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Selections: Medicine.

SOME FORMS OF DYSPEPSIA.*

BY FRANCIS DELAFIELD, M.D.

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GENTLEMEN:—We see during every year at the College Clinique, a considerable number of patients suffering from dyspepsia. In other words, they are patients suffering from a number of unpleasant symptoms, and these symptoms are due to the fact that their food is not properly digested.

In treating these patients, we can sometimes determine which of the viscera concerned in the digestive process is in fault. You know that the digestion and absorption of our food is effected by the physiological action of the stomach, the small and large intestine, and the liver. You will find, in practice, that you can distinguish cases of dyspepsia dependent upon diseased function of the stomach, others due to the condition of the small intestine, others to that of the large intestine, others to that of the liver. Of the pancreas, our knowledge does not enable us to speak.

It is not by any means always, however, that you can make the diagnosis of stomach dyspepsia, intestinal dyspepsia, liver dyspepsia, as the case may be; you will find some patients in whom none of the viscera act normally, and other patients in whom the symptoms do not enable you to locate the disease.

* [Indigestion is so productive of bowel affections during the hot season, that we feel quite warranted to occupy the space required to give Prof. Delafield's novel ideas on the subject to our readers, as being suggestive if they cannot be followed literally.]

After excluding all these cases, however, you will still find many persons in whom only one of the digestive organs is at fault.

Now let us see what are the characteristic symptoms of the different anatomical varieties of dyspepsia, and first, what are the symptoms of dyspepsia dependent on an abnormal state of the stomach.

The symptoms are nausea and vomiting, pain, loss of appetite, eructations of gas and of sour fluid.

The nausea and vomiting follow the ingestion of food, and seem to be directly due to the presence of the food. There may be only slight nausea after each meal, or every meal may be followed by vomiting. Both the nausea and vomiting may follow every meal, or they may select some part of the day—morning, noon, or evening—and only occur after the meal taken at that time. In some patients, such a condition of nausea and vomiting will continue for years. The vomited matters consist only of food, or of food mixed with a sour fluid; of this, the patient may vomit several quarts during each attack.

The pain also follows eating: it varies from a mere feeling of oppression to the most intense agony. The pain, like the vomiting, seems to be due to the presence of food in the stomach, and is usually relieved if the stomach is emptied. The pain is regularly followed by a desire to vomit, and after this is done the pain ceases. A fragment of bread not larger than a chestnut, remaining in the stomach, is sometimes sufficient to keep up the pain and retching for hours, until it is expelled. The appetite is usually small, capricious, and unnatural. The patients

often dread to take food on account of the pain and vomiting which they know will follow. In the older cases, there are frequent eructations of gas from the stomach. These may be so frequent and noisy as to be a serious annoyance. If the stomach be dilated, as is sometimes the case, this can be distinguished by percussion and palpation.

If the disease is of long standing and severe, the patients lose flesh and strength, and present a very deplorable appearance.

The lesions consist in a chronic inflammation of the mucous coat of the stomach, with a loss of power in the muscular coat. The inner surface of the organ is constantly coated with an increased quantity of tenacious mucus. The connective tissue between the gastric tubules is increased in amount, and the tubules themselves become atrophied. The stomach is sometimes found very small—in other cases much dilated.

The milder cases of the disease can often be cured by regulating the diet and life of the patient, without much resort to medical treatment. The severer cases are only temporarily benefited by such means.

The patient whom you see to-day is an example of the more severe form of stomach dyspepsia. She is an Irish servant girl, 40 years old. About two years ago she began to have pain and vomiting after her meals. After nine weeks these symptoms ceased, and she enjoyed tolerable health until eight months ago. At that time, she again began to vomit about fifteen minutes after eating. At the same time, there was a dull boring pain in the epigastric region and extending into the back. She has never vomited blood. The pain and vomiting continued; she became much emaciated, and was so feeble as to remain in bed much of the time. Her appetite continued to be good; her bowels were somewhat constipated. I saw her for the first time five months after the commencement of her illness. She was then very feeble and emaciated. She had been put under a variety of medical treatment and had been kept on milk diet for some time, but without relief. The pain and vomiting would cease for a few hours or a few days, and then return.

In the epigastric region was a globular tumor, tympanitic on percussion, which I supposed to

be the dilated stomach. At that time, three months ago, I stopped all drugs and washed out her stomach with the stomach-pump every day. This treatment was continued, with occasional intermissions, for two months. The pain and vomiting became less frequent, and then ceased entirely. She has steadily recovered her strength and flesh, and is now able to work. For the past month the pumping has been discontinued, and her health has continued good.

As a companion to this case, let me read you the history of a gentleman who has been under my care for a considerable length of time. He was a man 45 years old, by occupation a broker. About sixteen years ago he began to have attacks of pain and discomfort in the epigastric region, lasting several days, and ending in an attack of vomiting. These attacks occurred about once in four weeks. At that time his habits were irregular. His food was often eaten hastily, he worked hard during the day, used stimulants pretty freely, and frequently ate late dinners and suppers. In this condition he continued until about six years ago. At that time the attacks of pain and vomiting gradually became more frequent, were more readily excited by indiscretions in diet, and left the patient feeble and prostrated for several days. Any preparations of alcohol were almost certain to bring on one of these attacks. From time to time he consulted different physicians, and followed out several plans of treatment. On several occasions he became so much better as to think himself cured, but, sooner or later, the old symptoms always returned. The attacks of pain and vomiting gradually became more and more frequent, until they occurred almost every day. The pain was always the most distressing symptom, and the patient would often voluntarily excite vomiting in order to relieve the distress.

Finally, he was placed on a milk diet. This diet he carried out strictly for six months. For the first four months the attacks of pain and vomiting ceased, but, after that time, again recurred.

In the summer of 1874 he came under my care. I commenced to wash out his stomach with the pump, at first, every other day, and then every day. He soon learned to use the

instrument himself, and has continued to use it up to the present time. He eats all the ordinary articles of diet, has gained much in flesh and strength, and with ordinary prudence in diet, could easily give up the pump altogether. But, as he finds he can always prevent the bad effects of improper food, he is apt to take good dinners and suppers as he pleases, and pump himself out afterwards.

These two cases, gentlemen, will give you an idea of what I mean by dyspepsia confined to the stomach.

You will observe that in both cases we have the same set of symptoms—attacks of pain and vomiting, coming on, first at long, and then at short intervals. The attacks always excited by the ingestion of food, and the pain ceasing when the stomach is emptied. The disease lasting for years, and growing steadily worse. Medical treatment alleviating the symptoms for longer or shorter intervals, but never permanently.

For these cases, gentlemen, I believe the most rational and effectual treatment to be the systematic use of the stomach-pump.

The cause of the attacks seems always to be the presence of undigested food in the stomach. The longer the disease lasts, the less tolerant does the stomach become of any such substance, until, at last, every day there is an attack of pain and vomiting.

Why the stomach should become so irritable and intolerant of the presence of food, I do not know. Autopsies of such cases show only the lesions of chronic gastritis.

The vomiting, in these cases, seems to be the only effort made by nature to effect a cure. By the use of the stomach-pump we do the same thing, but much more easily and effectually.

Any pattern of stomach-pump will answer the purpose. It is more convenient to use one which holds about ten ounces. The œsophageal tube should be as large as can be easily introduced, and the holes at its end should be as large as possible. The best tubes are the English. They should be thoroughly softened in warm water before they are introduced. After the patient has become accustomed to the procedure, a piece of soft rubber tubing makes the best tube.

In introducing the tube, the patient should sit in a chair with the head upright—not thrown back. You will find that there are two points where the tube is sometimes grasped pretty firmly by muscular contraction—the lower part of the pharynx, and the œsophagus—just before it enters the stomach. Steady, but very gentle pressure usually overcomes that resistance very readily. In some patients, however, you will have to begin with a very small tube, until they become accustomed to it.

After the tube is introduced, you throw in about six ounces of tepid water, and then reverse the syringe, and draw out all the fluid that will come. Then again you reverse the pump and throw in water, and then again draw it out. This process you continue until the water comes out perfectly clear, and without any fragments of food. Adult stomachs will usually hold about twenty-five ounces of water; more than this gives distress.

The best time for washing out is the hour at which the patient has been accustomed to have his attacks of vomiting. If these attacks have occurred daily, the washing out should be done daily. After a short time, you can readily teach the patient to introduce the tube and manage the pump himself; after that, he can carry out the treatment at home, using the pump less and less frequently, as his health improves. At the commencement of the treatment, the patient should take for breakfast and tea nothing but milk, for dinner, mutton chops and baked potatoes. As he improves, you increase his solid food until he eats all the ordinary articles of diet. The rule is not to use the pump until three hours after a meal of solid food, in order that the stomach-tube may not be obstructed by large fragments.

Now let us consider those cases in which the symptoms are due to functional derangement of the small intestine, the stomach being unaffected.

In these patients the symptom which is apt to be the most troublesome is pain. This pain may be referred to any part of the abdominal cavity. It is usually described as a constant dull pain, not like that of colic. It has no special relation to the ingestion of food or to its quality. It occurs when the stomach is full or

empty; whether the food is spare and simple, or abundant and rich. The use of liquor will usually stop it for a short time. There may be some particular time of the day at which the pain comes on, with tolerable regularity; very often this will be late in the afternoon.

There may be nausea, but not vomiting. The nausea does not follow eating, but is apt to occur in the morning.

The appetite often remains good. Food is taken with relish and causes no distress.

The bowels may continue to act with perfect regularity. Flatulence is a common, but not a constant symptom.

The patients are up and about, and able to attend to their business, but they feel languid and good for nothing. Sometimes they become much alarmed about themselves, and imagine that they are suffering from cancer or some other serious disease.

Not infrequently persons have several attacks of this condition, at intervals of several months. The earlier attacks only last a few days, the later attacks are more severe, and may last weeks and months.

Some of the cases are very easily relieved by treatment, others prove very obstinate.

The drugs usually indicated are cubeb, ipecac, and assafoetida. Cubeb is given in the form of powder or of tincture. Ten grains of the powder, or twenty minims of the tincture is the usual dose, to be given three or four times a day. Ipecac is given at first in small doses—one-eighth of a grain—and then increased gradually up to one to four grains, three times a day. Assafoetida may be given in four-grain sugar-coated pills, or in the shape of the compound Galbanum pill.

Riding on horseback is often of very great service; walking, on the other hand, does not seem to be of as much benefit. Travelling for several months from place to place may effect a cure, when all other remedies fail.

I am unable to show you any case illustrating this variety of dyspepsia. It is rare among clinique and hospital patients, although in private practice it is sufficiently common.

Dyspeptic symptoms dependent upon disordered function of the liver are very common. The great majority of cases of dyspepsia coming

to this clinique are cases of liver dyspepsia, either alone or combined with disorders of the other digestive organs.

In this variety of indigestion the symptoms are very variable, and often very intractable to treatment.

Physiologists teach us that the liver performs several important functions. These functions are very well summed up by Murchison as follows:

1st.—The formation of glycogen, which contributes to the maintenance of animal heat and to the nutrition of the blood and tissues, and the development of white blood corpuscles.

2nd.—The destructive metamorphosis of albuminoid matter, and the formation of urae and other nitrogenous products, which are subsequently eliminated by the kidneys; these chemical changes also contributing to the development of animal heat.

3rd.—The secretion of bile, the greater part of which is re-absorbed, assisting in the assimilation of fat and peptones, and probably in those chemical changes which go on in the liver and portal circulation; while part is excrementitious, and, in passing along the bowels, stimulates peristalsis and arrests decomposition.

It is not easy in any given case to say which of these functions of the liver is disordered and gives rise to the existing symptoms. I have found it convenient, however, clinically, to divide these patients into two classes according to their general condition. In the first class I include those of florid complexion, and with well-developed adipose and muscular tissues. In the second class I include those of pallid complexion, spare figure, and feeble muscles.

It has seemed to me that in the first class the symptoms are due to the derangement of those functions of the liver which should effect the destructive metamorphosis of albuminoid substances, so that the patients receive a full supply of the nutritious portions of the food, but do not get rid of the excrementitious.

In the second class of cases, on the other hand, there is no failure of these destructive and excretory functions, but those functions which should effect the assimilation of fat and peptones are disordered so that the patient is imperfectly nourished.

In the one case, the tissues are over-manured, but badly drained; in the other they are well enough drained, but not manured at all.

I will show you first an example of the second class.

This man is thirty years old, a policeman by occupation. He tells us that his health has been good until within the last year. During this time he has gradually lost flesh, strength, and colour. His appetite is sometimes good, sometimes not; occasionally there is slight nausea in the morning. He has a dull, uncomfortable feeling in the head much of the time. There is a dull pain in the right hypochondriac region. His bowels are constipated. During the year he has consumed a large quantity of medicine at different times. His urine is normal, except for an increased amount of oxalate of lime.

You may see that his face is thin, pale, and anxious. He is very much alarmed about himself. This man's condition I believe to be due to the fact that his liver does not properly perform its functions of excreting bile. This is felt in two ways. There is insufficient assimilation of fat and peptones, and the large intestine does not feel the natural stimulus of the excrementitious bile.

Some of the patients belonging to this class are much troubled with flatulence.

Headache is a very common symptom and often very distressing. Curious nervous feelings in different parts of the body are often complained of. The patients say that the top of their heads feel like ice, or that they have cold chills down the back or limbs, or pricking sensations in the skin, or a feeling of constriction about the body. Very often they are much troubled by sleeplessness. They are very apt to be much disturbed about their own condition, and even to become very hypochondriacal.

There may be irregular action of the heart and pain in the precordial region. There is also often dull pain in the right hypochondriac region, which may extend into the back and shoulder.

The bowels are usually constipated. The patients lose flesh and strength. The urine is normal, or contains an increased amount of oxalate of lime, or sometimes stellate crystals of phosphate of lime.

This condition is often very intractable to treatment, and always requires continuous and systematic care.

The diet is to be carefully regulated, but should be full and nutritious. Wines, ales, and spirits are often of service. Cream and even cod-liver oil are sometimes indicated.

To relieve the constipation, strychnia, aloes, sulphate of magnesia, rhubarb, and podophyllin answer a good purpose. Bromide of potash, assafoetida, and guarana are of service in allaying the nervous symptoms and restlessness. To improve the appetite and act as a tonic nothing is better than the mineral acids. Exercise in the open air is to be insisted upon, and, in young persons, bathing the entire body, every day, with cold water.

The general principle which you bear in mind in treating these cases is that their symptoms depend on the failure of the liver to perform its share in the process of digestion, and as a result of this, the fact that the entire body is insufficiently nourished.

You must also remember that the various pains and uncomfortable feeling from which these patients suffer give rise to many errors of diagnosis. Congestion of the brain, paraplegia, uterine disease, heart disease, pulmonary phthisis, are all ascribed, not so very infrequently, to patients suffering from liver dyspepsia alone.

In the first class of cases of abnormal liver function, the appearance of the patients differs widely from that of the patients of whom we have just been speaking. These patients are stout and well-developed, often of rosy, florid appearance. They are usually persons who live well, drink, and use tobacco freely. They may even be in the habit of taking a good deal of exercise.

