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I. H. CAMERON, M.B.,
R. B. NEVITT, B.A., M.D., }

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NOTES ON THERAPEUTICS.

BY R. L. MACDONNELL, M.D.

(Asst. Demonstrator of Anatomy, McGill University, Montreal.)

The Treatment of the Venereal Diseases.—

The *Edinburgh Medical Journal* for November last contains a most readable and instructive article by Mr. A. G. Miller, entitled "Four and a Half Years' Experience in the Sick Wards of the Edinburgh Royal Infirmary." It is the introductory lecture to the course of surgery at Surgeon's Hall, Edinburgh. His remarks on the nature and treatment of the above-named diseases refer entirely to those of females, no males being admitted to Lock Wards at the Infirmary.

Gonorrhœa in the Female.—Dirt is very frequently both a cause and an aggravation of disease in the class of women who come under his care. Cleanliness, therefore, is the first point of treatment. The second item is rest in bed. Lastly, injections were employed. A pint or two of lukewarm water with sufficient Condy's fluid to make it a bright purple to be injected daily with Higginson's long tube. If the discharge was not greatly reduced in a few days, a solution of the sulphate of copper (gr. x to the ʒ) is then ordered for two or three days, but not longer. When the discharge is considerably reduced plain cold water or very weak Condy's fluid is to be used.

Gonorrhœal Warts.—The remedies most useful in keeping down warts are acetic acid and pyrogallic acid painted on, and calomel

or best of all, the desiccated sulphate of iron, dusted on. As they depend on moisture and warmth the best way to keep them down is to see that they are dry, and this is most thoroughly effected by the sulphate of iron powder. When the warts are pedunculated they can easily be removed by ligature or scissors.

Chancroids.—Dust with iodoform and keep dry, and they will heal in a few days. The action of iodoform on phagedœnic sores is more remarkable than on ordinary chancroids. To dust iodoform the crystals should be powdered very fine and applied with an insufflator. This should consist of a tube to which is attached a small rubber ball, pressure on which blows out the powder from the nozzle of the tube.

Buboes.—Mr. Miller objects to incisions made early. He thinks that when a bubo is opened early it does not heal quickly, and sinuses are apt to form.

Should suppuration be inevitable he incises it freely from end to end, squeezes out the pus and sloughing texture, and then fills the cavity with iodoform.

A healthy action is induced in a day or two, and the sore heals in a week or ten days.

Syphilis.—The dual theory is maintained by Mr. Miller, and syphilis is regarded as a fever. An evening temperature of 103° has been recorded at the outset of the secondary symptoms.

Condylomata owe their existence to the presence of moisture and warmth. They

grow, therefore, mostly on the genitals in the female, but they are also found in the groin, on the inside of the thigh, round the anus, under the mamma, in the axilla, between the toes, and occasionally on the back of the neck, under the roots of the hair. Dusting with calomel, and the interposition of a piece of dry lint between the labia. The calomel has no specific action being insoluble; but it adheres readily to moist surfaces and, being heavy, it flies in a fine cloud from the dusting instrument. A wonderfully small quantity suffices. Of course the patient must wash and dry herself thoroughly before the dusting, and again before night.

Mr. Miller has frequently demonstrated to the students that a single week of calomel dusting without any internal or other treatment whatever has made a great difference in even the worst cases. Sometimes hardened bases remain, which disappear under the application of sulphate of copper.

Mr. Miller found not uncommonly a syphilitic lupoid ulceration affecting the face and closely resembling lupus exedens. In one of his cases there was seen an ulcerated surface about an inch and a half in width occupying the position of the nose, which had been almost entirely destroyed. The sore healed under twenty grain doses of iodide of potash. I have met with two such cases in the practice of the Montreal Dispensary. The one is already reported.* The other, that of a very old woman, Mrs. C., came to me last summer, telling me that she had lupus. There was an ulcerated surface on one ala of the nose extending to the other side like a saddle. Under the use of iodide of potash it cicatrized though very slowly.

Mr. Miller then makes some remarks upon the actions of certain remedies as observed in the wards.

Mercury.—His faith in mercury has not always been equally strong; but it has always existed. At one time half the

patients were treated with, the other half without, mercury. Now and then, a patient had to be shifted to the mercurial side, because she was not getting on so well as the others. And again, the non-mercurial patients who went out of hospital apparently cured came back very soon afterwards. They were then treated with mercury. Lastly, this arbitrary division was given up, and cases were treated on their own merits.

Bichloride of mercury in $\frac{1}{32}$ — $\frac{1}{16}$ gr. doses was used. It is a pure form of the drug, and being unmixed with iodine it enables the observer to form a just estimate of its effects. Mercury has been given to almost all patients in the earlier stages of syphilis. It promotes the disappearance of eruptions, and it is useful occasionally in late syphilis in combination with potassium iodide. The former seems to assist the action of the latter.

Mr. Miller is of opinion, and most thinking and reading men will agree with him, that syphilis cannot be what it used to be. Some marvellous change has come over either the constitutions of this generation or over the disease. It is certain that the French malady of Shakespere's time bears merely a generic resemblance to that of to-day, just as the lion resembles the cat, and even within the recollection of living men the symptoms have greatly abated in severity. Mr. Miller thinks phagedœna is rare. It was seldom seen. It is certainly a rare disease in America. Most of us will agree with Dr. Keyes, who says, in his work upon the venereal diseases:

“It is a less serious matter to have syphilis than that one's father should have died of consumption or of cancer. Bad malaria or dyspepsia, or rheumatism or eczema or psoriasis or a number of other maladies are infinitely worse than ordinary syphilis, far harder to manage and more likely to relapse. The danger and severity of common syphilis is much overrated by the profession, as well as by the public.

* *Canada Medical and Surgical Journal*, vol. x., p. 596.

Bad syphilis is undoubtedly a horrible disease; but there is little bad syphilis in the community, compared with the total number diseased."

Salicylate of Soda In Acute Orchitis.—

Dr. Henderson, while in charge of the Shanghai General Hospital,* made trial of this agent in the treatment of acute orchitis caused by gonorrhoea. His results in the three cases in which he used it were extremely satisfactory. Case 1. The patient had had gonorrhoea for three weeks, and the testicle had been swollen and painful during the last week. On admission at 10 a.m. the temperature was 102°. The left testicle was about four times larger than the right, and the scrotum covering it was red, being stretched and glossy in front and somewhat oedematous below. Twenty grains of salicylate of soda to be given hourly until the pain should be relieved. At 4.30 p.m. four doses had been taken—namely at 11.10, 12.10, 1.10 and 4. He had sweated profusely, and the pain had greatly diminished. At 8 p.m. his temperature had fallen to 100°, and the medicine was ordered to be continued at intervals of four or six hours. On the following morning the temperature was 98.4°, and he felt easy when lying down. Three days after admission the pain had altogether left him, and the urethral discharge which had ceased upon the supervention of the orchitis returned. No relapse.

Case 2. This was more severe than the last. After six doses of twenty grains the pain was greatly relieved. It began to diminish in intensity after the first dose, when he began to perspire. On the next morning after admission he was quite easy when lying down, and could bear handling of the testicle with ease.

Case 3. The orchitis had gradually become worse, and the patient was found with a temperature of 101°; pulse 90: tongue clean and dry. Had passed a sleepless

night. No other treatment, local or general, than the administration of twenty grains of salicylate of soda, every two hours, was adopted. Five doses were taken. After the second dose, he had some ringing in the ears, and began to perspire. After the third dose, the sweating was profuse. At 4.30 p.m., after the fifth dose, the pain was relieved. On the following morning, his temperature was 99.4; pulse 88. He had taken two doses of the medicine during the night. He had slept well, and now complained only of slight pain confined to the upper part of the testicle.

Dr. Henderson advises that only acute cases be selected, the evidence of that condition being a distinct rise of temperature, as ascertained by the thermometer. The dose should not be less than twenty grains, and should be repeated hourly until at least three doses are taken; afterwards the same dose may be continued at longer intervals.

In Acute Tonsillitis. In the *British Medical Journal*, Dr. Edward McKay calls attention to the value of this drug in acute tonsillitis. Given in ten-grain doses every two or four hours, it lessened the pyrexia, and afforded relief at once to the pain. One, a surgeon, himself a sufferer, notes marked relief within twenty minutes. His treatment is by no means new. Dr. McKay cites his cases merely as evidence in favour of the use of the remedy. Hormazdi recommends 20-grain doses; and having noted relief in 57 cases of tonsillitis caused by cold and damp, concludes that such cases give the best results, and that when the malady arises from bad air or drainage, it is less amenable. Dr. McKay finds it useful in all cases.

As a Local Application in Gout. The same writer, in the same journal, cites three cases of gout in which great relief was afforded. But he has not given the salt alone. His lotion is composed of two drachms of salicylate of soda, and one or two drachms of laudanum, in eight ounces

* *Lancet*, 1832, vol. ii., p. 1027.

of water. This is applied warm on the lint, and of course the pain is eased. Did he try it without the laudanum? Most practitioners have had satisfactory results with this lotion without any salicylate of soda at all.

The Treatment of Delirium Tremens.—The great object in treatment is to supply the system with nourishment. This is the text of an article in the January number of the PRACTITIONER, by Dr. F. P. Atkinson. Death in alcoholism depends upon loss of sleep, but that depends in its turn upon want of food. The most important part of the treatment is to improve the quality of the blood as quickly as possible, by throwing into the system frequent supplies of light, nourishing, and easily digestible food. Dr. Atkinson suggests half a tin of Brand's liquid essence of beef and half a pint of milk, to be taken alternately every two hours. The beef essence is to be obtained at any leading chemist's. It is remarkably easily taken, and very palatable. The expense of it is its only drawback. The milk might be rendered much more pleasant to take by the addition of iced soda water.

The first dose of twenty-five grains of chloral, with thirty minims of compound tincture of cardamoms does not usually produce much effect, inasmuch as the brain is without the nourishment it requires; but after the second dose the food begins to tell, and sleep generally results. After ten or twelve hours' sleep has been obtained, the chloral may be stopped, and a mixture of five minims of the tincture of nux vomica with thirty minims of the compound tincture of gentian, may be given with it. This restores the tone of the nervous system and stomach, and creates an appetite. A little tincture of euonymin may next be substituted for the nux vomica, and some Carlsbad salt may be given in the morning when required.

Dr. Atkinson is glad to think that the homœopathic, or the "hair-of-the-dog-that-

bit-you" plan of treatment, is well nigh exploded. A body is saturated with a poison, and to obviate the effects of that poison we give more of it.

Apomorphia in Cases of Poisoning.—The alkaloid should be kept in a solution of 1 in 50 strength, and be given subcutaneously in doses of from $3\frac{1}{2}$ to 10 minims (1/15—1/5 grain). Emesis occurs in from two to five minutes, the contents of the stomach being usually voided in one rush without previous nausea, but with violent and visible muscular action of the stomach walls.

Dr. A. Routh* injected five minims of the above solution in a case of poisoning by oxalic acid. Emesis occurred in $2\frac{1}{2}$ minutes by the watch. The case did not recover. A lady had swallowed two bottles and a half of brandy. Shortly afterwards she became comatose, respiration stertorous and infrequent, pupils dilated and insensible, jaws clenched, pulse slow, and intermitting two or three beats in every eight. Three drops and a half of the solution were injected, and in exactly three minutes and a half, about a pint of alcoholic liquid was expelled, and altogether, in about five minutes, a quart (measured) of hardly altered brandy was vomited. The pulse and respiration now improved, the pupils becoming slightly sensible. After twelve hours' sleep she awoke none the worse.

The advantages of apomorphia are its celerity of action and that it can be given under the skin. It fails to cause vomiting in chloroform narcosis, but no other drug seems to be antagonistic to it, and there is no reason why it should not be used to get rid of even morphia itself.

The editor of the *Lancet*, in his review of the *Annus Medicus*, 1882, alludes to the introduction of apomorphia as one of the events of the year, and calls attention to the remarkable cases above cited. Apomorphia is mentioned in few of the *medica* books even of the last year. Far-

quharson merely mentions it, giving the emetic dose at 1/15 grain hypodermically. It has been in use for several years. I was surprised at the time to find that the 1879 edition of Ringer's Therapeutics did not mention it.

A CASE OF HIP DISEASE, WITH REMARKS.

WM. GANNIFF, M.D., M.R.C.S., ENG.

