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Original Communications.

CASE OF CEREBRAL TUBERCLE ?

BY J. F. W. ROSS, M.B., L.R.C.P., LOND.
(Reported to the Toronto Medical Society, April 10th, 1884.)

E. P., æt. 12; parents both living and well. Her *father's* family consisted of three females and five males, all living and well. Her *mother's* family consisted of the mother and father and twelve children, with history as follows:—

Father and mother both died of consumption.

Children—(1) Male, died, æt. 13, consumption; (2) Female, married, died æt. 32, of consumption. Her husband died, but was not consumptive. Two children both died in infancy; (3) Female, died, æt. 25, consumption, not married; (4) Female, died, æt. 19, consumption; (5) Female, died, æt. 20, consumption, unmarried; (6) Male, died, æt. 23, consumption, married, no children, wife living and well; (7) Male, died, æt. 22, consumption, unmarried; (8) Male, died, æt. 20, consumption, unmarried; (9) Male, died, æt. 17, consumption, unmarried; (10) Female, living and well; (11) Female, living and well; (12) Male, died, æt. 18, consumption, unmarried.

Patient has three sisters and nine brothers living and well; one sister died at the age of eight months.

History of previous illness.—Has had no disease but measles.

History of present illness.—Patient complained about four months ago of headache.

The pain extended all over the vertex; vomiting occasionally occurred; the mother had taken her from school; suddenly about six weeks after the first symptoms of headache and vomiting the patient was prostrated with vomiting, hard retching, and violent pain in the head; I was called to see her, and ordered ice to the head, and large doses of bromide of potassium; she was soon well again. About seven days after this her mother brought her to my office to consult me concerning the diplopia which had just developed; I examined the eyes with ophthalmoscope and found optic disc normal; the diplopia could only be obtained in the lower half of the square; no appreciable squint to be noticed; I concluded that the trouble was in the inferior rectus or superior oblique; ordered her to wear a bandage over the left, or sound eye; pupils acted well to light and patient could read if one eye was bandaged.

About two weeks after I was called to see her again; mother said she could not keep either eye bandaged as it made her feel sick and brought on the headache; she had just had another attack, commencing about the same time as the last one, *i. e.* at four a. m. The headache came first, then vomiting; and about four p. m. the same day she had a severe convulsion. The hands were thrown back; there was a slight cry; the teeth were ground together, and the tongue injured, so that it bled; consciousness was lost for three or four minutes, and then the patient spoke rationally, and complained of

the terrible pain in her head; tremor was well defined; the hands and feet were blue, cold, and shook; tendon reflex absent; no loss of urine or fæces, and no paralysis; same treatment as before, and she gradually became as well as ever; a flush to be seen on the cheek; skin dark; temperature, 98.4/5; pulse, 60.

Next day, March 29th—Pulse, 110; temperature, 98.2/5.

March 30th—Pulse, 96; temperature, 98.2/5; pulse easily increased on slight exertion or excitement, but not irregular.

April 4th—Called again and found the patient up and able to go about as usual; noticed slight internal squint in right eye, and diplopia in right hand square.

April 8th—Was sent for hurriedly; found patient had just recovered from another attack; she rose about four a. m.; went back to bed; felt it coming on as she expressed it, *i.e.*, pain in the head; rose, went into her mother's room to wish her a birthday greeting, returned to her own at 6.15, was seized with an attack of headache, vomiting with retching and a convulsion; was longer rousing from this one than usual, about 10 a. m. another convulsion occurred, preceded by vomiting; the aura was of very short duration, perhaps one minute; the family were at dinner; she said she felt sick, vomited almost immediately, and the head was thrown back, eyes turned up, hands and arms were drawn up, and then fell flaccid to side, pulse fell to 48 during the fit, hands and feet cold as before, a perspiration then broke out over the forehead, feet and hands became warmer, and pulse increased; temperature taken shortly after was normal; headache then entirely disappeared; this was unusual, as it continued for hours after previous attacks; consciousness was longer returning, and all night the patient lay in a semi-comatose condition; she vomited but once before the fit.

April 9th—Internal squint well marked in right eye, and patient said she could

sometimes see double both to the right, left and downwards; when I tried her double vision only occurred in lower and right hand square; muscles of face, eyelids, and tongue, act perfectly; no other paralyses but those of muscles of right eyeball; she complains of phlegm in throat, but no difficulty in swallowing either solids or fluids; no history of syphilis; appetite good; tongue clean; urine normal.

April 10th.—Was restless until about 4 a.m.; now easy; pulse, 80; temperature, 98.4/5°; no cough, chest normal; of abdominal organs nothing to be noted. No diarrhœa; bowels have been regular throughout. Has had three attacks of retching since. I saw her yesterday but no fits since; hands and feet warm; intelligence, unimpaired. Patient laughs and jokes as if in perfect health. The convulsive attacks were all bilateral. No enlargement of lymphatic glands. Patient's skin is clear and free from any disease; head well formed, intelligence very good; no evidences of struma or rickets; no otorrhœa or rhinitis; no sighing.

Diagnosis lies between: Tubercular meningitis, cerebral tuberculosis, cerebral tumour, hysteria, onanism reflex, epilepsy, intermittent fever.

I would be in favour of excluding meningeal tuberculosis; there would be more pain, the patient would be more restless and irritable, the symptoms would hardly abate so completely; no sighing; pulse, not characteristic, not slow and irregular. In cerebral tumour and cerebral tuberculosis for months the only symptom may be repeated attacks of eclampsia. In cerebral tumour the pupils would be unequal and optic neuritis would most likely be found. Cerebral tumours less usual at this age than tubercles. One case reported of large abscesses giving rise to intermitting neuralgia with intervals of perfect health, until finally epileptiform convulsions occurred. hemiplegia, coma, and case terminated fatally in a few days.

In hysteria pulse would not drop so suddenly; eyes would probably be closed; there would be some crying or laughing; child has always been nervous, but never hysterical. She is just at the hysterical age, but complains of none of the usual pains that usher in the menstrual molimen. She has not improved, but grown worse under treatment. The convulsions might occur if hysteria were lapsing into epilepsy. There is no family history of epilepsy. We have, however, a distinct aura and the fits are epileptiform; but what is the cause of them? The cause of the symptoms I think is central. Although the patient has been watched carefully, we could neither catch her in the act nor in any act that would rouse suspicion of onanism. No discharge could be seen either on linen or genitals.

As regards intermittent fever, Professor Henoeh gives one case of which the chief points were:—Healthy girl, *æt.* nine years, complained Friday 10 a.m. of diplopia and cold hands, soon followed by psychological disturbance; became unconscious and had a convulsion; convulsion repeated and alternated with coma for an hour. She then slept, after which patient felt well except slight headache. I thought of intermittent as no other cause could be found. They lived in a malarious district. Next day, well; day after at 4 p.m., attack renewed; child suddenly failed to recognize those around; hands were cold, and she complained of dizziness and diplopia in the lucid intervals. At 5 p.m. epileptiform attack and lasted till 6 p.m., when I found her cyanotic, pulse small and frequent. Under quinine no further attack occurred. At noon, following Tuesday, headache and vertigo and tremor for twenty minutes, but since then the patient has been quite well.

In some points this resembles my case but there was an absence of vomiting. I think the points of difference weigh down the resemblances, and I would put malaria at the bottom of the probable list. I lean

towards cerebral tuberculosis and would be glad to hear the opinion of the Society. There is room for much difference of opinion.

Since this paper was read the patient has been going about in fair health. When asked a question she hesitates before giving an answer. Her mother says she is becoming childish. The intellect is evidently weakened. Vomiting has occurred again within the last twenty-four hours. Under the use of the bromide of potassium no fits have occurred since April 8th. She complains of a feeling of weakness in the lower extremities. Diplopia and strabismus are still present. She has a short, dry cough, but as yet no evidence of pulmonary disease can be found.

Selections: Medicine.

SUDDEN DEATH IN DIABETES.

BY ROBERT SAUNDBY, M.D., EDIN.

Within the last few years a great deal of attention has been paid to the manner in which saccharine diabetes ends fatally, and especially to that striking and tragic form which has been called diabetic coma, from the constancy with which coma supervenes to close the series of remarkable and distressing symptoms.

The frequency with which such cases occur may be inferred from the statement of Dr. Stephen Mackenzie, that of the cases of fatal diabetes collected by him from the registers of the London Hospital, all under the age of 25, with only one exception, died of coma.

Its relative greater frequency in young persons and acute cases is quite certain, but for the most part its etiology remains obscure. Clinical experience has suggested the dangers of long journeys, muscular exertion, nervous shock, and exposure to cold. Constipation is generally present, is very obstinate, and is theoretically likely to favour the onset of these symptoms.

Drs. Bond and Windle, in their remarks on a fatal case of diabetic coma which occurred at the General Hospital, say that the change from ordinary diet to richly albuminous food has been present as a factor in this and one other case under their observation. While not doubting the influence which great and sudden changes in

diet can produce in the system, and bearing in mind that Charcot states that the converse change frequently produces glycosuria as in the instance of novices in the monastery of La Trappe, I do not forget that in the case published by my friend Dr. Rickards, the patient was taking ordinary diet. This relation has not been referred to by other writers, and was obviously absent in many cases reported where the symptoms came on during the course of treatment, or during no treatment at all.

The premonitory symptoms vary very much. Sometimes the attacks begin with maniacal excitement; more commonly abdominal pain or headache are complained of; a sudden fall in the sp. gr. and sugar contents of the urine has been sometimes noticed, and when observed should be regarded with suspicion, although such an alteration is by no means always a cause for alarm.

Prof. Lépine attaches much importance to the rapidity of the pulse as a trustworthy prodromal sign.

The urine gives a Burgundy red colour on the addition of a solution of the perchloride of iron, the colour disappearing on heating the mixture. This reaction was at one time supposed to be a test for acetone, but this is a mistake. It is certainly present in diabetic urine apart from coma, and has been met with in other diseases. Thus Jaksch has met with it in many acute disorders, especially measles, scarlatina, and pneumonia. He has also observed it in a case of gastric cancer terminating fatally by coma. Hoppe-Seyler has described it in a case of sulphuric acid poisoning as occurring during the time no food was taken. Senator observed it in a case of atropine poisoning which died comatose. Dr. Windle has observed it in pneumonia, Bright's disease, scarlatina, and several other pathological conditions apart from coma. It cannot be therefore regarded as in any sense a pathognomonic sign, and we sadly need data to enable us to say whether it is ever absent in cases of diabetic coma. So far as I am aware no one has published a case in which its absence is noted, but I am quite prepared to admit the possibility.

As you are probably aware, diabetic coma was first described by Kussmaul in 1874. In the group of symptoms to which he drew attention, great and well-deserved importance was attributed to the peculiar character

of the respiration, which is laboured and hurried, although the respiratory murmur may be plainly audible all over the chest. This symptom is so very striking, that Senator, in a recent paper, has maintained that it must be regarded as characteristic of Kussmaul's type of coma, and that no case of terminal coma in which this peculiar breathing is not present should be included in this class.

Frerichs, too, in his valuable contribution to this question, classifies his cases mainly according to the presence or absence of this symptom. Much as has been said about this dyspnoea, it is not always present in diabetic coma, and such a case was reported in the *British Medical Journal* by Dr. Prescott Roberts.

Senator, while regarding this respiratory dyspnoea as essential to the type of Kussmaul's coma, shows that it is by no means confined to diabetes, and publishes notes of cases occurring in chronic cystitis, gastric cancer, anæmia and atropine poisoning in which it was present.

Dr. W. Roberts gives "slow panting and labourous respiration with drowsiness, rarely coma, and very exceptionally convulsions" as symptoms of obstructive suppression of urine.

Another symptom which is very striking when present, but far from constant, is the peculiar odour of the breath, which has been variously described as like sour beer, apples, hay, chloroform, and acetone. Is it probable that all these comparisons have been applied to the same odour? It would seem that acetone or sour beer affect our noses very differently to apples, chloroform, or hay. Unfortunately, it is very difficult to institute any precise standard of odour. But Drs. Frederick Taylor and Stephen Mackenzie have never been so fortunate as to smell this odour. Frerichs groups several of his cases as not presenting this symptom; it has not been always noticed in the cases we have observed at the General Hospital.

These differences indicate the importance of observing and recording carefully all the facts in such cases when they come under observation. It is probable that there may be two or more types of sudden death in diabetes, and that these may be dependent upon an equal number of distinct morbid influences; but in order to determine this, we want first of all carefully recorded clinical histories. Perhaps I may be per-

mitted to say, that I have become convinced that too much reliance has been placed upon the assistance to be derived in the advancement of medical knowledge from laboratory work, and that the all-important value of clinical observations is too often forgotten.

For want of clinical data all pathological work comes sooner or later to a stand still. Morbid anatomy with all its refinements and aids from histology and chemistry, is not, and can never be a substantive science. It is the great adjunct to clinical medicine, but the latter must lead the way. It is therefore worth while to give a short account here of Frerichs' attempt to classify the various forms of diabetic coma.

He distinguishes three types. *In the first group* he places cases which suddenly, and usually after previous exertion, become prostrated, with cold extremities, small failing pulse, drowsiness, and loss of consciousness, terminating fatally in a few hours.

In the second group the duration is longer, and there is a prodromal stage which may be general prostration, gastric disturbance, vertigo, vomiting, constipation, or a local disease, a dental abscess, pharyngitis, an abscess with a tendency to gangrene, bronchitis, or catarrhal pneumonia. The attack itself commences with headache, restlessness, delirium, anxiety, sometimes with maniacal outbursts, dyspnoea, frequent deep respiration with free entrance of air into the lungs, sometimes with cyanosis, sometimes without it, feeble rapid pulse, low temperature, drowsiness and coma. The breath has a peculiar smell like fruit, or chloroform, or acetone; Frerichs is here not very definite about the smell. Such cases may recover temporarily, and in some rare instances the attack may quite pass away. The duration of the symptoms may be from 24 hours to 3 or 4 days, or even longer.

In the third group he places cases which present no dyspnoea or anxiety, have moderately firm pulses, and are fairly well nourished. The attack is characterised by headache, a feeling of intoxication, with disordered gait, sleepiness, and gradual coma, from which they do not awaken. The breath has the characteristic smell.