In spite of their healthy appearance, however, we find the same depression of spirits and tendency to hypochondriasis. They are liable to headache, but more so to attacks of vertigo. These attacks of vertigo may be so severe that they fall to the ground and lose consciousness.

The appetite is usually good. The bowels are sometimes constipated, sometimes regular. There is often an occasional diarrhoea from very slight causes. The urine is very apt

to contain an excess of uric acid or of the urates.

In many cases, the first symptoms of which complaint is made are the vertigo and the uncomfortable feeling about the head, sometimes also an inability to apply the mind to business, and a partial loss of memory.

These patients sometimes discover that a brisk purgative makes them feel much better for several days, and they become regular customers of the vendors of the different kinds of purgative pills.

One of the first requisites for successful treatment is an entire abstinence from every kind of alcoholic drink. No wine, beer, or spirits should be allowed, not even in small quantities. Tobacco is equally pernicious in these cases; it should be absolutely prohibited.

These patients require, not merely ordinary out-of-door exercise, such as walking and riding, but often pretty violent muscular exercise, such as is afforded by the gymnasium.

They are often much benefited by the natural alkaline and sulphur waters.

As regards drugs, there is no general plan of treatment that can be laid down, but in each case you endeavour to meet the special indications, trusting for a cure to the general hygienic management of the case.

The principal symptom of dyspepsia due to the condition of the large intestine, is constipation. This symptom is common to all the varieties of dyspepsia, and occurs also with various other morbid conditions. At the present time, however, I wish to call your attention to a class of cases in which the condition of the large intestine is the sole cause of the patient's symptoms, and in which this condition causes not only constipation, but other symptoms of indigestion.

This condition of the large intestine occurs in old people. It seems to be due either to a loss of power in the muscular coat of the intestine, or to a loss of sensibility in the mucous coat.

In the milder cases the condition is not constant, but occurs from time to time. The patient fails to have an operation of the bowels for several days. He feels dull, languid, loses his appetite, has headache, is troubled with

flatulence and uncomfortable feeling in the abdomen, which may even amount to colic. After a few days there is a slight diarrhoea. These passages are small, painful, do not give a feeling of relief. The patient is, at the same time, very much prostrated, vomits his food, and may even take to his bed. If you are called to attend these patients after the diarrhoea has begun, it is very important that you should recognise the true nature of the case. The administration of any preparation of opium, or of any drug which merely checks the diarrhoea, only does harm and prolongs the sufferings of the patient. A mild laxative, on the other hand, will very promptly relieve all the symptoms. The ordinary dinner pill is one of the best preparations for this purpose.

In the more severe cases the symptoms come on gradually. The patient is at first only a little constipated; the bowels move every few days, either of themselves, or with an enema, or with some laxative. And yet, during this time, the large intestine is not really emptied, but there is a constant accumulation of feces in the rectum. The constipation becomes gradually more pronounced, and the patient finds that enemata and mild laxatives no longer give him a movement. Then he may use more active purgatives, which produce a number of fluid stools and yet do not empty the large intestine of the hardened feces, which are still accumulating. So the patient goes on, from bad to worse, alternating between constipation and diarrhoea, always uncomfortable, often with very severe pain in the abdomen, losing strength rapidly. If the condition is not relieved, an old person may be so reduced in this way as to die without any other disease than constipation.

The first point in the treatment is to introduce your finger into the rectum and ascertain whether or not it is filled with hardened feces. If it is, the feces must be scooped out with the finger or some convenient instrument, and then the rectum should be washed out repeatedly until it is entirely emptied.

After this the patient must be constantly watched and examined, from time to time, to ascertain that the feces are not accumulating again. The diet must be regulated, and aloe

and strychnine may be employed to assist the action of the large intestine.

I have endeavoured thus to sketch out roughly for you some of the cases of dyspepsia in which only one of the digestive viscera is involved. I think that in your future practice you will be able to recognise some of these cases when you see them, and I think it will add much to your satisfaction in the treatment of all cases of dyspepsia, if you make the attempt to analyze the mass of symptoms and assign them to the different viscera to which they belong.—Vol. ii., No. iv., *American Clinical Lectures*, edited by E. C. Seguin, M.D.

REPORT ON EIGHTY CASES OF CHOREA.

BY GEORGE S. GERHARD, M.D.

(Physician to the Orthopaedic Hospital and Infirmary for Nervous Diseases, and Assistant Physician to the Children's Hospital, Philadelphia).

In the *Philadelphia Medical Times* of January 3, 1874, I published a digest of thirty cases of chorea, which was of interest not only on account of its having been the first of the kind ever made on this side of the Atlantic, but also as showing certain peculiarities manifested by the disease as it occurs in this country. Since then forty additional cases have been reported in the same journal for March 27, 1875, by Dr. Chas. K. Mills.

The present collection embraces fifty new cases, to which, for more extended study, I shall add those previously reported. The majority of the cases were obtained as before from the case-books of the Infirmary for Nervous Diseases; the remainder were under Dr. Weir Mitchell's private care, the notes of which he kindly gave me, or were seen by me during my terms of service at the Children's Hospital.

In studying the eighty cases in regard to the age and sex of the patients, I find that there were—

Under 10 years of age	23 cases	9 males	19 females
From 10 to 21 "	52 "	18 "	34 "
Total	80	27	53

The preponderance of the females over the males shown by this summary agrees with

the usual clinical experience, and may be explained by the greater liability of the former to disturbance of a nervous kind, and to their greater susceptibility, particularly during the age of puberty, represented by the second period of the foregoing table, to one of the great exciting causes of chorea, viz.: fright.

Side affected.—In twenty-seven cases the choreic movements were found to be general; in eleven to be general, but chiefly marked upon the right side, and in ten to be general, but better pronounced upon the left side. In thirty-two cases the affection was absolutely unilateral, being confined in twenty instances to the right side, and in twelve to the left.

The reports on chorea published at different times have varied greatly in regard to this point, but I am inclined to think that the more modern statistical accounts all point to the right side of the body as being the side especially liable to be affected. The present table agrees with the opinions expressed by such high authorities as Drs. Hughlings Jackson and James Russell, and it also coincides with the results obtained by me in 1874; but it is directly opposed to the statements of a number of French writers, among whom may be mentioned Ruzf, Trousseau, and Séé.

A certain number of cases of chorea beginning unilaterally ultimately become bilateral; but by far the greater number remain so throughout the course of the attack. Another, though a very rare result, is the passage of the disorderly movements from one side of the body to the other; thus, for instance, converting a right-sided chorea into one of the left side.

In regard to the alleged cause of the disease, in twenty-two cases out of the whole number none was discovered. In eleven cases it was attributed to fright; to rheumatism without heart disease in eleven cases; to rheumatism with heart disease in seven cases; to heart disease alone in six cases, and in three cases, though no actual exciting cause was found, to a strong hereditary predisposition to chorea.

Out of the twenty remaining cases the disease was ascribed to violent pain in seven instances, and to mental worry and miscellaneous troubles in thirteen.

The relation between chorea and rheumatism,

of the rheumatic diathesis, and valvular disease of the heart has given rise to much discussion, and to the advancement of many theories. Dr. Mitchell has frequently at his clinics expressed the opinion that chorea and the rheumatism of childhood are of kindred parentage; in other words, the former is simply another expression of the causes which give rise to the latter, and though he does not deny that the disease is sometimes intimately related to heart disease through embolism, he still believes that the majority of cases are not all connected with such a pathological condition. A seemingly strong objection to this view is, that in most of the fatal cases where examinations have been made, vegetations have been found upon the valves of the heart. But in opposition to this it may be urged that possibly the cases associated with vegetations are the ones most likely to end fatally.

The doctrine of embolism as a cause of chorea was first announced by Kirkes, who held that whenever an association between chorea and rheumatism was found to exist, there had been an inflammation of the valves of the heart, and the association was not between chorea and rheumatism, but between chorea and valvular disease of the heart. That is to say, that vegetations formed upon the valves as a result of inflammation, and becoming detached, were washed into the general circulation, causing an irritation of the nerve centres. Dr. Kirkes did not attempt to localize the seat of the lesion, as has since been done by Dr. Hughlings Jackson, who, accepting the theory of embolism, maintains that it is the nerve tissue about the corpus striatum which is rendered unstable by plugging of the smaller branches of the middle cerebral artery. Dr. Jackson also insists upon a distinction being made between instability of nerve tissue and destruction of function; the result of the former being disorderly movements, and of the latter paralysis. This really places chorea on the border-land of paralysis, and the frequent mingling of both conditions unquestionably gives much support to the view.

Season of Year.—In my first paper, I stated that Dr. Mitchell had called attention to the fact that chorea, as it occurs in Philadelphia at least, is much more prevalent in the spring

than at other seasons, and the analysis I made forcibly proved the correctness of the observation. Out of the eighty cases which form the basis of the present paper, the attacks occurred in the spring in thirty-nine instances; summer, ten; autumn, seven; winter, twelve; total, sixty-eight. In the twelve remaining cases the point is not mentioned. Thus it will be seen that more than half of the cases in which the point was noted occurred in the spring. It is difficult to offer any explanation for this remarkable preference, unless, as I before suggested, it is due to the enervating weather of the season in question. We all suffer more or less from constitutional depression in the spring, particularly in the early part; indeed the so-called "spring fever" has become with us an almost recognised disorder. I am not aware of any mention having been made of the point as it occurs in connection with chorea in other parts of our country. In Paris, however, according to M. See, the disease is most apt to occur in the autumn, the season which, I think, very closely resembles the spring of Philadelphia in point of temperature and tendency to cause enervation. The disposition of chorea to recur in the spring may also be shown. Thus, out of eighty cases previous attacks were noted in twenty-five, and all but seven of these occurred in the spring. Of the twenty-five cases, fourteen had had one previous attack, eight had had two, and in three instances the patients had suffered from three.

The presence of *partial paralysis* was noted in seventeen cases, the loss of power being confined in ten instances to the right side, and to the left in seven. The frequent occurrence of "choreic hemiplegia" is, as I have already said, a strong argument in favor of the view held by Dr. Jackson in regard to the seat of the lesion of the disease, viz., the convolutions about the corpus striatum.

In this connection I shall call attention to remarks made by Dr. Mitchell at his clinics in regard to the motor manifestations of certain choreas. For several years he has pointed out the existence of peculiarities in these manifestations which may be summed up as follows: Usually choreas begin with the exhibition of mere awkwardness of habitual voluntary acts,

and this increases until there is also added a new set of movements which in grave cases at last predominate. These are spontaneous meaningless motions, such as we all well know as choreic. In a certain number of the usual vernal cases, as well as in most of the post-paralytic choreas described by Dr. Mitchell, the second group of motor manifestations does not exist at all, or is seen in a minimum amount. That is to say, there is no disorderly movement except during an act of volition, when the amount of disturbance varies. In other words, as in some scleroses the hand when not in willed motion is quiet, but when moved by will trembles. So in these choreas, there may be no spasmodic acts until volitional motions are attempted, when these latter become at once irregular and inco-ordinate.

A third group is also to be found, but it is a smaller one. It is made up of children, who never have very severe chorea, but in whom it is constant and automatic, but ceases whenever a distinct purposive movement is made. Just as in paralysis agitans in its early stage, the tremor vanishes during a volitional movement, to recur when the part comes to a state of passive rest. As might be expected, the two last varieties of chorea are mixed together, so to speak, in variable proportions to form the first and more common class, but not rarely we meet with type cases of the other forms.

Dr. Mitchell has also noticed now and then at his clinics, and more often in private practice, cases of what may be called *painful chorea*. They are unilateral nearly always, and are accompanied with dull aches in the muscles and about the joints. He has never seen in them a distinct unilateral outbreak of joint rheumatism, but still thinks that there is some reason to regard the pains as of rheumatic parentage. Dr. Mitchell has of late had reason to think that some cases of chorea are like the traumatic neuralgias, and certain examples of arthritis liable to be unfavourably affected by the atmospheric changes which herald a storm.

The *treatment* of most of the cases consisted in the administration of arsenic in increasing doses. Beginning with a few drops of Fowler's solution three times a day, it is our custom to increase the **quantity** by the addition of a drop

to each dose on alternate days until a toxic impression is produced. When this occurs the dose is reduced to a few drops and again increased as before. In the more obstinate cases, many of which had resisted all other forms of treatment, the arsenic was pushed to its full toxic limit, that is, until decided puffiness of the face and gastro-intestinal irritation were produced. Fowler's solution was also in a few instances given hypodermically and with excellent results. The only advantage to be derived from this mode of administration is the lessening of the tendency of the drug to cause gastric disturbance—a complication which occasionally becomes an early obstacle to the treatment. We have also found that a much smaller and a less frequently administered dose is required to bring about the desired result of controlling the choreic movements.

Zinc in the form of sulphate was also employed in a number of cases, and with a result almost as good as that following the use of arsenic. Other remedies employed were bromide of iron, gelsemium, eserina, cimicifuga, and bromide of potassium, but of these the bromide of iron was found to be the most efficient. Arsenic, however, is the drug in which we place most reliance. Dr. Mitchell indeed, believing, as I have already stated, that chorea and the rheumatism of childhood are of kindred parentage, has of late been using in rheumatism of the young full doses of arsenic, and even arsenic hypodermically. The results have been promising enough to justify the testing of this means by a larger experience. The rheumatic cases have been given arsenic up to the toxic limit, and until the face became swollen.

The results of treatment of the eighty cases were as follows: Cure in 56 cases; improvement or unknown in 24 cases.

All who have had experience in dispensary practice are aware that many cases fail to return to make a final report, and consequently the results cannot be positively stated. In the present instance, knowing that chorea when properly treated is a very curable disease, it is fair to assume that the majority of the cases marked "improvement or unknown" ultimately recovered.

TREATMENT OF ALBUMINURIA.

