the more likely they are to meet with feces which are fluid enough to pass easily by the side of the scybalum, and then they do little harm. A case occurred in my practice not long ago of a woman dying slowly from malignant disease of the peritoneum. She was examined by myself and several physicians, who correctly diagonised the disease, but incorrectly diagnosed two egg-like tumors which were for many months felt in the belly floating in the ascitic fluid which was one of the indications of her disease. These were supposed to be malignant masses. After death they were found to be scybala in the transverse colon, which were causing no irritation and apparently giving no trouble.

When a scybalum is low down, especially if it is in the rectum, the feces are likely to be retained. In this case you not only have retention *of* a scybalum, but also *by* a scybalum. Then the woman's only chance of having her bowels evacuated, if the scybalum persists, is in the motion being fluid and passing by the side of the scybalum. Solid feces are often undoubtedly obstructed by it, but it is only when the feces are nearly solid that it produces ulterior consequences. It may permit passage of fluid feces copiously, and yet be causing retention of the nearly solid feces.

In this retention of feces by a rectal scybalum you have the best example of the disease that we are considering. A woman having any form of retention of feces may be truly described, in many cases, as being constantly purged; and in this way the practitioner is put off his guard. A woman having the greatest and most dangerous retention of feces may be incessantly defecating, and even in very fair quantity, and even nearly solid feces, as one of my cases for this day demonstrates. You can see very strong analogy between this and the retention of urine in the bladder, which I was speaking of in my last lecture. In that disease a woman may pass urine frequently and in large quantities, and yet there is retention. So it may be in the case of retention of feces. In a case of retention of feces by a scybalum in the rectum, the accumulation of feces takes place first in the rectum, and it produces at last a tumor, which can be felt gradually forming in the left iliac region. This tumor presents generally little or even no resonance, is densely hard, and is repeatedly taken for malignant disease.

A case which I shall presently read to you will further impress on you the danger of judging that there is no retention because a woman is defecating, even frequently. This has a very important practical bearing not only on the diagnosis and treatment generally, but it has a very important practical bearing on the question of colotomy. You are not to suppose that colotomy is necessarily excluded from consideration because the feces are passing. The retention of feces may be going on to a dangerous and even fatal amount, although feces are passing; and colotomy may be imperatively demanded.

I will illustrate this subject by several examples. For instance, pregnancy leads in the early stages frequently to ordinary constipation. But if you watch your cases of natural delivery you will frequently find in the extraordinary amount and in the character of the evacuations evidence that the advanced pregnancy had induced retention of feces, even when the bowels were truly described as moving regularly. A fibrous tumor of the uterus, and ovarian tumor both occasionally cause very dangerous and sometimes fatal retention of feces. Adhesions sometimes do the same. Another common cause of retention of feces is stricture produced by simple inflammatory disease or by lupus or cancer.

The next case is a still more interesting one. In this case the bowel was ruptured, probably at least partly in consequence of the distention of it. The patient died of peritonitis after two days. There was no stricture, but the obstruction was caused by cancerous degeneration of the wall of the dilated tube of the bowel for a great length. The cause of obstruction in this case was the same as is believed to be the cause of obstruction in enteritis. A considerable part of the bowel does not act; the feces accumulate in it, and are only propelled slowly by the *vis à tergo*, or not propelled at all. In the case that I am about to read to you the feces were

propelled, but inefficiently; and although she was, as you will observe, defecating frequently, and, to the eye of an intelligent nurse, defecating copiously, the feces were retained in an extraordinary manner, and no doubt helped to produce the fatal result from peritonitis. It was correctly diagnosed as a case of malignant disease in the left pelvic and iliac region but it was not ascertained, and I know no means by which we could have ascertained, that the lump in the left hypogastric region consisted chiefly of feces. We suspected it, but we had no means of getting further:

"E. W., aged twenty-five, unmarried. Menses began at seventeen; regular till two months ago; since have not appeared. Four months ago began to have difficult defecation. This gradually became worse, and for weeks the pain of defecation has been agonizing. For a month walking has been difficult, almost impossible, from hypogastric pain. Micturition is accompanied by shooting pains. A fortnight before admission she felt a lump in the left hypogastric region, which has increased in size and become the seat of pain. Bowels act, not scantily, twice daily. Urine natural. Is losing flesh. The belly appears natural on inspection, but on palpation a rounded hard swelling is felt, rising from the whole length of left Poupart's ligament. It is dull on percussion, sensitive to touch, quite fixed, and reaches as high as half way to the umbilicus. The tumor is felt to extend to the right, beyond the region of dullness, as far as the right pubic bone. The cervix uteri is on the right side of the pelvic excavation, and about an inch above the ischio-pubic ramus. It is indurated, and is in the midst of a dense sensitive hardness which fixes it. The bowels continue to act fully twice or oftener daily; feces hard and dark. On the fifteenth day she became suddenly worse, with symptoms of peritonitis, vomiting fetid green acid fluid in large quantity. She died two days after this aggravation of her condition. Post-mortem examination twelve hours after death. Peritoneal cavity contains fetid gas and a large amount of fetid, brown, semi-purulent fluid. The colon and rectum from cecum to anus is distended by a hard, solid, continuous column of feces the thickness of the forearm, greenish-black in color, and of the consistence of putty, nearly solid. No strictural obstruction to the progress of feces. The pelvic organs and the superjacent intestines to the left cohere in one mass. Malignant growth occupies the mesentery, which is half an inch thick; also the walls of the sigmoid flexure and rectum, which are thickened. The bladder and uterus are not affected. To the left of the uterus is a soft fibrous mass the size of a small hen's egg, being the left ovary containing a cyst filled with about a dram of green pus. The right ovary can not be discovered. The seat of rupture of the bowel can not be made out, the intestines having given way in several places during dissection."

You observe then that constipation is not a necessary symptom of retention of feces, and, that although retention of feces implies a certain kind of constipation, there may appear to be copious evacuations while retention of various kinds is still going on.

Retention with accumulation is diagnosed by feeling scybala, or by feeling the bowel distended by a mass which takes impressions like dough. Sometimes the hardness is so great and the pain produced by pressure so great that this doughy character can not be made out. When a woman suffers in this way from great retention of feces the belly is generally not tympanitic in any part. In one of the cases I have read to you there is sometimes intense griping, and if the retention is in the lower part of the rectum you may have tenesmus. In cases of this kind the whole body sometimes is infected by the fetid mass. The countenance is dull, the face sallow, and in some cases you can smell the breath distinctly feculent. The retention of feces, however, seems, so far as I have observed, to produce no very grave symptoms except what are mechanical.

The treatment of cases of this kind scarcely requires description. In common constipation you know the favorite purgatives are aloes and castor oil and turpentine, and such like. In cases of infarction of feces, where you can reach the feces you remove them, and you are recommended to remove them by a spoon or a lithotomist's scoop; but, so far as my experience goes, this is a very useless instrument; and although it may be disagreeable for the practitioner I recommend him to use his fingers as infinitely more efficacious than any scoop or spoon-handle. When the mass of feces is higher up I have tried what is called massage —pressure, gentle kneading of the bowels, to produce action and to produce a change of the shape of the feculent mass—but I have not been able to assure myself that this treatment has done decided good. Enemata are of very great service. The most valuable is the turpentine enema.

Lastly, in some cases of this kind, such as stricture of the rectum which can not be removed, or cases of paralysis of the rectum by malignant infiltration, you must consider the advisability of resorting to colotomy. Colotomy is intended to allow the stool to pass before it reaches the disease which causes the retention, and in many cases it is perfectly successful. It allows the feces to be passed through the loin in a manner causing great inconvenience to the patient, but perfectly successful. Of course if the disease is malignant, or otherwise a fatal disease, you can only get temporary relief; but that is a matter of very great moment.

Before concluding let me merely mention an

important and very disastrous set of cases in which there is circumscribed extravasation of feces as well as retention. When an ovarian dropsy or any such cyst bursts into the bowel it sometimes happens that feces regurgitate into the cyst, generally along with fetid air, and inflammation of the cyst is set up, with feverish and probably septicemic symptoms. Such cases generally, but not always, prove fatal. I have known life prolonged for months after the accident. A similar occurrence in every respect sometimes happens in the case of a perimetric or of a parametric abscess.

AIDS TO SURGERY.

By George Brown, M.R.C.S., Gold Medallist Charing Cross Hospital, &c.; Author of "Aids to Anatomy, &c."

HYDROCELE.

Definition.—A collection of serous fluid in close connection with the testicle or spermatic cord.

Varieties.

(*a*) *Vaginal Hydrocele;* when the fluid is contained in the tunica vaginalis of the scrotum.