In the first group the symptoms are those of collapse, coma occurring only at the end, and the duration of the whole attack is very short. In the second group, we have Kussmaul's typical complex of symptoms,

with dyspnoea, peculiar odour of breath, and coma. In the third group, there is no dyspnoea, the symptoms more closely resemble intoxication, but the breath has the characteristic smell, and coma is present.

I do not wish to trouble you with very much pathology, but as there has been so much discussion upon the causation of these sudden deaths, you might blame me if I did not attempt to tell you briefly the present state of the question.

There has never been any dispute that heart failure is the obvious explanation of a certain number of these cases, such, for example, as Frerichs places in his first group. This is said by Schmitz to be due to fatty degeneration of the heart, but his facts are not very conclusive. Frerichs has shown that the muscular fibres of the heart in diabetes undergo a hyaline or glycogenic degeneration, in which their power of contractility is lost, and it is to this, in all probability, that we must attribute the frequency of cardiac failure. But cardiac failure will not account for the symptoms in groups two and three. It has been suggested that the phenomena are uræmic. But to such a view there are many objections. I think we might have clearer notions than we generally possess as to what we mean clinically by "uræmia;" but certainly convulsive phenomena, from muscular twitching to complete epileptiform convulsions, are its most constant and characteristic features. But coma in diabetes is only rarely preceded by convulsions, and they never constitute a prominent symptom. If by uræmia is meant accumulation of urea in the blood; the facts clearly established in many cases contradict the suggestion. If this is not what is meant by uræmia, then I should require a definition of it, and some kind of evidence in favour of the view. So far as my information goes, I know of no constituent of the urine, and, indeed, of no substance whatever, which has been shown capable of reproducing the principal phenomena of diabetic coma. This is a sufficient answer to Ebstein's suggestion that the degeneration of the renal epithelium, which he has described, leads to an accumulation in the blood of normal or pathological constituents of the urine. Frerichs has shown, too, that this degeneration of the epithelium is due to infiltration by glycogen, that it is present in all cases of diabetes, and that it is not

specially marked in those dying with coma.

The suggestion that fat embola of the lungs or nervous centres could produce these symptoms is even less worthy of occupying our time. Milky or fatty blood has been present in only a small number of cases, and in a still smaller number have any fat embola been described. Not one of the classical symptoms is dependent upon the presence of milky or fatty blood. I think Dr. Barling and I have shown that even when fat is present in large quantities, it does not always cause embola; and that there is reason to believe that what have been called embola may have been only *post mortem* thrombi, containing fat globules. Finally, even in those cases in which the embola have been described, they do not appear to have been more numerous than may be seen in cases of fracture, where they have given rise, during life, to no symptoms at all.

Then there is the view advocated by Kussmaul that the symptoms are really due to poisoning by acetone; but Salomon has found that large doses, 20 to 25 grammes, caused no inconvenience to man or animals, nor did the urine give the ferric chloride reaction. In one case this substance was given in doses of 20 grammes daily to a diabetic whose urine previously gave the ferric chloride reaction, but without any disturbance of his general condition. Salomon also collected the expired air of diabetics with characteristic odorous breaths, but failed to find any acetone in it. Similar experiments with aceto-acetic acid, the substance in the urine which is supposed to give the red coloration with ferric chloride were also equally negative, except that large doses, 40 grammes, caused acetone to appear in the urine, but in no case did the ferric chloride reaction appear; there was no frequency of respiration, no tendency to somnolency, and even the appetite remained unimpaired. These experiments are at variance in one respect with those of Quincke who found that in poisonous doses this substance caused death with marked dyspnoea.

Von Jaksch, who has worked very assiduously at the chemistry of this subject, has succeeded lately in extracting from the urine the substance giving the ferric chloride reaction, and considers that it is undoubtedly aceto-acetic acid. This is probably correct, but it is also pretty certain, from what has

just been stated, that this substance is not the toxic agent to which the symptoms are due. What this substance is remains an unsolved question at present.—*Birmingham Med. Review.*

TYPHOID TEMPERATURES.—This is in entire accordance with our experience, and it has an important bearing on the treatment known as the "cold water treatment." According to the supporters of this treatment, it is apparently assumed that the only factor to be reckoned with in the disease enteric fever is the heat. The body is too hot. All the mischief arises from that. Let the heat be abstracted, and all will be well. The question ceases to be a complex question of biology, and becomes one of pure physics. Clinical experience contradicts this simple view. All the mischief does not arise from the heat. In addition to the heat, there is the individual who is affected by it, and in this respect individuals vary. One patient is restless and sleepless, with a dry tongue, and a temperature ranging between 102° and 103°, whereas another, with a higher temperature, is so slightly affected that, but for the thermometer, one would hardly know that he was ill. Take the following as an example: E. Searle, aged 23, was nurse of an enteric fever ward in the North-Western District Hospital from Nov. 17, 1882, to July 1, 1883 and from Sept. 10 to Oct. 12 last, when she complained of sore throat. From this time to the 18th she was off duty with what appeared to be an ulcerated throat. On the 19th she had so far recovered that she returned to duty, but she did not regain her appetite, and felt occasionally faint, dull, and out of spirits. In this condition she continued until November 9, when she found that she could not make her beds, had some pain in her back and stomach, aggravated by food and a troublesome cough. On the 15th she felt as if she had a severe cold, and looked dull and stupid. The case was complicated by a monthly period, which happened on the 6th; her periods were usually accompanied by pain in the stomach and back. This ceased on the 7th, and to this the patient attributed her illness. The pain in the stomach and back, however, continued. On the evening of the 16th the temperature was 102° F. On the 17th she tried to, but could not make her beds, and on the evening of this day she took to her bed. On the sixteenth day of the disease,

the temperature reached 106°5 F., an alarming condition of things to most people in enteric fever; but in this case the patient was as comfortable as if there had been nothing the matter with her. This discord between patient and temperature raised doubts as to the enteric fever, doubts as to the competence of the nurse who took the temperature, and doubts as to the accuracy of the thermometer. As regards the first, the patient was nursing enteric fever at the time. She had, as far as she knew, never had the disease, and was therefore, if she had not, susceptible. She became sick along with two others, one of whom was the night-nurse of the enteric ward of which Searle was the day-nurse, and the other a housemaid who frequented the enteric ward at a time when the wards were full of acute cases, to the number of fifteen in each. There was the slow hesitating mode of commencement by sore throat, as if it were the intention of the disease to throw one off the scent, as no doubt sometimes it has done—such cases have been mistaken for scarlet fever or diphtheria—the three weeks' fever, the constipation, the eruption, and the slow recovery, all which points to enteric fever. It was certainly not any other specific fever, and there were no local disturbances to account for a non-specific fever. There was the monthly period truly, but this ceased on Nov. 7, and her illness continued. On the whole, the probability is that it was a case of enteric fever. It is difficult, if it were not, to see what else it was. The second and third doubts were determined by testing the thermometer and rectifying the observation by taking it a second time. A consideration of temperatures in this case will also show how erroneous must be the conclusions drawn from single observations at some particular morning or evening hour. Thus at 2 a.m. of the tenth day of the disease the temperature was normal; at 4 p.m. of the same day it was 104° F.; at 8 p.m. it was 100°5 and at midnight over 104°. At 2 a.m. of the eleventh day of the disease, the temperature was slightly above normal, whereas between 2 and 6 p.m. it was about 105°. Now, supposing that in this case the temperature had been taken at 10 a.m. and 10 p.m., morning and evening hours, the gravity of the case as indicated by temperature (if gravity of case be indicated accurately by temperature) would have been missed. Even if the observer had chanced to make

his observations at 8 a.m. and 6 p.m., whilst he would have hit upon the highest temperature of the twenty-four hours, the all-important fact that this high temperature was continuous from 2 to 6 p.m. would have been missed. Now, supposing it were the habit of the observer to judge of the gravity of a case by the temperature, in this case he would have under-estimated it. On the thirteenth day of the disease the temperature from 10 a.m. to 2 p.m. was about 104°, whereas in the evening hours, from five to nine (between which hours it is very common to make the evening observations), it was below normal; but at 10 p.m. was nearly 104°. Take now the fourteenth day. At 10 a.m. of this day the temperature was 104°; at noon it was normal, and one hour after it was again 104°. It will be obvious how erroneous would be conclusions drawn in cases of this sort from observations limited to some morning and evening hour. That the disease has its rise and its fall is true, but these do not correspond to the evening and the morning of the English civil day. It would have been just as reasonable to make the enteric fever day correspond with the astronomical day, or with some other civil day, say the Greek, which commences at sunrise, or the Italian, which commences at sunset. All these are artificial divisions for which enteric fever has no respect whatever. The temperature, to be of real value, should in severe cases be taken hourly, unless the patient be asleep. For the most important point is not the actual height which has been reached on a given day, but the duration of the height. The accident of a visit from a friend, or some other trifling circumstance, will raise the temperature for a short time two, three, or more degrees. It is further of great importance where nurses or relatives, who may be ignorant or untrustworthy, must be left to take temperatures, that the physician should compare the general condition of the patient with the temperature, so as to see whether the temperature and the patient agree, or whether they differ. Nurses have been found to evolve the temperatures out of their consciousness, to save themselves the trouble of taking them. The patient should, therefore, be carefully examined in order to ascertain if the thermometer be a true witness. It will be found sometimes that the patient is better than his temperature, at other times that he is worse. In other

words, it will be found sometimes that patients with high temperatures are doing well, whilst others with low temperatures are doing badly, as Dr. Delafield says, and we entirely agree with him: "Some patients would be much more affected by a temperature of 102° than others by a temperature of 105°." In some cases it is the low temperature which indicates danger, not the high. We do not mean cases in which the low temperature is due to hæmorrhage, but cases towards the latter part of the disease where there is continued restlessness and sleeplessness with a temperature about 102°. Such cases are for the most part fatal. In a word, the value of the thermometer is relative, not absolute. It teaches nothing *in itself*, except caution in too readily believing it. The temperatures, moreover, even to be of this value, must, as far as possible, be the temperatures of the whole day of twenty-four hours—not that of one or two morning and evening hours, hours which vary with the habits of every physician. The morning hour of the man who breakfasts at 5 a.m. is likely to be very different from the morning hour of the man who breakfasts at 11.—*London Medical Record.*

DYSPEPSIA OF WEANING.—The most grave period of the growing infant is the time of weaning. The sudden or gradual transition from a uniform alimentation to a regime diametrically opposite, is a very trying time to the digestive organs. Without doubt the new dietetic principles which in general are composed of meat, albumen, starch, sugar, find already their respective ferments, such as ptyalin, pepsine and pancreatine; but, what they do not find is a stomach prepared, etc., to support an abundance of substances which are not alimentary or which are indigestible, such as tendons, aponeuroses, interstitial cellular tissue which are a tax on the digestive forces and exercise without profit the digestive fluids.

Therefore it is that at this time we have indigestions, even where there has not been excessive feeding, mucous or crapulous diarrhoeas, hientery, cholera infantum; all being modifications of the same morbid type constituting gastro-intestinal dyspepsia. The indigestions are temporary, the diarrhoea often permanent, and if it carries off too much of the food principles, before

their elaboration, the infant succumbs to hientery, that is, to complete aepsia, unless a more speedy calamity befalls it, such as a sudden alarming deperdition of all the intestinal liquids, including the pancreatic juice, and the bile, a complete expulsion of the gastric juices, and at the same time an exaggerated hyper-secretion which deprives the blood of its liquidity and its temperature, annihilating the circulatory forces; this is the tableau of cholera infantum. It is worthy of note that these grave perturbations are not always manifested immediately; often one, two, and even three weeks pass away without there being the least alteration in the health of the infant. Parents and the physician are encouraged; they consider weaning as successfully completed, when all at once and without any apparent cause, dyspepsia manifests itself under some one of its forms which I have indicated. Why this delay in the development of such grave accidents? We have to deal here with gradual failure of nutrition resulting from want of ability on the part of the stomach to separate from the alimentary melange offered it, the pure azotized principles, and to elaborate them by the gastric juice, which does not reach them till after having penetrated refractory membranes, themselves demanding a digestive elaboration. The provision for nutrition still exists, to wit; that albuminous liquid of the circulation which has been so well described by Voit and which is not immediately exhausted by the daily drafts made upon it, or even influenced all at once, by the kind of food ingested. But when this *reserve* is used up then commences the terrible sequel of dyspeptic symptoms. This is my explanation and this is the way I apply it to practice. To avoid loading the stomach with refractory products, I prescribe habitually raw meat suspended in broth made from lean meat, or in a soup made of dried legumes. I proscribe the usage of milk under any form whatever, at the same time I give as drink water containing some kind of alcoholic stimulant, and for these reasons; raw meat is meat deprived of all of its fibro-cellular elements; the azotized feculents are easy to digest and add *leguminose* to the action of the muscular fibrin; milk produces on the contrary, in many cases looseness of the bowels whose deplorable effect is to eliminate the alimentary principles before their

absorption; but this last function (*i. e.*, the retention of chyle till its complete elaboration) is one which should be protected above everything else, and this may be favoured by the use of some mild alcoholic stimulant such as astringent wine, or by the use of prepared chalk with or without opium.—*N. C. Med. Jnl.*

TREATMENT OF HÆMOPTYSIS IN EARLY PHTHISIS. Dr. T. Henry Green, of the Brampton Hospital for Consumption, gives the following hints on this subject in one of his lectures published in the *Lancet*. On the treatment of the hæmoptysis of early phthisis I would offer only one or two suggestions. In the first place, remember that this form of hæmorrhage is capillary, and tends to cease spontaneously; and that although it is a serious symptom, and one that requires most careful treatment, our anxiety is not so much on account of the bleeding as of the progress of the phthisical process which is so apt to result from it. Do not be too precipitate, therefore, in the administration of drug remedies. The practice of plying the patient with large doses of gallic acid, or some other astringent, as soon as some hæmorrhage occurs, is, I believe, a bad one. The remedies often do much harm to the stomach and no good to the lung. With the first sign of hæmoptysis absolute rest in bed should be enjoined, and it should be maintained for several days, even if the bleeding is slight and does not recur. The indication next in importance is to keep the patient warm. The bedroom should be airy and well ventilated. With the object of diminishing the blood pressure in the pulmonary vessels, the lower extremities should be kept especially warm by means of hot flannel, or in some other way. The diet should be temporarily restricted to cold concentrated nutritious fluids. The amount of liquid taken should be as much as possible diminished, and hot drinks and alcohol carefully avoided. Some ice to suck relieves cough, and so helps to maintain rest. Constipation, inasmuch as it favours the bleeding, should be judiciously obviated.