The *British Medical Journal* of June 3rd contains the "Croonian Lecture" of Dr. Dickinson on the pathology and relations of albuminuria, from which we extract the concluding paragraphs upon treatment:—"The disorders of the vital gland in question afford no exception to the rule that medicine must not be limited by the bounds of the *materia medica*. The circumstances of ordinary life, food, drink and temperature are to be considered as of the first importance; while the contents of the *Pharmacopœia* occupy the position of auxiliaries, whose services sometimes decide the battle, and at others are dispensed with without loss. Therapeutics to be successful must have a physiological basis. To give rest, as far as may be, to an inflamed structure is an old and sound maxim; and it is not less obvious in regard to the system at large that if a great channel of exit be obstructed the materials which therefore tend to accumulate should be sparingly introduced. The diet with albuminuria, save with that of lardaceous origin, in which the secreting power is until late little interfered with, while an exhausting discharge may have to be obviated, should be below the custom of health in its nitrogenous components. It may abound in milk and farinaceous matter, while fish may often take the place of flesh. The increase of albumen in the urine upon a too early resort to a meat-diet is a common experience. With regard to liquids, it can not be too strongly insisted upon that the functional strain upon the kidney is not to be measured by the quantity of water which filters through it, but by the quantity of refuse, mainly nitrogenous, which it has to convert and eliminate. Water, which probably transudes almost as through dead membranes, probably makes little demand upon the real secretive function. The worst kidneys, indeed, those most hopelessly incapable of their special work, will often discharge most of it; and it is easy to see that its passage, not to be regarded as the result of glandular effort, is salutary, both in the dilution of scanty and irritating urine, and also in washing out the solid products which, under the inflammatory process, collect mischievously

in the tubes. A further use is to be discerned in this law. The solids of the urine vary with its water. With given kidneys the solid excreta wax and wane with the bulk of the urine. Any means, therefore, mere aqueous filtration as safely as any, which increase this will also magnify the components of the secretions which are essential to life. With tubal nephritis, therefore, and scanty urine an aqueous dietary, even with the addition of distilled water, or the elements in some slightly sophisticated shape, will prove in every sense beneficial. In many, perhaps in most, cases of nephritis of tubal origin, these remedies of patriarchal simplicity, "spare diet and spring water clear," are all that are needed to guide the disorder to its natural cure. To this surest and safest of diuretics, others must often be added, both to lessen dropsy and to avert the dangers of uræmia. The old rule is that in recent cases digitalis should be used. It seldom fails to increase the flow of urine; but I am not sure that it does not sometimes do so with some exasperation of the inflammatory action. The bitartrate and acetate of potash, which have a purgative as well as a diuretic action, may probably be safely resorted to; and in chronic cases as much as may be done harmlessly by diuretics may be accomplished by means of scopolarium, nitre and juniper. Cantharides and the more irritating agents of this class are generally distinctly injurious. Perhaps, next to a regulation of the diet, it is most important to secure a daily and somewhat loose action of the bowels. Purgatives lessen the vascular tension, which in both acute and chronic cases is a measure of their danger; and while it is not advisable too largely to divert the urinary fluids by severe catharsis, increased hardness of the pulse, and other more obvious aggravations of the general state, seldom fail to ensue upon constipation. When cerebral uræmia is threatening hard purging by elaterium or otherwise is essential. As an habitual laxative a drug less used than it deserves to be, sulphate of potash, given two or three times a day in doses of from ten to twenty grains, is sometimes invaluable. It may be aided, if necessary, by Epsom salts or cream of tartar. This, or these, in their laxative action clear the obscured or blood-spotted retina and remove the

mists from the field of vision, slowly and not always completely, but in a manner which presents a remarkable contrast to the inutility of iron in this respect, and affords a testimony as to the use of alvine evacuations in lessening the arterial tension of which such lesions are the index. The chronic headache of the granular kidney is often similarly and equally relieved. While by such means the system is enabled to dispense, as far as may be, with renal function, it must be asked whether, particularly in circumstances of recent inflammation, any thing can be done directly toward the cure of the injured organ. Discarding counter-irritation as a method of punishing the skin for the errors of the organs which have no conscience to be touched by vicarious chastisements, it must be admitted that, beyond insuring sufficient irrigation of the tubes, our chief endeavor is to provide the gland with leisure to cure itself. But it is worth mention, in relation to a rapidly fatal form of nephritis, in which the tubes become widely sealed up as if with molten glass by a pseudo-croupous exudation of fibrin, the urine being almost suppressed, while the little that is passed is loaded, not only microscopically but as a bulky precipitate, with large fibrinous cylinders, that all plugging of the tubes from this cause can be prevented by alkalies. Alkaline urine is a solvent for fibrin, and with this in process of secretion the exudation retains its fluidity, and whatever harm it is capable of doing by solidifying in the tubes is obviated. The experiment is easy of trial. However numerous fibrinous casts may be, and I need not say that this term comprises all that are usually passed, they will, upon the alkalescence of the urine, quickly cease to appear, to return again with its acidity. There are cases in which such relief to the tubes must avert a pressing danger; but it is disappointing to recognize, as I fear we must, that the process of renal inflammation is seldom so simple as to admit of cure by this means. I may be permitted to say a word touching the use of iron. The impoverishing effect of albuminuria, possibly from the destructive action of the retained refuse upon the blood corpuscles, produces a pallor which can not but suggest this remedy; and in recovery from attacks of renal inflammation none is more hope-

ful. But a medicine which is effective for good is generally, and in somewhat the same measure, effective for harm; and iron in chronic albuminuria needs to be administered with more discrimination than it perhaps always receives. With high vascular tension, such as belongs to the granular kidney, with a hard pulse for its sign, an enlarged heart, retinal mischief, and possibly persistent headache and nausea as its concomitants, iron, however seemingly indicated by the look of the patient, is generally injurious, unless most guardfully anticipated and counterpoised by aperients. The perchloride, among other salts, is often of special service in dropsy; but where the vessels are not thus relieved, and the symptoms which threaten are uræmic, the drug is generally better withheld. In any condition it seldom fails to do harm if allowed to constipate, a result which may be obviated by mixing the ferruginous salt with sulphate or bitartrate of potash.

"In the treatment of granulative or lingering nephritis, climate should take no secondary place. Every organ of the body, according to the teaching of ancient medicine, was subject to a separate planetary or celestial rule; a fancy which has at least this much of truth, that functional activity, and with it the liability to disease, are apportioned among the eliminating organs largely by external temperature or solar influence. In the tropics, the stress falls upon the skin and the liver; in the temperate zone, upon the lungs and the kidneys. The comparative exemption of the kidneys from disease, save of the lardaceous kind, appears, as far as our evidence goes—and the experience of our ubiquitous race makes it tolerably extensive—to be common to warmer latitudes; and the inference that, under the same atmospheric influence, chronic albuminuria, when not of lardaceous origin, would find perhaps not organic cure, but at least systematic relief, has been amply justified by recent experience.

"Not to dwell upon the treatment of cerebral uræmia, in which the uses of drastic purging and forced diaphoresis are sufficiently well known as lessening the uræmic state, while means of controlling nervous irritability, the bromides, chloral, and chloroform, are helpful as withholding its convulsive effects, I will say

a word upon the less trite topics, the prevention and possible cure of the lardaceous state. This condition is one in which medical treatment would seem to be suggested by the nature of the morbid change, and encouraged by a tendency to natural recovery which the disease, even in an advanced stage, will sometimes exhibit. But with the curative power inherent to the human frame, not in this case, however, so often successful as might be wished, comes the ever-present vice of therapeutics, the attributing to art what belongs to nature, a possibility of error which will probably never cease to increase the confidence of the confident practitioner, and the distrust of him who, in one sense more foolish, is wise enough to doubt.

"When the disease is consequent upon syphilis iodide of potassium is of marked effect in lessening the organic enlargement and ameliorating its other effects. Sometimes when a long-continued suppuration has come to an end, or greatly diminished, a retrogression in the resultant disease can be slowly followed, though no antidotal drugs have found place, if only the diet of the patient be liberal, and his general surroundings favorable to health. The special remedy which pathology suggests—one which of late years I have used often and largely—is potash. I have found, in the first place, that under lasting suppuration potash salts can be given, not only without the depressing effects which sometimes attend their use as medicine, but to the improvement of the general health, and with the absence of lardaceous symptoms, which, in the circumstances of the case, would be at least a probable contingency.

"Further than this, I have given the salts of potash alone, or with quinine and iron, where visceral swelling, diarrhoea and albuminuria have betokened the disorder in an advanced shape. Under such treatment the liver and spleen have become measurably smaller, the urine less albuminous, the patient has gained flesh and weight, and all the symptoms have ameliorated. But chemicals put into the stomach are not brought to bear upon the tissues as if the treatment of disease were conducted in a test-tube, and the cure is at best a slow one. It is further obscured, or possibly simulated, by

a shrinking, which the swollen organs sometimes naturally undertake.

"The most striking instance of recovery under treatment which has come under my notice was one in which the disease was associated with syphilis, and the treatment correspondingly modified. Great enlargement of the spleen and liver, albuminuria, diarrhoea, and emaciation, gave evidence of the disorder in a degree of seemingly hopeless severity. Iodide of potassium was given with potash and its vegetable salts. The patient was apparently cured; and on his death from an accidental cause three years afterward the viscera were found to have returned to their natural size, and only such traces of the lardaceous change were discovered as to warrant the belief that he had once had more of it.

"On the whole, reviewing my experience in this matter, I must admit that the administration of potash by itself has proved, I will not say useless, but disappointing; less effective than pathological deduction would lead us to hope.

"As to the use of remedies of the restorative and tonic class, iron, quinine, and cod-liver oil, there is unequivocal evidence. If the deficiency of potash be connected, as I have ventured to surmise, with loss or insufficient development of leucocytes, the disorder may perhaps be more appropriately met by means which promote the formation of those essential instruments of nutrition rather than by the mere introduction of material which, in their deficiency, perhaps can not be turned to vital purpose.

"The measures I have commonly—and numerous experience justifies me in saying beneficially—used have been liberal diet, with beef-tea, Liebig's extract and vegetables which abound in potash-salts, together with liquor potassæ, phosphate of potash, iron, quinine, and sometimes cod-liver oil. The alkaline remedies have been urged with the most obvious advantage during the persistence of suppuration.

"Nothing now remains for me to do but to thank this accomplished and critical audience for the forbearance with which they have listened to many tedious and possibly familiar details. I trust I have shown how the varieties

of renal disease are not only complicated, but often inextricable; but how, according to the bias which prevails in each instance, different classes of secondary results follow; that among these the cardio-vascular change, however else it may arise, is a result of the vascular tension of uræmia, which, though more common with some forms of disease than others, may ensue upon any. Finally, in touching upon treatment, I have sought to show in what instances it is to be guided by a consideration of the special organic state, and where more frequently by the results which it has produced upon the patient."—*Louisville Medical News.*

SCARLATINAL EAR DISEASE.

This subject is one of such constant interest that we quote from the *Edinburgh Medical Journal* the following remarks upon it, by Dr. J. P. Cassells, M.R.C.S. :—

Scarlatinal ear disease, the most destructive of all the ear diseases, and the one most frequently met with in general practice, arises out of the nasopharyngeal affection, which is so marked a complication of this exanthem. The propagation of this congestion along the Eustachian canal, into the cavity of the tympanum, and thence to the mastoid cells, must have been frequently witnessed, even by practitioners not specially interested in the practice of this department of our art. When this, the initial step in the causation of the ear disease, has taken place, its progress and development proceed with extraordinary rapidity. The Eustachian canal, as a result of this tumefaction of its tissues, becomes concentrically closed; in consequence, there is a rapid increase in the congestion of the tympanic lining membrane, owing to the disturbance which a closed Eustachian tube causes in the balance of the tympanic air-pressure. Inspection of the membrana tympani, at this stage, shows it to be, in general, unaffected by the congestion of the tympanic lining membrane. The temperature of the patient, at this period, is considerably increased toward evening, without a corresponding fall in it in the morning; there is much restlessness, rolling of the head, and more or less delirium, the general febrile attack. If now the interior

of the ear is examined, the membrana tympani being still unaffected, except in a very slight degree, by the general congestion, it is generally possible to recognise through it the deeply purple-coloured tympanic lining membrane. As yet, there is no effusion into the cavity of the middle ear, although its flow is imminent. Up to this point in the progress of the malady it is possible, by the timely use of the knife, to bring about resolution of the diseased action; failing in this favourable and more desirable termination, the certainty nevertheless remains, that by this means the disease is deprived of its power to commit damage. This stage in the treatment of the disease I call that of resolution and prevention.

The next step in the onward progress of the affection is most characteristic, is surrounded with more risk, and is of shorter duration than the preceding one; and because the resolution of the disease is no longer attainable, nor all the dangers to which it gives rise preventable as they were in the earlier stage, I have named it the stage of preservation or cure. It is now that, owing to a marked increase in the hyperæmia of the tissues, and a diminution of the support usually afforded to the engorged vessels, there takes place an exosmosis of serous-looking fluid, which speedily fills the tympanum and mastoid cells. The pressure from this accumulation, constantly increasing as the fluid becomes greater in quantity, causes, at last, ulcerative absorption of one or several points in the parietes of the tympanic cavity, or mastoid cells; a process, I may remark, that goes on with astonishing rapidity, and, as may readily be supposed, leads to serious consequences. Indeed, the future of the case is determined, in a great measure, by this process, and the nature of the tissue in which it is set up; if it is the membrana tympani alone that suffers from the destructive process, less danger, both present and prospective, is likely to follow, than where the bony wall is broken down or perforated. The general symptoms from which the patient suffers, in this stage of the disease, are much graver than in the former one; there is, usually, agonizing pain complained of in the intervals of freedom from this symptom; there is often wild delirium, and not seldom a state of coma,

generally out of proportion to the violence due to the pressure of the effusion upon the labyrinth. Pain, as a symptom, however, is not, by any means, a constant one; when it is present, it usually indicates periosteal or meningeal hyperæmia. If the membrana tympani is now inspected, it will be found no longer possible to see the purple-coloured lining membrane of the tympanum, by reason of the changes which have taken place in the membrana tympani itself. It is now of a bottlegreen colour, with more or less bulging outward; or it may assume a yellowish colour, if the contents of the tympanum have degenerated into pus.

It is in this stage of the disease that aural surgery, as a preservative, displays its advantages over the *laissez-faire* method of treatment. A free incision through the bulging membrane gives exit to the fluid, and arrests the destructive processes that may have set up in some vital part of the organ. On the other hand, when the nature of the case is unrecognised, nature relieves herself by discharging the pus (happily for the patient if it be through the membrana tympani), with no other damage to the organ, even though a life-long otorrhœa is the consequence.—*Canada Medical Record.*

The *Journal des Connoissances Médicales* contains a review of certain curious observations made by Dr. G. Esbach on the conformation of the fingers in various diseases. In persons that perspire easily, or in the case of disorders that induce profuse perspiration, such as rheumatism, typhus fever, &c., the transversal curvature of the nail is increased to exaggeration. This symptom, which scarcely ever fails to present itself in rheumatic subjects, has led Dr. Esbach to establish by a statistical method the sudoral etiology of that affection, and in the immense majority of cases he has found the following results:—A man who perspires easily, and who inhabits a ground floor, becomes sooner or later rheumatic; if, on the contrary, he lives in a dry apartment he is never troubled with that malady. On the other hand, a man who is not subject to perspiration may live in a damp room with impunity. Rheumatism appears thus to be placed on its real ground; dampness may be the cause of it, but only in such habits as perspire freely.

LIQUOR POTASSÆ IN DIPHThERIA.

In a letter to the June number of the *Boston Journal of Chemistry*, Dr. Edward H. Sholl, of Gainesville, Alabama, says:—

Some five or more years since, my attention was called to an article on this subject in my weekly companion, the *Medical and Surgical Reporter*, of Philadelphia, by a physician of Philadelphia, whose name I do not now recall, directing attention to the use of the liquor potassæ in this disease.

Not satisfied with any treatment pursued in my practice prior to that time, the resolution was made to test this. An opportunity was soon afforded in a case of an adult male, and of extreme severity. To be certain, four physicians were called to examine and diagnose the case. All agreed as to its specific nature. For more than twenty-four hours the disease had been treated with iron, chlorate of potash, ammonia, etc., but the symptoms of debility, with local invasion of the throat, were rapidly increasing. All previous medication was suspended, and he was put upon the use of the liquor potassæ alone, in twenty-drop doses every three hours. In thirty-six hours every trace of the membranous deposit was gone, and the fever subsiding. The patient went on to speedy convalescence, and was soon able to leave my office, where I had kept him in order to conduct the experiment accurately. Since that time the remedy has been used, with like result, in every case of diphtheria coming under my care, and is given in doses suitable to age, every three hours. Usually, in the early stage, I alternate it with a four-ounce saturated solution of chlorate of potash, to which is added one fluid drachm of hydrochloric acid and two of tincture of iron, of which a small teaspoonful, properly diluted, may be given to a child six years old every three hours, allowing thus an hour and a half between the different medicines. When the membrane disappears, the iron mixture is discontinued, and an emulsion of cod-liver oil and syrup of lacto-phosphate of lime used till strength is restored. The liquor potassæ is continued as long as the membrane is present, and until the fever entirely gives way.