Eveline B——, aged 11, first came under my care on the 19th April, 1882. The following history of her ailment is derived from the patient's parent and the little patient herself :—

The child was always very active and full of life. When about six years of age, while at the sea-side in England, she, when running, met with a fall. She came to the ground with the left leg extended in an unnatural manner, and was unable to rise or walk. She was carried to her room, and for a day or two was lame, and then seemed to be all right. About a year later she was struck by a playmate with a poker. From the description given of the place, it is likely that the seat of injury was over some portion of the crest of the ileum of the left side. However, the blow was not followed by any immediate trouble. This occurred in the month of November, 1877. At the beginning of January following she was siezed with attacks of violent pain in the left groin. They came on with remarkable regularity twice a day, lasting from eleven to twelve in the morning, and from six to seven in the evening. These paroxysms continued for just three weeks. The pain was so severe that she would give vent to loud screams. There were neither swelling nor redness observable anywhere. They believed the attacks were due to rheumatism or growing pains. Between the paroxysms she could walk about, and in every way appeared to be quite well. In the following September, 1878, the child began to limp. The pain was now continuous, but never so

severe as before. By the following March, 1879, she had become much worse, and for the first time medical aid was procured, the consulting surgeon to the Royal Infirmary, Manchester, being consulted. He regarded it as a case of hip-joint disease, and treated the patient by extension with the pulley and a three pound weight. This was continued for three or four weeks, when the surgeon recommended her removal to the Children's Hospital, where he could treat her to better advantage. At this time there was a little swelling of the part. The day after admission an operation was performed to remove an accumulation of fluid in the joint. They did not learn as to the quantity or character of the fluid removed. A long splint was then applied, which remained on for eight weeks. A starch bandage was now substituted, extending from the waist, which it surrounded, to the leg below the knee, and the child returned home. The bandage remained on until December, having been used for about six months. During this time she had gone about on crutches. The general health had not at any time been much impaired. When the starch bandage was taken off not much change was observed in the appearance of the hip; the limb seemed thinner and straighter. In the following month, January, 1880, a small swelling appeared two inches above the knee. A scar marks the place, which is at the outer margin of the rectus femoris. A week later the abscess opened and discharged about half a pint of creamy, healthy-looking matter. The surgeon, who now again saw the patient, expressed no opinion as to the source of the matter, and recommended the application of carbolized oil. Meanwhile the patient was going about on crutches, always avoiding the use of the limb as much as possible, by the advice of the surgeon. Her health still remained very good.

In July, 1880, she sailed with her parents for Canada. While on the voyage the discharge ceased. The limb continued in

much the same condition until the month of March, 1881, when, now living in Toronto, a second abscess formed, pointing in the groin. It was allowed to open itself, and discharged about the same quantity as the former one had done, and of a similar looking matter. This also closed in July following. Her health continued good. She was very active on her crutch, and during the summer went to school. Her activity was remarkable, and she was noted for her exploits on one leg and the crutch. With the affected limb flying about, she would equal any one in speed up or down a hill, and could use the skipping-rope until she counted her hundred.

About the middle of September, 1881, a third abscess formed and opened. The discharge was copious, and of the same character as the former. This opening still exists, and is situated above Poupart's ligament, about an inch and a half from the superior spinous process.

At this time a homœopath was consulted, who recommended Hydrocaine and nourishing food. The discharge during the next few months varied in quantity, and would occasionally cease, but soon re-appear. She continued to go to school most of the time. In March, 1882, the discharge again became abundant, and the patient began to fail in health, and lost flesh and appetite. In April following I began to attend her.

The appearance of the girl at this time was characteristic of hip-joint disease in the third stage. She was confined to her bed; was pale and emaciated; had little appetite and ability to take food; she passed restless nights; I accepted the statement that she had hip-joint disease. There was much swelling over the iliac region, extending below the trochanter major. The limb was shortened, slightly adducted, and the thigh somewhat in advance of its fellow. She complained of much pain, which was increased by any attempt at motion of the limb. The pus seemed laudable. She was very excitable and fretful. I concluded

there was probably some dead bone, and that an operation, sooner or later, would be found necessary. An attempt to use the probe so terrified the patient that I did not use it; and, in fact, I have never used it; having been able to satisfy myself on material points for treatment without.

The treatment adopted was to strengthen the appetite, build up the system, meanwhile making the limb as comfortable as possible by attention to position and rest, also securing adequate discharge from the sinus. Wyeth's preparations were found useful in bringing the stomach into condition to take and digest food, which largely consisted of milk and egg, with Hydrocaine and Putner's Emulsion. The Elix. gent. with tinct. iron was continued for several months with great benefit. Under this management the general health gradually improved, the discharge became less, and the pain greatly diminished, even when the limb was moved. The motion, however, was limited. Attempts to extend the motion produced pain in the course of the adductor muscles. During the month of June I found increased swelling above and anterior to the trochanter major, followed by fluctuation. The patient was directed to lie more upon the stomach to favour discharge from the groin.

This had the desired effect, and the fluctuation and swelling referred to gradually subsided. The health of the patient continued to improve, and during the summer months she was, when the weather permitted, carried to the garden where a place was prepared for her to lie down. Toward the latter part of July she complained of pain in the back, and upon examination I found over the last lumbar vertebra and upper part of the sacrum, some swelling and tenderness. I decided to leave it alone so long as her health continued fair, and wait. Lying upon her stomach had no effect in increasing the discharge, or arresting the swelling; but it very slowly increased so that at the end of several weeks fluctuation could be detected. After this the increase

was more rapid. However, as her health continued satisfactory I was in no hurry to make an incision. At last febrile symptoms having appeared, an opening was made on the 25th Oct. The pus of this abscess was found to be healthy and free of smell. A poultice was at once applied, and the matter allowed to escape by degrees, no pressure being made. The febrile symptoms soon disappeared, and the general condition was satisfactory. I now noticed that she had greater use of the limb, and that moving it gave little pain. The limited movements of the limb seemed due to contractions of the muscles and adhesions in the vicinity of the abscesses of the thigh and groin. I could flex and rotate the thigh with no pain to the patient. There was little or no tenderness from pressure over the trochanter. Flexing the leg, the knee could be rapped sharply without causing pain in the hip joint. This was a state of affairs I had not anticipated. Taking it for granted that the primary trouble was in the joint, the disease had evidently not only departed from it, but had left the joint in a functionally very good condition. Finding this I instructed the patient to move about more and try to use the limb. Since that time she has acquired more use of the limb, and, I believe, could walk upon it if it were not shortened. Her health has improved and is now fully re-established. At the present time the discharge at the groin is very limited, and, from the contraction around the mouth of the sinus, seems likely soon to close. The discharge from the back shows no sign of ceasing, but it is never great. It is sometimes watery; but otherwise laudable pus. It does not irritate the integument around the opening.

The question naturally arises, What is the cause of the continued suppuration? What is its source? In a word, what is, and has been the pathological state of the structures involved.

A few days ago I made a careful examination of the patient. Directed to stand as

erect as possible, it is observed, looking at the back, that the spinal column is seemingly almost in a line with the axis of the right or sound leg. A closer observation shows that the pelvis is oblique, the left crest being nearly four inches higher than the right. The lumbar portion of the spine is curved. The left buttock stands out with marked prominence. The left leg is slightly flexed at the knee, and the limb slightly inclines across the opposite leg, but can be brought by the patient on a line with its fellow. The heel can be brought to about four inches from the floor, the toes about three. The limbs measured, while the patient is lying down, from the anterior superior spinous process to the ankle, shows the left leg to be one inch and a half shorter than the right one. From the summit of the crest to the heel of the left side, it is nearly four inches less than in the right. The thickened and indurated condition of the part prevents a satisfactory examination of the trochanter. The outlines are indistinct. But the distance from the pubes to the trochanter is pretty much the same. From the left superior spinous process to the trochanter, the distance is about an inch less than on the opposite side.

From the history of the case and the present symptoms, it will be seen that it is in several respects very singular. We have not the ordinary features characteristic of morbus coxarius; or rather, we have with many of the usual features, others of an exceptional character. To these I will now refer in the order in which they appear in the history of the case.

The first peculiarity was the paroxysmal pains, occurring twice a day at regular hours and the absence of any other symptoms. She was quite well between the attacks, and at the end of three weeks, without any treatment, the attacks ceased. After this she was seemingly quite well for about eight months. Now I must confess my inability to account for these very distressing paroxysms of pain. We may take it for

granted that either the fall, or the blow with the poker, or probably both, had in some way injured the structures of the joint so as to set up morbid action. Such accidents are a common cause of the disease; but in what way any pathological condition could give rise to the single symptom of regular periodical pains, followed by apparent health, is a question I cannot undertake to answer.

The formation of an abscess on the anterior and outer side of the thigh, near the knee, was an unusual occurrence. Of course it is a common occurrence to have pus burrowing from the seat of disease among the muscles; but the places where pointing usually takes place are behind the joint, or just below the tensor vaginae femoris, or in front of the joint, or at Poupert's ligament, or, by passing down by the side of the rectum, open on the back of the thigh. We find that in the summer of 1881, a year after coming to Canada, after a second abscess had closed in the groin, that the little girl was remarkably active, and that, although she did not attempt to use the leg in the way of walking, she was flying about on a crutch, and was good at using the skipping rope; and that the limb was allowed to swing about without any pain or discomfort in the hip joint. There can be but one inference respecting the joint at this time: namely, that there was no active disease there. Whatever may have been the condition of the joint while under treatment in Manchester, at this time the disease was evidently situated within the pelvis. From the account given of the case, it may be that the disease originated in the joint, beginning in the acetabulum. Whether there has been structural change in the constituents of the joint may be questioned. Or, it may be deemed quite possible that an external injury should affect the pelvic surface over the acetabulum, and that the resulting inflammation of the bone should produce inflammatory action within the contiguous

joint, that this latter action might come short of producing structural change and that eventually the inflammation should disappear from the joint, while intra-pelvic disease of the bone was in a state of progress. On this supposition we could account for the absence of pain in the joint at the present as well as at that time.

The aggravated symptoms and loss of health in March, shortly before I saw the patient, marked a crisis in the disease. According to statistics, disease involving the bones within the pelvis is usually fatal. But there are exceptions. Probably much depends upon whether there be caries or necrosis of the bone. In the former there is generally some constitutional fault, constituting the predisposing cause, so that the efforts at repair of the lung tissue are not by a want of vitality or a destructive action in the tissues, which cannot be overcome or resisted. While the older authorities, with a few modern ones, hold the opinion that morbus coxarius is always due to a constitutional cause of a scrofulous nature, I am of the opinion that in many cases the disease has only a traumatic origin. In this view not a few recent able writers coincide. In this case there is one fact which, to my mind, is sufficient proof that no caries has been present. I refer to the character of the discharge. At no time has it caused irritation of the skin around the sinus. Had the pus contained the debris of disorganized tissue, it would not have always presented the healthy appearance it has, and more or less irritation of the skin would have existed. As we have seen, the patient gradually rallied and after a few months recovered her previous state of health.

I now come to a noteworthy feature of the case, the unexpected formation of an abscess in the lumbar region. The origin of the pus is uncertain. Has the spine become affected, or has the pus, arising from iliac disease, found its way through the structures? Taking everything into considera-

tion, I am inclined to think that the disease, originally in the ilium, has extended by contiguity to the sacrum and left lumbar vertebrae, and that a new outlet was made by nature at a dependent point.

It will be noticed that in opening the lumbar abscess I made a free incision, without any what is called antiseptic precautions. I may state that I particularly inquired to ascertain if the discharge from either of the sinuses had at any time had an offensive smell; but the reply declared that such had never been the case. Except cleanliness nothing had ever been done in the way of antiseptic treatment. In my practice I have had occasion to open a goodly number of psoas and other chronic abscesses, and I have for a long time pursued the course I did on this occasion. After making a free incision, I apply a poultice, avoiding pressure or squeezing out of the pus; but allowing the matter to gradually flow through an unobstructed outlet. By this means the walls of the abscess and surrounding tissue can contract as the fluid flows out, and thus there is less probability of air entering to supply the place of the evacuated pus. The poultice at the time soothing, is of no use after a day or two; but may prove injurious. A pad of lint or two is then substituted. Particular care is taken to have a continuous free outlet for the discharge, and lint may be temporarily introduced from time to time.