Should, however, the hæmorrhage be considerable or continued, further interference is called for. Some saline aperient, which will act quickly, is now of the utmost service when the patient is not markedly prostrate. Dry cupping of the affected

side is probably of use. Of internal remedies, medium doses of the mineral acids appear often to be of service. Of the more powerful astringents, gallic acid in twenty grain doses, alum in twenty grain doses, with twenty minims of dilute sulphuric acid, are the most to be relied on. Ergot is probably more useful in the arterial hæmorrhage of old phthisis.

RULES IN DIAGNOSIS OF THE SEAT OF THE EXCITING CAUSE IN BELL'S PARALYSIS:

1. If the paralysis be limited to distinct parts of one lateral half of the face, the lesion affects only individual branches of the nerve, and is outside the cranium. An apparent exception to this rule is sometimes met with in connection with lesions of the *crus cerebri*—paralysis of the lower half of one side of the face being clinically observed to occasionally accompany a paralysis of the motor oculi nerve on the same side as the lesion.

2. If the fauces and palate exhibit paralytic changes, the lesion is within the cranium or in the temporal bone.

3. If the sense of taste be lost in the anterior two-thirds of the lateral half of the tongue on the same side as the facial paralysis, the lesion is either within the cranium, or in the temporal bone above the origin of the chorda tympani branch.

4. If the sense of hearing is rendered very acute upon the same side as the facial paralysis, the lesion is probably within the temporal bone, and involves the ganglionic enlargement found upon the nerve in the aqueduct of Fallopius.

5. Facial paralysis dependent upon cerebral lesions is commonly associated with hemiplegia, which may be on the same side as the lesion or on the opposite side.

6. Crossed paralysis of the "facial nerve and body type" indicates a lesion of the pons Varolii posterior to the line which connects the trigeminus nerve with its fellow at their escape from the pons. (Gubler.)

7. If the lesion be situated in front of Gubler's line the facial paralysis and the hemiplegia will be on the same side.—Dr. Ranney, *N. Y. Medical Record*.

CASTOR OIL IN IRRITABLE STOMACH.—In irritable stomach complicating constipation, Prof. DaCosta ordered, at the clinic, oleum ricini floated on ice water, and said it would be retained.—*Med. and Surg. Rep.*

SPONTANEOUS PNEUMOCELE THROUGH THE BASE OF THE XIPHOID APPENDIX.—M. Edmond Vignard reports (*Gaz. Méd. de Nantes*) the case of a man fifty-two years of age, who entered the Hospital for an obstinate bronchitis with emphysema. He was a mason by trade, and had a large reducible inguinal hernia. Two weeks after admission he made a false step on going down stairs. In the violent efforts to recover himself, he felt a sudden sharp pain in the chest above the pit of the stomach. He continued his walk for a short time, but the pain persisting he returned to bed. On examination, when the respirations were calm, there was found on the median line of the chest towards the extremity of the sternum, a very slight protuberance, spheroidal in shape, as large as a five franc piece and only a few millimetres in height. The skin was slightly stretched and showed no particular coloration. Ordinary respiratory movements did not sensibly alter the volume of the tumour. On making an effort the tumour increased to 1 cm. in height, and diminished when the effort ceased. On coughing, the elevation was sudden and more than $\frac{1}{2}$ cm. above the surrounding parts.

The tumour was soft, elastic, non-fluctuating. On making an effort, if the finger is applied firmly to the tumour, a fine crepitation is perceived, similar to that of lung tissue. By pressing more strongly the tumour is completely reduced and leaves a slight depression; it is reproduced in a few moments, and if the patient coughs a clear impulse is felt. When the tumour is reduced a round orifice 3 cm. in diameter is clearly felt, with osseous borders rounded below, squarely cut above, seated in the median line 1 cm. above the point of the xiphoid appendix. It was considered to be a part of the right lung, because the pulmonary resonance was continuous towards that side and the pain radiated towards the right side.

DIET IN DIARRHOEA OF CHILDREN.—Now, in the treatment of this patient, the first thing is a complete change of diet; let the condensed milk be abandoned, and let the child have instead cow's milk, diluted with one-third or an equal quantity of gum arabic water, gelatine water, or albumen water; when the diarrhoea is better, barley water may be used for the diluent. As I

have had occasion to say to you before, to dilute cow's milk with water is one of the worst of practices in infant-feeding, for by such great reduction of the nutritive properties of the milk, a double quantity of fluid must be taken, and thus indigestion from overloading the stomach or from too frequent feeding. Let me say still further as to artificial food for infants: It is impossible to say in a given case that one, or that another, kind of food will prove best; have as admirable theories as you please in the selection and combination of ingredients; the final test is in experiment, and the experiment sometimes sets at naught the wisest, most scientific theories. Therefore, when you are directing the sort of diet an infant is to have, you are simply trying an experiment, and if the experiment is a failure don't persevere in it—do not try vainly to compel facts to correspond with your theories, but yield obedience to the facts, and try another experiment.—Theophilus Parvin, M.D., in *Arch. Pediat.*

SLOP DIET.—There can be no question in the mind of any thoughtful man that diet must have a great influence upon the course of disease processes, hence it is that we note the following reply, in the *Lancet*, January 12, 1884, to one who writes to inquire more fully about slop diet:

The objects aimed at in giving slop diet may be—(1) depletion of the system by cutting off the supply of nitrogenous and combustible material; (2) the securing of rest to the digestive organs; (3) the avoidance of the ills which follow upon the taking of food upon which the digestive and assimilative organs are unable, through debility or actual disease, to exert their full function. Experience has shown that cutting off all food from healthy men causes death in about five days, and is attended with great suffering. If water alone be allowed, the suffering is very greatly lessened, and life can be prolonged for about the same number of weeks. The introduction of water entails no "work" upon the digestive or assimilative organs, and therefore it admirably fulfils the conditions of "slop diet" whenever required for any one of the three objects mentioned above. It is therefore the best "slop diet," and we believe that as such it is not sufficiently appreciated by the profession. Saline solutions stand next in order of merit, requiring no "digestion."

and undergoing little, if any, change when passing through the assimilative organs. Saccharine solutions must rank next; they are readily absorbed, but possessing distinct nutritive value, they are not so depletive as water, and, moreover, being liable to undergo fermentation in the alimentary canal, they do not afford such complete rest to that organ. They also have the disadvantage of being less palatable than the former. Decoctions of starch require distinct "digestion" and "assimilation," possess high nutritive value, if unabsorbed are liable to fermentation, and may leave a considerable residue of undigested matter to pass along the intestines. Solutions of albumen must be placed at the bottom of the list, as requiring digestion and assimilation, and as possessing the highest nutritive value, being "tissue-forming" as well as "force-producing."—*Med. and Surg. Rep.*

THE PROLONGED USE OF JABORANDI IN BRIGHT'S DISEASE.—Dr. F. A. O'Brien, of Atlanta, Ga., sends us a communication, in which he calls attention to the beneficial action of jaborandi, given in small or moderate doses, for a long time, in the various forms of albuminuria classed under the head of Bright's disease. He has found that the drug is better borne when combined with nux vomica than if exhibited alone. In his opinion the action of jaborandi is not to be explained solely from its sialogogue and diaphoretic effects. He believes that it has a specific influence on the kidneys, permitting the tubules to relieve themselves of the inflammatory products that block up their lumina.—*N. Y. Med. Rec.*

DEVELOPMENT OF APOMORPHINE IN OLD MORPHINE SOLUTIONS.—Dr. C. E. Jennings in the *Lancet* calls attention to the importance of preparing extemporaneously solutions of the alkaloids for hypodermic medication. He shows that, in addition to the loss of morphine from the development of the penicillium, there is also a certain amount of apomorphine formed. This may account for the violent vomiting sometimes following hypodermic injection of morphine. Since the syringe is so liable to get out of order from want of use, he recommends the substitution of a small graduated pipette, which operates without a piston, the fluid being discharged by blowing into the pipette through a rubber tube.—*Phil. Med. Times.*

HAIR TONIC, RECOMMENDED BY PROF. GROSS :

- R Tinct. Cantharidis ʒ iss.
- " Capsici gtt xx.
- Glycerine ʒ ss.
- Aquæ cologniensis ʒ vj.

M.

FREQUENT REPETITION OF DOSES.—Frank Warner, M.D., in a very sensible article in the *Cin. Lan. and Clin.*, draws attention to the importance of the frequent repetition of doses. In the night sweats of phthisis he has found great relief from the administration of atropia 1/120 of a grain every four hours, when a much larger dose given at bed-time failed. In nocturnal incontinence of urine frequently repeated small doses of atropia will afford relief, while a single dose at bed-time would be inefficacious. For pin worms small and frequently repeated doses of aloes has been followed by complete success, rectal injection of quassia solution being only temporarily successful. The aloes is administered in half teaspoonful doses of the tincture every four hours or a proportionate dose of the solid extract in pill form, kept up for a week or ten days. By this method the worms and their eggs are destroyed and the troublesome affection is at an end.

AN ANODYNE MIXTURE WITHOUT OPIUM :

- Chloroform Part. ʒ100.
- Ether, sulph., spts. " " ʒ25.
- Tinct. cannabis " " ʒ175.
- Acid hydrocyanic, dil. ʒ30.
- Ol. menth. piperit. " " ʒ603.
- Tinct. capsici " " ʒ603.
- Alcohol, 95 per cent. " " ʒ350.
- Hyoscyamia q. s.
- Glycerine ad 1,000.

Dose.—Ten to thirty minims.—*Louis. Med. News.*

SEMMOLA'S GLYCERO-TARTARIC LEMONADE :

- R Glycerine 30 parts.
- Tartaric acid 2 "
- Water 500 "

M. To be used freely as a beverage in typhoid fever.

TO DISGUISE THE TASTE OF IODIDE OF POTASH.—M. Gérard Lagüe, (*Lyon Med.*) states that syrup of gooseberry will completely disguise the taste of iodide of potash

SALICYLIC ACID IN CYSTITIS.—Prof. Bartholow recommends salicylic acid either, by injection or internally, in large doses for cystitis. Administered by the mouth it acts after being excreted in the urine.

DR. HENRY LEFFMAN says of potassium chlorate that the extraordinary claims made for this remedy are based upon erroneous notions of its chemical qualities. He protests against its advocacy as an oxidising agent internally. Under the temperatures and conditions met with in the human system, it is one of the most stable bodies and does not part with its oxygen or chlorine. In regard to the permanganate of potassium it is as little suited for internal administration for its oxidising qualities as the chlorate, but for an opposite reason. It is so readily decomposed that it is rendered inert very shortly after its administration. He has tested the pills made by one of the most reliable houses, and found the permanganate all decomposed. If it has any virtue it must reside in the manganese, and common sense would suggest the use of a soluble manganic salt.—*Cin. Lan. and Clin.*

BISMUTH BREATH.—Wm. Reiser, Ph. G., has been experimenting with bismuth in order to discover the cause of the so-called bismuth breath. Perfectly pure bismuth oxide did not produce the garlicky odour, nor did arsenious acid. Tellurium he found to be undoubtedly the offending agent. One dose of 1/125,000 of a grain of telluric oxide produced a perceptible garlicky odour in seventy-five minutes, and it lasted for thirty hours.—*Am. Drug.*

CONGENITAL ABSENCE OF ONE OF THE MITRAL VALVES.—Dr. E. F. Cordell reports a case of this rare affection, all the other valves being perfect. The mitral insufficiency was diagnosticated before birth from the peculiarity of the fetal heart sounds. The child died shortly after birth and the autopsy revealed the deformity.—*Med. News.*

Surgery.

POTT'S DISEASE, AS ILLUSTRATING THE PRINCIPLES OF DIAGNOSIS.—C. E. Webster, M.D., Chicago.—We make the following extracts from a paper published in a recent number of the *Chicago Medical Journal and Examiner*:

To illustrate these principles, let us consider the early recognition of Pott's Disease.

A glance at the patient may be sufficient for the provisional or snap diagnosis. You

see a sickly child with an anxious expression of face, moving cautiously, seeking support from external objects, and carrying its trunk erect. Throw some object on the floor for the child to pick up. It stoops by flexing the legs, but still carries the body erect and steady, as though the spine was made of glass, and it was afraid of breaking it. The seeking of support and carefulness respecting jar or strain of spine, are the most distinctive features, and may be variously modified according to the age of the patient, the location and acuteness of the inflammation, and other circumstances of the case.

With the first glance you have recognized spinal caries, but in so serious a matter an opinion should not be given until the exact diagnosis is reached, which necessitates a history of the illness and a thorough examination. If unwilling to assume the responsibility, or unable from press of business to take the trouble, send the case to one who will, for you have before you for treatment a patient destined to live in spite of the grossest negligence, but whose future happiness and usefulness alike depend upon the care and fidelity of some one who for years shall enforce those simple rules of life, and adapt with care and accuracy the necessary appliances.

I can well assure you, gentlemen, that highway robbery were a much more honourable mode of obtaining wealth than by careless diagnosis, procrastinating measures, or insufficient treatment, to rob a child of the slight chance of reaching that normal physical development, which is a prime requisite for maintaining his physical, mental and moral symmetry.

The history of the case will vary according to the variety of the disease. It is not intended to give a classification of these varieties; therefore it will suffice to mention all the symptoms likely to occur, promising that the absence of symptoms, or the inversion of their order, does not preclude the possibility of spinal caries.

A prodromal period, or period of incubation, is to be expected. During this stage, which may date from sickness or injury, or may arise without any assignable cause, and be of several months' duration, the patient shows an indifference to his ordinary amusements and an unnatural fretfulness. He may become awkward in his movements, stumbling in his gait, or as-

sume unlikely attitudes. There may be constitutional symptoms, as loss of appetite, anæmia and a rise of temperature. There may be nervous symptoms suggestive of paralysis, as weakness, numbness, or tingling sensations in the lower extremities, with irritability of the bladder. If the disease is high in the column, gastric irritation, with a sensation of constriction of the chest. If upper cervical, difficult deglutition, choreic movements of muscles of the neck, numbness of the arms, and laryngeal cough, or a choking sensation.