Materia Medica.

SALICIN AND SALICYLIC ACID IN RHEUMATISM.

The remedy of the hour in rheumatism is *salicylic acid*. Though now obtained by chemical synthesis, it exists in salicin, an alkaloid much employed by Southern surgeons during the war, in lieu of quinine.

On their comparative merits Dr. Maclagan says, in the *British Medical Journal*:—

As I am probably the only person who has experience of both salicin and salicylic acid in the treatment of acute rheumatism, perhaps I may be allowed space for a few remarks on the merits of these two remedies.

Which is the better remedy, salicin or salicylic acid? That each exercises a marvellous influence in cutting short an attack of acute rheumatism there can be no doubt. I have used salicin or salicylic acid in every case of acute rheumatism which has come under my care since November, 1874 (a year and a half), and invariably with the same result—a rapid cure of the disease. Seeing a patient suffering from acute rheumatism, I have no hesitation in assuring him that within forty-eight hours, possibly within twenty-four, he will be free from pain. That is a very different tale from any that can be told in connection with any other remedy.

Salicin is the remedy which I used first, but I have not confined myself to it. When salicylic acid was first recommended as a febrifuge, I determined to give it a trial in acute rheumatism. In the first case in which I used it, ten grains were ordered every two hours. On seeing the patient after four doses had been taken, the general condition was a little better, but she complained much of the medicine “burning her throat.” I urged her to continue it. This she did, and on the following morning the pain was less, and the temperature had fallen from 102.3 to 101.1; but to the burning sensation in the throat was now added sickness. I omitted the salicylic acid, and gave the same dose of salicin, ten grains every two hours. The sickness ceased; the burning sensation in the throat disappeared; and by the following

day the pain was entirely gone from the joints, and the temperature had fallen to 98.8. She made a good recovery.

This case well exemplifies what is the chief objection to salicylic acid—its tendency to produce irritation of the throat and stomach. I may have been unfortunate in my experience, but in every case in which I have given it this irritation has been complained of. All writers on the subject agree in referring to this irritation as one of its unpleasant effects. The salicylate of soda seems to give rise to the same disagreeable symptom. Salicin, on the other hand, never gives rise to any unpleasant effects. I have prescribed it within the last year and a half in many different ailments, in doses ranging from five to thirty grains. I am probably within the mark when I say that I have thus given it to at least a hundred different people, and I cannot recall a single instance in which any disagreeable effect was produced.

I have myself taken (by way of experiment) three doses of sixty grains—one in the forenoon, one in the afternoon, and one at night—without experiencing the least discomfort; but the smallest pinch of salicylic acid produces in me a feeling of heat and irritation in the throat, while a dose of ten grains gives rise to gastric irritation and a most unpleasant burning sensation in the fauces.

Salicin is a pleasant bitter, and is best given mixed with a little water, flavored with syrup of orange if desired. In adequate dose, say fifteen grains every two hours, it cuts short an attack of rheumatic fever, without producing disagreeable effects. It should be continued in smaller doses during the first fortnight of convalescence.

As remedial agents in acute rheumatism, salicin and salicylic acid seem to be equally efficacious; but the former has the advantage of producing no unpleasant effects. In time, too, it is sure to be much cheaper, a matter of some importance with a large class of sufferers from rheumatism.—*Med. and Surg. Reporter.*

Dr. Bernard, formerly Mayor of Montreal, died lately in California, where he had gone to recruit his health.

Surgery.

A CLINICAL LECTURE ON THE IMMEDIATE APPLICATION OF THE PLASTIC DRESSING IN FRACTURES OF THE LOWER EXTREMITY.*

BY DAVID W. YANDELL, M.D.

Gentlemen: The other day, after I had dressed a fractured leg in your presence, a member of the class asked me, "What was the best time to put up such fractures?" My answer, you may remember, was, "The earliest possible moment after the bone was broken. The sooner the better." And now, after weighing my experience in such cases as carefully as I am capable of doing, I wish to add this to my reply on that occasion: *Dress the fracture, if you can, on the spot.* Do not, if it can be avoided, have the patient moved a single foot from where he received the injury; for he can undergo no movement of the limb without augmenting his pain and increasing his risks.

A little while back a merchant of this city got a simple fracture of the bones of the leg. He was put in a spring waggon and started to his house. On the way the upper end of the tibia was thrust through the skin, and what, when he left his store, was a simple subcutaneous wound, had, before he reached his residence, been made an open wound and converted into a compound fracture. The second accident was worse than the first. I saw more than a score of times, during the late war, soldiers who were started to the rear with simple fractures of the lower extremity, who, when they reached the hospitals, had compound fractures. The jolting inseparable from the best managed transportation on wheels almost certainly gives rise to pain, which means, in almost every instance, additional injury to the soft parts, and, as I have just remarked, it is sometimes even sufficient to change a simple into a compound fracture. Carrying patients with broken legs on litters on men's shoulders is safer than on wheels, but this can not conveniently be done except for short distances; and no matter how carefully it may be executed,

* Phonographically reported.

it is nevertheless obnoxious in some degree to the objections I have just named. And this, too, though the surgeon may himself superintend the transfer, and before undertaking it encase the injured limb in a temporary, or what has come to be known as a field dressing; for this dressing, however well applied, is after all but a make-shift—it gives pain and disturbs the fragments of bone while it is being put on, and does the same when it is taken off.

Some years ago, when my lamented colleague, Professor Bayless, was lecturing one day on the subject of fractures, I was called to see a negro man with a broken thigh. I remembered it was the hour for my friend's lecture. The patient, who wished to go to hospital, was only a few blocks from the University. I thought the case would be an agreeable surprise to Dr. Bayless, and would serve better than diagrams or words to illustrate the subject of his lecture, and so after adjusting the fragments and applying a good field dressing to the limb, I placed the patient on a stretcher, and this on the shoulders of four stout men, and putting these under way, I accompanied the cortege to the lecture-room. When we took up our march, I must believe that the broken bone was well in place; but when we reached our destination, and removed the dressing, the extremities of the fractured femur were frightfully displaced, and the sufferings of the patient extreme. A part of both these features was due to the motion which is well nigh inseparable from every attempt to transfer persons with broken legs from one spot to another, and a part to the violent spasmodic action of the injured muscles which, primarily lacerated, were still further vexed by being still further disturbed.

So my injunction to you to-day is that if you would encounter a broken leg when the injury done is at the minimum, when in dressing it you would give least pain, and have it most in your power to avert inflammation and all the evils which journey in its train, you must do so on the spot where the accident has occurred, and as soon afterward as you can get to it. Every inch that a fractured leg is moved is hurtful; every moment lost before putting it up is injurious.

A man in the employ of the gas company

here sustained a fracture in the lower third of the leg, within a few feet of my office door. In less than forty minutes after, the plastic dressing was drying on the broken limb. Two hours later the patient was removed without the least suffering to his home, a mile away, and had he been accustomed to their use might have walked on crutches the next morning.

It will oftentimes happen, however, that the opportunity to act with the promptness I have advised is not afforded you. You may not see the fracture until after swelling has set in, and the limb has grown painful and red and hot. What then? Why, do just this: Put the fracture up as soon as you can get your dressing ready. Go to work then and there, and encase the limb in some form of fixed apparatus. It may be Paris plaster, or eggs and flour, or glue and zinc, or liquid glass, or shoemaker's paste; only let it be something plastic, and apply it instantly.

Those of you who have been following these lectures longest can not recall a single instance in which you ever saw me postpone dressing a fractured leg or thigh because of swelling in the parts. On the contrary, I have unvaryingly inculcated that swelling and pain are to be regarded as but so many additional reasons for fixing the limb—for rendering it immovable—for placing the fragments so that neither the movements of the patient nor spasms of the muscles can disturb them. Pain, as Mr. Hilton in his lectures on that subject has so well expressed it, is a monitor—the monitor, as he puts it; and here it clearly seems placed to warn the surgeon against further delay in fixing the limb, and so fixing it that displacement can by no possibility again occur. Nor is swelling to be regarded as much the inferior of pain itself as a monitor. The two speak the same language. If you are truly wise, you will heed alike the voice of both; their admonitions are the same—they are calls for rest; and I beg you to believe that the more quickly and the more perfectly you secure this, the more rapidly and the more completely will they quit the broken limb. Oftentimes the injury done to the soft parts by the ends of the bones being suddenly and violently displaced by muscular action, or by change in the

position of the patient, gives rise to some of the greatest dangers which occur in fractures. Hence, the sooner you adjust the fragments, and the more securely you provide against their subsequent displacement, the better you will have treated the case. Let neither pain nor swelling deter you from dressing the limb at once. If you see the fracture first at night, I pray you wait not till morning to put it up. Don't trust to sand-bags, or pillows, or splints, or this or that other device, and finally take your leave, saying you will call in the morning. A sight of mischief may occur between midnight and sunrise.

Some years ago a pilot jumped from the hurricane deck of a burning steamboat at the wharf at St. Louis, on to the boiler deck of a boat lying alongside, and sustained a fracture of both bones of the leg. The limb was well put up in splints, and the patient brought by rail to his home in this city. Forty-eight hours after the accident, when I first saw him, the limb was much swollen and very painful. I applied the plastic dressing at once, and had the satisfaction, not only of relieving all suffering immediately, but also of saving a man of very feeble constitution from the long confinement inseparable from any other mode of treatment.

An old gentleman fell, one Tuesday, and broke the two bones of the right leg above their middle. A medical man dressed the parts in the usual way. Thirty-six hours after I found the limb hot, painful, and much swollen. Did I wait for these conditions to abate? Not a bit of it. I ripped up the wrappings in which the leg had been enveloped and put on the final and only dressing which is required in such cases. The next day the patient sat up, and on the following Sunday he went on crutches, with his foot in a sling, two hundred yards to church.

A lady trod on a bit of orange peel, fell and broke her femur in its upper fourth. My friend, Professor Bayless, who, though he reposed great trust in the plastic apparatus, preferred waiting the conventional fortnight for the swelling, and so forth, to subside, applied the long splint, and made the orthodox extension and counter-extension enjoined in such

cases. The limb swelled enormously, and the pain was extreme. At the end of three days of very great suffering, I saw the case with my colleague, and applied the plastic dressing while the patient was under chloroform. There was no more pain after that, and in a week the lady could, when assisted, get on crutches and move about her room.

From that day, my lamented predecessor became a convert to the immediate application of the fixed apparatus, and among the last services it was my privilege to render him, when his failing health obliged him to abandon such work as called for much physical exertion, was putting up a broken thigh in one of his patients immediately after the accident happened. In that case there was no swelling; none had had time to occur, and the early application of the dressing had most certainly prevented swelling. In proof of this I need only refer you to my own experience in its use, and state that in all the cases in which I have applied it *I have never had occasion to remove it on account of swelling in a single one.* Many times when I have applied it to limbs already swollen, I have been obliged afterwards to open it and overlap the edges, or trim them down, in order to adapt the bandage to the shrunken condition of the parts. Nor is this my own observation alone. I may fairly say that it includes the experience of two surgeons very favourably known to you—Professor Cowling and Dr. Roberts, both of whom, former pupils and chiefs of this clinic, are now colleagues, and who, as I believe, have never dressed any fracture of either the leg or thigh by any other than the fixed apparatus. These gentlemen will tell you, as I have done, that when the plastic dressing is applied to a fracture before swelling occurs, none will occur; and that when it is applied after swelling has taken place, the swelling will begin at once to abate and soon disappear altogether.

Nor do these remarks apply alone to simple fractures of the lower extremity. They are equally true of compound fractures in this situation.

A boy, eleven years old, got a compound, comminuted fracture of the left tibia, just below the tubercle. The laceration of the soft parts was considerable. I picked out with my

fingers a number of loose fragments of bone, brought the edges of the wound together, and three hours after the accident put the limb in the immovable apparatus. I then cut out a space sufficient to dress and watch the wound. In less than a week the lad went in a waggon, over a rough road, nine miles into the country. In nine weeks he walked into my office with a firm, smart step, and without the slightest shortening.

Three years ago, while Professor Cowling was serving his term at the hospital, Pat Stanton, whom you occasionally see at this clinic, got an extensive compound, comminuted fracture of the right leg. The contusion and laceration of the soft parts were simply frightful. The accident happened in this wise, and I mention it in order that you may the better appreciate the real magnitude of the injury. Stanton and a fellow labourer were engaged in lowering a lot of whisky from the street into a very deep cellar. Stanton's post was in the cellar. By some mismanagement one of the barrels rolled off the ways on which it had been placed, and fell a distance of twelve or eighteen feet on to Stanton's leg. Now, a barrel of whisky taken at stated periods, is one thing; but taken on a sudden, and on one's leg, is another and a very different thing. Stanton was removed to the hospital, where he was soon seen by Dr. Cowling; the internes in the meantime having decided that it was clearly a case for amputation. I was sent for, and when, after consultation, it was decided to attempt to save the leg, Stanton drew me near him, and in a feeble voice, for he was still suffering from shock, said: "Doctor, had you told me my leg had to come off, I should have asked you to put a pistol ball through my head, and let me go at once." The plastic dressing was used instead of either the knife or the pistol, and you may now see Stanton almost any day earning his living on two good legs as a street cleaner. I hope you will not encounter, indeed it would be difficult to conceive of, a more unpromising case than Stanton's, or one which put the fixed apparatus to a severer test. I am convinced that no other dressing could have secured the same happy result; and even this would, I believe, have failed had its application

been delayed for the ten or twelve days advised by some surgeons.

In 1870, when I had six years' less experience than I now have in the use of the plastic dressing, and when among surgeons generally there was less positive knowledge of the inestimable advantages of its immediate application, I stated* that if the bandages were cut throughout their entire length, as soon as dry, and their edges subsequently brought together either by additional strips or by loop-knots, the principal objection urged against this dressing, namely, that it may become too tight as the swelling augments, or too loose as the swelling subsides, would be obviated. This statement grew out of my respect for the opinions of my seniors rather than out of the teachings of my own experience; for at that very time I was unable to recall a single instance where the dressing once applied, before swelling had occurred, that it afterwards became necessary to remove it because of swelling. *A limb timely put up in the plastic apparatus will not swell.* This is my dictum to-day. Hence there will be no occasion to open the dressing in these cases. Where swelling already exists it may, on subsiding, leave the limb, as you have seen, so shrunken as to render it necessary to cut and refit the bandage; but it is in these cases and in these alone.