(*b*) *Congenital Hydrocele;* when in infants the fluid is contained in the tunica vaginals of the scrotum, and a communication exists between the sac and the abdominal cavity in consequence of the tubular prolongation of the peritoneum remaining unobliterated.

(*c*) *Encysted Hydrocele;* when the fluid is contained in a cyst projecting from the epididymis or testis, and not communicating with the tunica vaginalis.

(*d*) *Hydrocele of the cord;* when the fluid is contained in a sac situated on some portion of the spermatic cord, either in or below the inguinal canal.

Causes.—Except in the congenital variety, the cause is generally obscure. Occasionally it is traced to a blow or strain, or to an attack of orchitis. Whatever the exciting cause may be, the secretion of fluid in vaginal hydrocele is due to some inflammatory affection of the serous membrane. In the congenital variety, whether of the cord or of the scrotum, the fluid gravitates into the part from the abdominal cavity, and, as long as the communication remains open, it can be pressed back into the abdomen.

Diagnosis.—Vaginal hydrocele has to be distinguished from scrotal hernia, hæmatocele, and cystic disease of the testicle. Occasionally hydrocele and hernia co-exist when the diagnosis is very difficult. The tumour in hydrocele is generally pyriform in shape, smooth in outline, fluctuates on palpation, is free from pain and tenderness, terminates (except in rare cases) at the external abdominal ring, cannot be reduced (except in the congenital variety), is translucent unless the fluid is thick, bloody, or opaque. Hydrocele may exist with enlargement of the testicle, when translucency may not be observed. The history of the case is important. In hydrocele, the swelling commences below in the scrotum, and ascends to the groin, whilst in hernia the swelling first appears in the groin and upper part of the scrotum. In hydrocele, the testicle lies at the back of the scrotum with the fluid below and in front, whilst in hernia the testicle lies at the lower part of scrotum below the hernial sac. In cystic disease of the testicle the fluctuation is limited to one portion of the tumour, whilst in hydrocele it is present all over the swelling. The translucency of hydrocele is generally sufficient to distinguish it from hæmatocele, but in doubtful cases a puncture with a fine trocar will decide the point.

Treatment.—The treatment of vaginal hydrocele may be *curative* or *palliative*. The palliative treatment consists of simply tapping the hydrocele with a fine trocar and canula, and drawing off the fluid. In a few months the sac will become refilled with fluid, and tapping must be repeated. Various methods have been recommended for the radical cure of hydrocele. The most simple, and the one generally adopted, is to draw off the fluid by tapping, and then inject through the canula a mixture of about equal quantities of tinct. iodine and water. Inflammation ensues, usually resulting in radical cure. Other fluids are sometimes injected, as port-wine, solution of sulphate of zinc and warm water. When injecting the sac fails, the seton or free incision may be resorted to, but the cases are rare in which these are necessary. *Hydrocele of the Cord* may be treated as vaginal hydrocele, but in this variety the seton will be found very successful. In *Congenital Hydrocele* active measures are seldom necessary, the application of cooling lotions to the scrotum being generally sufficient to effect a cure. Occasionally it is necessary for the child to wear a truss for a time, in order to obliterate the communication between the scrotum and the abdominal cavity.

HYDROPS ARTICULI OR, HYDRARTHROSIS,

Definition.—A swollen condition of a joint arising from excessive accumulation of fluid. Most common in the knee-joint, and is usually known as "dropsy of the joint."

Causes.—Chronic synovitis resulting from injury, rheumatism or osteo-arthritis.

Treatment.—Absolute rest to the joint; application of back splint in case of knee-joint, blisters and counter-irritations by means of iodine and other liniments. Scott's dressing often answers well, as also does strapping the joint with mercurial plaster. Iodide of potassium and tonics to be given internally. In

extreme cases the joint may be tapped by means of the aspirator.

IRITIS.

DEFINITION.—Inflammation of the iris.

VARIETIES AND CAUSES.—Three varieties of iritis are given, classified according to their causes.

(*a*) *Simple iritis*, from irritation of foreign bodies in the conjunctival sac, or on the cornea; blows, friction of the cornea by granular lids or inverted eyelashes, or general debility after acute illness.

(*b*) *Rheumatic arthritis*, met with in persons who are the subjects of attacks of rheumatism and gout.

(*c*) *Syphilitic iritis*, as met with in persons the subject of hereditary or acquired syphilis.

CHARACTERS AND SYMPTOMS.—This affection is characterised by great pain in the eye and intolerance of light; a zone of pink or violet vessels forms around the cornea, the pupil becomes diminished in size, and sometimes irregular in shape, and loses its mobility, the iris changes its color to brown or greyish green. The aqueous humor also assumes a muddy appearance. In bad cases lymph is effused in the structure of the iris, the surface of which acquires a rusty or nodular appearance, and adhesions either between the iris and cornea, or between the iris and lens-capsule (synechiæ), take place. In rheumatic iritis the patient is likely to have a frequent recurrence of the attack. In syphilitic iritis the symptons generally are more marked and severe, and frequently the surface of the iris becomes dotted with minute nodular excrescences of a dirty yellow celor, called lymph nodules. The patient's history is important in the diagnosis of syphilitic iritis.

RESULTS.—If proper and prompt treatment be adopted perfect recovery generally takes place. In severe and neglected cases the results may be atrophy of the iris, anterior or posterior synechiæ, closure of the pupil, or capsular cataract.

TREATMENT.—First remove the local cause, if any be present, then endeavour to relieve the pain by belladonna fomentations and the administration of sedatives. The pupil to be kept dilated by means of solution of atropia. The patient should be kept in a darkened room, or wear a shade. If there is much pain leeches should be applied to the temples. In severe cases, mercury with opium (2 grains of blue pill with $\frac{1}{4}$ grain of opium three times a day) should be given, care being taken not to proceed to salivation. In debilitated persons iron and quinine with cod-liver oil are indicated in rheumatic iritis, colchicum and iodide of potassium are valuable. If adhesions interfere with vision, or closure of pupil results from iritis, the performance of iridectomy is necessary.—*Hospital Gazette.*

TREATMENT OF EPILEPSY.

By W. R. GOWERS, M.D., F.R.C.P., Assistant Professor of Clinical Medicine University College, London.

The treatment of epilepsy, it was remarked, is a subject on which numerical analysis gives little help, because so many patients whose fits cease under treatment relapse when treatment is relinquished. The time available permitted little more than a statement of the remedies most useful in 562 cases in which the effect of treatment was carefully noted. The results showed that, while we must not rely *exclusively* on bromides, on these our chief trust must still be placed. Of the three alkaline salts the bromide of potassium deserves, as it has received, the first place. The salt of ammonium is more useful, only in proportion to the slightly greater quantity of bromine which it contains, while a careful comparison in a series of cases between the salts of sodium and potassium showed that the former is distinctly less useful. The maximum effect of each dose of bromide occurs the sooner, the smaller the dose; hence small doses used to be given frequently. Bromide lessens reflex action, perhaps by increasing resistance in the centre, since it antagonises strychnia, which is believed to lessen resistance. If the view that unstable resistance is the chief element in epilepsy is correct, increase of resistance may be the explanation of the action of bromide. The mode of administration is usually by continuous course, in doses just sufficient to arrest the fits. Given thus it was rarely found well to give more than a drachm and a half daily; if this does not suffice, combinations with other drugs answered better than increasing the regular dose. But it was urged that a course of large doses may be for a time employed, with a view of obtaining the full nutritive change in the nervous system, which bromide can effect. For this purpose it was thought best to give it in considerable doses, at longer intervals, beginning with half an ounce. The largest single doses given had been of one ounce, the doses being given at intervals of three to five days.

The value of the various combinations of bromide with other drugs had been tested by ascertaining first, during several months, the effect of a given dose of bromide, and then adding to it the agent to be tested. Of the combinations in common use, those with digitalis and belladonna deserve, as they have commonly received, the first place. Digitalis has enjoyed repute in epilepsy for two hundred

years. Alone it sometimes does marked good, and in 63 cases the combination of digitalis and bromide was distinctly more useful than bromide only; in 37 of the cases the attacks ceased during the treatment. The effect of this combination is not confined to the cases in which there is cardiac disturbance, although in these it is almost always useful. Digitalis markedly increases the effect of bromide in nocturnal epilepsy. A case was mentioned in which a patient had not had a single fit for two years on the combination, although he had a fit at night every few weeks on bromide only. Belladonna alone will sometimes arrest attacks. The combination of it with bromide was distinctly more useful than bromide alone in 35 cases, and in 15 arrest of the fits was obtained. Indian hemp is now and then of marked service even alone. A case was mentioned in which the attacks always ceased on this drug, and recurred at once when bromide was substituted. Other combinations which had been found useful were bromide with aconite, and bromide with hydrocyanic acid. The cases in which the addition of iodide to bromide increases its effect are rare.