There are two other features of the case I wish to speak of:—namely, the seeming integrity of the joint at the present time, and the marked prominence of the buttock of the affected side. When suppuration takes place within the capsular ligament, from disease of the femoral or acetabular portion of the joint, there usually follows more or less disorganization of bone, cartilage, ligaments, and synovial membrane; and when recovery takes place it is with the loss altogether, or mostly, of the function of the joint. There may be ankylosis by ossific union, or new formation of bone,

as in the specimen before you, may so lock the bones as to render motion all but impossible. The useful condition of the joint is more remarkable on account of the appearance of the iliac region above. Commonly hip-joint disease leads sooner or later to flattening of the nates. Long continued disease of the gluteal muscles results in atrophy. Now in this case the part is abnormally full. This seems to be due to thickening of the ilium, and the gluteal muscles, due probably to adventitious material thrown out in the tissues from inflammatory action. But although the function of the hip joint is so good it does not follow that no structural change has taken place in the bony constituents of the joint. Indeed the measurements I have given would seem to indicate some altered condition, either in the neck of the femur, or in the acetabulum. Not unlikely the bone, being for some time in a softened state, has yielded to continuous pressure at the intra-articular surfaces; the neck of the femur becoming shortened, or what is more likely, the acetabulum becoming deeper and higher. With regard to the ultimate result of the case, I dare not speak with any degree of certainty. But on the whole I have great hopes that recovery, with a shortened limb, will finally take place. With no sign of caries, and the health of the child re-established, there is a strong probability that any necrosed bone, which may exist, perhaps at present imprisoned by new bone, will either find its way to the surface, or be gradually softened and carried out in the discharge. Then we may reasonably expect that the efforts of nature, which have been so marked in the past, will fully restore the parts to usefulness. The child is shortly to have an artificial foot, and I have no doubt will very soon be able to walk. In time—probably without limping.

Charles Reade, novelist, is credited with having named a dog Tonic, because it was a mixture of bark, steal, and whine.—*Med. Age.*

CASES IN PRACTICE.

J. E. GRAHAM, M D., L.R.C.P., LONDON.

Lecturer on Dermatology, and Assistant Lecturer on Clinical Medicine, Toronto School of Medicine.

A CASE OF MULTIPLE MELANOTIC SARCOMA.

J. T., aet. 52, born in Ireland; occupation, farmer; admitted to Toronto General Hospital, Dec. 6th, 1878. History of present attack:—Some weeks ago the patient, after a long walk, experienced a good deal of pain in the right groin, and, on examination, found three swellings, irregular in shape, and each the size of a pigeon's egg. During the previous August he noticed on the outer side of the right thigh a tumour, which afterwards became a cauliflower excrescence about the size of a large bean. A few weeks before admission he first consulted a physician, principally on account of the state of his bowels, which were obstinately constipated. The tumours in the groin had not increased much in size up to the time of his admission into the Toronto Hospital. Since then, however, they have increased very rapidly, and have become painful and tender on pressure. During the past week there have appeared on different parts of his body, in the subcutaneous tissue, several small tumours, varying in size from a pin's head to that of a pea. His appetite has failed, and he is rapidly losing flesh. His health previous to the onset of the present disease has been good.

Family History.—Parents lived to an old age. He has several brothers and sisters who are in good health. He had a family of six children, all healthy. He has been a hard-working, temperate man.

Present Condition.—He is very tall and much emaciated. On the surface of the body there are several small, dark tumours, some existing in the subcutaneous areolar tissue, and others in the corium. They were situated as follows:—(1) Right inguinal region, 3; umbilical, 3; right lumbar, 3; epigastric, 3; right infra mammary, 3; right mammary, 3; right arm, 1; left arm, 1; left infra clavícula, 4; left mammary,

1; left infra mammary, 1; left axilla, 4; left lumbar, 3. There were in all thirty-three tumours. The viscera of the thorax were normal so far as could be made out by physical examination. There is no marked or general enlargement of the lymphatic glands. The patient left the Hospital on the day following that on which his history was taken, viz., Dec. 17th. From a letter, received from his wife some time afterwards, I learned that the patient went down rapidly after leaving the Hospital, and died during the month of February.

Remarks.—The earliest manifestation of the disease, so far as is shown by the history, was on the outside of the right thigh, and existed in the form of a cutaneous tumour, which rapidly assumed the form of a cauliflower excrescence. The disease spread rapidly, the internal organs becoming affected, as was shown by the emaciation, and loss of strength. The disease ran a more rapid course than is usually the case in sarcoma of the skin.

PSORIASIS FOLLOWING URTICARIA PAPULOSA.

This case came under observation in August, 1881, when the following notes were taken:—E. B., aet. 13, has been quite healthy with the exception of present disease. About six years ago a rash appeared on the skin during the summer months which gradually went away when the cold weather came. During the following spring the skin was again affected. It has thus attacked the patient each spring, existing to a greater or less extent in the summer, and disappearing in the winter. It lasts usually from the middle of March until the latter part of October. It begins over the extensor surfaces, especially of the forearm, gradually spreading to the flexor surfaces and to other parts of the body. At present (August 20th, 1881) the rash is thicker, and more irritable in appearance over the hips than over the other parts, but exists more or less over the whole surface of the body. It is

made up principally of papules, which are surmounted either by small crusts or coagulated blood. They are extremely irritable, and the itching is intense, especially at night. Besides the papules, there also exist patches of Erythema about the size of a twenty-five cent piece. The eruption appears to come on in successive crops, and by the time one attack has nearly passed off, another follows. The patient states that frequently it comes on at night with intense itching, and in the morning there will be found a number of fresh papules and vesicles. These vesicles if left to themselves will shortly form sort of pustules, which are extremely sore. When the tops are torn off small scabs form, and these scabs shortly fall off, leaving a slight mark. If the scab is torn off prematurely a bleeding top is left, and the scab is reformed. The eruption exists on the scalp as well as on other parts of the body. There is no infiltration of the skin between the papules. They are discrete and irregular in their arrangement. The papules and vesicles do not form as the result of rubbing, as they have appeared on parts protected from external irritation. The most intense itching exists when the papules first appear. The house in which patient lives is clean. There are six other children, none of whom suffer from any disease of the skin. Made enquiries as to the possibility of fleas, bed bugs, etc., being the cause. They do not exist in the house. If they were the cause of the eruption, other members of the family would be affected. Prescribed for patient a mild alkaline purgative, and the daily use of baths in which sodæ bicarb was dissolved.

September 6th.—Saw the patient to-day. The eruption has disappeared to a very large extent; the trunk is almost free from it. There are some papules and scales on the backs of the hands and the arms. There are only two or three new spots.

September 15th.—A new eruption made its appearance two days ago. There exist

now some papules, with broken vesicles, and others surmounted by crusts of dried blood. Also, elevated, flat surfaces, partly covered by broken vesicles. The papules are from the size of a pin's head to that of a pea.

From this time the eruption subsided. In the winter it had entirely disappeared.

The patient was not seen again until the following September (1882). The mother told me that the usual eruption did not appear in the spring, but that instead another form of disease showed itself. On examination, I was surprised to find a very typical form of psoriasis existing on the extensor surface of the arms and legs. The patches were not numerous, and were from the size of a ten cent piece to that of a large penny. The disease existed principally on the legs, near the knees.

February, 1883.—During this month I again saw the patient. The psoriasis still continues, the patches being somewhat more numerous than during the summer.

I prescribed arsenic internally, and unguicis liq. ʒ ij., zinci oxidi ʒ ss., ungu. aquæ rosæ ʒ i., for external application.

Remarks.—There is little doubt but that the eruption from which the patient suffered, on and off for six years, was the lichen urticatus of the older writers, or urticaria papulosa of Durhing. It differed from the description given in text-books, in that there were vesicles surmounting the papules, and that a mark was left on the seat of the papule, which did not disappear for some months. Another striking peculiarity was its recurrence during the warm weather. The eruption resembled very much those cases which one can see in such numbers in the London Clinic, and to which Mr. Hutchinson has given the name "summer prurigo." With regard to those cases, the writer was told by Mr. Waren Tay that they belong to people of the lower classes, and almost invariably get better after they were taken into the hospital, proving that the condition is caused by either want of clean-

liness or bad food, perhaps both. The case narrated occurred in the family of a mechanic. A very interesting feature was the termination of the disease, and the appearance of ordinary psoriasis. No psoriatic spots existed in the autumn of 1881, as a careful examination of the whole body was made. There was also no appearance of the urticaria papulosa after the psoriasis was discovered. If, as is supposed by many, both diseases are caused by some obscure nerve lesion, one can more easily understand how one condition could readily follow the other.

HERPETIC TONSILLITIS, OR DIPHTHERIA ?

BY MR. C. M. FOSTER, CLINICAL CLERK.

The following two cases of throat trouble, admitted into the General Hospital, Toronto, under the care of Dr. Cameron, present some points of interest, in relation to the diagnosis of diphtheria, from other throat affections which resemble it more or less closely.

Case 1. J. K., *æt.* 21, a strong healthy-looking young man, whose past history was in every respect good, and whose family history was also good, with the exception of a brother who was much subject to attacks of quinsy.

On the 18th of January he complained of slight drowsiness and chills in the forenoon. These became increased during the afternoon, together with severe frontal headache and pains down the thighs and legs; during the following night there was a good deal of fever, restlessness, and copious perspiration. On the 19th he felt better but kept in bed; in the evening the throat became swollen and painful, causing painful deglutition; "small painful lumps" were noticed at the angles of the jaws, more especially on the right side.

Throughout the night there was acute delirium, the patient talking loudly and making several attempts to leave the house; vomiting occurred five times during the

night; the face was swollen and very much flushed; saliva kept constantly pouring from the mouth. When admitted to the hospital, on the 22nd, the pharynx, palate, and fauces were very much swollen and congested, the tonsils especially. On the posterior wall of the pharynx three oval patches of a thin greyish deposit were seen, each being about $\frac{3}{4}$ by $\frac{1}{4}$ inch. It was found impossible to detach these without giving considerable pain, so that the attempt was abandoned; a similar but smaller patch on the left posterior pillar of the fauces was partially removed, leaving behind it simply a reddened and congested surface, without any bleeding points or ulceration. A curled up *διφθερα* or pellicle was adherent to right side of uvula. There was dyspnoea and huskiness of voice, the former being very much relieved on expectoration of considerable quantities of membranous shreds, some of which required some force to tear them apart.

On the 26th there was some improvement in the general symptoms; only one patch could be seen on the posterior wall of the pharynx which appeared to be due to the coalescence of two of those which were first seen, being about $\frac{3}{4}$ x $\frac{1}{2}$ in.; on the tonsils were a few small points of deposit about the size of a pea. Some of which were yellowish, soft, and pultaceous, and easily removable; other of these points appeared flatter, greyer, and less easily removable.

Improvement gradually continued until February 1st, when all the symptoms had disappeared; on the second the patient left the Hospital feeling quite well and without any unpleasant after effects of his illness, beyond symptoms of a slight bronchial inflammation.

While in the Hospital the temperature did not at any time exceed 100° ; on the 27th it had gone down to normal.

The pulse varied from 90 to 66, being at no time notably weak or irregular. The treatment in this case consisted in rest in

bed, a milk diet and eggs, and the following mixture:—

R. Acidi Sulphurosi, ʒ ij.
Acidi Muriatici diluti, ʒ iij.
Syrupi Aurantii, ʒ iij.
Aque, ad ʒ viii.

M. Sig. ʒ s s ex aq. o. h. iii.

Case II. W. D., æt. 23. Family history good; had himself been subject to frequent attacks of "sore throat;" but none so severe as the present. Had nursed J. K. until the latter was admitted to the hospital, and on the day after, *i. e.*, the 23rd, complained of general malaise, chilliness, and pains extending from the loins to the feet; very restless and feverish through the night; felt better next morning, pain in lower limbs having disappeared and feverishness not so great; kept in bed during the 24th; about 4 or 5 p.m. noticed difficulty in swallowing and pain about the angles of the lower jaw; during the night there was a considerable increase of feverishness with dyspnoea and general prostration.

There was no headache, delirium, or vomiting. Admitted on the 26th; tonsils, fauces, and pharynx very much swollen and congested, glandular swelling and tenderness at angles of lower jaw; three or four small greyish spots on the tonsils, and one large patch 1 x ¾ in. on the posterior wall of pharynx; these had a precisely similar appearance to those seen in the first case, and removal gave the same results.