To conclude: What I wish to impress upon you to-day is, that the best time to dress these fractures is the first moment after they have been inflicted. Every moment of delay is hurtful. The best place is on the spot where they have occurred. Every inch the limb is moved is an injury; and finally, no dressing is comparable to the fixed dressing.—*American Practitioner.*

TAPPING THE GALL-BLADDER.—Dr. E. L. Dixon (*The Practitioner*, April, 1876) reports a case in which the gall-bladder was tapped five times, not only with impunity, but with great relief to the patient, and a total of 87½ ounces of liquid was withdrawn. The cause of the distended condition of the gall-bladder was not clear during life, but was found after death to have been an occlusion of the common bile duct from malignant deposit.

* *American Practitioner*, July, 1870.

INTRA-CAPSULAR FRACTURE OF NECK OF FEMUR.

BY T. J. MAXWEAL, M.D., OLENA, ILLINOIS.

(Read before the Military Tract Medical Society, Jan. 11, 1876, at Galesburg, Ill.)

I wish to lay before this Society a single clinical observation upon a subject that Sir Astley Cooper put to rest more than half a century ago. I refer to the subject of fracture of the neck of the thigh bone within the capsular ligament. As my case, in its treatment and results, conflicts with the teaching and experience of the great master, I approach the subject with the most profound respect for his genius and great learning, and hope you will not think me presumptuous.

Sir Astley doomed every man and woman who should be so unfortunate as to suffer from a fracture within the capsular ligament of the femur to a life of halting and deformity. Indeed, such was his experience without exception, and such has been generally that of the profession since his time.

With these prefatory remarks, I proceed to give the history of a case that came under my observation, the method of treatment, and its results, together with some remarks on the subject.

Mrs. J. G——, æt. 50, on the morning of Jan. 14, 1871, slipped and fell upon the hard, icy ground while attempting to go up a short inclined plane, striking on the right hip. She said she felt somewhat stunned, but did not suspect any serious injury until she attempted to rise, and then discovered that she was unable to use her right leg. She immediately called for assistance, and was carried into the house and laid on a pallet on the floor, where I found her about one hour after the accident.

On examination, I found the foot of the injured side averted, lying on its outer edge. Free motion of the limb in every direction, rotation and flexion of the thigh upon the pelvis, could be accomplished without trouble or the application of much force, though with considerable pain to the patient. By measuring the limb from the anterior superior spinous process of the ilium to the interior malleolus,

it was discovered that the injured leg was fully one inch shorter than the other.

The leg could easily be extended to its full length, and on rotating a little in that position crepitation was developed. The lady was of thin, spare habit, and afforded an excellent opportunity for free examination about the articulation. I could grasp the trochanter major in its entire extent to the neck of the bone, and follow all its movements. There was but little swelling, and a moderate degree of pain on handling. One marked feature of the appearance and feel of the hip, was the flattening in the region of the trochanter major, which was in no way improved by extending the leg to its full length. Grasping the trochanter and rotating the leg showed that it did not describe the arc of a circle like the uninjured one, but rotated on its own axis, or nearly so. I applied Day's splint for fractures of the thigh. Had no trouble in getting the leg to its normal length; but that flattened condition of the trochanter was unchanged, and she complained of pain and uneasiness in the region of the hip and groin constantly.

I continued this appliance for ten days, and then determined to change, as it did not accomplish the purpose, that is, to keep the parts in coaptation.

Accordingly, the splint was removed, and the following treatment substituted: A pulley was fixed to the foot of the bed, and another to the side about the centre. The foot was elevated about nine inches on the front and about six on the back, and the front side of the head about three, so that the tendency of a person lying on the bed would be to slip to the head and back part. The patient was then placed in bed, and extension made by means of a weight attached to a cord passing over the pulley at the foot of the bed, and fastened to the ends of the adhesive straps which extended beyond the heel. These adhesive straps were applied to the whole length of the thigh and leg, and, of course, covered by a bandage from the toes to the body. The lateral extending bandage, about four inches wide, was then passed around the thigh close to the body, and fastened to a cord which was carried over the pulley at the side of the bed, to which was suspended a tin bucket for

weights. Weights were gradually added to the bucket at the foot until the leg was brought and kept at its normal length, and the lateral extension was increased, until the trochanter major could be grasped by the hand and felt to be as prominent as that on the well side.

The weight required to accomplish extension was about twenty pounds. For lateral extension—to lift the trochanter from its position against the posterior lip of the acetabulum—about twelve or fourteen pounds.

As soon as the lower fragment was brought out to its proper position, all pain ceased, and was not afterwards complained of during the long term of confinement.

She remained in bed with this apparatus until the fourteenth day of March, just two months to a day from the date of injury. When it was removed, motion and adhesion of the part appeared perfect. The adhesive straps, by which extension was secured, caused some slight abrasions of the skin; the knee joint was swollen and painful, and it was several weeks before it resumed its functions so as to be useful.

The leg maintained its normal length at the time of the removal of the dressing, and the lady walks to-day with the least perceptible halt.

I claim no originality for this mode of treating this kind of fracture, as the plan was fully set forth and illustrated by a wood cut, in a late number of the *American Journal of Medical Sciences*.

I venture to ask, may it not be more the inability of the surgeon to maintain the fragments in coaptation—as Prof. Gross states that no means yet known to the profession accomplishes this perfectly—rather than a physiological impossibility for the parts to unite by bony union, as claimed by Sir Astley Cooper? Had I followed that great master in the treatment of my patient, she would have undoubtedly become a cripple, and gone halting the balance of her life.

I do not think it possible to have had as good results follow the first application in this case. If by this report I shall induce the members of this Society to investigate the subject, and prove it good or bad, my object will have been fully accomplished.—*Chicago Med. Journal & Examiner*.

NOTE ON TREATMENT OF SYPHILIS.

We are very quiet in the matter of news in the medical world here, and my letter must be of a rather more practical character than its immediate predecessors. The subject of syphilis has received a considerable stimulus from the recent discussion on it, and many are finding their impressions on the subject rendered more vivid thereby than they were before, even if there has been nothing actually new added to their stock of information. As an outcome of this discussion, the matter of the treatment of syphilis has been considered. It would seem that there is already a reaction going on in the opinion of the profession as to the respective merits of mercury and iodide of potassium in the treatment of the remoter outcomes of syphilitic infection. The steady, persistent administration of mercury, especially in the form of the solution of the perchloride, is found to produce excellent effects. Neither does it follow that the persistent exhibition of mercury should cause salivation, or other unpleasant consequences of a mercurial course. But in order to secure good effects without evil consequences, or, rather, to reduce the evil consequences to the minimum, it is found that several points are to be attended to.

The first of these is to remember that the action of the mercurial is to break down material, so that it is rendered capable of being removed by the absorbent action of the lymphatics. It is by such a process that syphilitic growths, and the stores of syphilitic material laid up in the connective tissue of the body, are removed. But the effects of the mercurial, though most acutely felt by such material, are not solely confined to them, but act upon all tissues. It is necessary, then, that instead of the plan of continued hungering with a mercurial course, an opposite system, of feeding the patient well, is to be followed. In order to obviate the destructive effects of the mercury when long continued, it is most desirable to combine with it iron in some form. The perchloride of iron goes well with the solution of the perchloride of mercury, say as ten drops of the former to thirty drops of the latter, three times every day, it being as well to give it after

food, so that the two agents get thoroughly incorporated with the food. If there co-exist a cachectic condition, or the patient be worn out or anæmic, this combination renders it quite safe to push the mercurial freely, and that, too, without untoward consequences. If the nutrition be impaired, it is well to give also cod-liver oil. Such a mercurial course, so guarded and protected, may be continued for many months with the best effects. Since the adoption of this plan, the terrors of a mercurial course are greatly mitigated, in the writer's mind. For cachectic conditions, especially in middle-aged or elderly women, so common when the system is saturated with syphilis, and in children from a year or two old up to puberty, where a condition of arrested growth with distinct anæmia is so frequently found as the consequence of an inherited taint, such modified mercurial course is invaluable. It is no matter for surprise that when given alone, and freely pushed, mercury should produce baneful consequences in broken-down constitutions. But if given with the above auxiliaries, and with attentive watchfulness as to the requisites of each case, a course of mercury will often be found most beneficial, and at the same time not to be followed by unpleasant consequences. In cases of syphilitic eruptions, too, it is well to apply the mercurial locally. That is, instead of unctuous of mercurial ointment into the inside of the thigh and upper arm, it is well to rub the mercurial over the syphilitic part, and get the local advantages of the effect of the agent upon the new growths forming the eruptions. Whether mercury acts as a direct antagonist to the syphilitic poison, as the late Dr. Headland described it, or whether merely such growths as syphilis produces are more readily broken down and brought within the action of the absorbents than normal tissues, is practically immaterial. The explanation is quite subordinate to the clinical fact.—*London Letter to the Philadelphia Medical Times.*

Dr. A. Gamgee, F.R.S., Professor of Physiology, in Owen's College, Manchester, has in the press a treatise on the Physiological Chemistry of the Animal Body.

NOTE ON THE TREATMENT OF GLEET.

BY JOHN CHIENE, F.R.C.S., F.R.S.E.

Lecturer on Surgery, Assistant-Surgeon, Edinburgh Royal Infirmary.

Inflammation of the male urethra, the result of promiscuous sexual intercourse, is often a very intractable disease. This is specially true of the chronic stage of the affection. In no case can the duration of the disease be foretold; and frequently, even with the greatest care on the part of both patient and surgeon, the watery discharge may last for months, defying all forms of treatment.

Many reasons have been assigned for the tedious nature of the complaint; none are, to my mind, altogether satisfactory. A consideration of the natural history of balanitis, and of many cases of soft chancres with phymosis, in which opposition of the inflamed glans and inflamed prepuce is the sole cause of the persistent nature of the inflammation, must, I think, lead to the conclusion that the same cause may be at work in gleet. If such is the case, then separation of the surfaces of the urethra should, in cases due to this cause, be followed by a speedy cure.

I first thought of a flexible india rubber bougie, to be worn at night; but as this method hardly appeared suitable, I mentioned my difficulty to Dr. Cadell, of this city, who suggested a trial of clay earth, or kaolin, and directed my attention to a paper by Dr. F. W. Godon, in the *American Journal of Syphilography* for October, 1874. In this paper the good effects are attributed to the soothing and antiseptic properties of the clay, which is injected every four hours as a thick paste, and retained for a minute. If retained for some hours, then it would act mechanically, keeping the inflamed surfaces apart—acting, in fact, as a piece of lint in the cure of balanitis. It therefore seemed suitable for my purpose; and since the beginning of 1875 I have given it a trial in every case of gleet, after having satisfied myself that the discharge was not due to stricture. At first I used it only in intractable cases; latterly I have used it in every case of gonorrhœa after the acute state has subsided. The result has been satisfactory in the majority of

cases. In some the rapidity of the cure has been very marked; in only one case has any evil consequence followed, the patient using an impure preparation, which hardened in the urethra, and was removed with difficulty. I have not used it in the acute stage of the disease, and have never injected more than sufficient to fill the urethra anterior to the triangular ligament. In those cases in which no good result has followed its use, I believe the source of the discharge was in the posterior part of the urethra.

It may, even in such cases, if sufficient quantity is injected to fill the whole urethra, do good, but I have always feared to use it in case some of the injection passed back into the bladder, and, being retained, might act as a nucleus for calculus. The fear may be groundless, but it has hitherto prevented me from adopting it. I beg, however, strongly to recommend it in gleet caused by inflammation of the anterior part of the urethra.

The kaolin is mixed with water, or with oil and water, so as to make a very thick paste, which is placed in the glass syringe, and injected very slowly into the urethra night and morning, after micturition; a piece of lint is then placed over the meatus, and the prepuce drawn forward to keep the lint in position. The kaolin at the meatus soon dries, and the plug of kaolin remains in the urethra. It is retained with difficulty during the day, but at night there is no difficulty if the case is chronic, and the injection be performed very gradually.

The good effects are undoubted: the true explanation of its action may be questioned. It may simply act as an antiseptic, as stated by Dr. Godon; in my opinion, however, there are some grounds for supposing that it acts mechanically. I have used it with great advantage in balanitis and in soft chancres with phymosis. Until something better is found, the use of clay-earth in keeping chronically inflamed surfaces separate is worthy of further trial.—*Medical Times and Gazette.*

PERSONAL.—Dr. C. E. Taylor, a graduate of Toronto University, has settled in Clifton. We wish him success.

Midwifery.

EVACUATION OF THE UTERUS AFTER ABORTION.

Professor Alexander R. Simpson, in an interesting paper upon this subject, in the *Edinburgh Medical Journal*, May, 1876, rejects the use of instruments, and very sensibly urges the importance of using the fingers for intra-uterine work in securing complete delivery. He speaks as follows in regard to the methods of operating :

To begin with, the patient should, as a rule, be anæsthetized. The manipulations necessary to secure a satisfactory result cause suffering, though not to a great degree, which we can always save the patient by bringing her under the influence of chloroform. And at the same time that her sense of pain is abolished, her voluntary muscles are completely relaxed, and it becomes easy for the practitioner to press down the uterus through the abdominal parietes. I have often found myself baffled in the effort to reach the fundus uteri in such a patient until I had chloroformed her ; for, however willing the woman may be to further your efforts for her delivery, involuntarily she contracts the recti abdominis when you make pressure on the hypogastrium, or withdraws herself when you press the other hand against the perineum. The patient, then, having been anæsthetized, we may render the uterine cavity accessible to the exploring finger in one or other of two different ways.

First. We can push down the fundus uteri from above. The patient may lie either supine or in the ordinary obstetric position on her left side, with the knees drawn up ; most frequently the right hand will be used for internal manipulation, while the left is applied to the abdominal surface. It rarely suffices to pass one finger alone into the vagina. In most cases the index and middle fingers are passed into the vagina, and while the middle finger is folded in the fornix to steady the uterus there, the forefinger is passed through the cervix. Or the middle finger can sometimes be more satisfactorily employed for the intra-uterine digitation, or, better still, both fingers may be passed into

the uterine cavity. In the last case it may become necessary to have the other two fingers carried into the canal of the vagina, the thumb alone remaining external to the vulva. It is usually only in patients who have miscarried at the fourth month, or beyond it, that the hand requires to enter so far for the separation of the placenta, and then the vaginal cavity is relaxed and roomy enough easily to permit of it. Whilst the fingers of the right hand are thus seeking their way up to the recesses of the uterus, the left hand, applied above the brim of the pelvis, is pressing the uterus forcibly and steadily downwards into the pelvic cavity. In this way, in the great proportion of cases, we obtain perfect command of the uterine contents. The fingers of the two hands recognise each other through the double thickness of the abdominal and uterine parietes ; and while the left hand keeps the fundus fixed firmly downwards, the forefinger of the right peels off the adherent mass and forces it through the cervical canal. In the great proportion of cases, I repeat, we can in this manner compel the evacuation of the uterus, and when it fails us our resources are not yet at an end ; for,

Second. We can drag down the cervix from below. The first is the method that has most frequently been employed, and it has this in favour of its common employment that abortions are more frequent in multigravid than in primigravid women ; in women, therefore, in whom there is usually a degree of abdominal relaxation, which greatly favours its execution. But where the walls are more resistant, or the patient is so fat that the combined external and internal manipulation fail us, then we must seize one or other of the lips of the uterus—usually the anterior—with a volsellum, double or triple-pronged, and slightly curved. One of the blades grasps the vaginal aspect of the front wall of the cervix as high up as the roof of the vagina, the other at a corresponding level within the cervical canal. The uterus is capable of being dragged far down without any injury to its ligaments or laceration in the bite of the volsellum. It may be pulled down with the right hand and kept fixed with it, whilst the fingers of the left pass into the cavity and explore and evacuate it. Or the volsellum may

be held in the left hand, or given to an assistant, to keep the uterus depressed, whilst the more familiar right-hand fingers do the intra-uterine work. The cavity of the uterus is thus brought within full reach of the fingers, and we can—and in all those cases of imperfect delivery in the early months we ought to—control the emptying of the cavity from fundus to os.