Pain is one of the most unreliable of all the symptoms. It is generally located anywhere, rather than at the seat of the disease, and many patients are entirely free from it. It is thought to be caused by the irritation of the spinal nerves at the point of their exit from the foramina, and is referred to the ultimate termination of those nerves. When it occurs it may be constant, if local; intermittent, if remote from the spine; and be increased by fatigue or sudden jar. Acute pain is suggestive of a suppurative inflammation, while a dull ache is more characteristic of dry caries. The location of the pain indicates the location of the disease. If thoracic, the disease is cervical. If in the abdomen or lower part of thorax, the disease is thoracic; while, if through the thighs, the disease is lumbar.

A satisfactory history of the case having been taken, the patient is to be stripped and inspected. Flexion of the spine is avoided, and a constant effort made by the patient to support himself. He leans upon the furniture, rests his hands on his thighs, or lies across some object. His movements are constrained in order to avoid jar; he shuffles in his gait. From reflex muscular spasm there may be a partial flexure of the thighs, and a local stiffening in the portion of the spine affected. Torticollis may occur. The head may be thrown back, and the shoulders raised. The respiration may be grunting in character, with limited motion of the ribs. The first evidence of the location of the disease visible to the eye may be a slight flattening of the normal curves of the spine, with stiffening of the affected part, an indication of little value in young children when the curves are not developed. There may be a slight bulging, or a slight lateral angle in the line of the spinous processes at the diseased point;

and finally, as the commencement of the deformity, there is the formation of a knuckle produced by the tilting up of the spine of the vertebra whose body is most eroded.

Follow the inspection by a physical examination to establish the diagnosis and locate the disease. Let the patient jump down from a slight elevation, as a low stool. This concussion may produce a cry of pain, a slight confusion of ideas, the child looking surprised, or even a fall. Another method of producing the same result is to press down on the head and shoulders, producing a cry and muscular spasm. These are both rather dangerous experiments. Rubbing the back briskly with the knuckles makes the vertebral spines stand out in red spots. This may assist in detecting any displacement. Pain may be produced at the point of disease by percussion, firm pressure, compression of the chest, crowding the heads of the ribs against the diseased vertebra, a piece of ice or a thimbleful of hot water passed down the back; and, lastly, by lateral flexion of the spine, the patient lying on his face, and the body being grasped by the pelvis and shoulders. If, with the patient standing erect, the palm of the hand be placed against the suspected region, and then the spine bent in various directions, any local stiffening can be detected, the neighbouring healthy parts being felt to move. The heat of the inflammation can sometimes be detected by the hand or by the surface thermometer. There may be also slight diffuse swelling. If the patient has pain of any sort, impeded respiration, or any uncomfortable sensation, lay him across the knees, on a table, or place him in a spiral swing and make firm gentle extension or partial suspension. Observe if his symptoms are relieved. If he gives a sigh of relief and breathes freely while there is a cessation of his pain, and if the reverse of these manœuvres, by pressing the diseased bones more closely together, aggravates his symptoms, the diagnosis may be considered as fully established, and a plan of treatment adopted.

There are cases where the first symptom noticed is the knuckle of the commencing deformity, and others where paraplegia or abscess may occur without deformity. In obscure cases where the direct diagnosis is difficult, or in any case where especial ac-

curacy is desired, a table for differential diagnosis will be of service. Error in case of some of the diseases mentioned is much too common, and an occasional reference to such a table, though it be far from exhaustive, will be a valuable aid to the memory.

Theories of treatment and facts of general science can be stored in text-books; they may be held in memory, or, when needed, sought by reference, as is most convenient; but it is the duty of the student, ere he becomes a practitioner, to become at least tolerably expert in the snap diagnosis of common diseases, if not invincible in exact diagnosis.

How are these powers to be acquired? By only one process—by the study of disease; by noting the gross appearance of disease, as well as its most minute features; by clinical practice, supplemented by careful reading, and by acquiring the greatest possible proficiency in all those methods of physical exploration, without which scientific medicine would be an impossibility. Many a young graduate enters the sick-room of his first patient with trembling and abject fear. He has learned to auscultate and percuss with an instructor at his elbow, and to listen by the bedside in the hospital to an exact description of a patient's symptoms, but to interrogate and examine a patient with a view to identifying his disease and relieving his sufferings, is a thing to him as strange as were mounted horsemen to the American aborigines.

At the commencement of one's course, if he could learn the practical duties of a nurse and accustom himself to attendance on the sick, he would have done far better preliminary work than if he had mastered every department of natural science, for then the clinic would be real practice, the didactic lecture an illumination of intelligible pictures, and not a weird phantasmagoria of the unreal. While the work of pathology would become the survey of old battle-fields, the study of the historic part which is to fit him for coming victories.

In conclusion, let me quote my honoured teacher in anatomy, Dr. Oliver Wendell Holmes, who, for the eminence attained by a life of philosophical labour, sends down this clue to guide the student groping among the underbrush of routine study: "I would not undervalue the branch I

teach. I recognize the incidental importance of all the subsidiary branches which form a part of the curriculum of this and other schools. Do full justice to these, or you will not, probably, do justice to your more immediately practical studies. But your hardest study must be at the bedside. To go hastily from the library of old books and the laboratory of new experiments to the bedside of disease, is imitating the presumption of those rash profligates who, as Thomas Barton says, think they can take a 'leap out of Delilah's lap into Abraham's bosom.'"—*Cincinnati Med. News.*

THE USE OF COLLODION IN ACUTE ORCHITIS AND OTHER CONDITIONS.—Collodion is not adequately appreciated and utilized, according to Dr. Gamgee (*Birmingham Medical Review*, January, 1884). Its ready evaporation and contraction give it the dual antiphlogistic power of refrigeration and compression. In acute orchitis, for example, Dr. Gamgee knows of no plan of treatment so simple, rapid, and satisfactory as coating the cord and scrotum with layers of collodion by the aid of a camel's hair brush. The sensation is momentarily sharp, the shrinkage rapid, and so is the subsidence of the inflammatory process. To swollen parts which cannot well be bandaged, collodion is especially applicable for the compression attending its contraction.

When the nasal bones are fractured, a very effective mould for keeping them immovable, after adjusting them with the fingers, may thus be made; place over the nose a thin layer of absorbent cotton soaked in collodion; as it dries, another layer of cotton and more collodion, taking care that the application extends sufficiently on each side to give buttress-like support. The patient compares the feeling to the application of a firm bandage on the nose, and the bones consolidate effectively under the shield, which may be renewed as it cracks and peels off.—*N. Y. Med. Rec.*

TREATMENT OF MASTOIDITIS.—My plan of treatment on detecting pain and tenderness over the mastoid and around the ear, is first to paint with a tolerably strong solution of nitrate of silver (gr. 40 ad. ʒ i), or I often try first the lin. Pot. Iodidi c. Sapon, having previously applied two or three leeches, if much redness and swelling, followed by fomentation; sometimes threat-

ening symptoms are entirely averted by liniment of opium and belladonna; if, however, the symptoms are not thus mitigated, of course the treatment by poultices, fomentation and opiates have to be resorted to, but I have found from considerable experience that in nine cases out of ten, those remedies are sufficient to cut short the periostitis and to check the progress of inflammation, and also prevent suppuration; avoiding thereby any necessity for incision of the periosteum, and the patient also escaping, what I take to be, a severe mode of treatment.—Chas. Warden, M.D., F.R.C.S., in *Birmingham Rev.*

ARTHROTOMY FOLLOWED BY SEPTIC FEVER DUE TO IMPURE CATGUT LIGATURES.—Dr. Gerster (*N. Y. Med. Jnl.*), performed arthrotomy for a sub-coracoid dislocation of the humerus of twelve weeks' standing. The dislocation was easily reduced, but reduction could not be maintained. A piece an inch long and half-an-inch wide was excised from the inner aspect of the joint capsule, while the arm was forcibly rotated outward. A counter incision was made through the posterior part of the joint and capillary drainage established with strands of catgut. The anterior wound was closed by sutures. Six hours after the operation alarming septic fever set in. The wound was opened. Among the seven catgut ligatures applied, three were found turbid and infiltrated with and surrounded by pus. The strands of gut for drainage were replaced by a rubber drainage tube. The wound was treated openly. The case then progressed favourably. The function of the joint promised to become normal.

TARSOTOMY FOR OBSTINATE CLUB-FOOT.—M. Fochier (*Lyon Méd.*), states that when ordinary means have failed in diminishing the infirmity recourse must be had to wedge-shaped resections of the tarsus. The intervention should be very bold, generally it should take in not only the astragalus, but the cuboid, the anterior portion of the calcaneum and the entire scaphoid. The following is the process: An incision starting from the posterior border of the head of the fifth metatarsal and reaching to the posterior part of the tibio-tarsal articulation. Not to be intent on taking away the bones methodically by isolating their surfaces, but to gouge them from within outwards and

extirpate them in fragments. The bones are, at this age, cartilaginous and easily attackable. A brilliant and methodic operation must not be attempted.

ABDOMINAL WOUNDS.—When the abdomen has been pierced by a narrow instrument and the bowel does not protrude, the true nature of the case must be solely matter of conjecture. Perforating wounds may occur and the abdominal contents be not interfered with.

The two principal signs which must serve to guide us in these uncertain cases are tympanites and a discharge of blood by the anus. The occurrence of tympanites is unquestionably a symptom of great value. Jobert, who was the first to notice it, regards it as the most reliable of all the phenomena when there is no escape of fæces, mucus, bile or other fluid at the abdominal wound, and in this opinion the results of my personal observation fully coincide. The tympanites supervenes at various periods, sometimes almost immediately after the wound in the bowel has been received, and is then always of proportionate diagnostic value; at other times it supervenes very gradually, and in some cases, again, it does not make its appearance under twenty four, thirty or thirty six hours. However this may be it is always diffused, not circumscribed and sometimes reaches an enormous height, the belly emitting a hollow, drum-like sound on percussion, and is then always very painful.

Although tympanites is generally present in lesions of this kind, there are cases in which it is entirely absent, as, for example, when the wound in the bowel amounts to a mere puncture, in which the opening is effectually closed by the protrusion of the mucous membrane, thereby preventing all escape of gas into the peritoneal cavity.

A discharge of blood by the anus, I regard as a very valuable symptom of a wound in the bowel. It is especially valuable when it makes its appearance within a short time after the infliction of the external wound, and when it continues, more or less abundantly, for some days afterwards. As the blood is always intermixed with the contents of the bowels it seldom comes away in a pure state, but is generally of a dark colour, and of a grumous consistence.—S. D. Gross in *Med. News.*

STRETCHING THE SPINAL CORD.—Professor Hegar writing of the nervous manifestations often associated with pelvic disease in women, considers that they may be due to an affection of the lumbar cord; because they frequently begin after an unwonted strain and persist after the uterine disease is cured. Experiments on the cadaver proved that by forced flexion of the body the spinal cord could be appreciably stretched, and also by stretching the sciatic nerve, the cord is stretched. He has devised a method of stretching the cord which he has employed therapeutically with advantage. This method consists in forcibly bending the head down towards the knees, the patient seated on a firm table or laid upon the back and the legs raised, in either case the knees are to be kept straight and stiff. The amount of flexion is gauged by the degree of pain produced. He advises caution in the selection of cases in which to employ this method, as it rests upon empirical grounds solely.—*N. Y. Med. Jnl.*

CARCINOMA FOLLOWING LONG STANDING ECZEMA OF THE NIPPLE.—Dr. Conner had been consulted in a case where not only the nipple, but a circular area with a radius of two inches presented a florid surface with distinct granular points. The entire gland was involved by a tumour, and the axillary lymphatics were enlarged. It is a question whether this is simple eczema or a form resembling, but not true eczema. There was some retraction of the nipple in this case. This symptom does not possess the value attributed to it, anything that attacks the bundles of fibres which surround the ducts will retract the nipple.—*Gin. Lan. and Clin.*

MR. SAMPSON GAMGEE gives the following advice to surgical operators and dressers: "Cultivate light touching as an art; probe without thrusting, cut without bruising, separate without tearing, manipulate without mauling."

PROF. S. W. GROSS has noticed that urethral strictures are very often caused by masturbation in persons who never had gonorrhœa.—*Coll. and Clin. Rec.*

IODOFORM COLLODION.—Iodoform, ten parts; collodion, ninety parts. To be applied with a camel's hair brush; the wound being held shut until it dries. For wounds in exposed situations.—*Coll. and Clin. Rec.*

Midwifery.

DEATH OF THE FŒTUS IN UTERO.—Dr. G. V. Convery made the following remarks: Under the class of a vitiated condition of the spermatic fluid it has been maintained that if such spermatic fluid has the power of producing conception, its work has been done, and thenceforward the ovum is dependent wholly upon the mother for its future sustenance and development, and that the simple fact of impregnation does away with the theory of paternal weakness. On the other hand, quoting from Cazeaux, "a vitiated spermatic fluid communicates to the new being a principle that does not fail, sooner or later, to destroy it;" and Guillemot holds it to be incontrovertibly proved that strong, healthy females, who have married men, though of a suitable age, showing signs of decrepitude and early senility, have consecutively given birth to still-born children, while the issue of second marriages of the same women have been numerous and lusty.

Passing at once to the next heading, we find that the ovum is liable to diseases which greatly compromise it, and, in some cases, may cause its death. One of these diseases is dropsy of the amnion. The normal amount of amniotic fluid is variable; but, when it exceeds three or four pints, it may be attributed to some morbid condition. This condition has been ascribed by some to a sanguineous plethora, but Dr. Mercier was of the belief that it is due to an inflammation of the amniotic membrane, and professed to have seen, in several cases, the amnion covered with false membrane. Whatever may be the morbid agent in the production of this disease, it has been noticed by many observers to occur in the subsequent pregnancies of the same woman, and to be much more frequent in twin than in single pregnancies. The immense amount of fluid in these cases (sometimes forty or fifty pints) arrests the development of the child, and it dies in its mother's womb—though occasionally it is born alive, soon to die. If death occur at an early stage of its development, it may become dissolved in the fluid, and no trace of it afterward be found; and, in later stages, the fœtus may be affected with either ascites or hydrocephalus, as we learn from the investigations of Bunsen and Kiel.