Zinc deserves some of the repute it has enjoyed for more than a hundred years. Of a large number of cases, in which the oxide was used in doses as large as the patient could bear it, it was distinctly useful in ten, but in only three did the attacks cease. Bromide of zinc, in doses which could be borne, and the bromide of camphor, had seemed of small value. The addition of arsenic to bromide in no case had any influence on the fits, although largely used, on account of the certainty with which the bromide rash could thus be lessened or removed. Turpentine (recommended by Dr. Radcliffe) had been found distinctly useful only in hystero-epilepsy. The use of iron in epilepsy was discountenanced by high authorities. In some cases it seemed to increase the attacks, but in the majority in which it had been given its influence was distinctly beneficial. In four cases the attacks ceased on iron only; in eight others iron alone was distinctly better than bromide alone; and in nineteen the addition of iron to bromide had a marked influence; in eleven the attacks, which had persisted on bromide, ceased when iron was added, and remained absent as long as the combination was given. In several inveterate cases, in which bromide had little effect, the lecturer had given borax in doses of ten to fifteen grains twice or three times a day. In some it was useless, in some its beneficial effect was most distinct. Several cases were narrated in which the attacks ceased for a long time under its use. Occasionally it causes gastro-intestinal disturbance, but many patients bear it well. Cocculus indicus had not been tried sufficiently for an opinion to be fromed, but very little benefit had been observed from its alkaloid, piciotoxine. The same conclusion was drawn from an interesting series of cases in which Dr. Ramskill had employed it hypodermically, which showed, however, that a dose of eighteen milligrammes will almost invariably produce a fit in from twenty to thirty minutes. Other drugs which had been tried and found useless were benzoate of soda and nitro-glycerine.

In hystero-epilepsy bromides, sometimes useful, often fail. Belladonna, iron, valerianate of zinc, and turpentine had appeared of greatest value. The treatment of the actual attacks of hystero-epilepsy is often a matter of difficulty. In the slight fits Dr. Pare's plan of closing the mouth and dose is often useful. When this fails Faradisation of the skin and cold douches on the head and water poured into the open mouth are often efficacious. Chloroform is of little value. Where all fail the lecturer had found the hypodermic injection of apomorphia invariably successful. After a twelfth of a grain had been injected, in four minutes all spasm was over, in six minutes the patient would get up, in eight minutes vomit, and then, except for slight nausea, be well.

In conclusion, the lecturer remarked that although the condition of many epileptics was still gloomy enough, yet the present generation had witnessed an advance in the treatment of the disease equalled perhaps in no other branch of therapeutics. Thanks to the influence of the drug the use of which in epilepsy was wholly due to Fellows of that College, hundreds of sufferers had been cured, and thousands were leading useful lives who would otherwise have been incapacitated by the disease. For all the victims of the disease we might surely trust that the progress of the recent past is the dawn of a brighter day.—*Dublin Medical Press, March* 10, 1880.

TOPICAL USES OF ERGOT.

In the *American Journal of Medical Sciences*, July, 1879, Dr. Wm. C. Dabney mentions some local uses of ergot. He writes:—

In cases of *pterygium* I have used it with decided benefit. A solution of the strength mentioned above was applied three times a day, and the growth was checked thereby. In none of the cases where I have used it thus far has it exerted a curative action, but it is highly probable that if persisted in the blood-vessels supplying the pterygium would become so much contracted as to cause an actual diminution in the size of the growth.

In *pharyngitis* I have obtained excellent results from the application of a solution of Squibb's solid extract of ergot to the throat; indeed, no other remedy has given anything like such satisfactory results in my hands. Just as in oph-

thalmia, the remedy seems to act much better in chronic than in acute cases. It is especially applicable when the blood-vessels of the pharynx are enlarged and tortuous, and when the secretion is not very great. In those cases where the mucous membrane is thickened, it acts much more slowly, and in acute cases it possesses no advantages over other remedies. In affections of the pharynx, and in other cases to be mentioned hereafter, a combination of ergotine with tincture of iodine, as in the following formula, is especially efficacious:—

℞ Ergotine, grs. xx
Tinct. iodine, f ʒ j.
Glycerine, to make f ʒ j. M.

To be applied to the pharynx freely, twice a day, with a camel's-hair brush.

In *hypertrophy* of the *tonsils*, which is so often an accompaniment of chronic pharyngitis, the same solution applied to the glands two or three times a day gives excellent results.

It is probable that nasal catarrh would be benefitted by ergot, locally applied. The great trouble in these cases has been that remedies applied with the nasal douch have remained in contact with the congested Schneiderian membrane too short a time to do any good. About two years ago Dr. George Catti proposed the use of gelatine bougies, which were to be inserted through the anterior nares, and then allowed to soften and flow out by the posterior nares. These bougies could be medicated with any agent which it was thought desirable to use, and in a note appended to the translation of Catti's paper in the *Virginia Medical Monthly* I suggested the use of ergot in this way. I have never tried the bougies myself, however. In one case of catarrh, when the inflammation was seated near the posterior nares, I applied a solution of ergot and iodine by means of the post-nasal syringe, but the result of the treatment is not known. A solution of ergot in glycerine may also be applied to the nasal mucous membrane by means of a camel's-hair pencil, but I cannot say that I have had satisfactory results from any mode of application which I have tried thus far. If the medicine be applied to the Schneiderian membrane in any way, the iodine should not be added to the mixture at all, or else only in very small quantity.

It is unnecessary to say anything as to the use of this agent in *hemorrhoids*, as it is mentioned now in nearly all the text-books on therapeutics, and is in common use.

It seems almost needless, also, to say anything as to its use in *metritis* and *endometritis*. But, although it is mentioned now in nearly all the works on gynæcology, its value does not seem to be recognized by the majority of general practitioners.

It appears to be especially applicable in *cervical metritis*. The manner in which it should be applied depends on the season of the year and the temperature. When the weather is sufficiently cool suppositories are preferable, but in warm weather it is difficult to handle them and keep them from melting. The addition of extract of belladonna increases the efficacy of the ergot, and also tends to relieve any pain which may be present. The following formula I have found serviceable:

℞ Ergotine (or solid extract of ergot), grs. xx.
Extract of belladonna, grs. ij.
Cocoa butter, q. s. M.

Make into six suppositories, and insert into the vagina every night after using the hot douche.

In warm weather a solution of ergotine and extract of belladonna in glycerine and water may be used in place of the suppositories, as in the following formula:

℞ Ergotine (or Squibb's solid extract), ʒ ss.
Extract of belladonna, grs. vj.
Water and glycerine, aa f ℥ iv. M.

A pledget of cotton is to be saturated with this solution, and inserted into the vagina at bedtime after the hot douche. (The cotton should, of course, be removed in the morning.)

It has been proposed to paint a solution of ergot on the os and cervix with a camel's-hair pencil, and favorable reports of this mode of treatment have been published. So far as my own experience enables me to judge, those cases where there is a copious discharge of mucus or pus are much less amenable to treatment than others, and this is probably due to the fact that the medicine remains in contact with the diseased surface such a short time before it is washed off. And I would call attention just here to the advantages of glycerine over water as a *vehicle* when ergot is applied to mucous membranes where it is liable to be speedily washed off. The tenacious properties of glycerine keep the remedy longer in contact with the diseased surface, and in addition to this the glycerine itself is, as Dr. Marion Sims long ago pointed out, of decided value in reducing some of these chronic inflammatory engorgements.

A TASTELESS SALINE PURGATIVE.

M. Yvon finds that the disagreeable taste of sulphate of magnesia may be completely concealed by the addition of a few drops of the essence of mint, provided that the quantity of the vehicle be small. He advises that ʒ vi. of the sulphate should be dissolved in about ℥ i of water, two or three drops of the essence of mint being then added; or the flavoring agent may be added to the salt, and the patient directed to dissolve the whole in as small a quantity of water as possible.—*Paris Médical*, 14th August, 1879; *Lyon Médical*, 31st August, 1879.

FLAGELLATION A PREVENTIVE OF UTERINE HEMORRHAGE.

(By Isaac E. Taylor, M.D., Emeritus Professor of Obstetrics and Diseases of Women, and President of Bellevue Hospital Medical College of New York.)

1. Flagellation of the child's back previous to its complete delivery as a *preventive* of uterine hemorrhage.

2. Flagellation of the abdomen of the woman after the delivery of the placenta as a *substitute* for the introduction of the hand into the cavity of the uterus.