Whilst the method of gaining access to the interior of the uterus by pressing it down from above is that which has hitherto been ordinarily followed, my own experience leads me to expect that this second method, which I have just described, will largely supersede it. For, first, it is applicable in all cases where the other can be employed, and in some where the rival method is not available. Second, it is less painful, and may be carried out occasionally when there is not time for the administration of an anæsthetic. Third, it saves the expenditure of muscular power demanded of the practitioner, who presses and keeps the uterus pressed down from above only by overcoming the resistance of the abdominal walls. The one circumstance that will enable the bimanual method to hold its ground is, that we may find ourselves called on to clear out the uterus at a time when we have no volsellum at command, whilst our hands we always carry about with us.—*American Practitioner.*

SOLUBILITIES.—The following list gives approximately the number of grains of the salts mentioned, that can be readily dissolved in one ounce of water at the ordinary temperature. If this limit is much exceeded, a clear solution cannot be expected :

Potassium Iodide.....	500
Ammonium Bromide.....	300
Potassium Bromide.....	240
“ Bicarbonate	120
“ Nitrate	100
Sodium Borate.....	40
Potassium Chlorate.....	30
Mercury Bichloride.....	25

It should be remembered that the bulk of the solution exceeds that of the solvent; thus an ounce of water and an ounce of potassium iodide make about an ounce and a half of solution.—

St. Louis Clinical Record, June, 1876.

TO PREVENT THE SECRETION OF MILK IN THE FEMALE BREAST.

I have for more than ten years employed the following method to prevent the secretion of milk in the breasts of women who may have had still-born children, or who, after having nursed their child for a few months, found it necessary to wean it. It is perfectly clean and painless as far as my experience goes, and as such I beg to recommend it to the notice of my medical brethren.

We will take, for instance, the case where the infant has been born at the full period, but is dead, or dies within a few hours of its birth. The milk makes its appearance in the breasts generally about the second day, sometimes longer, and sometimes it is ready when the child is born, and in the case of still-born children my experience leads me to think that in such cases it makes its appearance earlier than when the child is born alive. My plan consists in taking a piece of emplastrum adhæsivum of about ten inches square, round the corners, cut a hole in the centre for the nipple, then from the centre of each corner make a straight cut towards and within two inches of the centre hole; having now got it ready, let the patient lie on her back, her body being perfectly horizontal; warm the plaster and place it over the breast, then strap one of the lower corners down first, draw the opposite one tightly upwards and fix it in its place, then the other lower corner, and lastly the opposite upper one, having drawn it sufficiently tight first; now take a piece of plaster two inches wide and about sixteen or eighteen inches long and put it on from below and outside the breast, across close by inside of nipple, and fasten the end over the clavicle; another piece may also be put on in an opposite direction, it being drawn over the shoulder. Of course, in cutting the plaster and strips the size of the breasts must be taken into consideration, there being so much difference in the size of female breasts.

The above plan I always follow when one of my patients wishes to dry the milk, as they usually call it, or when they are compelled to do so either from the death of the child or any other cause. I also am certain strapping will prevent mammary abscess if resorted to in the earlier stage; I at least have found it do so in many cases.—*Dr. J. W. Lane, in Med. Press & Circular.*

TREATMENT OF PLACENTA PRÆVIA.

Dr. T. Gaillard Thomas, after narrating to the New York Obstetrical Society (*American Journal of Obstetrics*, Feb., 1876) the notes of a case of placenta prævia, made the following remarks. Is it better to allow a pregnancy, during which the woman has become exsanguinated and dangerously reduced by repeated hemorrhage from placenta prævia, to go on to term, or should premature labour be induced? He chooses the latter alternative, and has lost but one case of placenta prævia in which he brought on labour prematurely; the case died of post-partum hemorrhage. The children, of course, usually succumb. In the case just mentioned he detached the placenta (which was centrally inserted), cut the cord and removed it, leaving the child in the uterus; no hemorrhage occurred; twenty-four hours later the child was safely expelled. The uterus contracted well apparently, but three hours afterwards the family physician was hurriedly called and found the lady dying of hemorrhage. In his opinion the induction of premature labour offers greater safety, both to the mother and the child, than the plan of allowing the pregnancy to go on to term. The hemorrhage from this malposition of the placenta generally occurs suddenly, often at night, and before the physician can reach the patient she is beyond medical aid, or at least at the point of death. These repeated depletions also debilitate the child, and the question arises whether a child born prematurely at the eighth month is not fully as likely to live, or more so, than one weakened by repeated hemorrhages. If the labour is induced by rubber bags, the hemorrhage will be slight, and the danger to the mother not great, for these rubber dilators compress so thoroughly as to arrest the bleeding from the placenta during the dilatation of the os; of course the diagnosis should be correct, and a granular endocervicitis producing occasional discharge of blood should not be mistaken for placenta prævia. This method of treatment is not mentioned in the obstetrical text-books.

Albuminuria, after the external use of iodine, is said to be of common occurrence. (*Gazette delle Cliniche*.)

THE TREATMENT OF OVARIAN CYSTS BY ABDOMINO-VAGINAL DRAINAGE.

At the last meeting of the *Société de Chirurgie*, M. Delore presented a paper on a new method of treating ovarian cysts by abdomino-vaginal drainage. In a case of unilocular cyst this treatment has been completely successful. By means of repeated applications of caustics to the abdominal wall and to the posterior cul-de-sac of the vagina, continued until the cyst was opened, M. Delore succeeded in establishing a free communication by a drainage tube between the openings in the abdomen and vagina. The same operation was performed thirty years ago by Récamier, but without good results; Thomas, Peasley, and many others have punctured the vaginal cul-de-sac for the cure of ovarian cysts, but the novelty of M. Delore's treatment consists in opening the cyst per vaginam with caustics, and establishing a perfect drainage. At the discussion of the paper several objections to M. Delore's operation were raised. (1) The difficulty of applying the caustic in the posterior cul-de-sac. (2) The chance of finding a portion of the intestinal canal between the cul-de-sac and the cyst. (3) The time required for the applications of the caustic and the pain produced by it. Several ovariologists further objected that every open tube introduced into the peritoneal cavity is an invitation to septicæmia, and pointed out that the great mortality in ovariectomy is chiefly due to septicæmic complications.—*Paris Letter London Examiner*, April 13, 1876.

DELIVERY OF A LIVING CHILD FROM A DEAD MOTHER.—Dr. Kelly (*Am. Jour. of Obstetrics*, Nov. 1875) reports a case in which a woman died in labor from rupture of a thoracic aneurism. The os was rapidly dilated, and a living child delivered in about fifteen minutes after the death of the mother. The child has since done well. Cases have been reported in which live children were born half an hour after the death of the mother.—*Clinic*.

Medical Jurisprudence.

"POST-MORTEM EXAMINATIONS."

The following are the deductions from Dr. Littlejohn's remarks on "Post Mortem-Examination (B. Internal Examination)" taken from his papers on Medical Jurisprudence, now being published in the *Edinburgh Medical Journal*.

"In this description of an ordinary *Medico-legal* dissection we have specially insisted,—

"1st. That the external examination should, in the first instance, be limited to the front of the body.

"2nd. That the organs of the chest and abdomen should be first exposed.

"3rd. That the heart should be carefully examined *in situ*.

"4th. That the inspection should then be proceeded with from above downwards.

"5th. That no hammer, or mallet, should be used in detaching the skull-cap (because, 'should the cause of death prove to be injury to the brain and fracture of the skull, this violent procedure must always leave us in doubt as to the exact causation of a fissure in the cranial bones). We hold it to be essential that as little violence as possible be applied to the cranium in the separation of the skull-cap; and for the last 25 years have used with satisfaction and success the following adaptation of the ordinary chisel. A stout crosspiece of steel—one end of which forms a screw-driver, for obvious uses, and the other a blunt hook to avoid the dangers arising from the use of the fingers in removing the calvarium—'is loosely fitted by an aperture (in the centre) to the chisel, and, gravitating by its weight, is arrested at the shoulder of the instrument, forming an ordinary cross where the two portions are adjusted. By sawing deeply over the frontal sinuses, the sharp end of the chisel is easily inserted, and by simply turning the chisel round, the internal table at once gives way with a slight crack, and the skull-cap is felt to be detached.'")

"6th. That to enable us to form an estimate of the condition of deceased, as to sobriety at, or about, the time of death, and also as to his general habits, any serum in the ventricles of

the brain should be preserved for the detection of alcohol, and portions of the heart, liver, and kidneys, submitted to microscopic examination.

"7th. In ordinary circumstances, where the dissection satisfactorily disposes of the case, it is not necessary to take the trouble of weighing the various organs where these present no unusual dimensions or appearance; and such phrases as *enlarged in size*, or *much enlarged*, etc., may be employed; but, in suspicious cases, remembering that our report must convey as much information as possible to those whose advice may be asked to support the allegations of a prisoner, the weight of the principal viscera, more especially of the heart, liver, spleen, and kidneys, must be given, should these not be described as normal; care being taken at the same time to indicate the size and configuration of the body of deceased.

"8th. When, after a searching examination, we have failed to ascertain the cause of death, our duty is plain. We seal up, and retain, the contents of the stomach and intestines, and we examine with the microscope the portions which we have removed from the heart, liver, and kidneys. These organs may prove to be so diseased as to enable us to advise the authorities that an analysis of the contents of the digestive canal is not necessary; but should the microscope give no positive indication of the presence of disease, then our report must be a negative one; and we place in the hands of the authorities the vessels, duly authenticated, in which we have secured the contents of the stomach and intestines."

At a meeting of the Medico-Chirurgical Society, at Edinburgh, on the 3rd of May, Dr. J. Batty Tuke, exhibited a *brain prepared by Charcot's process*. The brain to be preserved is steeped for six weeks in diluted nitric acid, and then allowed to dry. By this means it shrinks to about one-fourth of the natural size, but preserves most perfectly the anatomical relations. Professor Charcot uses such preparations as a means for recording lesions of the convolutions, instead of employing flat charts. Brain so prepared must also prove useful for teaching purposes.—*Edinburgh Medical Journal*.

Translations.

ON POISONING BY FUNGI.

WE summarize, from the *Gazetta Medica Italiana*, a review and criticism of an oral communication made by Prof. Schiff to the *Società Medico-fisica*, of Florence, in May.

In the first place, Schiff calls to mind that in the last century and in the present, each fungus was supposed to have its own special poison; but all differences have been found to arise from the co-existence of other elements which have acted differently in different organisms, but the poisonous principle is the same in all. It was discovered by Schmeedberg in the *amanita muscaria*, and is called *muscarina*.

The symptoms are first increased salivation, due principally to increased secretion from the submaxillary gland, the parotid being less affected. This has been tested by experiments on cats and dogs, not on man or the runinantia. It occurs even after division of the nerve trunk. It, at the same, time depresses the heart, making the pulse fuller and slower, though a small quantity will at first accelerate. It decreases the circulating pressure (at the surface), which seems to be due to dilatation of the small peripheral vessels. Respiration is more depressed according as the pulse is or not, although it does not bear a direct ratio. The abdominal secretions and intestinal movements are increased, the former phenomenon being shown by increased mucous secretions, sometimes tinged with blood; the latter, by direct inspection of the exposed viscera, and by abdominal auscultation. Contractile movements of the tail and other muscles sometimes occur, in these cases the heart is readily stopped by electric or mechanical irritation of the pneumogastric. Respiration is disturbed less by the fungi than by *muscarina* alone. So far the reviewer agrees pretty well with his author, but now the latter is quoted as saying:—

“With the poisonous fungi, when the stomach has not been promptly relieved by vomiting, besides the phenomena noted from the *muscarina*, there are some dependent on the central nervous system, on which it seems that *muscarina* does not exercise any direct action.”

“In poisoning with the *amanita muscaria*, besides the symptoms described, there are restlessness of the animal, convulsions, which often seize on the muscles of respiration, dilatation, or on the contrary contraction of the pupil. In man, also, these phenomena have been observed, resembling those produced by opium or by morphia.”

* * * * *

“There seems to be a very great analogy between the action of the Calabar bean and that of the poisonous fungi. But the Calabar bean, according to Schmeedberg, augments the sanguineous pressure, and according to the author, determines in a greater degree the contraction of the muscular fibres.”

* * * * *

“The symptoms described are the opposite of those presented in poisoning by *atropine*, *daturin*, and certain *solanaceæ*. This antagonism denied by Rossbach, really exists, and the author has also made certain experiments to see whether the *solanaceæ* are antidotal to poisonous fungi.”

The reporter then states that Prof. Schiff has made experiments on the lower animals by bringing them to the verge of death with fungi, and then restoring them with *datura stramonium* and *daturin*.

He has also proved by experiments on animals and on himself, that *daturin* produces certain cerebral phenomena analogous to the fungus poisons; but does not think these should stand in the way of using it as an antidote, inasmuch as these pass off of themselves, as soon as the danger from the action on the circulation and respiration are averted.

The editor of the *Gazetta* is astonished at the statement that poisonous fungi produce symptoms like opium and morphia, which, he says, is quite opposed to fact; on the contrary, he thinks opium and alcohol are the antidotes of the fungus-poison, and has published cases “by hundreds” in which cures have been thus effected.

He objects to the deductions drawn from the physiological action of poisons on the lower animals being hastily applied to man without further testing them, and refers to some unhappy results of this having been done. He also refers to the diverse action of certain poisons on different orders of animals.

A CASE OF CONGENITAL ABSENCE OF THE KIDNEY WITH HYPERTROPHY OF THE HEART.

The autopsy of a man twenty years of age, who died with symptoms of apoplexy, revealed hyperæmia of the dura mater, and a number of coagula at the base of the brain, particularly on the under surface of the pons and of the left fissure of Sylvius; also, coagulated blood in both lateral ventricles, particularly in the left. The brain substance around the left lateral ventricle was very much degenerated, and that in many places it had almost the consistence of thin gruel. The septum between the ventricles was perforated to the extent of about one and a half centimetres. The vessel from which the blood had been extravasated could not be found.

The left ventricle of the heart was enormously hypertrophied, its wall was two and a half centimetres thick, and the columnæ carneæ were also hypertrophied. The right kidney and infra-renal capsula were entirely absent, and in the place of the right renal artery there was found a rudimentary, solid band of connective tissue, and at the point where the band joined with the aorta, there existed a hard knot of what had the appearance of cicatricial tissue. The left kidney was normal. The hypertrophy of the heart and the extravasation of blood in the brain might be explained in this case by the absence of the kidney, as on this account the liquid was not separated from the blood in as large quantities as it should have been, which circumstance gives rise to an increased fullness and a greater distension of the aorta, and caused an increased amount of work for the heart.