Patient complained of great thirst; temperature 104° 3/5, perspiring freely, breath offensive, breathing difficult, voice husky.

On the 27th there was less dyspnoea and the patient felt easier; temperature, 103° 2/5; pulse 104. Urine contained a slight trace of albumen.

The tonsils were still very much swollen, but all the points of deposit had disappeared; on the posterior wall of the pharynx were four small patches having a semi-transparent, greyish-white appearance. On the 29th patient said he felt quite well, temperature normal; pulse 98, slight cough with

a few moist rales present, swollen and congested condition of throat greatly diminished. Only one small patch on pharynx.

Feb. 1st, Temperature normal, pulse 75, urine S. G. 1,023, no albumen.

Feb. 2nd, left the hospital.

The general treatment in this case was similar to case I.; the following mixtures were given:—

R. Quinia Sulph. ʒ i.	et	R. Acidi Boracici, ʒ ij
Acidi Sulphurosi ʒ ij.		Glycerini, ʒ i.
Syr. Aurantii, ʒ ij.		Aq. ad. O i.
M. Sig. ʒ ij ex aq. o. h. iii.		M. Sig. To be used as a gargle frequently.

The most important point in connection with these cases is the arrival at a correct diagnosis. Many of the symptoms would seem to point to diphtheria and would very possibly have been at once put down to that disease by some, more especially those whose cases of diphtheria are both numerous and are attended with a remarkably large percentage of cures.

The true nature of the disease in these cases seems to be clearly indicated by the remarks made by Professor William Pepper, in a clinical lecture delivered at the Hospital of the University of Pennsylvania, in November, 1882, and reported in the *Philadelphia Medical Times* for February 10th, 1883. The subject of the lecture was "Herpetic Tonsillitis: its Relation to Diphtheria." In this form of Tonsillitis there is redness and swelling of the pharynx, fauces, and tonsils, upon which latter in the severer cases are found "from one to a dozen white spots, which are slightly prominent, and rising above the surface of the tonsils." These spots, Prof. Pepper goes on to say, are not fever deposits, and cannot be stripped off, being simply "the crypts of the tonsil, distended with a clear or cheesy material."

The high temperature in Case II. may have its explanation in the following remark made by Prof. Pepper, he says:—"In adults this apparently trivial affection may be ushered in by marked chill, vomiting, high fever (a temperature of 104°), rapid

pulse (115 per minute), headache, backache, pains in the limbs, intense soreness in the throat, and great difficulty in swallowing."

He states further that he has frequently seen the separate spots run into one another to form irregular white patches, which may be associated with membranous exudation upon the surface of the tonsils, rendering the differential diagnosis exceedingly difficult. Nevertheless, however different the diagnosis may be, this disease which is under consideration in the lecture is essentially and entirely separate from true diphtheria.

On the tonsils, in each case, greyish-white spots were seen, not removable by gentle manipulation, together with other more prominent ones, having a more distinctly yellowish color and easily removable.

It may be worth while mentioning that the walls of the stables in which both these men worked were damp, and covered with a green fungoid-looking growth.

The remarks made by Prof. Pepper on Herpetic Tonsillitis would appear to be applicable to the two cases, the histories of which have been given, and would therefore diagnose them as examples of that disease.

Selections : Medicine.

LECTURE ON EMPHYSEMA.

BY BEVERLEY ROBINSON, M.D.

The older writers defined emphysema as an infiltration of air into the cellular tissue of the lung between the lobules. Later researches have shown that this interlobular form is rare, the commoner form is vesicular in which the pulmonary alveoli and sometimes the terminal division of the bronchi are enlarged.

Vesicular emphysema is the more important form, on account of its symptoms and also by reason of the tissue changes, consequent upon its continuous presence. It is sub-divided into varieties according to

the manner in which the pulmonary tissue is affected. *Partial lobular emphysema* when only a portion of a lobule is affected the remainder being normal, and *real lobular emphysema* when the entire lobule is equally dilated. The first, seldom exists alone but generally accompanies the second, which is frequently found at the free margins of the lungs. Lobular emphysema often accompanies pulmonary phthisis and pneumonia. The dilated lobules are prominent and bulging, and the interlobular septa, are seldom, and only in very rare cases, broken down.

The third form of vesicular emphysema, and the most important is the lobar. It may attack both lungs, and if severe be the immediate cause of death. The surface of the lung is smooth, the interlobular septa have disappeared. The lung appears to be too large for the chest, and the ribs and sternum cause depressions on the lung surface. It has a doughy consistence. The air sacs at first only dilated, gradually become thinner, until two or more communicate; at this stage, interlobular emphysema is sometimes present, and generally spreads from some point near the root of the lung. The larger air sacs are near the distal portions of the lung. The capillaries are widely separated, producing the white appearance. The perforations of the alveolar walls in lobar is more frequent than in lobular emphysema, even when the dilatation is not greater, showing that the degeneration of lung tissue is further advanced. The large bronchi are dilated, and their mucous lining thickened, the small tubes narrowed and bloodless. The circular muscular fibres are more developed than in healthy lungs.

In interlobular emphysema, the air passes into the cellular tissue between the lobules, and may penetrate into the mediastinum and cellular tissue of the neck. The worst cases have been found in children, after severe attacks of whooping cough.

Vesicular emphysema shows dilatation of

the alveoli, their perforation and atrophy; it is more marked at the apex, and along the margins of the lung. If it follows a violent and persistent cough, mechanical obstruction appears to be the method of production. If, as sometimes occurs, it comes on insidiously without cough, the changes are due to some constitutional dyscrasia. Senile changes affect the lung tissue, as well as other parts of the body. In lobar emphysema, fatty degeneration of the walls surrounding the air sacs, has been affirmed; fibrosis of lung tissue from prolonged bronchial congestion, is another explanation. From the fact that there is an hereditary tendency to the transmission of emphysema, as in gout, forces the opinion that there is an underlying blood dyscrasia in most of these cases not explainable by mechanical obstacle.

The general nature of the affection is shown by its insidious progress, its hereditary character, implication of both lungs in their entire extent, and the effects of remedial measures, which are likewise found useful in degenerative changes of other organs.

Two theories of the formation of Emphysema are:—1. That forced inspiration dilates and breaks through the air cells; 2. That forced expiration is the efficient factor. The first view was based upon the supposition that the air cells contained retained air—which forced inspiration compressed—a mucous plug obstructing its outflow. The expiratory effort being the stronger would force air past any obstruction which allowed air to pass on inspiration, and the shape of the bronchial tube would permit an obstructing plug to move more easily in the expiratory direction than the inspiratory. The result would be atelectasis, not emphysema. Traube's experiments support this explanation. The expiratory theory of emphysema is further borne out by the fact that in forced expiration after cough the supra-clavicular spaces become bulged out and hyper-resonant; the

margins of the base and the anterior borders of the lungs being outside of the direct axis of pressure, and containing less air than other portions of the lungs are apt to become emphysematous. In forced expiration the diaphragm and thoracic parietes contract with force to press the air toward the apices and anterior borders—the cartilaginous portions of the ribs yield to the pressure, allowing expansion—as in a case of absence of the sternum, on forced expiration, the anterior borders of the lungs become prominent through the opening present. Thus it is seen that the causes, pathology, and mechanism of lobular and lobar emphysema differ much. A prominent symptom of emphysema is a constant sense of oppression, or smothering, which is most painful to witness, and may be aggravated by bronchial, gastric, or emotional causes. Such patients are usually more tranquil, and suffer less in summer. Such patients cannot sleep, and are troubled with real asthmatic attacks, with cyanosis, lowering of temperature, icy extremities. Expectoration abundant. After intense and painful cough during the day, the expectoration is small in quantity, though the cough be severe. The sputa may be tinged with blood, owing to rupture of some of the altered capillary vessels. Pain is sometimes present at the epigastric region, and may be increased by pressure. The right side of the heart may be enlarged and the liver congested. It is only in very advanced cases that we find evidences of valvular incompetency of the heart.

The physical signs are numerous. The shape of the chest, if the affection be bilateral, is larger; the ribs more prominent, the intercostal muscles sunken, the movements peculiar—moving up and down instead of expanding—the back is curved antero-posteriorly, the shoulders carried forward, the abdomen prominent, and its movements exaggerated. The inspirations are short and quick; expirations, long-drawn and jerky.

Percussion over the anterior and upper chest gives hyper-resonance, also over the precordial region; however, pleuritic adhesions may prevent the lung from overlapping the heart. The apex beat cannot be felt or seen. Near the ensiform cartilage we have epigastric pulsations and dullness. Heart-beats are distant. If scarcely audible at both apex and base, the heart has been carried backwards; if dullness is pronounced in lower sternal region, and epigastric pulsations are exaggerated, the heart has been carried forwards and to the right side. Inspiration, short and feeble; expiration, prolonged and noisy. This weakness of the respiratory action may be present before percussion gives hyper-resonance. There is but a slight difference in the size of the chest before and after inspiration and expiration. Circulation is interfered with and temperature lowered from insufficient aeration of the blood. Congestive bronchitis frequently complicates the disease, and the sputa are rapidly formed, and endanger life by causing apnoea. There is a tendency to the formation of fibrinous clots in the pulmonary arteries and right heart. Severe asthmatic attacks cause an increase of the muscular layer of the bronchi and hypertrophy of the heart, with tricuspid regurgitation and general anasarca; and, owing to the displacement of the heart, even if there be forcible pulsations, the pulse is feeble and weak.

The primary indication for treatment is to avoid accidents which may develop complications, or augment existing bad symptoms. Emphysema is usually more serious in adult life than in old age, as then the respiratory need is greater, and there is more danger of attacks of acute bronchitis. To those who look upon the disease as of bronchitic origin, the treatment is largely climatic; to those who regard it as a dyscrasic affection, such treatment is not sufficient, but constitutional remedies must be used; and chief of these is iron, and careful attention paid to diet and regimen.

Strychnia is contra-indicated; breathing compressed air has been highly recommended, and it is of temporary use. The diet should be nutritious and easily assimilable, yet not such as to produce too much blood. If such patients have an attack of acute bronchitis, stimulant expectorants should be given, and alcohol when the pulse is feeble and rapid, counter-irritation to the chest walls, by turpentine, mustard, dry cupping, croton oil, etc. The bowels should be moved every few days. Lastly, turpentine internally, in small doses, the good effects of which are often noticeable in a few days. When the heart is worn out, digitalis in frequent small doses; when this fails, 10 gr. doses of powdered ipecac every ten or fifteen minutes, until free emesis is produced, sometimes drags the patient back to life; for we have to fear apnoea from filling up of the bronchial tubes with the sputa. The emetic empties them and restores the use of the lung. Depressant emetics should not be used, for fear of pulmonary fibrinous coagula. When chronic bronchitis is persistent, copaiba or cubeba modifies the bronchial mucous membrane and diminishes the secretion; the general system being at the same time kept up by tonics.

Essential asthma is a rare affection. It is mostly connected with some organic changes in lung or heart, and frequently with emphysema; hence the attack is frequently relieved by turpentine, etc., and not by the anti-spasmodics, stramonium, etc. In very low conditions, when food and drink are taken with difficulty, strong black coffee, with about one-third brandy, stimulates the cardiac contractility, breaks up the spasmodic closure of the bronchial tubes, and actually causes sleep by its direct influence upon the activity of the cerebral circulation.—*Abstract from N.Y. Med. Record.*

PATHS OF CONDUCTION IN THE SPINAL CORD.—Dr. Wasil Kusmin has made a number of experiments as to the path of the fibres in

the spinal cord of the dog, and gives the following summary of his results, confirming, in the main, the results obtained by Woroschiloff, Ott, and R. Meade Smith, with the same methods of study.

1. The lateral columns contain the sensory and motor fibres.

2. The anterior columns consist mainly of centrifugal fibres which, after destruction of the lateral columns, are capable of assuming their functions to a certain extent.

3. The posterior columns are largely formed of centripetal fibres.

4. The gray substance contains no continuous path of conduction.

5. The sensory fibres from the lower extremities decussate in the cord.

6. After a hemisection of the spinal cord the motor fibres of the lower extremity preserve their functions as high as the anterior roots of the nerves on the level of the section on the opposite side of the cord.