I most cheerfully assent to the wish and action of the Obstetrical Section requesting me by resolution to present the views and opinions which I laid before them December 23, 1879, for the consideration of the Fellows of the Academy this evening.

The title of my paper is embodied in two propositions:

First. Flagellation or spanking the child's back previous to its complete delivery, as a *preventive* of uterine hemorrhage.

Second. Flagellation of abdomen of the woman after the delivery of the placenta, as a *substitute* for the introduction of the hand into the uterine cavity.

We will all admit the physiological fact that the uterus is the only organ in the female economy that has an habitual sanguineous fluid issuing from it. We also know that it is the only organ which physiologically has large, oblique, open sinuses without valves, the blood from these sinuses coming directly from the vena cava and the heart itself, and not coming from the returning veins of the uterus.

The slightest derangement, either from a physiological or a pathological process, in the separation of the maternal from the fetal circulation may entail an unfavorable and sometimes a fatal termination. Frequently not the slightest evidence is given before or after labor has commenced. Every thing in the lying-in chamber before and after delivery of the child appears to be progressing favorably; the countenance of the mother is radiant with joy, and that of the attendants and the medical man cheerful and encouraging, when the blood is suddenly heard gushing forth in a full and rapid stream, and the patient is in a state of extreme syncope.

Blundell has seen two cases die suddenly in one night from this cause. In cases of this decided character, though not frequent, it is imperative that the obstetrician should be provided with all possible resources, and they should be employed for the welfare of his patient. He should possess in himself calmness, courage, judgment, decision, promptness of action; and if not thus fortified mentally and prepared, he should never, as Lee has said, "cross the threshold of the lying-in chamber."

At the meeting of the American Gynecological Society, held in Philadelphia, September, 1878, two papers on the treatment of Post-partum Hemorrhage were read and presented for consideration. A long discussion ensued respecting the different methods of treatment in those cases. One of the papers—that by Dr. Wilson, of Baltimore—advocated the hand as a curette to remove all or whatever portions of the placenta that may remain, and to excite uterine contraction by scraping the inner surface of the uterus. The other paper was by Prof. Penrose, of Philadelphia, who recommended very highly, after several years' experience, the introduction of a rag or pocket-handkerchief saturated with common vinegar in the uterine cavity and squeese it. Both of these papers had reference to, and were suggestive of, treatment by art after the delivery of the placenta.

From the nature of the remarks which were made on that occasion I am induced to present and suggest another method or means to the many already before the profession and so generally pursued. I am fully aware that it might seem almost superfluous for me to even attempt or hint another method, but the favorable results arising from it prompt me to do so. It is one, however, simple, efficient and decided. One always on hand and at hand, having for its recommendation a physiological basis, not only as a means for arresting the blood or flooding in many cases decidedly after the delivery of the child, but, secondly, it is especially of more and greater importance as an aid to prevent the flooding from taking place before and after the delivery of the placenta. I shall consider the method of treatment which I present, as I said, in two propositions:

First. Flagellation or spanking the child's back moderately every now and then after the delivery of the shoulders, permitting the breech and the extremities of the child to remain in the vagina, and the feet thus placed in apposition with or in the cervix uteri, remaining for fifteen or twenty minutes or more without being withdrawn. Pressure over the uterus by the hand is to be avoided till the delivery of the child, which should be slow and gradual, as it might effect the delivery of the child before we had gained our object, and at the same time the spanking should be quick but gentle, and not too harsh, and continued until the delivery of the child is completed.

Second. After the delivery of the placenta, should hemorrhage occur, expose the abdomen and flagellate it with a towel doubled up, the ends held in the hand, saturated or not with ice water. Several rapid and powerful strokes should be made, when the unrecognized uterus will be almost immediately felt contracting or contracted, no matter how profuse or rapid the flow may be. In one instance, having ocular

demonstration after the delivery of the placenta, the stream of blood was as large, full, and rapid as that which flows from a croton faucet.

Should uterine contraction ensue and relaxation take place, a milder application of the same means may be resorted to till the contraction is deemed secure and other measures adopted, if necessary.

There can be no procrastination or temporizing action in these sudden and violent cases. The appearance of the method to those present, or to the patient herself, if conscious, with the suddenness and rapidity of its application may seem harsh, abrupt and unnecessary. We have, however, nothing to do with appearances or feelings in such critical emergencies. We are imperatively reminded that life or death is swaying in the balance. Duty commands decided and prompt action. By this procedure I have in some instances had the gratification of feeling the apparently lifeless organ fold itself up under the touch, the uterus contracting or contracted, and our patient's life safe certainly for the time being. Under such circumstances, hot or cold water injections, as well as the hand internally, has in many instances failed to arouse into contraction the perfectly atonic or moribund organ.

After contraction has once been secured, then that treatment which the views or experience of the medical attendant may elect can be pursued, whether by hot water or cold, externally or internally, or mixed with other substances, or by tincture iodine or sulphate of iron, accompanied with the ordinary and usual manipulations externally over the uterus.—*The Independent Practitioner.*

TREATMENT OF CRACKED NIPPLES.

Dr. Haussmann treats cracked nipples by applying lint soaked in a two per cent. solution of carbolic acid. The wet lint should be applied every two or three hours. The treatment gives instant relief from pain, and, although the child continues to use the nipples, cure is established within three days.—*New Remedies.*

HOW TO MAKE A SPICE-BAG.

Dr. A. A. Smith, in the *New York Medical Record*, gives the following directions: Take half an ounce each of cloves, allspice, cinnamon, and anise-seeds, bruised, but not powdered, in a mortar; put these between two layers of coarse flannel about six inches square, and quilt them in. Soak this for a few minutes in hot spirits (brandy, whiskey, or alcohol) and water, equal parts. It is to be applied while warm; renewing it when it gets cool. Used in the diarrhœa of infants and children, it has not only the effects of a poultice, but also the sedative and antiseptic effects of the spices.

THE TREATMENT OF CHRONIC NASAL CATARRH.

In the *American Journal of the Medical Sciences* for January, 1880, we find an article on a new method of treating chronic nasal catarrh, by Harrison Allan, M.D., Professor of Physiology in the University of Pennsylvania, in which the author points out that, in the normal nasal chamber the turbinated bones do not touch the nasal septum, neither do the middle or inferior turbinated bones impinge on each other, or the floor of the nose. Should, however, chronic nasal catarrh be present, the middle turbinated bone is often seen lying close against the septum, or the inferior turbinated bone is found occluding the inferior meatus.

But the mere contact of the anterior portion of the middle turbinated bone against the septum should not be looked upon as of necessity an exciting cause of nasal catarrh. Not infrequently perfectly healthy persons will exhibit such contact over a small surface. But in such instances the contact is often found to be slight—the apposed surfaces barely touching—and a probe can be passed without pain or sense of obstruction. In the contact which has clinical significance we should expect firm pressure of the scroll and septum against one another, and some pain to follow manipulation.

When the point of contact is recognized, the indication for treatment is to destroy it. This is accomplished by means of local remedies applied to the mucous membrane at and about the places of contact, or, in examples of abnormal deflection of the nasal septum, by removal of the offending portions of bone. In the case of the inferior turbinated bone, the swollen and engorged tissues occupying the inferior meatus may be removed by the knife.

To make topical applications to the interior of the nasal chamber, the author employs a simple cotton carrier, closely resembling the instrument in common use by the aurist. It consists of a single tapering rod of soft iron, slightly roughened at the smaller end, for convenience of holding a pledget of absorbent cotton, and fixed in a small wooden handle at the other. A wooden handle is preferable to a metallic one, since the latter is liable to fall out of the nasal chamber from its own weight, if the hand supporting it be removed for but a moment. It may be bent at an angle, and the absorbent cotton can be steeped in any desired substance, and carried to the spot selected through the nasal speculum. The pledget of cotton should be moistened in water and warmed for an instant over the flame of the lamp. Thus prepared, it does not irritate the mucous surfaces more than any other intruding solid substance. After employment of various agents, the author has found the best results from a combination of tannic acid with carbolic

acid or iodoform, held in suspense in gelatine. The object of employing gelatine rather than water or spirit, is to enable the medicine to remain for a long time in contact with the affected parts, and, in dissolving, to form a thick fluid which measurably imitates the consistency of the normal secretions of the parts.

The following formulæ are those ordinarily made use of by the author:—

Stiff iodoform preparation, with geranium and carbolic acid:—

℞.	Pure carbolic acid,	grs.v
	Fl. ext. geranium maculatum,	gtt.xv
	Distilled glycerin,	gtt.x
	Powdered iodoform,	ʒ iijss
	French gelatine,	ʒ j
	Water,	q.s.