This case seems to strengthen the hypothesis of Traube, that hypertrophy of the heart is a consequence of Bright's disease.—*Rundschau*.

THREE CASES OF PENETRATING WOUNDS OF THE ABDOMEN, WITH PROTRUSION OF THE OMENTUM, are quoted by the same journal from the *Allgemeine Med. Central-Zeitung*, as recovering in Pirogoff's method, the omentum being left in the wound. Blinberg, who reports these cases tells of another in which the omentum was returned, and peritonitis and death resulted.

A CASE OF LYMPHANGITIS SIMULATING SYPHILIS.

At the session of the 6th March of the Medico-Chirurgical society of Edinburgh, Dr. Francis Cadell related the particulars of a case of lymphangitis simulating syphilis. This case drew its principal interest from the great difficulty which was found in determining the syphilitic or non-syphilitic character of this affection. In June, 1875, three weeks after, a suspicious connection the patient, a man of thirty-three years of age, in good general health, felt in his prepuce a small knot the size of a grain of wheat. Five weeks afterward, when Dr. Cadell saw this patient for the first time, there was at the level of the preputial orifice a small knot containing a little pus, but not ulcerated, the lymphatics of the dorsum of penis, and the glands of inguinal region were indurated. About the tenth week a second knot formed in the course of the lymphatic vessels, which were as large as crow-quills. A spontaneous opening caused a free flow of pus, which lasted until the fifth month of the disease, the patient's health, meanwhile, suffering to some extent. No syphilitic manifestation appeared, and now, at the 8th month, the induration has almost disappeared. Cases of this kind, carefully observed, furnish the best means of a scientific study of syphilis, and the diseases which resemble it. If, as Dr. Joseph Bell remarks, this patient had been treated by a physician convinced that mercury can prevent syphilitic symptoms, this physician would have here found an excellent proof of the virtue of medicine; but in this case the patient took no mercury.—(*Paris Medical*, June 1st).

A SIMPLE METHOD OF EXTRACTING FOREIGN BODIES FROM THE ŒSOPHAGUS.

Dr. Edmond Le Bele proposes the following which has enabled him to dislodge, twice from the same person, large bones in the œsophagus:—

A medium sized piece of iron wire is bent and twisted in itself, forming a loop at its lower end. The instrument is curved to suit the bucco-pharyngeal canal, and the looped end is guided by the finger down the posterior wall of the canal. When it meets the foreign body

it is pressed well back, and with a little jerk, is passed behind and below the body, the lower end of which becomes engaged in the loop. The body is then withdrawn by careful traction. The twisted wire occasions less inconvenience and resistance than forceps. (Bull. de la Société de Med. de la Lartho.)

INFECTION WITH VACCINE LYMPH, AND FATAL CONSEQUENCES.

On the 29th of March, 1874, eight dragoons of the Fifth Dragoon Regiment were vaccinated with lymph, procured from a foundling hospital near by. On two of the men the vaccination was not successful. The other six men became ill twenty-four hours afterwards, being seized with a chill, heavy fever, great weakness and delirium, and between the second and fourth day after the vaccination there appeared a phlegmonous inflammation of the arm, in some on one side and in others on both. And after a few days more, gangrene set in. Four of the men died and two recovered completely.

At the same time nine phials of lymph were taken from the same source, the foundling hospital, and used extensively, no bad results following its use. Whether the vaccinations were made with different instruments or not, is not stated.—*Rundschar.*

HYPODERMIC INJECTIONS OF COFFEE AND WHISKEY IN OPIUM POISONING.—Dr. John M. Flood, of Elmira, N. Y., reported the case of a patient who was so profoundly narcotized that, for a time, the respirations were but one per minute, and the pulse forty-two per minute. For the space of four hours the hypodermic syringe was constantly used injecting whiskey and coffee, and several times during the same period, tincture of belladonna was injected in doses of from ten to twenty drops. Success at length rewarded these measures. Probably more than two hundred injections of whiskey and coffee were administered in the space of four hours. — *Proceedings of the Chemung County Medical Society.*—*New York Medical Record*, May 20.

THE CANADIAN

Journal of Medical Science,

A Monthly Journal of British and Foreign Medical Science, Criticism, and News.

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 sending their addresses to the corresponding editor.*

TORONTO, AUGUST, 1876.

INTERNATIONAL MEDICAL CONGRESS.

PHILADELPHIA, SEPTEMBER 4-9, 1876.

The International Medical Congress will be formally opened at noon, on Monday, the fourth day of September.

The sessions of the Congress and of its Sections will be held in the University of Pennsylvania, Locust and Thirty-fourth Streets.

The General Meetings will be held daily, from 10 to 1 o'clock. The Sections will meet at 2 o'clock.

Luncheon for members of the Congress will be served daily in the University building from 1 to 2 o'clock.

On Wednesday evening, September 6th, Dr. J. J. Woodward, U. S. A., will address the Congress on the Scientific Work of the Surgeon-General's Bureau.

The Public Dinner of the Congress will be given on Thursday evening, September 7th, at 7 o'clock.

The Registration book will be open daily from Thursday, August 31st, to Saturday, September 2nd, inclusive, from 12 to 3 p.m., in the Hall of the College of Physicians, N. E. corner of Thirteenth and Locust Street, and at the University of Pennsylvania on Monday, September 4th, from 9 to 12 M., and daily thereafter from 9 to 10 A.M. Credentials must in every case be presented.

Letters addressed to the Members of the Congress, to the care of the College of Physicians, N. E. corner Locust and Thirteenth Streets, Philadelphia, during the week of meet-

ing will be delivered at the University of Pennsylvania.

The Secretaries of State and Territorial Medical Societies are requested to forward without delay to the Chairman of the Committee on Credentials, I. Minis Hays, M.D., 1607 Locust St., Philadelphia, lists of their duly accredited delegates to the Congress.

Delegates and visitors intending to attend the Congress are earnestly requested individually to notify immediately the same Committee.

This information is desired to facilitate registration, and to ensure proper accommodation for the Congress.

Members intending to participate in the Public (subscription) Dinner of the Congress will please notify the Secretary of the Committee on Entertainment, J. Ewing Mears, M.D., 1429 Walnut St., Philadelphia.

Gentlemen intending to make communications upon scientific subjects, or to participate in any of the debates, will please notify the Commission before the fifteenth of August.

UNIVERSITY OF TORONTO.—EXAMINERS IN THE FACULTY OF MEDICINE FOR 1877.—Physiology and Comparative Anatomy, C. Y. Moore, M.B.; Surgery and Anatomy, W. J. Wagner, M.B.; Medicine and Therapeutics, A. Beith, M.B.; Midwifery and Medical Jurisprudence, W. Forrest, B.A., M.D. *Medicine and Arts*.—Chemistry, R. A. Reeve, B.A., M.D.; Natural History, Prof. R. Ramsay Wright, M.A., B.Sc.

THE CANADIAN MEDICAL MUTUAL Benefit Association has elected the following officers for the ensuing year:—President, Dr. Hodder; Vice-Presidents, Dr. Canniff, Dr. Jas. H. Richardson; Sec.-Treas. Dr. Bridgman; Directors—Drs. Winstanley, Pyne, Agnew, Rosebrugh, De La Hooke, and Oldwright, of Toronto; Dr. Jukes, St. Catharines; Dr. Lander, London; and Dr. Henderson, Ottawa.

CANADA MEDICAL SURGICAL JOURNAL.—Our Montreal contemporary has come out in a new dress. The leaves being cut is a great improvement, and the addition of a department of translations from foreign journals will be valued by all who interest themselves in the advance of medical science.

Communications.

To the Editor of the CANADIAN JOURNAL OF MEDICAL SCIENCE.

HINTS ON THE USE OF ATROPINE.

BY R. A. REEVE, M.D.

Surgeon to Toronto Eye and Ear Infirmary, Ophthalmic Surgeon to Toronto General Hospital, &c.

As atropine is invaluable in ophthalmic practice, and, indeed, should be used much more largely than it is, it is highly desirable that its poisonous nature should not prevent its faithful application whenever indicated. Those who apply it constantly and in a great variety of cases, see its toxic effects so seldom, that it were a great pity to allow one instance of such, or even the occasional occurrence, to have undue weight. Every ophthalmic surgeon is compelled to put it into the hands of nurses and attendants, many of whom are ignorant or heedless. The rarity of misadventure, therefore, attests the immunity of patients when the drug is properly prescribed, but offers no palliation for its careless use.

These remarks have been prompted by the record of "*Atropia poisoning from the application of a solution to the Eye*," by Dr. Nettleship, (*Brit. Med. Journal*, April 8, 1876).

A woman, æt 44, had a mild attack of iritis in one eye, and sol. Atropiæ sulph. grs. iv. ad. \mathfrak{z} was ordered Jan. 29, to be used several times a day. "This was repeated at her next visit, Feb. 2nd. She then did not come again till the 12th, when she excused her absence by saying that she had been ill with a bad 'bilious attack.' On further inquiry it transpired that the chief symptoms of this 'bilious attack' had been dryness of the mouth and throat, a sour taste in the mouth, dryness and burning in the stomach, repeated vomiting, and partial delirium. These symptoms had not entirely passed off, and she still had the dryness of the mouth, and sense of burning at the stomach. The drops had lasted since the former visit, she had been using them all the time, and the pupil of the inflamed eye had become widely dilated. There was no dilatation of the other pupil. The atropine was discontinued, and her disagreeable symptoms subsided in a few days."

We make no comments on this particular case, but venture to affirm that it were infir-

itely better for a few amongst the legion with iritis to have such a 'bilious attack,' and come out of it with a 'widely dilated pupil,' than to suffer the irreparable mischief that often ensues from closed pupil or adherent iris, owing to the non-use or inefficient application of a mydriatic. Too frequently in iritis a gr. $\frac{1}{4}$ or gr. $\frac{1}{2}$ ad. $\zeta j.$ solution is ordered once or twice a day, with little or no effect; instead of a 4 gr. sol., after the maxim, "get the pupil fully dilated and keep it so," even if the drops require to be used every hour for the first day or two.

There are some precautions that should be observed in prescribing atropine. "*Poison*" should be conspicuous on the label—fortunately druggists are now compelled to observe this point. Precise directions should be given how to apply the solution, and at what intervals. In adults, one drop at a time generally suffices, and the solution should be dropped into the conjunctival sac near the outer canthus. In cases of copious lachrymation, as in the strumous ophthalmia of children, two or three drops are necessary, because the strength is almost instantly reduced by the tears. The most thorough and merciful method of making the application (without anæsthetic) in infants and young children who resist, is to compress the head between one's knees as in a vice, the nurse having the patient on her lap and holding the hands. The eyelids can then be separated, or the upper lid drawn back with a small duck-bill speculum, or with the index finger, the end of which is placed against the free border so as to avoid everting the lid. The tears should then be wiped away or soaked up before putting in the drops. Again, it is much better to order the applications "every 2, 4, or 6 hours," *e.g.*, than to put the indefinite "three or four times a day." The *sulphate* of atropia should be used as it is very soluble, neutral, and unirritating, while the alkalioid is quite insoluble in water, and requires the addition of acid, spirits, &c., for solution.

To avoid danger and alarm, those concerned should be told the initial symptoms of poisoning by atropine, and how to act if they develop; and also its power of dilating the pupil, and, in strong solutions, of paralysing the accommodation; even through the medium of a soiled finger or handkerchief. The unpleasant dryness of

the throat caused by repeated instillations of strong solutions, 2 or 4 gr. ad. $\zeta j.$, can be easily relieved by an occasional sip of an aqueous solution of glycerine, or of gum arabic with sugar, &c. The progress of cases under atropine treatment should be carefully watched, and patients requested to report at short intervals. Atropine is a very costly as well as poisonous drug, and economy, efficiency, and safety are gained by using some form of drop-tube, and prescribing but a small quantity of the solution at once, as decomposition readily occurs, and irritation is produced. In lieu of drop-tubes specially made, one can easily attach an artificial rubber teat to the end of a short piece of narrow glass tubing, first sealing the few tiny holes by lightly touching their edges with the point of a heated probe or wire. A quill, barrel-pen, brush, &c., are also made to do duty. To secure dilatation for ordinary ophthalmoscopic examinations it is unnecessary and improper to use a strong solution, which will keep the pupil dilated, and accommodation paralysed for days; gr. $\frac{1}{8}$ or $\frac{1}{4}$ ad. $\zeta j.$ suffices (2 or 4 drops of 4 gr. sol. ad. $\zeta j.$ aq.), and the pupil contracts in a few hours.

To the Editor of the Canadian Journal of Medical Science.

CASE OF RECURRENT APOPLEXY.

BY WILLIAM OLDRIGHT, M.A., M.D.

SIR,—Believing that the following will be of interest on account of the obscurity of the case at the outset, its melancholy clearing up at the end, and the post-mortem confirmation, I send it for publication.

I was called to see Mr. Pearly on Sunday morning. I found my friend, Dr. Bridgman, who had been summoned at the same time, already there. The symptoms, as described by the friends were epileptiform, but the pulse was very slow, and *rather* full. During the day the patient's condition improved, and I had good hope that he would recover.

On the following morning he was not quite so well, temperature high, face somewhat flushed, pulse about 125, and a good deal of headache, especially in front part of head; would readily answer questions and converse, but appeared dull. On visiting him again, about 6 p.m., I was told that I had been sent for about

4:30, at which time he suddenly began to grow much worse, falling gradually into a state of *coma*. I remained with him, and the *coma* became rapidly more profound during the first twenty minutes of my stay; the face became purple, the veins of the head intensely engorged and the breathing stertorius. I took about a pint of blood from the arm, but he died in about half an hour after my arrival.

I had feared on the first day that the case might be one of those cases of apoplexy which Watson so well describes, where slight extravasation takes place, but is stopped by the clot plugging the bleeding orifice of the blood vessel, and in which the bleeding often recurs with fatal result.

The autopsy showed this to be the case; the left lateral ventricle was distended by a clot which, I think, would weigh two and a half ounces. The greater portion of it was soft, but imbedded in it at its anterior and inferior surface was a firmer clot about the size of a nutmeg which was difficult to break with the fingers, and which cut firmly with the knife. This was evidently the explanation of the slow, full pulse, and other phenomena of the first morning. The exact number of beats I cannot now remember, the case having occurred about three months ago, but it was not much over forty.

TRAUMATIC EVISCERATION AND RECOVERY.—

The *Gaz. Med. Ital.* quotes from the *Montpetra Med.* a remarkable case. A young girl, aged 12, fell on a large bottle and caused a wound through the abdominal parieties and omentum. Part of the small intestine transverse colon and greater curvature of the stomach protruded. They were returned, but again and again forced out by vomiting. Injections of morphia were given, the wound stitched up, and pressure maintained. The colon had to be punctured in several places to relieve it of gas before it was returned. The wound healed in a fortnight.

The students of Paris are endeavouring to form a Scientific Association, found a library, &c. (*Paris Med.*)

Hospital Reports.

LONDON HOSPITAL.—SEPARATION OF EPIPHYSIS OF ANTERIOR INFERIOR SPINOUS PROCESS OF ILIUM BY MUSCULAR ACTION.