7. Vaso-constrictor fibres run only in the lateral columns.—(*Med. Jahrbuch*, 1882. *Am. Jour. Med. Sc.*)

A NEW REMEDY IN DIPHTHERIA.—The *Phila. Med. & Surg. Reporter* quotes from the *Pharm. Centr. Anzeiger* an account, by R. Münch (Kronen Apotheke, in Leipsic-Sohlis), of a new remedy in diphtheria, the efficacy of which he proved on one of his own children. It is the *Oleum Terebinthinæ Purificatum*, and is given to children in teaspoonful doses, night and morning; adults take a tablespoonful. It may be given in tepid milk, or followed by a draught of that fluid. (It seems to act through its influence on the capillary circulation, and perhaps also by its antiseptic properties.—Ed.)

BACILLI IN PHTHISIS, by Balmer and Fränkel (*Berl. Klin. Woch.*)

1. The prognosis can be stated with certainty on the number and state of development of the bacilli found in the expectoration.

2. The quantity of bacilli is not constant, it increases with the advance of lung destruction and reaches its maximum at the end of life.

3. The distribution of the bacilli is not in all cases uniform. At times they are evenly found throughout, at other times in groups.

4. Their state of development is very varying; in many cases they are small, sparse, and inactive.

5. Such bacilli are found in cases where the disease is progressing slowly, or where there are old cavities with a tendency to heal.

6. In all examples where the disease is rapid and marked with severe symptoms as to fever, night sweats, etc., the bacilli were abundant and larger, and the spore formation more visible.

7. Generally all examples ran as follows: where the bacilli were many the fever was high; as their number lessened so did the fever.

8. A very constant relation existed between the quantity of bacilli in the expectoration from fresh cavities and that from previous ones. If in early cavities they were very numerous, in later ones they were few.

9. The sputum appeared to be a better soil for the bacilli than the lung tissue.

10. The introduction of air to the lung cavities do not warrant one in saying that the bacilli develop there on that account, for they can be found in the broken down tissues and matter in a knee, affected with tubercular inflammation, when such matter is first let out.

11. The existence of tubercle bacilli does not only occur in the sputum and walls of lung cavities, but in the lung tissue, in a lung abscess, in the wall of the intestines, or a knee joint. The discovery of these bacilli indicate a general disease and point to its tubercular nature.

Dr. Schmidt has discovered that his fat crystals are not Koch's bacilli.

PULMONARY SYPHILIS.—Interest in the question of pulmonary syphilis has been revived by the appearance of some recent works upon the subject.

These works discuss pulmonary syphilis, as it appears in the adult only. That of the infant forms a chapter apart, the matter for which has been gathered since Cruveilhier, by Robin, Virchow, Cornil and Ranvier, Parrot, etc., who consider its characters so marked as not to be confounded or assimilated with any other lesion. The knowledge of the pathological anatomy of the specific pneumonias of adults has nothing like this precision. Many physicians hesitated to recognise their existence, and some have denied it, or they conceded that syphilis might give rise to destructive alterations of the lung, but attributed these lesions to a phthisis which played the part of a secondary diathesis. A. Paré and others attributed a phthisiogenic influence not only to syphilis, but even to blennorrhagia. The specific nature of pulmonary syphilis has been definitely accepted quite recently. An anecdote is told which marks the change of front of the doctrine. A patient of Bambilla, supposed to be phthisical, lay next a syphilitic, for whom had been ordered the traditional inunction of mercurial ointment. In those days the distribution of medicine was subject to slight irregularities. The blue ointment was given to the lung patient, who believing he had received an electuary, conscientiously swallowed it in small doses and was cured. Morgagni and Lemonnier believed in the existence of syphilitic phthisis upon clinical proof only. It is a curious fact that during this period of about thirty years which began in 1804 with Laënnec and which was so to speak the renaissance of pathological anatomy, syphilis was almost completely forgotten, due probably to the opinion of Hunter, who scarcely believed in the visceral accidents of syphilis. In 1826 only, whilst Andral and Laënnec were disparaging venereal phthisis, Van der Kolk asserted

that syphilitic subjects "might succumb *with the appearances of phthisis*, to an ulceration of the lung most often situated in the middle lobe and *without tubercles*." Lastly, with Ricord, came the restoration of syphilis and pulmonary syphilis was rehabilitated, not because syphilis was found everywhere and *à propos* of everything, but because it was really and incontestably one of the profound manifestations of the venereal infection.

Pathological anatomy at the hands of Lancereaux and others has confirmed the possibility, and even the frequency of syphilis of the lung. Then the histologists took up the question, but not very profitably from their point of view. A short experience demonstrated that the microscope only obscured matters. The intimate modifications of a syphilitised lung appeared to be no more than the common inflammation in which nothing revealed the specific origin of the process. So it became necessary to return to the contemplation of gross lesions as being altogether more demonstrative. And thus once more was justified the assertions made by Broca, that "the microscope has taught us to make use of the naked eye."

In the lung as elsewhere the destructive or substitutive action of syphilis results in gummata or scleroses.

The scleroses are most often superficial; they are pleuro-pulmonary, and present themselves under the form of elongated depressions more or less profound, more or less confused which seem to be produced by a close network. This comparison, however, can be applied to the lung with the same justice as to the liver and the spleen. From the surface of the organ these fibrous bands are buried in the parenchyma and converge towards the hilum of the lung, like the trabeculae of the testicle towards the body of Highmore.

The gummata on the contrary are almost always situated in the thickness of the viscus, and especially around the large

bronchi, generally few in number, they have a firm consistence, a yellowish colour, a dryness which distinguishes them from most other morbid products, of very variable dimensions, but which seldom surpass that of a hen's egg. As a rule they coexist with a sclerous induration of the parenchyma, disposed around them in rings or fibrous spheres. The large bronchial tubes are often ulcerated, and the caseous substance, of which the glands are largely composed, may be spontaneously eliminated through the apertures of communication. This mode of evacuation has elsewhere been pointed out for some time in most of the chronic processes of destructive form of mediastinal adenopathy.

In all this there is nothing very new if attention is paid only to the nature of the lesion. But after reviewing all the observations published up to the present, it is not without profit to remark that the gummatous form of pulmonary syphilis shows a certain predilection to canton itself in the neighbourhood of the hilum, in order to further propagate itself from within outwards towards the deep parts of the parenchyma. One may indeed ask if this anatomo-pathological variety of gummatous degeneration is not in principle a kind of peri-bronchial mediastinitis. The inter- and peri-bronchial glands represent, as we know, chains which follow the course of the bronchi up to the third and fourth divisions; in the pathological state these glands may be seen as far as the fifth and sixth divisions, which is very probably due to a simple hypertrophy of the small glandular nodules invisible in a healthy state to the naked eye.

So while not at all denying the possibility of a primitive gummatous pneumonia, are we not right in admitting that the peri-bronchial gummatous adenopathy is the more ordinary process? The degeneration of these gummatous glands, would very amply explain that of the adjacent parenchyma, finally all the constituent parts of the lung surrounding the centre of origin

would undergo the same fate to very nearly the same extent.

From these anatomical observations are deduced important points for clinical application. The great difficulty in diagnosis almost always resides in the differentiation of syphilitic and tuberculous lesions. These give rise to lesions equally destructive, to symptoms of the same character, to very analogous consumptive phenomena, to inflammatory or congestive symptoms (broncho-pneumonia, bronchial catarrh, hæmoptysis), equal in quantity and quality, solely their topographical distribution is different, and this is not a simple shade of difference in a diagnostic point of view it is of prime importance, and it must be placed far higher in value than the frequency or abundance of the hæmoptysis. It has been said that in pulmonary syphilis these are more even and less abundant than in tuberculosis. This is quite inexact as may be seen from the observations; and again how many consumptives succumb without even having an hæmoptysis.

The explanation is that the presence of a destructive centre occupying the middle portion of the lung, putting gangrene aside, may have given rise to hesitation or timidity in the diagnosis. Now it is almost constant that a subject who dies of syphilitic pneumopathy has other specific lesions in the viscera, particularly in the kidney, in the osseous system, or on the surface of the body. If these accessory lesions are manifestly recognised as products of the pox, and if on the other hand the pulmonary localisation has not the usual characters of common phthisis, the chances are greatly in favour of the lung like the rest of the viscera being affected with the specific lesions.

We should not then recoil before the diagnosis of syphilitic phthisis, especially if we consider the advantages the patient will derive from a correct diagnosis. The treatment is always the best touchstone, and to its happy influence is due the rarity of autopsies.

UNILATERAL ANASARCA.—M. Potain has observed five cases of contusion over the renal region which were followed by anasarca of the same side. One of these was a lead workman who fell while carrying a heavy leadpipe. The end of the pipe bruised the region of the kidney, and was followed by albuminuria and anasarca of that side. Another, after a contusion on the right flank and exposure to cold and damp, had an cedematous swelling of the right cheek, extending gradually to the eyelids, and an ophthalmia of that side, accompanied by albuminuria. Mr. Potain concluded that a contusion of one of the hypochondria may give rise to catarrhal nephritis of the contused side, followed by a partial anasarca of the same side. This is opposed to the view generally accepted of the pathogeny of anasarca, and is probably due to the implication of the nervous system, especially of the great sympathetic. The late experiments of Brown-Séguard and the recent observations on a case of myxoedema lend some probability to this view.—*Gaz. des Hôp.*

ASTHMA.—THE CAUSE OF.—Ten years ago Leyden attributed the asthmatic paroxysm to irritation of the terminal filaments of the vagus nerve in the bronchioles and pulmonary vesicles by little sharp, colourless, octahedral crystals, which he had found in the sputa of asthmatic patients, and which had been previously described by Charcot and Robin, and go by the name of Charcot's crystals. Last year Ungar, of Bonn, taking up the subject, showed that the crystals were present in the sputa of every one out of 39 asthmatic patients under his observation; but he went further and determined that they were not always present in fresh sputum, but developed after keeping the expectoration three or four days in a moist atmosphere. He also found long thread-like, stringy masses, sometimes knotted and twisted up into little balls, of granular cells, the central and most degenerate of

which contained Charcot's crystals in abundance. Hence he concludes that these crystals are the product of cell degeneration, just as those found in leucaemic blood were shown to be by Zenker. The theory he advances to account for the paroxysm is:—The smaller bronchioles, having no cartilage in their walls, constantly vary in size with the movements of respiration, dilating or expanding in inspiration, and then contracting by virtue of the inherent elasticity of their walls. Their muscular fibre he regards as mere stays to prevent overstretching of the elastic tissue and incapable of producing a spasmodic constriction of the tubes. A plug of the above-mentioned exudation being in existence may suffice to completely block a bronchiole at rest; expansion of the bronchiole occurring inspiration air may pass by the obstruction, but the moment the action of the chest walls is relaxed the bronchiole returns to its former size, and the air is imprisoned. (Abstract from *N. Y. Med. Record.*)

OSSEOUS PAINS.—M.M. Charrin and L. Guignard conclude a study upon the pathogeny of certain osseous pains, as follows: In tuberculosis, in diabetes, and especially in osteomalacia, we observe clinically osseous pains; phosphaturia frequently co-exists. Etiologically, chemistry and experiment show us a tendency to the accumulation of acids in these diseases. It is allowable to suppose that in these different morbid conditions, it is the acids which attack the osseous tissue, its nerves and all its elements, dissolving its calcareous salts and thus give rise to the pains and the phosphaturia.—*Arch. de Méd. Gaz. des Hôp.*

PETRONEON SOLID PNEUMONIA.—The author states (*Lo Sperimentale*, Nov. 1882) that solid pneumonia was established as a separate variety of pneumonia by M. Grancher in 1878 (*Gaz. Méd. de Paris*). Six cases are recorded here: one by the author the others by Grancher, Brissaud, Beaumann.

and Leroux. In physical signs, the cases counterfeit pleurisy with large effusion. There are absolute dullness, and total extinction of vocal fremitus, of vocal resonance and of respiratory sounds. After death the bronchi are found filled with a solid, fibrinous, and sometimes fibrillated material, like diphtheritic membrane, slightly adherent to the mucous membrane. The diagnosis is more or less uncertain. But in cases of doubt an exploratory puncture may, owing to its harmlessness, always be tried. Although many cases have been recorded (as M. Grancher has recognized) by clinical and by pathological observers, this variety of pneumonia has not yet found its way into the text-books. Wm. R. HUGGARD, M.D.
—*Lond. Med. Record.*

THE BEST FORM IN WHICH TO ADMINISTER PUMPKIN SEED.—Dr. L. Wolff (*Proc. Penn. Pharm. Assoc.—Canada Pharm. J.*), recommends for adults:

First. Fifteen grains of the resin in pill form. (The resin may be prepared by exhausting the recently dried and well comminuted seed with petroleum benzine, treating the residue repeatedly with ether, chloroform, and alcohol, and evaporating to dryness; or by extracting the oil with ether or chloroform, and shaking with stronger alcohol, or by evaporating an emulsion of the seed to dryness, treating with stronger alcohol, filtering and drying.)