Rokitansky states that, in certain cases, adhesions more or less extensive form between the amnion and the embryo, and that these, probably the result of inflammation, may so arrest the development of the child as to cause its death.

Beside this dropsical condition of the amnion referred to, cases are met with in which the villi of the chorion become distended with fluid, giving groups of them the appearance of gooseberries. If this dropsical condition becomes general—when all, or nearly all, the chorionic villi are thus affected, the embryo dies; and in this case also may be dissolved and lost. The villi of the placenta may undergo a like degeneration, and here, after causing the death of the child, it fills the amniotic cavity, forming the blighted ovum—vesicular or hydatidiform mole—the *acrophalocystis racemosa* of Laennec. Aside from this affection of the placenta, this organ may present functional derangements and textural lesions that imperil or cause dissolution of the product of conception. Plethora, congestion, and diminution in the rapidity of the circulation through the placenta may, if prolonged, so impede aeration of the fetal blood as to result disastrously.

Among the textural diseases, inflammation is the most frequent; it generally affects small areas of the placenta, but does sometimes appear extensively. This inflammation generally gives rise to plastic fibrinous infiltrations, which, reddened from the colouring matter of the blood, give rise to the large, heavy, hepatized placenta, and from the plastic deposits the placenta is nodulated. In the course of time these nodules become pale or yellow; at the same time they become dense, and the placenta, with its remaining tissue, contracts and shrivels. The inflammation in this case terminates in induration and obliteration of the placental tissue, which is converted into a tough, leathery callus, resembling yellow elastic tissue.

In rarer cases the inflammation gives rise to a purulent product, causing a diffused infiltration, circumscribed globular abscesses forming in the tissue of the placenta and general suppuration supervening—*phthisis placentæ*. Either of these conditions will cause the death of the fœtus by cutting off its blood-supply. Instances of ossification of the placenta have been men-

tioned by some writers, but I have been unable to glean any data of importance concerning them. Tuberculous, encephaloid, scirrhus, and fatty degenerations of the placenta have been mentioned by as many authors; but these cases were, according to Cazeaux and Rokitansky, erroneously described as such, having been obliterations of the placental tissue after inflammation, indurated inflammatory products, or old, decolorized extravasations of blood. Placental apoplexy, though generally the result of traumatism, occasionally occurs idiopathically, and, if of frequent occurrence, may result in death of the ovum. Hitherto I have used the terms fœtus and embryo interchangeably; but, from the period of quickening, the product of conception is known only as the fœtus, and, as such, it and its diseases we will now consider.

A most important morbid process, and one of rather frequent occurrence, the ætiology of which is obscure, is inflammation. Inflammation attacks almost all the organs of the fœtus, including the thymus gland and supra-renal capsules. It gives rise to plastic products with adhesions between contiguous organs, and in some cases ends in suppuration. The serous membranes are more frequently inflamed than any other tissue, and the peritonæum the most frequently of all. The inflammation of the peritonæum may originate in unknown causes or in causes that are demonstrable, such as constriction of the intestines, hæmorrhage from the liver into the peritoneal cavity, and extravasation of the contents of the intestines or bladder.

Inflammation of the brain and resulting softening, and, in some cases, complete liquefaction of the cerebral substance, are found. Endocarditis affecting the right side of the heart, and pericarditis also, occur in fœtal life, and death may ensue in the one case as a sequel to embolism, and, in the other, from interference with the heart's action. Hyperæmia and inflammation of the alimentary tract have been found, and may be accompanied by ecchymoses in the tissues and extravasations into the intestinal cavities. In the intestines, Peyer's patches are found in some cases of a "fleshy, sarcomatous" appearance, containing a grayish, curdled, flocculent fluid. These conditions resemble greatly the induration and breaking down

of the Peyerian glands in typhoid fever, and may result, says Rokitansky, if not from an identical cause, from a very similar one. Autopsies on fœtuses have also shown a diffused croupous inflammation of the intestinal mucous membrane.

In the respiratory apparatus we may find disease; hepatization, and even abscesses have been seen in the lungs.

The liver of the fœtus is often the seat of congestion and hyperæmia, and, from the delicacy of the tissue, apoplexy and rupture occasionally occur. Infiltration into the hepatic tissue may form, giving the fatty, waxy, and lardaceous livers.

The urinary organs of the fœtus do not often become diseased, but in a few cases apoplexy of the kidney is found, and supuration of the supra-renal capsule occurs; and, from contraction or an impervious condition of the urinary passages, the bladder has been found ruptured.

The fœtus is not only affected with these local diseases, but may suffer from the various zymoses, and may even die; and this either while the mother is coincidentally affected, or independently of her. The fœtus may become affected with variola, even though the mother never had the disease; this fact is attested by Bouchut, Rokitansky, Jenner, Deneux, and others.

If malarial toxæmia is ever the cause of death, I think it might be noted as a possible cause of pre-natal death, especially in those localities where the malarial miasm is of a virulent character; for it has been proved by several observers (Stokes, Schuric, Jacquemier) that women affected with malarial toxæmia may communicate the disease to the fœtus. Finally, there is one disease which I put in this category, first, because the fœtus becomes affected with it, and, secondly, because it enables me to dodge the question as to whether it is communicated by the father or the mother; and that disease is syphilis. Of all the diseases to which humanity is heir, none compares in destructive ability with syphilis. Various is its mode of action, in fact, many if not all of the lesions of the fetal organs may be due to the action of this poison; inflammation, abscess, and supuration of the different organs have been ascribed to it by many authors, and monsters of arrested or perverted growth by others.—*N. Y. Med. Jnl.*

RELATIONS OF OVULATION TO MENSTRUATION.—Mr. Lawson Tait read a paper on "Relations of Ovulation to Menstruation." He gave an historical sketch of the literature of the subject since 1843, the date of the publication of Dr. Ritchie's papers, and observed that although Ritchie's discoveries had been amply and frequently confirmed, the text-books still reiterated the mistaken view that menstruation was the equivalent of the œstrus or rut, and that it was due to the ovarian excitement of the ripened follicle. He next gave a series of observations derived from his surgical practice, in which it was shown that in forty-nine observations there was evidence of the concurrence of ovulation and menstruation in nine only, whereas in forty cases the evidence was either negatively (fifteen cases) or positively (twenty-five cases) against the ovulation theory of menstruation. It was therefore impossible to maintain a theory which was controverted by nearly 82 per cent. of evidence. Mr. Tait showed a large soft œdematous myoma, without pedicle, removed successfully from a woman aged forty-three; also a specimen of abscess of right ovary.—*Birming. Rev.*

DR. CLIFFORD ALLBUTT AND SPECIALISM.—In his Gulstiniian Lectures on the "Neuroses of the Viscera," Dr. Allbutt thus refers to the Gynæcologist:—A neuralgic woman seems thus to be peculiarly unfortunate. However bitter and repeated may be her visceral neuralgias, she is either told that she is hysterical, or that it is all uterus. In the first case she is comparatively fortunate, for she is only slighted; in the second case she is entangled in the net of the Gynæcologist, who finds her uterus, like her nose, is a little on one side; or again, like that organ, is running a little, or it is as flabby as her biceps, so that the unhappy viscus is impaled upon a stem, or perched upon a prop, or is painted with carbolic acid every week in the year, except during the long vacation, when the Gynæcologist is grouse-shooting, or salmon-catching, or leading the fashion in the Upper Engadine. Her mind thus fastened to a more or less nasty mystery, becomes newly apprehensive and physically introspective, and the morbid chains are rivetted more strongly than ever. Arraign the uterus, and you fix in the woman the arrow of hypochondria for life.—*Brit. Med. Journal.*

ANTISEPTIC MEASURES IN OBSTETRIC PRACTICE CARRIED TOO FAR.—A correspondent of the *N. Y. Med. Record* tells of a friend, a thorough Listerite, who owns a large ranche and supplements his private practice with veterinary duties. He injects a four per cent. solution of carbolic acid into the vagina of his cows before labour is expected for several days, and also for several days after labour. Trying the same process on a favourite mare with foal, he and his syringe were kicked into an adjoining field, happily without serious injury.

NEW METHOD IN ADHERENT PLACENTA.—Dr. J. Field, of Kansas City, reports that in six cases of adherent placenta he has saved the woman by pumping cold water through the umbilical cord. In one case the patient was in convulsions when the afterbirth came away.—*Med. Rec.*

THE
Canadian Practitioner,
(FORMERLY JOURNAL OF MEDICAL SCIENCE.)

TO CORRESPONDENTS.—*We shall be glad to receive from our friends everywhere, current medical news of general interest. Secretaries of County or Territorial Medical Associations will oblige by forwarding reports of the proceedings of their Associations.*

TORONTO, JUNE, 1884.

THE ONTARIO MEDICAL ASSOCIATION

On Wednesday and Thursday of this week, June 4th and 5th, the Ontario Medical Association will hold its fourth annual meeting in the City Hall at Hamilton.

Amongst the invited guests will be the Mayor of Hamilton. Dr. Workman, Dr. Covernton, and Dr. Macdonald, ex-Presidents of the Association, and Dr. Fenwick, of Montreal. Delegates from the New York State Medical Society have also signified their intention of being present.

In addition to the large hall for the general meeting a number of committee rooms have been obtained for the use of the various committees, where their business may be transacted quietly, and without interruption.

For the convenience of the visitors arrangements have been effected by which street cars will await the arrival of every train for the purpose of carrying the members directly from the depot to the City Hall.

Members will be supplied with neatly printed cards bearing the names of the officers of the Association—the *personnel* of the various committees, the rules of order, and as far as possible the list of papers; an attempt will be made to indicate the approximate hour at which each paper will be read. In this way the progress of business will be facilitated, and members who desire to hear or discuss a particular paper will be able to do so without loss of time or weariness of spirit.

The morning session will begin promptly at 10 o'clock, and will most probably be fully occupied by the registration of members and the receiving the reports of committees. The address of the President, Dr. Daniel Clark, will be delivered at 3 in the afternoon of Wednesday. The sessions will probably be held in the morning, afternoon and evening. It was deemed to be unadvisable to separate into sections at present; a plan similar to that successfully pursued in Toronto last year will most likely be found best adapted to the needs of the association in its present form. In this way ample time will be afforded both for the reading of papers and for the discussions upon them, and for the exhibition of specimens and cases.

We are pleased to learn that the committee of arrangements do not propose to depart from the precedent afforded at the former meetings. Beyond a warm and hearty welcome no formal and organized attempt will be made to demonstrate the pleasure experienced at the advent of so many visitors to the city.

The railways, as before, have allowed each member of the association a round trip ticket for one fare and a third. This privilege to be extended to the members of the

physician's family, and also to include any patient he may desire to show to the association. The ticket holds good until the following Monday.

We look forward to a most enjoyable meeting. The range of subjects included in the list of papers is wide, and will afford abundant opportunity for receiving and conveying instruction, for airing pet theories, or for submitting hard facts. The interchange of ideas will afford material for thought and reflection which will bear fruit in increased experiment, investigation, and comparison. At no time have the prospects of the society looked brighter, and during the course of a very vigorous existence this association has never displayed such an amount of activity and vitality as during the past few weeks.

UNIVERSITY OF TORONTO.

The following gentlemen have passed the University examinations in medicine:

FOURTH YEAR.—J. W. Clerke, *Gold-medalist*, J. Johnston, A. F. Mackenzie, J. W. Patterson, J. Spence, S. Stewart, R. L. Stewart, J. Bray, J. S. Draper, G. A. Bingham, E. G. Knill.

THIRD YEAR.—J. H. Howell (*scholarship*), L. Carr (*scholarship*), D. Bourke, A. Broadfoot, F. W. Cane, G. H. Carveth, A. B. Knisley, C. A. Crick, D. J. Minchin, H. E. Webster, M. R. Saunders, H. N. Hoople, D. M. Staebler, H. Bascom, G. A. Cherry.

SECOND YEAR.—G. A. Peters (*scholarship*), D. R. Johnston (*scholarship*), A. W. Bigelow, J. C. Carlyle, W. P. Caven, W. J. Greig, H. J. Hamilton, J. Marty, D. Mackenzie, J. W. Mustard, C. T. Hoecker, S. G. Parker, J. W. Peaker, O. Weld, H. E. R. Little, C. H. Britton, J. Macoun.

FIRST YEAR.—W. D. Green, J. B. Reid (*æq. scholarship*), F. P. Bremner, H. E. Drummond, J. H. Eastwood, A. Ego, D. Johnston, M. J. Keane, J. A. McMahon, J. Olmstead, A. H. Perfect, W. O. Stewart, W. R. Walters, W. R. Watson, A. B. Eadie, A. E. McKay, A. B. Thompson, J. D. Thorburn.

CITY BOARD OF HEALTH.

There was convened on Monday, the 26th ult., at the City Hall a meeting of the newly elected Board of Health for the city. This board consists of four aldermen, Dr. Carroll, Mr. Defoe, Mr. Blevins, and Mr. Irwin, and four representatives from the citizens, Dr. Pyne, Mr. A. R. Dennison, Mr. Alan Macdougall, C.E., and Mr. Meredith. After meeting and appointing Ald. Blevins chairman they adjourned until the next morning. At the meeting on Tuesday morning, they endeavoured to arrive at the best means of carrying out the duties assigned to them by statute. They adjourned to meet again on Friday.

A DOMINION SANITARY BUREAU.

We publish in another column a letter from Dr. Playter, referring to our notice of the plan proposed for establishing a Sanitary Bureau at Ottawa. The inaccuracy of which he accuses us resulted from a careful perusal and study of the details of the plan submitted to us. Its results, however, amount to the same thing; instead of the chief officer of the Bureau holding a non-salaried office, it is the chief officer of the large and unwieldy committee who is to serve his country and his government for the honour and distinction conferred, with the exception of a small per diem allowance common to him with the other members of the committee. Dr. Playter agrees with us that his estimate of the funds requisite for the organization of the Bureau, even without the salaried chairman, was too small, and proposes to double the estimate for the ensuing year. At all events he will have a more correct idea of the cost of the experiment by that time. In regard to the probabilities of the duties of the Dominion Board, conflicting with the privileges of the Provincial Boards, Dr. Playter is silent. If the Dominion Board confines itself to those objects which come directly within the jurisdiction of the Federal au-

thority there will be sufficient work to keep the department busy without interfering with the excellent work already done by Provincial Boards. This will require some tact and some management, but it can, and should be effected. We wish Dr. Playter every success in his undertaking. The Dominion Bureau has its field of labour; but the labourers should have their work defined, and should be remunerated properly for their labour.