Dissolve the gelatine in a little water, then add the other ingredients, and rub to a smooth paste.

Stiff iodoform preparation without geranium:—

℞.	Pure carbolic acid,	grs.v
	Distilled glycerin,	gtt.x
	Powdered iodoform,	ʒ iijss
	French gelatine,	ʒ j
	Water,	q.s.

Dissolve the gelatine in a little water, then add the other ingredients, and rub to a smooth paste.—*Philadelphia Medical and Surgical Reporter.*

TIGHT-LACING.

Dyce Duckworth, M.D., F.R.C.P., in an article published in *The Practitioner*, January, 1880, says—

I have to state, then, that I find in a considerable proportion of women, among hospital patients, and frequently in the case of those in higher ranks, that the stays are either too small, or are fastened too tightly. In many instances this compression is practiced unwittingly. Stays last for a long time. The wearer grows, and the stays are too small, or they are procured just as any other article of dress, without reference to the particular figure they are to encircle.

In most instances stays are made by the gross, like gloves, stockings, or boots; they are kept in different sizes, but no care is commonly taken to secure a proper fit. It must be borne in mind that they constitute a very important article of clothing for the poorer women, since they are by them regarded chiefly for their warmth, and not merely for support. It usually happens that they are adopted in early life, and as puberty approaches, insufficient attention is paid to the changes occurring in the figure at that period. And thus at an early age young girls come instinctively to accustom themselves to a measure of constriction from their stays.

When new stays are required, there is at once a repugnance to such as would fit properly, and, therefore, the same degree of tightness is imperatively demanded as has been hitherto borne. Thus it is that when one comes to examine into the matter, the unvarying remarks are offered: "I am not at all tight; my stays are quite easy and comfortable; I could not endure to be tight; I never lace tightly."

The result of the inquiry almost as commonly is, that the stays are found to be from one to four or five inches smaller in girth than they ought to be.

This miserable imprisonment is, as I have observed, in most instances involuntary; it is not practiced because it is fashionable, it is not the result of ambition to have a small waist, but it comes about for the most part in the manner I have described. Of course, in many cases, it is done deliberately.

The results are more harmful than is generally believed, but they are only such as might be predicated.

I find many cases of dyspepsia in women yield quickly to the use of proper stays. Again and again I have known chronic vomiting in young girls to be due solely to tight stays. Palpitation and dyspnœa, not due to anæmia, are frequently caused by bad stays. The worst cases naturally occur in young women who are inclined to *embonpoint*, and whether this be constitutional or aggravated, as is that condition, by anæmia, the obese tendency commonly both adds to the compression, and gives cause to the wearer to increase her troubles in the efforts to retain (what she conceives to be) shapely proportions.

LINIMENTS FOR RINGWORM.

A writer in the *British Medical Journal* gives the formula for Coster's paste, thus:

℞. Iodine pigment.....2 drachms.
Oil of cade or oil of juniper tar.....1 ounce.
Mix. For an embrocation.

He finds the following formula, however, most effectual:

℞.	Iodine pigment.....	4 drachms.
	Creasote.....	4 "
	Oil of cade.....	4 "

Mix.

This, he says, in cases of early ringworm, is an effectual remedy if well brushed into the roots of the hair. The addition of a quantity of iodine makes the preparation more valuable.

The *iodine pigment* of the British writers is made by dissolving one drachm of iodine in one ounce of alcohol, and allowing the solution to stand in a glass-stoppered bottle for several months before it is used, when it will become thick and syrupy.

CALLING THE DOCTOR.

The following item from the *Louisville Medical News* illustrates one of the ways in which medicine is practiced in that city:

The other morning, as a belated member of the Owl Club was steering home through the dense fog, which the writer is reliably informed hangs over the city at 3 a.m., he passed the house of a well-known physician. The vestibule of this residence was open, and on its side the dim rays of the moon, struggling through the gloom produced by the efforts of the city gas company, disclosed the mouth of an accoustic tube, underneath which was the inscription, "Whistle for Dr. Potts."

Not wishing to be disobliging about so small a matter, the Owl stumbled up the steps, and steadying himself against the wall, blew into the pipe with all the strength of his lungs.

The physician, who was awakened by the resultant shrill whistle near his head, arose; and after wondering at the singular odor of whisky in the room, groped his way to the tube and shouted. "Well."

"Glad to know you're well," was the reply; "but, being a doctor, I s'pose you can keep well at cost price, can't you?"

"What do you want?" said the man of pills, not caring to joke in the airy nothing of his nightgown.

"Well," said the party at the other end of the tube, after a few moments' meditation, "O, by the way, are you young Potts or old Potts?"

"I am Dr. Potts. There is no young Potts."

"Not dead, I hope?"

"There never was any. I have no son."

"Then you are young Potts and old Potts, too. Dear, dear, how singular."

"What do you want?" snapped the doctor, who was beginning to feel as though his legs were a pair of elongated icicles.

"You know old Mrs. Peavine, who lives in the next block?"

"Yes. Is she sick? What's the matter?"

"Do you know her nephew, too—Bill Briggs?"

"Yes. Well?"

"Well, he went up to Bridgeport, shooting, this morning, and—"

"And he had an accident? Hold up a minute. I'll be right down."

"No, he's all right; but he got sixty-two ducks—eighteen of 'em mallards. I thought you might like to hear it."

And the joker hung on to the nozzle and laughed like a hyena digging up a fat missionary.

"I say," came down from the exasperated M.D., "that's a jolly good joke, my friend. Won't you take something?"

"What?" said the surprised humorist, pausing for breath.

"Why, take something. Take this."

And before the disgusted funny man could withdraw his mouth a hastily-compounded mixture of ink, ipecac and asafetida squirted from the pipe and deluged him from head to foot, about a pint monopolizing his shirt-front and collar.

And while he danced frantically around, sponging himself off with his handkerchief, and swearing like a pirate in the last act, he could hear an angel voice from above sweetly murmur:

"Have some more? No? Well, good night. Come again, soon, you funny dog, you. Bye-bye."

TREATMENT OF LARYNGISMUS STRIDULUS.

W. H. Day, M.D., physician to the Samaritan Hospital for women and children, writes, in the *Medical Press and Circular*, Feb. 12th, 1880—

The first indications are to remove all exciting causes. If the bowels are disordered they should be set right as soon as possible by proper aperients, and healthy digestion promoted. If the child has taken a heavy meal, or indigestible food, an emetic may be advisable; and should the gums be swollen, and dentition appear to invite the complaint, they ought to be scarified. The child should occupy an airy apartment, and noise and excitement be precluded. If seen during the paroxysm it should be kept in an upright position, and the windows opened, so that it may be encouraged to breathe. In severe cases, especially if a convulsion threaten, it may be immersed in a warm bath, while cold water is sprinkled at the same time over the face. Dr. Morley Rooke recorded a case of laryngismus stridulus in a child nine months old, where occlusion of the larynx during the fit produced symptoms like those of "a recently drowned person." The little patient "showed no sign of life" when first seen in the seizure; the lips were blue and swollen, the face a livid grey, and the eyes half closed and glassy. Dr. Rooke thrust his finger between the teeth to the fauces, when the child gave a short heave and a gasp; on repeating the movement inspiration took place, and in a few more seconds breathing ensued. On two more occasions, when occlusion of the larynx was equally severe, a similar manœuvre brought round the child. This is a mode of treatment well worth bearing in mind when the child threatens to die from spasm of the glottis. The cure was completed by bromide of potassium, which was taken for eleven months. Dr. Wardell also points out the beneficial effect of "rotating the finger in the throat" in these cases; it induces an attempt to vomit, when the laryngeal muscles become relaxed, and air is admitted into the trachea. He says

it is the first thing to be done, and he has seen it succeed when death seemed imminent." In extreme cases, where death threatens from asphyxia, the operation of tracheotomy should be employed. The inhalation of chloroform has been recommended in some cases, but then its influence soon passes off, and it cannot be said to have any curative effect. When there is much restlessness, and the child can obtain no sleep, the excitability of the nervous centres must be calmed, and for this purpose small doses of morphia may be cautiously employed. In the intervals of the seizures the bowels must be kept freely open, so as to remove all sources of irritation that might sympathetically excite spasm.

Among the chief drugs are belladonna, in the form of extract or tincture, which sometimes has the effect of diminishing the glottic spasm, but in most cases it fails altogether. Bromide of potassium is very serviceable given with citrate of potassium, sal volatile, or quinine, according to the peculiarities of each case. Carbonate of ammonia, henbane, bark, and mild preparations of iron, as the ammonio-citrate, or the syrup of the iodide, are remedies to be selected. If the child is strumous and rickety, or in any way delicate, cod-liver oil is invaluable. It is a remedy which ought to be persevered with, as, by improving the general health, we may so keep off the disease.