Secondly. One to two fluid ounces of the alcoholic fluid extract in broken doses and largely diluted; both of these taken fasting in the morning, to be followed two or three hours later by a dose of castor oil. Or, better than either of these for children, are emulsions of one ounce of the recently dried and finely comminuted seed, and one-half ounce of granular sugar, with four ounces of water, in which preparation the natural oil works as a mild laxative; this also to be taken in broken doses, following closely on each other after a fast of six to eight hours.

THE DIFFERENTIAL INDICATIONS FOR THE USE OF DYNAMIC AND FRANKLINIC OR STATIC ELECTRICITY.

BY DR. A. D. ROCKWELL.

When a distinguished professor can say to a large class of students that a simple Faradic apparatus will practically answer every purpose in medical electricity, it is in order to discuss this subject. To state that electricity has been used conveys but little meaning unless the *kind* of electricity is mentioned, and, still further, the method of its application. It is not, however, to be supposed that one form of electricity is adapted to one line of disease, a second to another, and a third to still another. But there are certain pathological conditions which always call for a certain kind of electricity, and if benefit is to follow it must be through this special form, all others being useless, or worse than useless. For example, in hemiplegia, where there exists, as is often the case, an exalted electro-muscular contractility, electricity, if used at all, should be in the form of Faradization, and with an exceedingly mild, rapidly interrupted current. Even when muscular contractions are somewhat less readily called out than in the normal condition, the same current is, as a rule, preferable. On the contrary, when there is very great diminution of electro-muscular contractility, the galvanic current is always indicated, the Faradic coming into play only when the muscles give evidence of positive reaction to its influence.

In most cases of paraplegia, complete or proximate loss of Farado-muscular contractility exists, at least for a short time. The galvanic current alone is applicable in these cases, and for the purpose of restoring nerve-excitability. The Faradic current may be useful in attempting to improve the impaired nutrition of the paralyzed members. When we wish to directly affect the central nervous system, the constant current alone is applicable. In the majority

of diseases where electricity is indicated, each one of its forms, Galvanism, Faradism, or Franklinism, may at one time or another possess a positive value over the others. This is illustrated in the treatment of neuralgia. The well-known power of the galvanic current to relieve many forms of pain has been repeatedly emphasized, and the inference has been that Faradism is of but little value for this purpose. The truth is that Faradism is not only invaluable in many forms of pains, but in certain conditions relieves, where Galvanism is not only useless, but may even aggravate the symptoms. The effects of pressure in the various forms of neuralgia, are exceedingly useful, as giving symptoms indicating the proper current. In the great majority of cases of neuralgia, where firm pressure over the affected nerves aggravates the pain, the galvanic current is indicated, whereas, where pressure does not cause an increase of pain, the Faradic current has the greater power of relieving pain. For hysterical hyperæsthesia, the Faradic current is infinitely superior to the Galvanic. Special characteristics of the cases regulate the measure of benefit to be derived from one form or another of electricity, and yet it is impossible to point to many diseases where one current is to be used to the absolute exclusion of the other; but it is possible to name a variety of conditions where, as a rule, one method of treatment and one form of current is superior to another. In the class of cases commonly spoken of as general debility the Faradic current is indicated. It is selected for its tonic effects. Very much, however, depends upon the method of its use. General Faradization is of the first importance. With regard to individual conditions that seem to demand the Faradic current alone there is not much to be said. There are but few distinct organic or functional diseases that in every phase of their manifestation demand alone and always a special form of electricity. Asthenopia, accompanied by hyperæsthesia

of the retina and ciliary nerves, is one of the few distinct conditions which seems to demand the Faradic current alone. According to his experience, Galvanism is practically excluded in these cases. The paralysis following diphtheria is another condition for which Galvanism is of but little service.

The author then related the history of several cases. For special irritation or special neuralgia so-called, Galvanism is almost exclusively indicated. Galvanism is specially serviceable in certain sequela of cerebro-spinal meningitis, such as severe pain, sometimes beginning in the eyes and extending over the head to the neck and lower cervical vertebrae, associated with a stiffness of the muscles of the neck, etc. Exophthalmic goitre requires Galvanism. For the restoration of the senses of taste and smell, Galvanism succeeds where Faradism fails. Galvanism is superior to Faradism in the treatment of skin affections. For the relief of the pain of herpes zoster Galvanism is eminently efficacious. Galvanism, according to his experience, was preferable in the treatment of extra-uterine pregnancy. For chorea, if the appetite is good and nutrition unimpaired, and the strength vigorous, central Galvanism was almost invariably indicated; on the contrary, if the patient is weak, anæmic, and nutrition impaired, general Faradization is indicated.

In amenorrhœa the same principle holds good. In dysmenorrhœa both currents, either alone or in alternation, have proven efficacious, although the Galvanic is most frequently indicated. With regard to Franklinic electricity, he should say that while its constitutional tonic effects are unequal to those which follow general Faradization, where this method is carried out properly and with due attention to details, yet as an adjuvant or supplement it was invaluable. Occasional cases of nervous exhaustion, as well as other forms of disease, after improving to a certain

point under the influence of Galvanism or Faradism, cease to improve, but a new start can frequently be given by then resorting to Franklinism. Pain is sometimes relieved by Franklinism after both Galvanism and Faradism have failed, but it is not the rule. The pain of muscular rheumatism, however, is relieved by this method sooner and more effectually than by the others. For this purpose the treatment by the roller is superior to treatment by sparks. In the various forms of true neuralgia Franklinism is not comparable in power to Galvanism. The pain so successfully relieved by Galvanism is generally of a chronic character confined to no special nerve-trunks, dull aching, and with no tenderness on pressure. In these instances Faradism is superior to galvanism, and recent experience had convinced him that Franklinism was superior to either. In the enlarged joints of sub-acute and chronic rheumatism, and to facilitate absorption in chronic synovitis, Franklinism (sparks) is frequently more efficacious than either Faradism or Galvanism. In old contractures and in cutaneous anæsthesia Franklinism is frequently superior to either of the other forms of electricity. In electro-diagnosis, Franklinism is of but limited value.

Valuable as is Franklinic electricity it has a more limited range of usefulness than dynamic, and the more strongly this fact is impressed on the professional mind the better. He who begins with Franklinism to study and practise medical electricity begins at the wrong end.—*N. Y. Medical Record.*

DIALYZED IRON.—Dr. Prosser James has lately said, in a summary of the position which dialyzed iron is entitled to hold in medicine, that the persalts of iron are frequently employed solely on account of their astringency, while the proto-salts are occasionally considered as being destitute of this quality. The

freshly-prepared carbonate is an excellent mild chalybeate, but difficult to keep in an unaltered state, so that preference is given to reduced iron. The scale preparations of iron are held in repute, both from the extreme facility of their use, and their agreeable taste. When these three forms of iron are inadmissible, dialyzed iron may be resorted to with admirable effect. It is a milder chalybeate than the three preceding, and does not produce the slightest irritation.

A recent analysis by Professor Tiehborne of Wyeth's preparation agrees almost exactly with Graham's statement, that dialysed iron contains 98.5 parts of the oxide and 1.5 parts of hydrochloric acid. The liquid thus obtained differs altogether from an ordinary solution of salts of iron, by its not giving rise to the blood-red colour on the addition of alkaline sulphocyanide, nor to the blue precipitate with ferrocyanide of potassium. It does not become cloudy on boiling, nor when agitated with two parts of ether and one part of alcohol is the ether layer coloured yellow. It is so sensitive that ordinary spring water will cause a precipitate, yet no precipitate is produced by nitric, acetic, or muriatic acid. Graham's solution gelatinized in about twenty days, and he regarded it as a solution of colloid ferric hydrate which, he considered, existed in both a soluble and insoluble form. It is however, never free from chlorine. Theoretically, therefore, the liquid is a solution of a basic oxychloride, but it can never be imitated by dissolving saturated solutions of the hydrate. All these artificially-made liquors are astringent, with ferruginous taste and acid reaction.

Respecting the therapeutic value of dialyzed iron, of which there has lately been some inclination to doubt, Dr. James says there is no question. By the method now followed of counting blood-corpuscles it is found that the taking of dialyzed iron both increases their number and improves their condition. Dr. James gives, as an average

dose, twenty to fifty drops, daily, in three doses. Dr. Weir Mitchell, of Philadelphia, gives as much as a drachm at a time.

Specimens have appeared in the market which are not only innocent of any acquaintance with a dialyzing membrane, but seem little else than diluted solution of perchloride of iron.—*Chem. and Drug.*

THE ACTION OF SODIUM SALICYLATE ON THE HEART.—It has been supposed by probably the majority of practitioners that this remedy has a tendency to weaken the heart's action. Liebermeister's well-known views, with reference to the dangers of giving it to a patient whose heart is weak, as for instance, in typhoid fever, were generally accepted as correct. Prof. Maragliano, of Genoa, has, however, recently investigated the subject, and the results of his carefully conducted experiments, show conclusively that the salicylate has no depressing effect on the heart's action, on the contrary the effect is to strengthen it.

PROF. ELLENBERGER (*Archiv für Veterinarwissen*) speaks very highly of painting the skin with impermeable applications for parasitic diseases. He has used collodion, tolu in ether, rubber in chloroform, etc. When the part is covered with these mixtures, the parasites, animal and vegetable, alike, soon die. He has experimented with dogs and other animals, and finds that they can stand from one-half to one-third of the body covered in this way.

PELLETIERINE is an excellent remedy if given with certain precautions. If it fails, it is because the purgative is given too late. M. Tenneson is in the habit of administering a purgative half an hour before the vermifuge is given, so that the purgative may act upon the worm intoxicated by the pelletierine. The tania is then always passed entire. M. Laboulbène proceeds in exactly this way, and a long time ago recommended the practice.—*L'Un. Méd.*

SYPHILIS AS A CAUSE OF DEMENTIA PARALYTICA.—H. Obersteiner, in *Monat f. P., Dermatol.*, concludes, after a review of 1,000 cases that syphilis is an important factor in the production of this condition. He divided the patients into groups according to age, and found a varying percentage of from 4.1 to 54, with a syphilitic history. In 26% of one group of 73, syphilis and dementia were co-existent. He thinks that when syphilis acts as a cause the dementia appears early in life by about the thirty-fifth year.

Surgery.

HYDATID CYST OF THE PROSTATE.

M. Tillaux reported to the *Société de Chirurgie* a case of a man, aged 43, suffering from complete retention of urine. The bladder could be entered easily by means of a rubber catheter, but not by a metallic instrument. There was pain in the loin, towards the sacrum and lower portion of the spine. The rectal touch revealed the existence of an enlarged prostate, filling the rectum, and crowding the urethra towards the pubis. The tumour was perfectly regular, smooth, and fluctuating. The diagnosis, based upon the miserable appearance of the man, and an old cicatrix of cold abscess upon the thorax, was cold abscess of the right lobe of the prostate. As the patient continued to suffer, lost appetite, and flesh, and strength, the abscess was opened from the rectum, and gave issue to a slightly coloured fluid, and which at first was thought to be urine, but it had not the urinous odour, and the bladder was subsequently emptied, per urethram, of perfectly limpid urine; showing that the bladder had not been punctured. The tumour was then a cyst of the prostate, and a microscopic examination revealed the presence of hydatid hooklets. Two days afterwards, at stool, a considerable mass of hydatids was expelled, per rectum. Cases of hydatid cysts of the prostate are exceed-

ingly rare. According to M. LeDentu, there exists no authentic case on record.