THE CATTLE BYRES AND THE BOARD OF HEALTH.

The suit which has been terminated by a compromise between the plaintiffs, certain citizens of the east end of the city, and Messrs. Gooderham & Worts, proprietors of the cattle byres near the mouth of the Don River, was one of considerable interest in a sanitary point of view. The Provincial Board of Health, under its able chairman, Dr. Oldright, displayed a gratifying interest in the public welfare in instituting this complaint and evinced a commendable spirit in its prosecution. At the conclusion of the case for the plaintiffs, the proceedings were stayed by a compromise in which the defendants agreed to erect settling tanks and not to drain the overflow from these into Brown's or Ashbridge's Bays, and certain other measures which are deemed sanitary improvements. Also to limit the number of cattle in the byres to 4,000 head; and by paying the costs of the suit.

A PEPTONE IN WHITE OF EGG.—E. T. Reichert, M.D., in *Phil. Med. Times*, signifies the discovery by him of a peptone in the white of egg. This is only the third peptone ever discovered as existing as a natural constituent of a secretion—the first having been discovered in milk, and the second by Dr. Reichert and S. Weir Mitchell in the venom of various snakes.

PAPERS TO BE READ AT THE ONTARIO MEDICAL ASSOCIATION MEETING AT HAMILTON.

The following is a list of the papers to be read at Hamilton received up to the present by the Secretary.

Progressive Pernicious Anæmia, Dr. Graham, Toronto.

Prevention of Puerperal Fever, Dr. Adam Wright, Toronto.

Actinomycosis, the new infectious disease, with microscopical preparations, Dr. Duncan, Toronto.

Studies in Uterine Displacements, Dr. Turver, Parkdale.

Excision of the Tonsils, Dr. Ryerson, Toronto.

Cerebro Spinal Meningitis, Dr. Worthington, Clinton.

Case of Bilocular or Double Uterus and Vagina, Dr. Riordan, Toronto.

Management of the Third Stage of Labour, Dr. Tye, Chatham.

Case of Hodgkins Disease, Dr. Hutchinson, Brussels.

Later Antiseptics in private practice, Dr. Powell, Edgar.

Reports of cases of Ovariectomy and Strangulated Hernia, Dr. Brouse, Brockville.

Glimpses of Transatlantic Surgery, Dr. Brown, Galt.

Vaccination, Dr. Harrison, Selkirk.

Boracic Glycerine in diseases of the Ear, Dr. Rosebrugh, Toronto.

The Relations of the Public and the Medical Profession, Dr. Playter, Ottawa.

The Operative Treatment of Fluid Effusions of the Chest, Dr. Groves, Fergus.

Inversion of the Uterus, Dr. Harris, Brantford.

Case of Cancer of the Cæcum, with specimen, Dr. Griffin, Brantford.

The Use of Carbolic Acid in Purulent Affections of the Eye, Dr. Burnham, Toronto.

Case of Fracture and Dislocation of the Vertebrae, Dr. Thorburn, Toronto.

TORONTO UNIVERSITY SENATE ELECTION.

We regret exceedingly to announce that Dr. Thorburn was defeated at the recent election of the Senate of Toronto University. This diminishes the number of medical representatives by two, as Dr. Graham was one of the retiring members. This result has arisen, not from any objection to Dr. Thorburn personally, but because the Graduates in Arts so largely predominate. We fear that we may lose our medical representative entirely, unless some change is made, by which the graduates in the different departments will be allowed to elect their own representatives.

The members elected are Messrs. Loudon, Coyne, and Kingsford, with whom we have no fault to find. If we had to choose from the *arts men* alone, better men could scarcely be selected.

ETHERISATION BY THE RECTUM.

While it is universally admitted that of the two great anæsthetic agents ether is by far the safer, it is no less generally admitted that chloroform is the pleasanter both to administer and to inhale. Any method then which promises to lessen the unpleasant primary effects of the safer agent, while in no way increasing the dangers of its administration, will be received by surgeons the world over with feelings of thankfulness and satisfaction.

Dr. Daniel Mollière, of Lyon, acting upon a hint derived from Dr. Axel Yversen, a surgeon of Copenhagen, has been producing profound anæsthesia in a few moments by ether injected into the rectum. In his first case the ether mixed with air was forced into the rectum by a Richardson's atomizer. In ten minutes the taste of ether was perceived in the mouth, and the breath exhaled a strong odour of the ether—the patient began to talk incoherently; a few whiffs of ether to the nostrils immediately produced profound anæsthesia. In his other cases the ether was made to

boil by placing the flask containing it in a vessel of water at 50° C. The vapour was conducted into the rectum through a rubber tube connecting with the neck of the flask. The quantity of ether necessary was very small; it was estimated to be about ten grammes in one case; very small or insignificant in others. The period of excitement was suppressed, or so slight as to be scarcely noticeable. The time required to bring the patient under the influence of the ether was short, five or six minutes. There was no nausea or vomiting, and it leaves the surgeon untrammelled in operations about the face.

M. Delore, of Lyon, who also successfully tried this plan, found that a too rapid disengagement of the ether vapor gave rise to severe intestinal colic and escape of ether from the anus, his patient also was nearly asphyxiated, which he attributes to an accumulation of the ether in the intestine, which continued to be absorbed after the withdrawal of the tube, and after profound anæsthesia had been produced. He found it a difficult matter to regulate the quantity of ether absorbed.

Since the appearance of Dr. Mollière's article in the *Lyon Médical*, the New York surgeons have been making successful trials of this method. Their experience in the main corroborates that of the Lyonnais surgeons. At the same time they have met with drawbacks, such as intestinal irritation and diarrhœa, which was considered the cause of death in one case. Their conclusions appear to be that it is a valuable addition to the ordinary method, but is not advisable for prolonged operations.

The method apparently possesses advantages, and may be applied in hospital cases and in private practice in most cases. It remains to be seen whether it is applicable, or rather if it will be submitted to by patients who desire anæsthesia for the extraction of teeth, a class of cases which has given rise to a large number of accidents, and which we at least always under-

take with trepidation, and would hail with devout thankfulness any method which rendered the administration of the anæsthetic swift, sure and safe.

A MALPRACTICE SUIT.

Early in May, at London, there was concluded a suit brought against a medical man, claiming damages for malpractice in the treatment of a fractured ankle. The plaintiff, a young lady, fell and sustained a dislocation of the ankle and fracture of one of the bones of the foot. The limb was treated scientifically by the application of plaster splints, and rest enjoined. This injunction was disregarded, and serious consequences resulted. The jury very properly gave a verdict for the defendant. The medical testimony was perfectly conclusive in regard to the propriety of the treatment. There appear to have been no reasonable grounds for instituting proceedings against the attending surgeon. Indeed, the plaintiff was urged on by injudicious friends in the face of advice from other medical men, who stated that the treatment had been well devised, judicious and correct.

We heartily congratulate Dr. Arnott on the successful issue of this harassing and distressful action. To a conscientious man it is ever a source of regret that his skill and judgment have been called in question, even though no shadow of reason was shown for the doubt. The annoyance, the loss of time, the personal inconvenience, and the probable loss of prestige from the mere fact of his skill being questioned, even though triumphantly vindicated, cannot be compensated for by any monetary consideration, nor yet by the satisfaction of a successful and overwhelming rebuttal of the charges.

A TOXICOLOGICAL PSEUDONYM.—Under this caption the *Louisville Medical News* in its usual forcible and happy style directs attention to the poisonous properties and the easy accessibility of the compound

termed "Rough on Rats." An extract from the *Therapeutic Gazette* in which "the poison—'Rough on Rats' is simply white arsenic" is given and then the thanks of the profession are tendered "to our esteemed contemporary for thus making known its active ingredients." We agree most cordially with all that our vivacious contemporary has uttered on this subject. We also modestly take unto ourselves a modicum of the thanks generously bestowed, for in our issue of December, 1882," Dr. Zimmerman communicated the result of an analysis of this "Rough on Rats" made by Mr. Thos. Heys, in which he says he finds "it consists of white arsenic. (As, O₃) coloured with a little charcoal. The amount of arsenic is over ninety-nine per cent."

Correspondence.

To the Editors of the *Canadian Practitioner* :

DEAR SIRS.—In the April number of the PRACTITIONER, in referring to a plan for a Dominion Health Bureau and for the collection of disease reports or statements, which I had laid before a meeting of medical men in the Parliament House here, and which was adopted by the meeting, there was an error, arising, doubtless, from a misunderstanding of the plan, which I should be glad to correct. Absence from home and illness in my family prevented me writing in time for this month's number.

Your remarks, in reference to the plan, I thought very fair, and the error was only this: You stated in effect that, while it provided for salaries for the chairman and secretary of the advisory committee, it did not provide for a salary for the chief officer of the bureau. The plan proposed a salary of \$2,000 for this chief officer, and one of \$1,500 for the secretary of the committee, but no salary for the chairman of the committee. This position being honorary, with a per diem *honorarium* while on duty, the same as other members of the committee.

Further, you thought, and properly enough, the estimated cost altogether too low; but the estimation was only for a com-

mencement, the first year, and it was thought after a show of good work the appropriation would probably be doubled the next year, as in the case of the Ontario Board of Health.

Permit me to add: that, besides the Medical Members of the House, and the members appointed by Government, the chairmen of all Provincial Boards of Health, and perhaps in Provinces with no Provincial Board, the chairman of the board of the principal city, might well be *ex officio* members of the Sanitary Committee. This would make this committee large, but it need meet in full only once a year, and at Ottawa; sub, or special committees meeting as required.

In conclusion, I would state that a sort of sub-department of health, of that kind submitted in the plan, would, it is thought, be more in accord with our system of Government—more of a responsible body, than a Dominion Board, as Boards are ordinarily constituted.

By giving the above an insertion you will oblige,

Yours, truly,
EDWARD PLAYTER.

Ottawa, }
1st May, 1884. }

NOTES FROM THE GERMAN MEDICAL CONGRESS.—FRERICHS' FESTIVAL, ETC.

BERLIN.

By a happy coincidence the festival in honour of Frerichs and the Congress of German physicians took place at the same time in Berlin, and brought together the most celebrated clinicians of the country. There were present: Liebermeister, Nothnagel, Gerhardt, Mosler, Baumler, Quincke, Ziemssen, Leube, Jürgensen, Rühle, Huebner, and many others whose names are familiar to us. The local profession was fully represented. The Congress opened on Sunday evening, the 20th, with a social gathering in the Kaiserhof Hotel, and on Monday at 10 a.m. Prof. Frerichs, the President, opened the session with a brief sketch of the work which had been planned.

The discussion on *Pneumonia* occupied the entire morning, and attracted a great deal of interest from the "coccus" with which the disease has recently been endowed. Prof. Jürgensen opened the debate

and remarked that this most thoroughly studied disease had now to be reinvestigated from a new standpoint since the discovery of the specific germ by Friedlander. It was a general affection, arising through infection with a special poison, the effects of which were manifested chiefly in the lungs. The fact that in at least twenty per cent. of the cases the disease arose from cold did not render this view any less tenable. Direct transmission from one person to another was possible, and he referred to a number of instances in which the contagiousness appeared evident. The dependence of the disease on meteorological conditions could be explained by the influence of these conditions on the growth of the micrococcus. The disease often hung about certain localities and dwellings like typhoid. He claimed that at Amberg the coccus had been discovered in the filling below the floor, had been cultivated, and produced the disease in an animal when inoculated with it (!) Flint, in six years, had been able to trace in two-thirds of the patients a direct or indirect connection with other cases. He referred to the affection of other organs than the lungs, in cases of pneumonia, the kidneys, the brain, the serous membranes, just as in typhoid and other specific fevers.

Dr. A. Fraenkel then gave a detailed account of the micrococcus of pneumonia, discovered by Friedlander. He concluded as follows: The coccus of pneumonia can be isolated by cultivation, and is directly transmissible to animals. The effects are somewhat variable; some of the inoculated rabbits resist the disease, others die with a severe general affection and localized regions of disease in pleura, pericardium and lungs. The encapsuled form (which was thought to be characteristic) of the coccus is not peculiar to it, but is met with in other varieties.

Dr. Friedlander then gave an account of recent experiments with blood drawn by cupping glasses from pneumonia cases. Five of the six cultures remained sterile, but the sixth was successful, and with the micrococci mice and rabbits were inoculated. The former all died with pneumonia and pleurisy, the latter remained healthy.

The discussion which followed did not bring out any new points. There was a general feeling of hesitancy about accepting the coccus as the fully established *materies*

mobi. Beautiful specimens of it were shown by Dr. Friedlander. The coccus is usually surrounded by a sort of gelatinous capsule, and in its mode of growth on sterilized gelatine it appears distinct from other forms.

Poliomyelitis and Neuritis. Professor Leyden opened an interesting discussion on these points. Sir Chas. Bell first distinguished between muscular atrophy and paralysis. The progressive muscular atrophy and the spinal paralysis of children, though at first by Duchenne and others regarded as spinal, were subsequently believed to be largely of local myopathic origin. Charcot, in a number of these cases found degeneration of the motor cells in the anterior horns and the spinal view of their origin again prevailed. Duchenne and Joffroy grouped all the atrophic paralyses together into acute and chronic divisions. In the first were placed the acute paralysis of children and the analogous process in the adult, and in the latter the progressive muscular atrophy and the progressive bulbar paralysis. Charcot believed the process to be a parenchymatous inflammation of the grey matter, and Kussmaul gave it the name of poliomyelitis. Friedreich, in his monograph upon muscular atrophy, opposed this view and regarded the process in this affection as myopathic, and in many cases, carefully investigated, the cord was found intact. But it would appear that there are different forms of progressive muscular atrophy, and Hayem and Charcot published cases in which there was undoubted affection of the grey matter. Eisenlohr, Lichtheim, Remak, and Eichorst had shown by their cases that *neuritis* could produce a clinical picture of progressive muscular atrophy. In the case of Eichorst, which ran a rapid course, the cord was intact, but the nerves were macro- and microscopically affected. Leyden had published in 1879 two cases of paralysis with atrophy resembling very much the Duchenne's paralysis, and in both the cord was unaffected, but the nerves were diseased. The clinical picture of this form of peripheral neuritis is characterized as follows:—The disease appears in a previously healthy person, attacking the extremities symmetrically, either all four or the two lower, the most distant muscles being the most affected. Usually atrophy quickly supervenes. A light, medium, and

severe grade of the disease can be distinguished. In the first the electrical condition of the muscles is scarcely altered: in the severe form, the faradic excitability almost completely disappears, and only the galvanic remains, and there is extensive atrophy of the muscles. Between these there is a medium form characterized by slight loss of electrical excitability and moderate atrophy. The disturbances of sensation are at first slight, but usually there are pains, most intense, towards the periphery. Often the nerves are tender to pressure. The course of the disease varies, sometimes it is very acute, in others recovery may take place in a few weeks, or it may be protracted to months. The prognosis is much more favorable than in the acute atrophy from spinal disease. The disease appears not infrequently associated with or following upon rheumatism. When this is the case salicylate of soda appears beneficial. Rest is an important element in the treatment, and it is a great mistake to make too early attempts at movements of the muscles. When regeneration appears to have set in then the electrical treatment may be begun. Subsequently friction, massage and movements.