Diet is of great importance, and, when carefully selected, the disease may disappear without drugs. If the child is fed at the breast, it is sometimes advisable to change the nurse or to give cow's or ass's milk. If older the food must be light and nutritious, and given frequently, in small quantities. The clothing should be warm, and, if the child is not too ill, he ought to be taken out in the open air daily.

CONFLAGRATION FROM THE USE OF THE THERMO-CAUTERY DURING ANÆSTHESIA FROM ETHER.

The *British Medical Journal* (November 22, 1879,) from a French source, gives an account of an operation under ether for arthritis of the knee-joint, in which the actual cautery was employed. Five ounces of ether had been employed. The window had been opened, the room was large, and the ether-bag was to a certain extent separated from the thermo-cautery. Suddenly the room was in flames, and the bed was enveloped in them. The ether-bag was thrown down on the floor, and the patient quickly removed. She was only slightly burned, but the physician who was administering the ether was severely injured. Similar accidents have been noticed elsewhere. Ignition does not occur when the wire is only heated to redness: a white heat is necessary. Some years ago Dr. Dolbeau practiced local anæsthesia with ether spray on the hemorrhoids of a patient about to be operated upon. The apparatus having been removed, the red-hot iron was applied, but the ether vapor caught fire, and produced a general conflagration and extensive burning of the surrounding parts without affecting the hemorrhoids.

THE TREATMENT OF SYPHILIS.

In a paper read before the Los Angeles County Medical Association, November 7th, 1879, and published in the *Pacific Medical and Surgical Journal*, December, 1879, Walter Lindley, M.D., thus describes the plan which he has adopted and practiced for many years:—

When a patient comes to me with a well marked syphilitic chancre and bubo, I tell him distinctly that I will not undertake to cure him unless he will remain under my treatment for one year. If he consents, I prescribe—

℞.	Iodoform,		3 j
	Mucilage,		
	Glycerine,	aa	gtt.x
	Oil of peppermint,		gtt.j M.

Make into a paste and apply to the chancre after washing, night and morning. This combination disguises the offensive odor of the iodoform.

For the bubo I usually prescribe iodine for paint, but doubt whether it is of much advantage.

Internally I give—

℞.	Pil. hydrarg.,	gr.iss
	Quiniæ sulph.,	gr.ss. M.

Ft. pil.

Sig.—Take one three times daily.

If the patient is in the secondary stage, I give a mixture, as a rule as follows:—

℞	Hydrarg. chlor. corros.,		gr. ij.
	Pot. iodidi,		
	Pot. chloratis,	aa	ʒ iiss
	Syrup sarsaparillæ comp.,		ʒ iv. M.

Sig.—Take one teaspoonful three times daily.

Substituting comp. tinct. cinchona for sarsaparilla in atonic cases.

In the tertiary stages I increase the quantity of iodide of potassium, but adhere to the mixed treatment.

In the first of my practice, when I was in charge of the out-door surgical clinic, Brooklyn Eastern District Hospital, I often had cases of marked tertiary syphilis on whom I would first try the much vaunted large doses of iodide of potassium. The patient would improve for a while and then stop. I would add corrosive sublimate, and the change would be wonderful. He would gain in flesh and strength, and soon be free of pain.

Some advocates of the iodide treatment say

that about one-sixth of the tertiary cases need mercury.

As corrosive sublimate is known to produce red blood corpuscles, to act really as a tonic, it is, in my opinion, the safer plan to always combine it, or some other form of mercury, with the iodides in the treatment of syphilis. In all forms of syphilis, primary, secondary or tertiary, I continue mercurial or mixed treatment for at least one year.

CLINIC OF PROFESSOR SAMUEL D. GROSS, M.D., LL.D., D.C.L., OXON.

OLD DISLOCATION OF THE ELBOW.

CASE III.—This child, twelve years of age, has been brought here with a marked deformity of the elbow, and the statement has been made that it was caused by a fall three months ago. I explained to you, when on the subject a few days ago, the difficulty of reducing a dislocation of the bones of the forearm at the end of a fortnight or three weeks; but when it has existed for several months I always despair of obtaining a satisfactory result. This case has the characteristic deformity of a backward dislocation of the forearm. The olecranon process is extremely prominent, the three-headed extensor muscle is relaxed, the elbow, unnaturally full in front, and standing out in bold relief, partially flexed, and moveable only to a limited extent.

This is what we call an "old" luxation of the elbow; as you know, some dislocations become old, *i. e.*, difficult to reduce, in a shorter time than others. What changes may take place in this joint in the short space of a few weeks, that will often make it impossible for us to restore the articulation to its proper relations, is a question which has never been answered by surgeons, and I cannot myself offer any satisfactory reason, but such is the fact; and a dislocation of the elbow that could be readily reduced at the time it occurred, in the course of three weeks may be practically irreducible.

Dislocations are sufficiently frequent at all periods of life. The elbow-joint may be luxated in four principal directions—backwards, forwards, inwards, and outwards. I call your attention, in this case, to the relaxed condition of the triceps muscle, which is one of the most important features in this form of dislocation. The forward dislocation is very rare. It is very uncommon when unconnected with fracture of the olecranon process. Lateral luxations are also very rare.

After giving the patient ether I will try the effect of forced extension, with counter-extension, holding the arm firmly, and drawing the wrist and hand downwards and backwards, and then suddenly flexing the forearm upon the arm.

It is much to be regretted that such a dislocation as this should not have been recognized and reduced at the time it occurred. All that is necessary, as the rule in recent cases, is to put the patient under the influence of an anæsthetic, then place the knee in the bend of the elbow, extend the forearm, and then suddenly flex the joint, when the bones will slip into their normal position.

There is great danger at this age, in making powerful traction and forcible extension, that the humerus may give way at the epiphyseal cartilage above the condyles. A twisted sheet placed in the armpit affords good counter-extension, while strong traction is made upon the forearm. The treatment in these neglected cases is generally unsatisfactory. The best rule is to make out the diagnosis and apply the remedy at the earliest possible moment. The surgeon in these powerful manipulations not only runs the risk of separation of the humerus above the condyles, but also of fracture of the olecranon, which has happened to me several times; but this is an accident which is perhaps not always to be regretted, as it does not interfere materially with repair.

The division of the tendon of the triceps has been proposed, and two cases have been reported in which it was performed by Dr. Sayre, with asserted good results. I fail to see how this expedient could effect any good purpose, as the muscle is already relaxed; the olecranon is carried, as you see, backwards and upwards, so that the tendon is not tense, but quite the contrary.

I will not make any further attempts this morning, but will bring the girl before you again after she shall have had a few days' rest in the hospital.

[On several occasions, subsequently, attempts were made to reduce this dislocation, but without success. Division of the lateral ligaments, by subcutaneous section, was also ineffectually performed. Even Dr. Sayre's operation was practised, as a dernier ressort, without avail. The patient was finally discharged, to return to her home, without being relieved.—F. W.]

GUTTA PERCHA FOR FISSURED NIPPLES.

Dr. KING, in the St. Louis *Courier of Medicine*, recommends the application to fissured nipples of a solution of gutta percha in benzine or bi-sulphide of carbon. He paints this solution all over the nipple, except the apertures of the milk ducts. It remains on two or three days, and usually the parts are entirely healed. Occasionally it needs to be re-applied. It is suggested that the cement used by cobblers in mending shoes, by what they term "seamless patch," would answer the above indication, but better still would be to use the officinal solution of gutta percha in chloroform.

NEW METHOD OF PLUGGING THE POSTERIOR NARES.

Ed. *Phil. Med. and Surg. Reporter*:—

Below I give you an extract of a paper read by me before the Highland County Medical Association, July 10th, 1878, on the subject of Purpura Hemorrhagica, setting forth a new plan, so far as I know, of passing the loop preparatory to tamponing the posterior nares.

"Probably the best device for the mode of operating to which I refer consists of a piece of round, fine-linked, gold chain, slightly flexible and smooth, about one-tenth of an inch in diameter and an inch or more long, attached by one end to a fine waxed silk cord, a foot or more long. If such a chain is not procurable a short strand of metallic cylindrical beads, or bird shot, compressed on a cord, or small strips of sheet lead wrapped on the cord, might answer the purpose, the essential qualities of a nasal gravitator being smallness, smoothness, heft and slight flexibility. After providing an instrument, which can generally be done at any farm house, the patient is then laid upon the back, the floor of the nose brought as nearly vertical as may be, and the loaded end of the gravitator lowered into the pharynx. Its arrival there will generally be announced by coughing, retching or clearing up of the throat. The patient then being brought to an erect position easily hawks up the weight and carries it forward on the tongue, when the operation of plugging may be proceeded with as usual."