M. Nicaise, at the same session of the Society, gave notice that he shortly intended to report a case of hydatids of the prostate. —*L'Union Méd.*

REDUCTION OF DISLOCATED FEMUR.—Dr. Samuel Logan, of New Orleans, (*Gaillard's Med. Jour.*) re-asserts the plan proposed by him some years ago to reduce, by manipulation, luxations of the femur. He was induced to do this by the recital of the difficulties incurred and the means taken to overcome them in a case by Dr. C. Johnston, of Baltimore. This difficulty, mentioned by Mr. Callender, consists in the slipping of the head of the femur around the rim of the acetabulum during the process of the ordinary manipulative means for reduction, thus lodging the head of the femur either into the thyroid or sciatic-foramen, instead of into the acetabulum. This danger may be obviated, according to Dr. Logan, by making use of the anterior border of the pelvis as a fulcrum by which the head of the femur may be lifted over the rim of the acetabulum. When the thigh is fully flexed upon the abdomen, the limb, at the junction of its middle and upper third, impinges upon that portion of the pelvis just below the anterior superior spine of the ilium. Forced flexion now lifts the head of the femur, and rotation, outward for any form of posterior, and inward for any form of anterior dislocation, will throw the bone into place. An analogous idea has occurred to Dr. George Sutton, of Indiana, who suggested an artificial fulcrum of the arm of an assistant, or a roll of cloth placed in the groin. Both plans resemble the ancient method of placing a pillow between the thighs as a fulcrum for a similar purpose.

BLENNORRHAGIC PERIURETHRAL TUMOURS.—M. Mauriac concluded a paper read before the *Société de Médecine de Paris*, as follows:—

1. The glandular apparatus, including the glands of Méry or Cooper, and their accessory glands, is sometimes inflamed in the course of blennorrhagia.

2. The acute process nearly always ends in suppuration, and the formation of abscesses.

3. When Méry's glands are alone affected, which is the usual course, the affection terminates very constantly in a perineal abscess.

4. When the process is confined to the accessory glands, the tumour is situated beneath the curve of the urethra, at the summit of the scrotal region between the testicles.

5. Here, also, suppuration is the rule, but the glandular engorgement may, however, proceed to resolution.

6. In its chronic form it constitutes a large tumour, hard, ovoid, knobby, not fluctuating, which occupies the middle portion of the scrotal region, in the midst of which it remains firm, and which only forms fortuitous adhesions with the testicles and epididymis. The duration may be very long.

7. In its sub-acute form, after a sudden invasion and rapid increase, the inflammatory phenomena all at once cease, and complete resolution is effected in a few days.

8. Active intervention is unnecessary in the two last forms; a moderate antiphlogistic medication suffices and favours the cure, which, however, may take place spontaneously. In the phlegmonous forms, on the contrary, the tumour must be opened very early, even before fluctuation is apparent.

9. Whatever their form and tendency, these urethro-scrotal tumours, although proceeding directly from the canal, are evolved outside of it, and cause it no damage. M. Mauriac has not seen them open into the canal when they were purulent, nor form urethral fistules.—*L'Un. Méd.*

KERN'S CATAPLASMS.—In the session of October, 1882, of the Berlin Medical Society Drs. Senator and Schlesinger advocated *sapo viridis* in the form recommended by

Kern and Bush for Peritonitis and Inflammation of the glands. The formula and manner of application of these cataplasms is as follows: Powdered mustard and *sapo viridis* are mixed in the proportion of one to four (or five) and spread between two layers of muslin and applied for six, eight, or ten hours. In the case of lympho sarcoma, for instance, these cataplasms are to be repeated daily for weeks. Senator reported numerous cases of peitonitis and perforations treated successfully with the *sapo viridis* alone, and Schlesinger related at length the successful treatment of various grandular swellings with the cataplasms of mustard and *sapo viridis*.—*Berlin Klin. Woch.—Therapeutic Gazette.*

WHITE LEAD PAINT IN ERYSIPELAS.—Mr. Barwell, of Charing Cross Hospital, in *Lancet*, March 10th, gives a report of three cases of erysipelas, in which he obtained unusually good results by the application of the old-fashioned remedy, white lead paint. No medicine used, excepting, in some cases, the previous administration of a purge. He applies the paint (made by rubbing up the carbonate of lead with linseed oil, and mixed with turpentine as a drier) over inflamed skin, and a little beyond it, says that in all cases the pain ceased almost immediately after the application; temperature became normal and a rapid cure resulted. The paint is left on until it gradually comes off with slight desquamation of epidermis. The remedy probably acts by occlusion of air. It may be obtained in any paint shop.

TREATMENT OF VARICOCELE.—Mr. A. Drennett Spanton, F.R.C.S., recommends in *Brit. Med. Jour.*, a subcutaneous ligature used as follows:—A needle threaded with silk or catgut is passed between the vas deferens and spermatic vein, and a loop left on one side, and the free ends on the opposite. A second needle similarly threaded is then passed in the opposite direction between the vein and the skin, and withdrawn, leaving a loop as before. One of the threads

is then passed through the loop on each side, the ends drawn together and firmly tied. The threads are then cut off short, and the ligature sinks away from the skin punctures.

Midwifery.

PREMATURE DELIVERY FOR THE PREVENTION OF BLINDNESS.—Dr. Edward G. Loring, of New York, in a lengthy communication to the *New York Medical Journal* cites a number of cases and otherwise strongly supports the view that it is occasionally necessary to induce premature labour for the sole purpose of preventing blindness. His conclusions may be briefly stated thus:—Examinations of the eyes of pregnant women should be made much more frequently than they now are, indeed, as a matter of routine, even without complaints on the part of the patient, since about one-third of these with organic lesion of the optic nerve or retina from kidney trouble, make no complaint. That evidences of albuminuria (*sic*) not infrequently show themselves in the eye before any manifestation can be had in the urine. That although the uræmic cases may begin late in gestation, the albuminuria frequently occurs early, and examination of the eyes will reveal the danger and suggest the remedy. That the use of the ophthalmoscope for this purpose should be within the ability of every obstetrician; that where marked deterioration of vision has occurred, with or without ophthalmoscopic changes, and where blindness is threatened, premature delivery is not only justifiable, but often demanded; that when a permanent loss of vision has occurred from a preceding pregnancy, premature delivery, surrounded by its proper safeguards, is not only justifiable, but at times absolutely necessary; that where blindness has once occurred, the husband and wife should be warned that the trouble is constitutional and not local, and that a repetition of pregnancy may result, not only in a loss of sight, but also of life.

RINGER AND MURRELL ON AMENORRHOEA.—Drs. Ringer and Murrell have for some time made extensive trial of permanganate of potash as an emmenagogue in those cases of amenorrhoea resulting from some trivial cause, such as getting wet or catching cold. In their experimental observations they gave the one drug only. The most striking results were in young women between the ages of eighteen and twenty-five, who had missed two or three periods. The administration of one or two grains of permanganate of potash in pill three or four times a day for a few days before the time of the expected period will bring on the flow almost to a certainty. As a rule, the medicine must be taken three or four days successively to call out the catamenia. *Lond. Med. Record.*

PICININI ON ASSAFŒTIDA AS AN AID TO THE BETTER DEVELOPMENT OF THE FŒTUS.—The author refers to the works of Laferta and Professor Giordano, and the recent writings of Cazzani on this subject. He states that he can confirm their conclusions as to the good effect of assafœtida, having administered the drug with great advantage in several cases. In the discussion which took place on this paper, in which many gynæcologists took part, all agreed in attributing to assafœtida the property of preventing abortion, especially where there was no taint of syphilis; over which it has no influence.—*Lond. Med. Record.*

NEW REMEDY FOR THE VOMITING OF PREGNANCY.—Dr. T. C. Wallace, of Cambridge, N. Y., says, in the *Phila. Med. & Surg. Reporter*, that for the last four years he has found one remedy uniformly successful in relieving this troublesome complaint. It is the quickly-roasted grain of a species of Indian corn, too well known as pop-corn to need any description. It should be popped in a wire popper, not (as is sometimes done) in a spider, with grease; should be white and light, sprinkled with a little salt, and eaten freely.

TUBERCULOSIS OF THE FALLOPIAN TUBES.—Dr. Justus Schramm, of Dresden, lately contributed to the *Archiv. für Gynäkologie* a short paper on the above subject. Out of three thousand three hundred and eighty-six autopsies upon women he found this condition present in about one per cent.—*Louisville Med. News.*

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

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

TORONTO, APRIL, 1883.

ONTARIO MEDICAL ASSOCIATION.

This flourishing Association meets in Toronto, the first Wednesday in June, when a most interesting meeting is expected. The indefatigable Secretary, Dr. White, is endeavouring to gather a collection of Pathological specimens, which are to be preserved for the use and information of the members. Specimens may be forwarded to the Secretary as early as possible. It is to be hoped that the members of the Association will join hands in this laudable undertaking, and endeavor to gather and preserve the numerous and valuable morbid specimens scattered through the country. The Museum of the Royal College of Surgeons, London, had a beginning.

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LOCAL ELECTIONS FOR ONTARIO.

At the recent elections eight medical men were elected: viz., Dr. J. Baxter, Cayuga; Dr. C. H. Brereton, Bethany; Dr. J. Cascaden, Iona; Dr. J. F. Dowling, Eganville; Dr. J. W. McLaughlin, Bowmanville; Dr. R. H. Preston, Newboro'; Dr. J. H. Widdifield, Newmarket.

MEDICAL SCHOOL FOR WOMEN.

We believe there is some foundation for the rumours which recently appeared in lay and professional journals respecting the organization of a Medical School for Women in Toronto. Such a scheme is under consideration, and it is thought arrangements will soon be completed, whereby a commencement will be made in October of this year. One of the most serious difficulties in such an undertaking will be the all-important question of money, of which a considerable amount will be required in inaugurating the movement; but as there are many of both sexes in this city who have strong convictions on the question of the education of women, and as such persons have intimated their willingness to give substantial assistance, the promoters have reason to believe that the means will be provided by such parties to form an endowment fund, which will place the proposed school on a permanent basis, and guard against the possibility of failure.

THE ASSOCIATION OF AMERICAN MEDICAL EDITORS will hold its next annual meeting in the City of Cleveland, Ohio, simultaneously with that of the American Medical Association, on June 5th and 6th, 1883. The President, Dr. N. S. Davis, of Chicago, recently selected as Editor of the forthcoming weekly Journal of the American Medical Association, will deliver an address on "The Present Status and Tendencies of the Medical Profession and Medical Journalism." Dr. Marcy will address the meeting on "Journalism Devoted to the Protection and Concentration of Medical and Surgical Science in Special Departments." Other interesting papers and addresses will be read at the sessions, which are to be between those of the American Medical Association, and all physicians present at either gathering are invited to take part in the proceedings and discussions. Dr. Jno. V. Shoemaker, of 1031 Walnut Street, Philadelphia, is Secretary.

SUMMER SESSIONS.

All arrangements have been made to commence the Summer Sessions in the Toronto Schools in the latter part of April.

"MEDICAL MISCELLANY."—With a view to diffusing amongst the people generally some correct notion of the "duties of patients to their physicians," Dr. F. N. Darby, of Morrow, O., has conceived the idea of printing upon sheets of paper, designed for wrapping medicine bottles in, the teachings of the Code of Ethics of the American Medical Association upon that subject, conspicuously displayed amongst selections of wit and wisdom, to catch the attention of the reader. It is so printed that the sheet may be torn into halves, quarters, eighths, or sixteenths without interfering with the reading matter. It is hoped that the sheet may come into extensive use as powder and wrapping paper by Druggists and Physicians. The price varies from \$1.50 per hundred to \$9 per thousand, and additional thousands at \$8. The idea is certainly a good one, and the effort to disseminate wholesome and necessary information on a subject more often occasioning offence through ignorance than through design, deserves the general widespread support of the profession.

DR. CANNIFF requests us to thank those of the profession of Toronto, who kindly and voluntarily supported him as an applicant for the position of Health Officer for the city. At the same time he asks for the co-operation of the profession, either by offering suggestions, or in any way they can.

Correspondence.

To the Editors of the Canadian Practitioner:

GENTLEMEN,—Dr. Lavell has a long letter in your March number about the late difficulties in his school. The troubles to which he alludes, *died*, and were thought to have been *buried* in December last.

My only reason for noticing the Doctor's letter is that he mentions me by name several times, and even goes so far as to cast doubts on my truthfulness in regard to at least one point. He refers to newspaper statements and to street gossip, as the sources from which he obtained his version of what took place some months back, when certain Kingston students applied to enter Trinity Medical School. He accepted the information so gathered, as quite reliable, hence all his subsequent random vapourings; and this has led, not only the Doctor himself, but also a good many other well-meaning people, entirely astray as to the actual facts.