The Etiology of Diphtheria.—Dr. Löffler, one of Koch's assistants, gave a *resume* of the experiments which had recently been made upon the nature of the contagion of this disease. Material was obtained from thirty-two cases either immediately *post-mortem* or from the patient. There were present: first, a great number of different sorts of bacteria and micrococci; second, a group of chainlike cocci which were found at the site of loss of substance, as in the tonsils, and also in the internal organs, and third, small rods, already described by Klebs, which existed in the superficial part of the membrane; of the two last groups pure cultivations were obtained and inoculations made. With the chain-like cocci the experiments were all unsuccessful, nothing like diphtheria was produced; in rabbits a curious inflammation of the joints followed, similar to what happened with the coccus of erysipelas. The inoculations with the cultivations obtained from the small rods of the third group were unsuccessful upon mice and rats. Birds and guinea pigs often died the next day, and the rods were found at the site of inoculation but not in the inner organs. On the conjunc-

tiva the trachea and the vulva false membranes were produced by the inoculation and several animals were exhibited with well marked and thick membranous exudation in these situations. The question was not regarded as settled, but it was thought that these rods might play a certain role in the etiology of the disease.

Micro-organisms in the Intestines.—Dr. Stahl, another of Koch's assistants, has been busy determining the number of forms of micro-organisms which may occur in the fæces. So far twenty-five different sorts of lower fungi and bacteria have been found. A series of beautiful preparations of these forms was exhibited.

Papayotin.—Dr. Finkler, of Bonn, described the action of this drug in dissolving albuminous substances and of its use in diphtheria. It is a vegetable ferment obtained from South America, but not much of the pure material can be got. His preparation was obtained direct from a German chemist in the county. It is capable of dissolving 1,000 times its own weight of fibrin either in an acid, alkaline or neutral medium. He had used it with the greatest success to dissolve diphtheritic membrane, which has sometimes disappeared in a few hours after its use. A further advantage of this material will be its use in peptonized foods.

Goltz on Cerebral Localization.—The well-known Strasburg physiologist had the largest audience of the Congress, partly attracted by a desire to see one of his celebrated dogs which he had brought with him, and partly because it was hoped that a very lively discussion would follow. He went over the same ground as at the International Congress in 1881, and demonstrated to the satisfaction of all the members that destruction of the motor area in the dog did not induce permanent paralysis, but that the animal could stand, and run and perform various voluntary movements almost as well as a normal animal. But the movements were often clumsily effected. Thus an animal with extensive destruction in both frontal lobes could not gnaw a bone so well, and could not hold it down cleverly with the foot. In grasping a piece of meat held up before him, the dog would do it awkwardly as if it did not know how to estimate properly the degrees of muscular effort required. An interesting result of extensive operations on the cortex is the

alteration in character of the animals. With extensive lesion of the frontal lobes they are exceedingly cross and vicious, will bite and snap at persons with whom previously they were on the best of terms. On the other hand with lesions of the posterior lobes the animals are quiet and docile even if they have previously been bad tempered. The animal exhibited had the so-called motor centres removed on both sides in October last. The next morning the brain was demonstrated and the lesions were found to be symmetrical and involved the superficial part of the organ about the cruciate sulci. The lesion was scarcely as extensive as had been expected, and in each hemisphere it is quite possible that part of the motor centre remains.

It is evident that in the dog permanent paralysis does not follow extirpation of the motor centres—this Ferrier admits—but it seems quite as evident that destruction in monkeys of the convolutions bounding the fissure of Rolando does produce a permanent paraplegia of the opposite side. It seems a pity that Prof. Goltz cannot be provided with monkeys in which to go over the experiments. I missed the exceedingly interesting discussion upon nervous dyspepsia opened by Prof. Leube.

The Frerichs' Festival.—A good custom prevails among the German universities of celebrating the twenty fifth anniversary of the academical activity of their celebrated professors. Dr. Frerichs came here from Breslau in 1859, as successor to Schonlein and has been an eminently successful teacher and worker. His former assistants met and presented an address of congratulation, and the annual dinner of the Medical Congress was dedicated to his honour. About 400 were present and a great deal of enthusiasm was manifested. Although only sixty-five, Prof. Frerichs looks much aged in the ten years which have passed since I last saw him. He still continues to hold his clinic and has a large consulting practice.

W. O.

“Boss, has you got any of those confound contartic pills?” “Yes. Do you want them plain or coated?” “Dunno. I want dem dat's whitewashed.” He got 'em, and departed. There was a fine opening in the near future for a scholar of his calibre.

Meetings of Medical Societies.

TORONTO MEDICAL SOCIETY.

March 27, 1884.

The President, Dr. Graham, in the chair. The minutes were read and confirmed. Dr. Macdonald, of Church street, was elected to membership.

Dr. Graham read a paper on a peculiar case of suppurative disease. (See CANADIAN PRACTITIONER, May, 1884, page 158.)

Dr. Nevitt thought the history pointed to chronic pyæmia. He cited a case which had been under treatment for a number of years. A great variety of treatment was used with indifferent success; the patient became emaciated; a foreign body was carefully sought for, but was not found; and the diagnosis made was of some form of spinal injury. The patient was sent to an hospital, and after a further minute and careful search a foreign body was found and extracted, and prompt recovery ensued. The abscesses in this case were in the connective tissue.

Dr. Macfarlane was disposed to agree with Dr. Nevitt, that the case was one of chronic pyæmia. In strumous cases the glands about to suppurate are indolent taking a long time to mature, while in Dr. Graham's case the abscesses formed rapidly. He thought it difficult to draw the distinguishing line between tubercle and scrofula. He spoke of a family of four children, whose parents died of consumption. Two of the children were tuberculous, and two were scrofulous. In all cases of this kind there is a cachexia, whether it attacks glands or lungs, or brain, the same cachexia exists. He was disposed to think them the same disease; but attacking different structures.

Dr. Ferguson spoke of a case which had occurred under Mr. Heath's care, where multiple abscesses occurred, and at the autopsy no cause for the pyæmia could be found, save a carious condition of the teeth.

Dr. J. F. W. Ross was inclined to regard these as mixed cases. If it were simple pyæmia there would more likely be severe or well marked rigors. There had been two or three points omitted in the post-mortem examination which might have thrown some light upon the case, especially as to the presence or absence of tubercle in the lungs, in the meninges, and in the abdomen.

Dr. McPhedran was disposed to agree with Dr. Nevitt, that the case was not scrofulous, or at least not entirely so. In regard to a remark made in the paper that syphilis is a predisposing cause of scrofula, he quoted Treves to prove it a direct cause, the first children of syphilitic parents being syphilitic, and the later children scrofulous.

Dr. Graham admitted a pyæmic condition in his patient in the later stages. The great difficulty of the diagnosis occurred in the early part of the disease, and in the intervals of comparative health. In scrofula the parts affected particularly are lymphatic glands, mucous membranes, and the joints. The mucous membrane of the ileum in this case was affected.

Dr. Cameron presented some atypical temperature charts of typhoid fever.

Dr. Cassidy had been pleased with the action of quinine as an antipyretic administered hypodermically. He made a solution of the bisulphate with hydrobromic acid. He injected ten grains of the salt, and in half an hour a second dose of ten grains. The effect upon the temperature was marked, and the reduction was more permanent than when given by the mouth.

Dr. Graham referred to a case which he had exhibited to the Society upon a previous occasion—a case of alopecia universalis. The patient is again under his care, this being the fourth time that she has lost her hair. The first time of the falling of her hair was during her first pregnancy; the other occasions were during lactation. When she ceases nursing the hair grows in. On one occasion she weaned the child at two months, and the hair immediately began to grow. At present she is nursing a seven months old child, and the hair is still absent.

The President stated that the meetings of the Society will be weekly after the general meeting in May.

April 10th.—President, Dr. Graham, in the chair, minutes read and confirmed.

A case of Dr. J. W. Lesslie's of impetigo contagiosum was exhibited. A child, four years of age, a long time ago had an eruption on the hand, beginning as a red elevation of the skin; in twenty-four hours becoming vesicular, then pustular and surrounded by a red areola; it then dries and disappears; it is more abundant on the

arms and buttocks, at the gluteo-femoral fold and about the knees.

Dr. Wright thought the case to be one of impetiginous eczema, but saw no reason for considering it contagious. He was a believer in the existence of impetigo contagiosum.

Dr. Ross had found difficulty in distinguishing between impetigo contagiosum and varicella in an epidemic.

Dr. Spencer had met with the same difficulty.

Dr. Cameron had had a case beginning as an urticaria, but which developed into varicella.

Dr. Graham presented a patient with Paget's disease of the nipple; a woman fifty-five years of age. The disease began about fourteen years ago with an eczematous appearance around the nipple, soon followed by ulceration and induration of the neighbouring glands. The nipple had ulcerated away in about a year. There was no history of syphilis; the disease has run a natural course. At present the breast has almost entirely disappeared, and there exists an ulcerated surface extending from the sternum to the axilla, measuring about eight inches in the vertical diameter. The surface discharges freely, and unless frequently dressed exhales a bad odour. The ulcerated surface is surrounded by an eczematous margin about two inches in breadth. This condition precedes the ulceration. The surface bleeds freely. The glands in the neck are enlarged. There is œdema of the right hand and arm. Severe pain is complained of in the arm and hand, especially in the thumb, fore and middle fingers.

Dr. Cameron thought that Paget's disease was an eczematous condition of the nipple, followed by duct cancer and sometimes by true scirrhus, he thought the epitheliomatous form was rare.

Dr. Adam Wright thought there was considerable confusion about what is called "Paget's Disease;" and that many cases now received that designation which did not correspond with Paget's original description of this form of cancer. Mr. Paget described an eczema followed by the *duct cancer*, with a portion of apparently healthy tissue existing between the two.

The patient presented had more probably, in his opinion, the scirrhus of the *cutis*

form, which was occasionally very chronic in its character.

Dr. Carson related the case of a lady who had been under his care. She was of a family with a cancerous history. She suffered from an eczema of the nipple, which, on more than one occasion had been cured but had reappeared; he asked if she was doomed to look forward to epithelioma.

Dr. Graham presented a kidney from a young man who was being treated for gonorrhœa and orchitis. A short while after entering the Hospital delirium came on followed by coma and death. The heart was slightly fatty, the lungs and liver fairly healthy. The spleen was enlarged, weighing twenty ounces and unusual in consistency and colour. The right kidney weighed four ounces and contained numerous cavities filled with sero-purulent fluid. Mulberry calculi were in some of the cavities, which were situated in the cortical and pyramidal portions of the kidney. The capsule was adherent. The left kidney was hypertrophied and congested. The right testicle and tunica vaginalis and vas deferens acutely inflamed. In the brain there was a sero-purulent fluid in the arachnoid.

Dr. J. F. W. Ross read the history of a case. (See page 161).

Dr. Cameron related the details of a case of cancer of the larynx, in which Dr. Ryerson performed tracheotomy for the relief of urgent symptoms. After the operation which had given considerable relief, there was sternal emphysema and regurgitation of fluids through the tube.

Dr. Ross had frequently seen fluids after operation regurgitate through the tube, it had occurred in a case in which he had lately operated. He thought it due partly to enlargement of the glottis and partly to dulling of sensation.

Dr. Palmer thought that when the diagnosis of cancer was made the line of treatment adopted became of interest. Of late years extirpation of the larynx was growing more common, within the past two years the number of recorded operations had risen from sixteen to eighty. As to tracheotomy whenever the function of respiration was interfered with the operation was advisable. Life being frequently prolonged and in some cases the activity of the disease suspended.

Dr. Oldright made some remarks relating to the constitution of Boards of Health and

recent legislation thereupon. He called upon the profession to support the endeavour to obtain accurate and immediate notification of infectious diseases, stating that the great objection to former methods, *i. e.*, the quasi notoriety from the postal cards used was about to be removed by the substitution of sealed letters.

Book Notices.

Weekly Health Bulletins and Maps for April and May. Issued by the Provincial Board of Health for Ontario. P. H. Bryce, M.A., M.D., Secretary.

Surgical Delusions. An abstract of the address in Surgery to the Medical Society of the State of Pennsylvania for 1884. By John B. Roberts, M.D.

Elements of Surgical Pathology, by Augustus J. Pepper, M.S., M.B., Lond., F.R.C.S., Eng. Illustrated with 81 engravings. Henry C. Lea's Son & Co., Philadelphia.

This little manual for students of medicine comprises within a very small compass the great truths of Surgical Pathology, arranged and set forth in a manner suited to the necessities of the Medical Student of to-day. That other individual, who is so generally credited with limited time at his disposal, *viz.*, the Busy Practitioner, will also find it useful in occupying some of his few spare moments.

The Dissector's Manual. By W. Bruce-Clarke, M.A., M.B., F.R.C.S., and Charles Barrett Lockwood, F.R.C.S. Illustrated with 49 engravings. Henry C. Lea's Son & Co., Philadelphia.

The authors have been very successful in their endeavour to describe the way in which the various structures of the body can be displayed. For a full account of such structures the ordinary text-books of Descriptive Anatomy are to be consulted. The descriptions are very full and very clear. We can cordially recommend the work to students, and all those engaged in the study of the structure of the human body. The cuts are mostly new, many of them are diagrammatic, but none the less useful on that account.