The practicability of this procedure I have had occasion to demonstrate frequently, and find it much less annoying to the patient than Bellocq's sound or other unyielding instruments.

J. M. SPEAR, M.D.

Highland, O., Oct. 20th, 1879.

FIRST SUCCESSFUL CASE OF CHOLECYSTOTOMY.

At the Royal Medical and Chirurgical Society, Mr. Lawson Tait recently reported the first successful case of this operation. The patient had been married eighteen years, had borne six children, and menstruation was normal and health good till the summer of 1878. At that time she had spasmodic pains in the right side, aggravated by walking and lifting any light weight. A swelling noticed in September slowly increased, and during last winter pain became more intense, and she presented a cachectic appearance, suffering from incessant headache, sickness and obstinate constipation. The seat of pain was over the right kidney, where there was a heart-shaped tumor, firm and elastic, without fluctuation, tender to the touch, and movable to each side. The urine gave only negative results. At a consultation with the author's colleague, Dr. Edginton, no decided diagnosis was attempted, and the opening of the abdomen was agreed upon, which was performed on August 23rd, in the middle line, to the extent of four inches. The tumor was found to be a distended gall bladder, containing a white, starchy-looking fluid, and two large gall stones, one lying loose and the other impacted in the entrance of the duct and adherent to the mucous surface. The latter was removed after a tedious and very difficult operation (fully described in the paper). The stone and fragments weighed 6.11 grams. The wound in the gall bladder was stitched up to the upper end of the wound in the abdominal walls by continuous sutures, leaving the aperture into the bladder quite open, and closing the rest of the abdominal opening in the usual way. The operation was performed antiseptically, under ether. The patient rallied completely in a few hours, and the dressings of the wound were found stained with healthy bile. The flow of bile from the wound continued till September 3rd. The wound was completely healed on September 9th, when the patient began to take solid food, up to that time the diet having been restricted to milk and beef tea. On the 30th she went home quite restored to health. A temperature chart indicated the evenness and rapidity of the recovery. An entire absence of symptoms of gall stone rendered an accurate diagnosis impossible, but this was of less importance as late improvements in abdominal surgery made an early exploratory incision for ascertaining the true nature of the disease feasible. The author, in stating that he always used rigid antiseptic precautions in his abdominal sections, expressed some doubts as to his success being attributable in any way to them.

PHOSPHIDE OF ZINC.

Phosphide of zinc has proven a most efficient agent in the successful treatment of a certain class of affections. In very many instances it has been far more curative than phosphorus. Considered in the light of a curative agent, the phosphide of zinc stands alone, not only for the certainty, but for the rapidity of its action as a nervous tonic and stimulant. Its value, in these respects, has of late been fairly tested in the last and exhaustive stages of typhoid and other fevers, where the nervous energies have been so far prostrated as to render convalescence, if not doubtful, at least tedious and protracted. The great therapeutic value of the phosphide is evinced in the most distinct manner when used in the treatment of neuralgia. While phosphorus is seldom curative in doses of less than one-twentieth or one-tenth of a grain, phosphide of zinc yields as reliable and more speedy results in doses of one-tenth to one eighth of a grain. Few stomachs can tolerate more than one-thirtieth of a grain of phosphorus before

manifesting symptoms of irritation, which, in connection with the "matchy" taste soon evolved in eructations, often engender a disgust to its further continuance. On the other hand, experience with the phosphide of zinc has proven that it enters the circulation far more readily than the element, and in doses of from one-eighth to one-twelfth of a grain produces its curative influence far more rapidly, and is equally as permanent in therapeutic power.

It has been found extremely serviceable in neuralgia, in angina, in loss of memory and impotence, in loss of sleep from combined mental anxiety, and generally in those nervous affections that owe their origin to exhaustion and depression of the nerve force. Dr. Hammond's formula is one-sixteenth grain phosphide of zinc with one-fourth grain of extract of nux vomica, made into a pill.—*Buffalo Med. and Surg. Journal.*

TREATMENT OF URTICARIA.

Dr. L. Duncan Bulkley, in *Archiv. Dermatology*, says that in the treatment of urticaria he has commonly afforded much relief by the external application of a tolerably weak solution of bicarbonate of soda (ʒ ij. to ʒ vj. to the pint) with a little glycerine, the surface to be bathed with this morning and night, and to be subsequently lightly dusted with starch or rice powder. Carbolic acid (ʒ ij.—ʒ iv. to the pint) gives much relief. The *liquor picis alkalinus*, diluted with ten to twenty parts of water and used as a wash, will often afford perfect relief. The formula for this preparation of tar is:

Tar	2 drachms.
Caustic potassa	1 drachm.
Water	5 drachms.

Dissolve the potash in the water and add slowly to the tar in a mortar with friction. Baths are often of the greatest service, especially the *alkali and starch bath*. This is made as follows:

Carbonate potassa	3 ounces.
Carbonate of soda	2 drachms.
Powdered borax	1 ounce.

Mix. Use one such powder for a thirty-gallon bath, with from one-quarter to one half pound of starch. The surface may afterwards be anointed with cosmoline, containing from five to ten grains of carbolic acid to each ounce. When the itching is uncontrollable, the *chloral camphor ointment* will surely give relief. This is prepared thus:

Chloral hydrate	1 drachm.
Camphor	1 "
Rose ointment	1 ounce.

Rub well together the camphor and chloral in a mortar until a liquid results, and add to it the rose ointment. It should not be forgotten that irritating underclothing may excite and keep up urticaria, and in severe cases, silk garments should be worn next the skin, or a very thin muslin may be interposed beneath a woollen shirt or drawers. In addition to the local treatment, hygienic and dietetic as well as constitutional treatment should be employed.

QUININE FOR CHILDREN.

It is probable that a very large proportion of the sulphate of quinine prescribed for the diseases of children is not administered as prescribed. The child objects to it on account of its bitterness, the nurse neglects to give it on account of the child's objection, the doctor does not observe the effects which he had anticipated, and is disappointed. Fortunately, the difficulty may be entirely overcome by the substitution of the neutral tannate of quinine for the sulphate. Five grains of the former equal two grains of the latter. The neutral tannate, moreover, is thought to be not inferior to the sulphate. However this may be, the absence of difficulty in its administration, and the consequent fact that it will generally be administered according to directions, would compensate for any possible inferiority of this sort as compared with the sulphate. It is tasteless, insoluble in water, and should be given in syrup or jelly. Its adoption entirely obviates all of the usual objections to the administration of quinine for children. It is a matter of surprise that its use is not more nearly universal.—*Chicago Medical Gazette.*

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MONTREAL, MAY, 1880.

The breeze, which for the last couple of months has stirred the Medical politics of Montreal, in connection with a vacancy which it was believed would occur in the attending staff of the Montreal General Hospital, though it has all but died away, has left behind it a few lessons which it may be worth while to glance at. The presumed vacancy, it was believed,