It is useless to repeat the whole story now, as it is sufficiently well-known. Yet, it appears necessary to tell the Doctor again, that the telegram from the students, was our very first intimation of trouble in the Kingston School; and this gave us to understand *most clearly* that the dissatisfied students had *left the school "not to return"* to it. This telegram made no allusion to fees, and only asked a very few most reasonable queries. It was answered briefly, and the reply likewise, had no reference to fees. In *twenty-four hours*, at furthest, after the students' telegram came, we got, through the daily papers, full information regarding the matter. We thus ascertained that, to a certain extent, the telegraphic message had misled us, as the students had *not left*, and there even appeared to be every probability that a satisfactory settlement would shortly be brought about.

Having got this fresh information, which was to us most welcome, I wrote my first letter to Dr. Lavell, and, of course, in the reference made in it to the students, spoke of their *leaving with an "if"*; in short, with the telegram *only* in our hands we believed they *had gone*, while, with the further information, we found they *had not*, and *so wrote*.

It seems impossible to believe that in regard to so small a matter, and one so

easily explained, Dr. Lavell would have permitted himself to seek to asperse the veracity of a very old friend. However, *chacun à son gout*.

The very day Dr. Lavell was first written to, I also wrote to a Kingston student, who had asked some questions about the telegram, to the effect, that it would not have been answered at all, but for the belief that the students had actually left; that, as they had not, and as everything was being nicely settled in the school to which he belonged, his questions needed no reply. I expressed my regret at not having been present at the Kingston School's annual dinner, and hoped it would have many such, and closed by wishing that, on its reopening after the Christmas holidays, it might be more prosperous than ever.

This was the end of the official correspondence, consisting in all, of one telegram, in answer to a few civil questions, and a letter written some twenty-four hours later, of congratulation, at the satisfactory prospect of a speedy and peaceable ending of the difficulties.

Shortly afterwards I received Dr. Lavell's second letter, containing the specific questions he refers to, and thought it unnecessary to answer them formally. First, and this of itself was to my mind a sufficient reason, because, by the time the questions reached me, the difficulties to which they had reference were, I believed, practically at an end. I also felt that the giving Dr. Lavell in my reply, as I did, the exact facts of the case so far as we were concerned, in a second letter, couched in the most friendly language I could use, was likely, if pleasing him had been possible, to be far more satisfactory than were categorical replies to three or four questions, some of which were based on absolutely false statements, gathered from unauthorized and unreliable sources.

To show further and as fully as could be, my feelings in the whole matter, I sent Dr. Lavell a copy of most of the letter I had written to the Kingston student, above

referred to. I thought then, and see no reason for changing my opinion now, that a fuller or more frank explanation of our position in regard to this matter, could not have been given. I am sorry Dr. Lavell thinks otherwise, and attribute his doing so altogether to the annoying and harassing character of the whole trouble—the like of which I trust may never occur again, either in Kingston or in any other school.

Now that what was called “*the astounding offer*” to receive the Kingston students for *half fees*, has been proved to be a fabrication pure and simple, “*without even a single vestige of truth*” on which to rest, that cry has been dropped. Dr. Lavell, and even the CANADIAN PRACTITIONER, however, affect to be much shocked at the bare idea, and I deeply sympathize with their extreme sensitiveness, of something which *never happened*—viz., what Trinity Medical School *might perchance* have done, in regard to receiving the Kingston students, had the co-education of the sexes in all the branches of medicine, which the Faculty had declared to be their fixed policy, been persisted in, instead of abandoned.

It is alleged, that had the Kingston men left as they threatened, and had they been refused by their late teachers certificates of attendance during the first half of the session, as was highly probable, owing to the strong feeling which prevailed; and further, had they gone to Trinity School, that that Institution would actually have accepted the affidavits, or sworn declarations of these young men, in lieu of the certificates which it was not possible for them to get.

Be it specially noted that the only stain upon the characters of these students was simply, that they felt longer attendance as members of *mixed classes* to be intolerable.

I would not, for a moment, express any opinion, nor write a single word here, in regard to any ladies, who see fit to study medicine, but it goes without saying, that the feeling of the Kingston students as to

the *impracticability* of *mixed medical classes*, is shared in by nineteen out of every twenty professors and other members of the profession, and such classes *must be* particularly unpleasant to any ladies who may happen to attend them.

But *would* the above possible action, even had it been carried out, as it was not, have constituted so fearful a charge against Trinity Medical School? Educational and other institutions in all countries, are every now and then, from necessity, laying themselves open in the same way—viz., accepting sworn declarations where formal certificates cannot be got. Under many conceivable circumstances no other course can be pursued; and I submit that it is a most unworthy and entirely unwarrantable aspersion of the character of Canadian medical students to insinuate that such sworn documents would be otherwise than perfectly trustworthy.

To go no further, in the Toronto General Hospital, one of the best in America for the practical advantages offered to students, *certificates of attendance* are signed, on the written declaration of the students; yet who would dream of even suspecting the reliability of such declarations?

But why all this affected horror of what *might have been, but never was*, accepted from certain students who *might* have entered Trinity School but who never did so? Verily there never was a sadder or more puerile exhibition of impotent and foolish ill-feeling than this Kingston fiasco has called forth.

Trinity School never wished a single man to leave any other institution to join her classes, and never will. *Students*, however, have rights as well as *professors*, which cannot with propriety, and should not, be overlooked; and one right most assuredly is, that the unanimous conviction of a class should be courteously received, and dispassionately discussed and acted upon. For circumstances over which students have no control may now and then develop

under which their studies can no longer be pursued in the school of their choice either with pleasure or profit. Rightly or wrongly, the Kingston students all but unanimously came to regard *mixed classes* as belonging to this category. Hence the whole trouble. And it was well for their school that the Faculty, realizing at length the true state of matters, yielded the point in dispute, so restoring that harmony, without which no institution can prosper, and which I hope may never again be broken.

WALTER B. GEIKIE,
Trinity Medical School.

March, 1883.

Book Notices.

Fifth Biennial Report of the Illinois Southern Hospital for the Insane, at Anna, 1882.

President's Address before the N. Y. Medical-Chirurgical Society, 1882. E. P. FOWLER, M.D.

Transactions of the American Ophthalmological Society. Eighteenth Annual Meeting, Lake George, 1882.

Weekly Health Bulletins, published by Provincial Board of Health, Ontario. P. H. BRYCE, M.A., M.B., Sec.

The Electric Light in Surgical Diagnosis. By ROSWELL PARK, M.D., Chicago. (Reprint from *Annals Anatomy and Surgery*.)

Secondary Batteries and the so-called Storage of Electricity. By ROSWELL PARK, A.M., M.P. (Reprint from *Chicago Med. Jour. and Examiner*.)

The Percentage of College Bred Men in the Medical Profession. (Read before American Academy of Medicine). By CHARLES MCINTIRE, jr., M.D., Easton, Penn.

Weekly Health and Mortality Bulletin of the City of Lansing and State of Michigan, Published by State Board of Health. Henry B. Baker, M.D., Sec., Lansing, Mich.

Compend of Anatomy; for use in the Dissecting Room and in Preparing for Examinations. (Third Edition). By JOHN B. ROBERTS, A.M., M.D. Philadelphia: C. C. Roberts & Co.

The exhaustion of the first edition of this work, the rapid appearance of a second and so shortly followed by a third is conclusive

evidence of its saleable character, and that the author's method of teaching his subject is judicious and excellent.

The Systematic Treatment of Nerve Prostration and Hysteria. By W. S. PLAYFAIR, M.D., F.R.C.P. Henry C. Lea's Son & Co., Philadelphia; N. Ure & Co., Toronto, 1883. Price, \$1.

This pamphlet, written with the usual clearness and polished diction of the well-known author, is a collection of the papers upon the subject published by him in the *London Lancet*. The ends in view and the means to attain those ends are forcibly urged, and the relation of the cases is vivid. The pleasure of reading the pamphlet is enhanced by the excellent typography.

Illustrations of Dissections; Representing the Dissection of the Human Body. By GEO. VINER ELLIS, Professor of Anatomy, University College, London, and G. H. FORD, Esq. The drawings are from nature by Mr. Ford, from dissections by Prof. Ellis. Vol. ii., second edition. New York: Wm. Wood & Co., 1882. Toronto: Willing & Williamson.

This is the February Number of Wood's Library Series for 1882. The work is too well and favourably known from the English Edition to require comment. This volume takes up the Perinæum, Abdominal Parietes, Pelvis, and Lower Limb, and comprises plates xxix. to lviii. inclusive.

First Annual Report of the Provincial Board of Health of Ontario, 1882.

The first Report of the recently erected Provincial Board of Health is now before us. It is divided into three parts: the first comprising an account of the organization of the Board, the collection and dissemination of sanitary information, investigations into the causes of, and remedies for, various outbreaks of disease, the action taken in connection with reported nuisances and unsanitary conditions, the collection of disease statistics, the relations of the Board to various classes, and a forecast of the work to be done. Part II. contains eight appendices to the Report proper, consisting of Reports of Commissioners instituted by the Board, copies of documents, pamphlets, circulars, and memoranda issued by the Board during the year; and Part III. is

made up of addresses, lectures, and papers read or delivered by members of the Board, or under its auspices, most of which have already been abstracted or referred to in these papers. The volume as a whole, contains much valuable and interesting information, and fully attests the utility and efficiency of the Board. While the subject-matter is very good, in many instances the manner is anything but commendable, exhibiting too great a disregard of perspicuity and eloquence of diction—a fault the more remarkable since we observe that four out of the seven members are College-bred men. Pope's ashes must surely glow with the heat of indignation at the line quoted on page XXXII, unless in truth the dead care not what we mortals think.

Personal.

Dr. Uzziel Ogden expects to start for Europe in May.

Dr. Mills, of Montreal, left March 14th, for Strasburg and Leipsig.

Dr. Stewart expects to attend the April meeting of the German Surgical Society at Berlin.

Dr. W. J. Neilson has been appointed Health Officer at Winnipeg, with a salary of \$1,200 a year.

Dr. W. H. Aikins has left Vienna and will soon return to Canada. Drs. Stewart, Edvardson, and Nattress are still in Vienna.

We are glad to be able to report that Dr. J. A. Stevenson, of London, is somewhat improved in health, although he is still confined to his room.

Dr. Buller, of McGill, Montreal, suffered for some time from sub-acute rheumatism. We are glad to learn that he has recovered, and has resumed practice. Report says that active work, including the task of looking after his *noisy tenant*, is more congenial to his taste.

As we anticipated in our last issue, Dr. William Canniff has been appointed City Health Officer for Toronto, at a salary of \$1,500 a year. The choice is highly approved by the profession in and outside the city. Our only regret is the small compensation, as the duties are very onerous, and will interfere very seriously with active practice. In connection with the latter the Dr. will probably be able to attend to little excepting consultations. We believe he has

been advised by friends to confine himself to consulting practice. His large experience and well-known ability would make him well fitted for such a course.

OBITUARY.

HENRY H. CROFT, D.C.L., F.C.S., ETC.

Professor Croft, after filling the Chair of Chemistry in University College, Toronto, for about 35 years, was superannuated in 1880, and shortly afterwards resided at his son's ranch until his death, which took place last month.

Although not a physician, few men were better known to the Medical Fraternity of Canada than this distinguished Professor. While connected with the University he taught medical students (chiefly those attending the Toronto School) for 30 years; and the relations existing between teacher and student, whether in the lecture-room, the laboratory, the "University Rifles," or in private social intercourse, were always of the most pleasant description. Being possessed of great ability, untiring energy, almost inexhaustible good nature, unbounded courtesy, and rare kindness of heart, he was at the same time one of the most skilled scientists, and one of the most successful and best beloved teachers that this country has seen.

ARTHUR MOREN, M.D., EDIN.

Probably few physicians have visited Halifax without meeting the kind, genial, and courteous Dr. Moren, who was for a number of years Health Officer for that city. The news of his sudden death on the 27th of February, will be a source of the deepest regret to all such, as well as his host of personal friends in the Lower Provinces. His health had been poor for some years, and his sudden death was caused by hæmorrhage from the stomach.

Miscellaneous.

THE COLDEST TOWN IN THE WORLD.—The coldest inhabited town in the world is, according to *L'Union Médicale*, not Irkoutsk, as has been formerly believed, but Verchojansk, in Siberia. In this place the mean temperature during the month of January was -43° F.; in February, -56° F.; in March, -37° F. Once the thermometer recorded -81.4° F.