(Under the care of Mr. Maunder.)

For the following notes we are indebted to Mr. H. Habgood, house-surgeon.

William G—, aged eighteen, was admitted into the hospital on April the 5th. He stated that on the previous day, while running in a flat-race, he thought it necessary to "put on a spurt," and whilst doing so suddenly felt a sharp snap, followed by acute pain in the right groin, and accompanied by a sensation of "something being out of its place." He also found he could not advance his right foot another step, but being within a few feet of the winning-post he threw himself forwards, and, grasping it, saved himself from falling. He then found it impossible to stand upright without great pain in the right groin, which was somewhat relieved by resuming the stooping posture. He was carried off the field by his companions.

On admission the patient was found to be a strong, healthy-looking lad, with well-formed limbs, and exhibiting no evidence of bone or other disease. There was no history of syphilis, strumous disease, or rickets; and he had ten brothers and sisters who were all healthy. He was observed to lie flat on his back with the thighs extended and the right foot slightly averted. He could rotate the right thigh inwards or outwards, but with slight pain. There was total inability to flex the thigh upon the pelvis, and the attempt to do so caused great pain in the groin. A little fullness was evident in the position of the spinous processes, and the inferior spinous process (the attachment of the straight tendon of the rectus femoris muscle) was found to be detached and freely movable. Cartilaginous crepitus was very distinctly felt, both by the patient and the surgeon. This, and taking into consideration the patient's age—eighteen (the epiphysis unites with the rest of the bone at about the age of twenty-five)—led to the conclusion that it was a case of separation of the epiphysis. The patient was simply kept in bed, the thigh flexed in order to relax

the rectus femoris muscle, and a couple of pillows were placed under the knees.

April 21st.—All pain and crepitus on manipulation had disappeared, and patient could flex the thigh without discomfort.

April 25th.—Firm union had evidently taken place, and patient could walk about the wards with ease. Discharged.

The above case is very interesting on account of its extreme rarity.—*Lancet*.

ST. THOMAS'S HOSPITAL.—CONGENITAL CLEFT PALATE TREATED BY THE APPLICATION OF STRONG NITRIC ACID, AND WITHOUT OPERATION.

(Under the care of Mr. Francis Mason.)

Mr. Mason has at the present time under observation at this hospital several interesting cases of congenital cleft palate, which he is treating by the application of strong nitric acid alone, and consequently without the use of the knife. The ages of the patients vary from a few weeks to several years. Mr. Mason thinks that this method of affecting union is especially applicable to cases in which the cleft is of average extent, and even where the hard palate is partially implicated. In more severe instances the ordinary operation may be required. Mr. Mason finds that the application of the acid is attended with no pain or inconvenience whatever to the patient, and although the cure is more slowly accomplished, it has the advantage of being sure, and of completely closing the fissure in the most perfect manner, without the risk of the parts giving way, either wholly or partially, as too often happens after the usual operation of staphyloraphy. A further gain seems to be that the cases may be dealt with as out-patients, as in all the examples now under notice. Mr. Mason, after many trials, prefers the strong nitric acid to any other form of caustic. We shall continue to watch the progress of these cases, and give the results on a future occasion.—*Lancet*.

Subjects were so scarce last session in Edinburgh that twenty dissectors were allotted to each body, instead of ten as formerly.

Meetings of Medical Societies.

HALDIMAND MEDICAL ASSOCIATION, ANNUAL MEETING.

The annual meeting of the Haldimand Medical Association, was held in the Town Hall, Caledonia, on Monday, the 17th of July, when the following members were present:—Dr. McCargow, Caledonia, President; Dr. Davis, York, President; Dr. Hillyer, Caledonia, Secretary; Dr. Bethune, M. M. C., Mount Hope; Dr. Baxter, M.P.P., Cayuga; Dr. Dee, Tuscarora; Dr. Harrison, Selkirk; Dr. Jones, Hagersville; Dr. Dillaburgh, Caledonia; and Dr. Burnburg; Dr. Henwood, of Brantford, M.M.C., for the Territorial Division, was also present, by special invitation.

The minutes of the preceding meeting having been read, and certain accounts presented and ordered to be paid, the Association proceeded to the election of officers, when it was—

Moved by Dr. Bethune, seconded by Dr. Baxter, That all the officers of last year be re-elected.—Carried.

Several members having expressed their pleasure at seeing the representative of the Territorial Division, Dr. Henwood, present, it was—

Moved by Dr. Davis, seconded by Dr. Bethune, That this Association has much pleasure in admitting Dr. Henwood as an honorary member, and that the Secretary record his name on the roll as such.—Carried.

Dr. Henwood acknowledged the compliment in a few well-timed remarks, and took the opportunity of thanking the members for their unanimous support of his candidature at the last Territorial Division election.

The following resolutions were then introduced, and elicited an animated discussion, in which Drs. Henwood, Bethune, Baxter, Davis, and others, took an eloquent part.

Resolved, That this Association considers that it would be to the interest of the profession and of the general public if the number of the representatives in the Medical Council were increased, and that with this object it would be desirable to have the Medical Act so amended as to enable each Territorial Division to return two members instead of one as heretofore.

Dr. Henwood in a very eloquent, forcible, and logical speech, laid before the Association the advantages and dis-advantages which might accrue from an increased representation, and concluded, upon the whole, that such a measure would be premature and impracticable at the present, the financial condition of the College not justifying the increased expenditure incident thereto.

Drs. Bethune, Baxter, and Davis, also expressing similar views, it was laid over for further consideration.

Resolved, That this Association views with sorrow and amazement the attempts of a certain influential journal to discourage the efforts of the profession to elevate the standard of medical education and to protect the public from the ignorance and rapacity of charlatanry, and desires to record its unqualified denunciation of such an unpatriotic course.

Several members spoke to this resolution, and generally expressed the view that altogether too much importance had been attached to the utterances of the sheet in question. That, already puffed up with an inordinate conceit of its powers, it was administering to a morbid vanity for medical men to notice publicly diatribes whose vulgar insolence was only equalled by their impotence. It was then voted to be laid upon the table.

Moved by Dr. Davis, seconded by Dr. Harrison, *Resolved*, That as the Medical Profession of Ontario has no proper place for the meeting of its representatives, the Medical Council, that the Member for Haldimand, Dr. Baxter, be requested to bring before the Legislative Assembly the propriety and justice of assisting the profession in purchasing a suitable building for its meetings and examinations, which may hereafter be known as the College of Physicians and Surgeons of Ontario.—Carried.

The tariff for the Council, as revised by the Committee appointed at the last annual meeting, having been brought forward and thoroughly discussed, it was—

Moved by Dr. Davis, seconded by Dr. Bethune, *Resolved*, That the Secretary be authorized to communicate with the President and Directors of the various Life Associations doing business in this region, that the members

of the Haldimand Medical Association desire to express their opinion that the fee for examination of applicants for life assurance should be five dollars in all cases; the work of examination and writing being identical.—Carried.

At this period of the proceedings Dr. Jones, of Hagersville, preferred a charge of unprofessional conduct against a medical man resident in the same village, Dr. Dumble, who, it seems, had visited a patient of his suffering from a fracture of the femur, in his absence, and having taken off the bandage and splints, went through the process of re-setting when there was no displacement, re-adjusting his splints and re-bandaging the limb, with no other apparent object but to bring discredit upon his brother practitioner.

It was the unanimous opinion of the meeting that Dr. Dumble had been guilty of a gross breach of professional etiquette, and ungentlemanly conduct, but as he was not a member of the Association it had no power to deal with the case.

After the discussion of some other questions of general importance and partaking of a bounteous repast, served in his best style by mine host of the Diamond Hotel, it was—

Moved by Dr. Dee, seconded by Dr. Bethune, That this Association do now adjourn *sine die*.

P. S. HILLYER, M.D.,

Honorary Secretary.

CHROMIC ACID FOR WARTS.—Three or four applications of this acid will cause the disappearance of warts, however large, hard or dense they may be. The application gives rise to neither pain, suppuration nor cicatrices, the sole inconvenience being the production of a dark brown color.—*Union Med.—Med. Times and Gazette.*

All the colleges in the Province of Nova Scotia, except Acadia, the Baptist institution, have agreed to affiliate with the new University of Halifax created by the Act of last session of the Local Legislature. Each of the colleges affiliating will nominate two members for the Senate of the University, and their students will go up for examination to the new institution.

Miscellaneous.

THE Medical Profession of Toronto have decided to invite the Canadian Medical Association to an excursion to Couchiching.

COMPLIMENTARY SUPPER TO DR. BULL.—Dr. Bull, of Weston, was entertained by a large number of gentlemen from Toronto, Weston and its surroundings, and South York, generally, on the occasion of his leaving Weston for European travel.

ORILLIA ASYLUM.—Dr. Wallace, of Spencer-ville has been appointed medical superintendent of the Orillia Asylum for the Insane. The idiots at present inmates of the various Asylums in Ontario, will now be removed to Orillia, and be replaced by a large number of lunatics at present committed to the Provincial gaols.

NEW MEDICAL JOURNALS.—The *Archives of Clinical Surgery*, published in New York, and edited by Dr. Bermingham, is a valuable addition to our periodical literature. It promises to deal with surgery in all its special branches, and advertises a list of influential and able contributors. *The Ohio Medical and Surgical Recorder* is the title of a new monthly published in Columbus, U.S. We wish the new journals every encouragement.

TOOTHACHE REMEDY Mr. C. A. Guild writes to the *Clinic*: "I have found collodion mixed with enough carbolic acid to form a jelly-like mass to be an excellent remedy for toothache. About equal parts will form a 'stiff' jelly, which may be taken on the end of a pine stick and placed in the cavity of the aching tooth. The pain will be relieved almost instantly if it depends on an exposed nerve. I have found this the most reliable and convenient remedy I ever tried."

In a paper read at the Madrid Academy of Medicine, Dr. St. Martin, having examined into the condition of 551 infants resulting from 149 consanguineous marriages, comes to the

conclusion that the belief which prevails of the danger of such marriages rests upon a very slender foundation. In support of this opinion the "Independencia Medica" states that at the Deaf and Dumb School at Barcelona there have been admitted 253 children during 31 years, and of these only 15 were the issue of consanguineous parents.

THE CONVENTION OF THE MEDICAL COLLEGES OF THE UNITED STATES was held on June 2nd and 3rd last, at which the following resolutions in regard to beneficiary scholarships were unanimously adopted:—*Whereas*, The practice of reducing or remitting in individual cases the established fees of a college has the objectionable feature of discriminating between students who may be equally deserving, and opening the door to possible gross abuses; therefore, *Resolved*, That this convention regards the above privilege as one to be deprecated in general, and if put into practice at all, to be exercised both rarely and reluctantly, and only in unusual circumstances, and after unsolicited application by proven deserving candidates. *Resolved*, That anything like a wholesale system of such reduction or remission of established fees, or *any open solicitation of recipients of such favors*, be regarded as in the highest degree improper, and that any college indulging in such practices deserves to forfeit its place on the *ad eundem* list of medical colleges.—Those who may be looking forward to have tickets or degrees recognized in other colleges would do well to keep this in mind.—*Louisville Medical News*.

COLOUR CURE FOR INSANITY.—The theory that colours exert an influence on brain diseases is being practically tested in Italy, with most extraordinary results. A certain Dr. Ponza gives an account of some successful experiments recently tried upon lunatics at an asylum for the insane at Alessandria, Italy. The following instances were cited as illustrations of the treatment and its effects:—"A taciturn and melancholy lunatic, who rarely ate of his own accord, was made to lie down in a room with red glass windows and the walls painted red.

In three hours he was lively and gay and asked for food. Another patient was accustomed to pass the day with his hands contracted over his mouth, to keep out poisoned air. He lay down for a time in the same red room. The following day he ate heartily, and from that time forth was cured. A violent maniac, for whom a strait jacket was necessary, was kept in a room with blue glass and walls; in an hour he was much calmer. Another mad person was cured by being kept in a violet room. Dr. Ponza considers that the treatment might be applied in various cases of nerve-disease, such as chorea, hysteria, epilepsy, &c.; and he thinks the violet colour adapted to give the best results. It is known to have a very marked influence on animals and plants; the former fatten rapidly in violet light; and plants, under a cover of violet glass, grow with an unwonted vigour. Following P. Seechis' advice, Dr. Ponza constructs his coloured chambers with an eastern or southern exposure." These reports seem incredible, yet there is probably a foundation for them in the soothing influence on the brain and nervous system of subdued colours and softened lights.

DEATH OF STROMEYER, OF HANOVER.—It is with much regret we record the sudden death of Stromeier. On the morning of June 15 he rose in his usual health, and at ten was dead from apoplexy after a few minutes' illness. He died in harness, being actively occupied in his profession till the last. We do not at present propose reviewing Stromeier's scientific life. Two years since, Stromeier published, under the title of "Recollections of a German Surgeon," his autobiography. It created much interest and some controversy in Germany, yet appears to be unknown here. From beginning to end this book reads like a novel: is full of interesting details of places and men, the Danish wars, the overthrow of the King of Hanover, the last great war. Besides the details given concerning the teachers under whom Stromeier himself studied in various German universities and in London, his own experiences as a professor are vividly set forth. Only in April last Stromeier had all possible honours

heaped upon him; and not the least, one may be sure, in his estimation was that offered to him by his English colleagues. The bust that it was decided to obtain is nearly ready, and is stated to be an excellent one. The Committee of the Stromeier Testimonial purpose shortly issuing a final circular reporting their proceedings to the subscribers, and with this they promise to send an admirable photograph of Stromeier, especially taken for the purpose. The first copy of this photograph, which is a splendid likeness, came to Mr. Mac Cormac from Miss Stromeier, with the announcement of her father's sudden death, and stating that the last words he wrote were upon the back of the photograph. They were so admirable in their simplicity, so characteristic in their modesty, and under the circumstance so pathetic that we gladly accept Mr. Mac Cormac's permission to publish them:

'MY DEAR MAC CORMAC,—

You wished to see my photograph
Adorned with crosses and with stars,
The gift of emperors and kings.
It fades away; a marble bust
Will take its place in memory.
Shining in its simplicity.
There is no room for vanity
Amongst your peers of surgery.

Hanover, June, 1876, Marion Strasse, 8."

—*London Lancet.*

Births, Marriages, and Deaths.

BIRTHS.

At Peterboro', on the 13th inst., the wife of Dr. C. Burritt, of a daughter.

MARRIAGES.

On Tuesday, July 11th, at the residence of the bride's father, by the Rev. J. McAlpine, Johnclair, M.D., St. Mary's, to Elizabeth, eldest daughter of W. Dale, Esq., Blanshard.

At the residence of the bride's father, on the instant, by the Rev. Alexander Topp, D.D., of K church, Henry McLaren, to Sarah, third daughter of Dr. A. A. Riddel, Toronto.

At St. James' church, Kingston, on July 11th, the Rev. F. W. Kirkpatrick, M.A., incumbent, Douglas Glass, Manager of the Bank of Montreal, N.B., to Barbara, youngest daughter of Dr. Barker, Kingston.

DEATHS.

At Newcastle, on the 29th June, David Galbraith, F.R.C.S., Edinburgh; aged 67 years.