would occur by the resignation of Dr. Reddy, a gentleman who for twenty-five years has satisfactorily and faithfully performed his duty. This gentleman while still in the prime of life, and as full of energy and activity as he ever was, conceived the idea that, by resigning from the in-door staff, one of the out-door staff would be promoted to his place. The vacancy thus created on the out-door staff he hoped to secure for his son, a young physician of promise, who has lately commenced practice in Montreal, after a couple of years sojourn among the most celebrated Hospitals of Europe. To this end, he began a canvass among the Governors of the Hospital, in whom the power of election lies. While meeting with considerable success in his canvass, he found some at all events who held the opinion that there were others whose claims for such an appointment were stronger than those of Dr. Reddy, jr. As the day drew near when, according to the by-laws of the Hospital, the entire staff had to be re-elected, it was currently rumored that, as Dr. Reddy did not feel that his son's election was secure, he would not resign. That such was the actual state of matters, subsequent events have proved. Now we have no hesitation in stating that in our opinion Dr. Reddy made a very serious mistake in acting as he did, for he practically said to the Governors, if you will not elect my son, I will not give you the opportunity of electing any one else. It was but human nature for the Governors to feel that in truth Dr. Reddy was claiming the right of dictating to them, and there consequently arose among them a feeling of strong irritation. This found vent at the quarterly meeting of the Governors, held two days previous to their annual meeting, in a notice of motion to place Dr. Reddy and Dr. Wright upon the consulting staff. This motion gave rise to very great excitement for it was the first time in the history of the Hospital that an attempt was to be made to place any of the attending staff upon the consulting staff without their express desire, and actually against their will. For so many years the annual re-election of the same staff had taken place, apparently simply as a matter of form, that it seems not to have entered the heads of any of the Medical staff that the day might, and very possibly would, come when this annual round robbin would end. But the vast increase in the number of Governors during the last two or three years has, while giving the Hospital a considerable addition to its permanent funds, also given it a number of Governors who very properly hold the opinion that appointments upon its attending staff should not be held for periods extending in some cases considerably over a quarter of a century. They feel, very many of them, that there should be a limit to the time during which such appointments can be held, and while they do not desire to curtail it to a degree which would render it to a great extent valueless, yet there is a limit which it should not exceed, unless in exceptional cases, such for instance as those who hold appointments as clinical lecturers. Up to the time when this notice of motion was given, while some predicted it as regards Dr. Reddy, few thought to find coupled with it the name of Dr. Wright. This gentleman has, we are well aware, done the Hospital good service during the nearly if not quite thirty years of his appointment, and we think in times long past it equally returned the compliment. But for somewhere in the neighborhood of the past fifteen years, Dr. Wright has been an ordained priest of the Church of England, and as such has retired from the practice of his profession, although he retained his professorship in McGill University Faculty of Medicine, as also his Hospital appointment. In this position we are aware he is not entirely singular, it being possible to find at least one other similar case. Be that as it may, there is no doubt of this fact, that the rank and file of the profession in Montreal feel that Dr. Wright should, under the circumstances of his position, have long ere this retired from the Hospital staff. That a like feeling exists among the Governors, the introduction of his name into the resolution clearly proves. Its actual strength we are of course unable to estimate for when the annual meeting of the Governors took place, which it did on 20th of May, the two names were separated, and the vote taken first upon the transferring of Dr. Reddy to the consulting staff. Twenty-six names voted yea, and thirty-four voted nay. The motion being thus lost, Dr. Reddy was again elected on the attending staff, and that concerning Dr. Wright

was not put to the meeting. Thus ended this brief excitement, but its results are still evident. That it will be revived next year, is heard on every hand. How it will then result we do not predict, but we believe we are correct in saying that the strength which the vote developed was a surprise to many.

Before we close we desire to say a word as to the accommodation which the Governors room affords for such meetings. It is utterly inadequate. Many are unable to gain admittance to it, and when a vote is taken, many who are crowded on the gallery are, we have been assured, ignorant of the fact, and have thus been deprived of voting. If the by-laws render it necessary to meet within the Hospital building, is it not possible to adjourn to where larger accommodation can be obtained.

"Thackeray as a Draughtsman" is the subject of a paper by Mr. Russell Sturgis in the June *Scribner*, which brings together thirty or more of the novelist's sketches. As Mr. Sturgis says, Thackeray was by no means a good draughtsman; but the humor, "character" and picturesqueness of his pencilings have such an interest for most readers that technical deficiencies are apt to be forgotten. The examples selected are largely from early numbers of "Punch" and from the novels. The famous "Three of Spades," "from the original in sticking-plaster by Miss Williams," the initial to the "Ballad of Eliza Davis" and the "Horrid Murder," from "Punch," are among the wittiest and best.

REVIEWS.

A Guide to the Practical Examination of Urine for the Use of Physicians and Students. By James Tyson, M.D., Professor of General Pathology and Morbid Anatomy in the University of Pennsylvania, &c., &c., &c. This edition revised and corrected, with illustrations. Philadelphia, Lindsay & Blakiston, 1880. Montreal, Dawson Brothers.

This small manual has so recently been noticed in these columns that little more is left for us to say. That it is well adapted for being a guide to so important a study as the Pathological secrets, revealed by a urinary examination, is amply proven by the fact that a very few months has sufficed to dispose of a second edition. We have for several years had this volume a constant occupant of our clinical laboratory, and have rarely found it fail to give us just the information we needed. We have heard others express a similar opinion.

Richet's Histology and Physiology of the Cerebral Convolutions. pp. 142. W. Wood & Co., N.Y.

Perhaps in no department of medicine has greater advances been made during the past decade than in cerebral physiology. Previous to the past five or six years take up any work on physiology, and you will find the functions of the cerebral convolutions described as being limited to the functions of thought. It is quite true that Hughlings-Jackson, fifteen or sixteen years ago, had published in various periodicals his views on the probability of the cerebral convolutions containing centres for the regulation of certain definite and methodical movements, but it is not yet ten years since anything approaching these suppositions were actually verified by experiment. With the publication of the results of experiments by Fritsch and Hitzig, and the more satisfactory ones of Ferrier, a new era commenced in cerebral physiology. We now know that, besides being associated with the mind, certain convolutions, if not actually possessing "centres," are capable of giving rise to certain definite movements when stimulated by electricity.

Subsequent to the publication of these experiments a host of other investigators, notably French and German, have entered the field of enquiry, and contributed much to the elucidation of the subject. The work, the title of which heads this article, besides containing a description of the histology of the convolutions quite up to date, has also a resumé of the most important researches that have been undertaken by these investigators for the purpose of ascertaining their functions. Richet does not seem to have added much to our knowledge through his own investigations. We cannot quite agree with him in his preferring galvanism as a stimulant for the centres. We think faradization as applied by Ferrier is more likely to develope the purposive movements of the so-called

"centres." Galvanism can only momentarily stimulate upon opening or closing the current; when the current is passing, its electrotype action at once manifests itself.

While agreeing with Ferrier to some extent, the author does not believe in the existence of actual "centres" capable of originating movement.

The book contains a mass of information regarding the cerebral convolutions that is absolutely necessary every medical man who wishes to hold even a mediocre position should know, part of which he will find only in two or three of the most recent works on physiology.

Nervous Exhaustion (Neurasthenia). By GEORGE M. BEARD, M.A., M.D. New York, William Wood & Company, 27 Great Jones street Montreal, Dawson Bros., St. James street.

This is a treatise written by a gentleman who has had great opportunities of gaining experience in nervous affections. It covers the ground fairly well, and adds another link to the chain of investigations that are now taking place in the many hundred manifestations of different nervous diseases.

We may not agree with all the opinions expressed, but we can confidently recommend it to the general practitioner.

Electricity in Medicine and Surgery. By JOHN J. CALDWELL, M.D., Baltimore, Maryland.

This pamphlet is a practical essay on some of the uses of electricity. It is evidently written to extol Kidder's batteries, and, from what we have heard of them, they are not too highly praised.

FOOD AND FOOD-MEDICINES IN SURGERY.

"I have long regarded food as the first of remedies, and have taken it as chief maxim in practice that a return to health lies through a return of the assimilative powers and a desire for natural aliment; that whenever a drug is administered it is but a means to this end; and that, in every instance, its nauseant powers, which are generally certain, are to be weighed against its antidotal virtues, which are, except in few instances, doubtful. * * * * * *

"Concerning the virtues of Extract of Malt, which was introduced into this country from the German pharmacopœia four or five years ago by the "Trommer Extract of Malt Co.," I can speak in a decided manner. An extensive trial of this remedy in the acute and chronic disorders of Surgery, during the past three years, has convinced me that it is a food-medicine of undoubted power, and the general hold it has gained upon the professional mind in America in this period shows that I share a very common opinion in regard to its merits.

"The introduction I had to this remedy was such as to make a lasting impression upon me. In August of 1876 a patient, aged five, in whom I had far more than a professional interest, after a slight indisposition for several days, began to show an elevation in temperature. As this was decidedly periodic, I thought it, of course, to be of malarial origin, and gave myself but little concern about it until I discovered it could not be permanently controlled by quinine. In decided doses the temperature would come down for a day, to rise again the next—reaching a maximum of 101°. Languor, weakness and anorexia increased; within a fortnight cough and bronchitis were established, and the patient was at length forced to keep her bed. As the symptoms did not improve the thought came to me that it was tubercle I had to combat. Oil was rejected, or taken after such a struggle that I substituted Trommer Malt Extract, which about that time was coming into some use in Louisville. Its beneficial effects were apparent in a very short time. The temperature speedily came down and remained down, the cough disappeared, and in a fortnight the child was at play. Whatever was the name of the disease, it was one of malnutrition; and I have always thought that what was or might have been the development of tubercle was arrested by the malt and milk upon which alone the child was kept after the first futile attempts to arrest the disease with anti-periodics.

"With such an introduction as this, of course I was led to use it in practice, and there are few accidents or diseases of Surgery in which I have not tested its virtues—so much so, in fact, that I fear their enumeration will sound much like an index." * * * *Extracts from paper by Richard O. Cowling, A.M., M.D., Professor of Principles and Practice of Surgery, University of Louisville, in the Louisville Medical News.*