Clinical Chemistry. By Charles Henry Ralfe, M.A., M.D. Cantab. Illustrated with 16 engravings. Henry C. Lea's Son & Co., Philadelphia.

This is one of the series of manuals for students of medicine, published by the well

known firm of Lea's Son & Co., of Philadelphia. It deals in a concise manner in six chapters of the Organic and Inorganic Constituents of the Animal Body, their Chemical Relations, the Blood, Chyle Lymph, Milk, Morbid Conditions of Urine, of the Digestive Secretions and Morbid Products, Calculi, the Degenerations, Dropsical Fluids and Contents of Cysts, Pus, Diseases of Bone.

The whole concludes with a very copious index. The paragraphs are headed in black-letter and catch the eye readily.

Elements of Human Physiology. By Henry Power, M.B., Lond., F.R.C.S. Illustrated with forty-seven Engravings. Philadelphia; Henry C. Lea's Son & Co., 1884; Toronto: Hart & Co.

The author's object in this little manual has been to give the student a general outline of the Physiology of Man. The work is published as part of a series of five, of which Klein's Elements of Histology, Ralfe's Clinical Chemistry, McGregor Robertson's Physical Physiology and Bell's Treatise on Comparative Physiology and Anatomy form the complementary volumes. Of the book before us, we can say that its subject matter is presented with all of Mr. Power's well-known skill and ability, as teacher and writer, and with that keen insight into the needs of the Student of Medicine begotten of his experience as an Examiner in Anatomy and Physiology at the Royal College of Surgeons. So far as our test survey of the text extended, the information imparted has been brought well down to date.

Veterinary Medicine and Surgery in Diseases and Injuries of the Horse. Compiled from Standard and Modern Authorities, and edited by F. O. Kirby. Illustrated by 4 coloured plates, and 168 wood engravings. New York: Wm. Wood & Co.

This book is the December (1883) issue of Wood's Library. It seems to be an excellent compend on the subject; and although we do not really possess the necessary technical knowledge of the subject to pronounce an authoritative opinion, we can safely say that we have perused its pages with pleasure and advantage, and doubt not that other Physicians would do likewise. The Physician is so closely identified with his horse, and therefore so deeply interested in his well being, that certainly some work of this description should be upon his shelves and frequently in his hands. The

great lacuna in the present work seems to us to be the absence of a section upon shoeing from whose ill-performance so large a part of the incapacity and suffering of the horse arises.

Estudios Clinicos de Neuropatologia. Por José Armangué y Tuset. Barcelona, 1884.

The greater portion of this work has been already published in the scientific journals of Spain, France, and Italy. They show a spirit of close observation of minute details and an intimate acquaintance with the literature of the subjects treated of, such as is common in the effete civilization of Europe, but unhappily in our young and enterprising country few have attained to such a degree of intimacy.

The article upon Meningitis Granulosa is a monument of clinical observation and serves for a display of profound erudition and acute criticism. He draws a distinction between Granular and Tubercular Meningitis. Granular tuberculosis is curable for these reasons, viz.: It is not always tubercular; although it may be tubercular it cannot be denied that tuberculosis is curable; there are material proofs from autopsies that tubercular lesions of the brain have been recovered from. He recommends the iodide of potash as the medicament most likely to be of service. The article upon Ophthalmic Megrim bears also the marks of the masterly learning and unwearied industry of the author.

Elements of Modern Chemistry. By Adolphe Wurtz (Senator), member of the Institute, etc. Second American Edition. Translated and Edited from the Fifth French Edition by William H. Greene, M.D. With one hundred and thirty-two illustrations. London and Philadelphia: J. B. Lippincott & Co., 1884.

It has been said that the characteristic of the French nation is lucidity. Nowhere than in their scientific writings is this characteristic more marked. The present work even in its English dress is a good example of the correctness of this observation of the great English critic.

The strength of argument supported by the aptitude in illustration, together with the clearness of diction, combine to afford us unmitigated pleasure in reading this small volume. In no work have we seen Berthollet's Laws or Mendelejeff's Periodic Theory more succinctly stated or more clearly set forth.

The scientific excellence of the work and its adaptability to the educational needs it was designed to meet are sufficiently indicated by the appearance of numerous editions in its native land. Since writing the above the dolorous news has come that the celebrated chemist has passed over to the majority. But a short time ago we had to deplore the loss of Dumas, and now Wurtz is no more. Light may the earth lie upon him.

Personal.

J. B. DUMAS, the eminent French chemist, is dead, aged 84.

DR. O. S. WINSTANLEY has returned from his California trip.

DR. ELLIS was elected President of the Canadian Institute.

PROF. C. ADOLPHE WURTZ, the eminent chemist of Paris, is dead.

DR. R. L. MacDONNELL, of Montreal, spent a few days in Toronto in April.

WILLARD PARKER, M.D., LL.D., died on the 25th April in his 84th year.

M.R.C.S., ENG.—H. H. GRAHAM, M.B., Toronto, passed on the 30th April.

DR. COVERTON has assumed the duties of Chairman of the Provincial Board of Health.

DR. W. S. OLIVER, after a very short residence in Toronto, has returned to Halifax.

DR. WM. H. WELCH, having accepted a position in the Johns Hopkins University, leaves Bellevue.

PETER SQUIRE, of the "Companion to the British Pharmacopœia," died on April 6th, in the 86th year of his age.

DR. J. W. LESSLIE has been appointed surgeon to the Queen's Own, and Dr. Nattress assistant surgeon.

GEO. COLQUHOUN, M. D., of Iroquois, has been appointed Coroner for the counties of Stormont, Dundas and Glengarry.

PROF. S. D. GROSS, M.D., LL.D., died in Philadelphia on the 6th of May, at the age of 84 years. His body was cremated.

THE new City Board of Health is composed of Dr. Pyne, Mr. Alan Macdougall, Dr. Carroll, Mr. A. R. Denison, Mr. Meredith, Aldermen Blevins, Defoe and Irwin.

DR. MACFARLANE left for England in the *Parisian* on the 23rd ult. for a three months' trip. Dr. Fulton had engaged his passage on the same vessel but illness in his family prevented his departure.

DR. STRANGE has resigned his position as surgeon to the Queen's Own Rifles, having been appointed as surgeon to the Infantry School in Toronto.

L. R. C. P. & S. Edin. — D. G. Inksetter, Ontario, and W. D. Brydone-Jack, N. B., were admitted to the double qualification in April and May.

DR. PHILIP STRATHY has returned from the pursuit of honours and learning in England to begin the practice of his profession in this city. He is located high up on Yonge street.

DR. T. S. GOVERTON we are pleased to learn has passed the examination before the Edinburgh College of Physicians and Surgeons. He was immediately appointed resident physician to the Carlisle Hospital.

CANADIANS ABROAD.—F. H. Sawers, M.B., Toronto, was admitted Licentiate of the Royal College of Physicians, London, on April 24th. W. G. Anglin, M.D., Kingston, was admitted M.R.C.S., Eng. on the 22nd.

DR. McCAMMON, representative of Queen's College, at the Ontario Medical Council having accepted the chair of Clinical Medicine at the Royal College, tendered his resignation to the Council. He nominated as his successor Dr. V. H. Moore, of Brockville.

We regret to learn that, amongst the passengers of the ill-fated steamer *State of Florida*, was a son of Dr. Norman Bethune, of this city. Mr. Angus Bethune was 28 years of age, was educated in this city, studied for three years at Edinburgh, and was a competent physician.

DR. JAS. B. WHITELEY, of Goderich, and Dr. Thomas Reeve, of Clinton, for sending a smallpox patient in a G.T.R. car from Goderich to London, were charged with committing a nuisance at common law. Dr. Reeve was acquitted on a plea of ignorance of the disease. Dr. Whiteley was committed for trial.

We regret to hear of the terrible affliction that has befallen Dr. Bethune of this city. On Tuesday, May 27th, at her home on Richmond street, Mrs. Bethune died very suddenly in a fit of apoplexy. This is the second time within the month that death in its awful sudden form has visited Dr. Bethune's family.

Miscellaneous.

Even delirium tremens is now traced to a micrococcus: "the worm of the still."

I am requested to respond to the toast of the "Family Physician," and although it is always understood that one may say as little about the subject matter of the toast as he chooses, I venture to break the rule and enquire, what is a doctor, anyhow? Voltaire says: "He is one who pours drugs of which he knows little, into a body of which he knows less." Swift says: "Apollo was the god of physic and the sender of diseases. Both were originally of the same trade and still continue so." Chesterfield puts in the mouth of one of his characters this description: "The best doctor is a horse, and the best apothecary an ass." But this would be rather hard upon the druggists of Detroit and might interfere with the division of the percentage. Then comes Ovid, who says: "Time is the best doctor."

Well, when all these writers differ, who shall say what a doctor is? Is it not true, as Magendie says, that in the actual condition of medical science, the physician often plays the part of simple spectator of the sad episodes which his profession furnish him?—*Med. Age.*

Poor Nussbaum is such a cripple that he cannot walk without the aid of an assistant, and is wheeled through the hospital in an invalid's chair. He is a sufferer from hip-joint disease, has had his legs and his back broken. His pin-hole pupil and absent-minded dreamy style would seem to indicate that he was under the influence of an opiate. All in all, he is a peculiar and remarkable man. Every one about him seems to love and honour him, and his treatment of us was more than polite. As he was conducted from his wheeled chair and led upon the arms of two assistants through the wards, patients thanked and blessed him, and once or twice kissed his hand. He speaks in an absent-minded way, often repeating his words over and over, and is profuse in expressions of tenderness to all about him. He is a great admirer of Lister, whom he says has made the only grand discovery in surgery during the past decade.—*N. W. Lan.*

A man who abstains from liquor, as shown by insurance tables, at 20 years of age has a chance of living 44.2 years; at 30, 36.5 years; at 40, 28.8 years. An intemperate man's chance at 20 is 15.6 years; at 30, 13.8; at 40, 11.6.

Not the least of the qualifications for professional success are, then, good manners; but these must be genuine, and not sham. The physician should be a gentleman; I do not mean in appearance only, in outward demeanour, in the cleanliness of his linen or the cut of his clothes, but in very heart. The illustrious Thackeray, in his lecture on George the Fourth, asks, "What is it to be a gentleman? It is to have lofty aims, to lead a pure life, to keep your honour virgin, to have the esteem of your fellow citizens and the love of your fireside, to bear good fortune meekly, to suffer evil with constancy, and through evil or good to maintain truth always. Show me the happy man whose life exhibits these qualities, and him we will salute as gentleman, whatever his rank may be." High as these attainments may seem to reach, I am sure I have seen not a few of our own profession who, in the modest performance of the duties of life, have touched the standard. —*Col. & Clin. Rec.*

A man some 50 years of age, smoking a cigarette in a jaunty Scotch cap, striking pantaloons, long sandy English cut whiskers, sandy complexion, and as perfectly typical Scotch face as if he enjoyed the euphonious appellation of "Sandy." But the fancy tie, pants, and attitude bespoke in a remarkable wise the "sport." As my companion afterwards remarked, he looked as if he were going to say, "Well, boys, what are you going to take?" He removed the funny cap, and did not look so sportive. He greeted us kindly and began to look quite different. The operator had improved in our eyes. Then followed an explanation of the cases with chalk at the board, and with each step a remarkable change in his appearance, in so much that he seemed to us entirely another man. By the time he had finished examining his candidates, we concluded that Dr. R. Volkman most emphatically is not a *dude*, but a genius of rare ability, but with some eccentricities. —*N. W. Lan.*

But woe to the man who, through his own inefficiency, has lost confidence in the drugs he prescribes; these very peculiarities of his patients will unsettle his opinions, render him uncertain as to his prescriptions, and vacillating in his advice. The only justification a man can have for administering a drug to anyone is his belief in its likelihood to be of service,

and any one who, from ignorance or inefficiency, has no confidence in drugs can never be at his own command, nor in possession of a clear conscience, if he prescribes them. —*Med. Ann.*

AN OLD DEFINITION OF THE MEANING OF "DOCTOR."—A. Cresswell Rich writes to the *British Medical Journal*: The following epigram appears at the end of the preface to "The Practice of Physic," by Lazarus Riverius. From my study at Montpelier, July 1, 1653. It is signed "W. R." :—

"Doctors, or Teachers, they of Physick are
(Whether by Pen they do it, or in Chair,
With lively Voyle), that teach the way to know
Man's Nature, Health and Sickness, and do show
Diseases, Cause, and Cure. But they who spend
Their Life in Visits, and whose Labours end
In taking Fees, and giving Paper-scrowls,
FACTORS of Physick are; and none but Owls
Do count such Doctors, that no Latin know,
From whence that Name did to our Language flow.
W. R., Doctor, and Factor of Physick."

—*Can. Med. and Surg. Jnl.*

THE following placard hangs in a Tennessee store window :

Peppermint Ile for.

Hed ake

Bellë "

Tooth "

A disconsolate looking doctor on meeting an Hibernian friend, attributed his sorrow to the fact that he had just returned from his vacation and found his wife in bed with cerebro-spinal-meningitis. "Howly Moses!" says Pat, and fwhy didn't yeesh shoot the Oifalian scoundrel." —*Med. Age.*

A writer in *Hygiene Pratique* states that boots and shoes may be rendered waterproof by soaking them for some hours in thick soap-water. The compound forms a fatty acid with the leather.

A prominent surgeon once had a female patient in whose bladder was a calculus concreted around a hair-pin, and he remarked that the patient's misfortune was probably due to an attempt to pin up her water-fall.

Married.

DUNCAN—LUKES—On Wednesday, April 30, at the residence of the bride's father, Church st., Toronto, by the Rev. William Briggs, J. T. Duncan, M.B., to Alice, eldest daughter of William Lukes, Esq.

GRACEY—SCOTT—On Wednesday, April 30, J. Archibald Gracey, M.D., Essex Centre, to Miss Abbie Scott, eldest daughter of C. Tait Scott, Esq., Wingham.

MACHELL—BROUGHALL—On Wednesday, April 30th, at St. Stephen's Church, by the Lord Bishop of Ontario, Emily, eldest daughter of the Rev. A. J. Broughall, to H. T. Machell, M.D., of Toronto.