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# THE CANADA MEDICAL RECORD.

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### *Original Communications.*

#### CLINICAL LECTURE ON HÆMORRHOIDS.

Delivered at the Montreal Dispensary.

By A. LAPHORN SMITH, B.A., M.D., M.R.C.S. ENG.,  
Professor of Botany, Bishop's College, Medical Faculty.

GENTLEMEN,—Owing to the enormous increase in the number of patients attending this institution, I deem it my duty to make some use of such a vast amount of material for your benefit, by calling your attention by means of a series of short clinical lectures to certain classes of cases which we have frequent opportunities of observing here, and which in a few years from now, when you are immersed in private practice, you will be most frequently called to attend, without perhaps having the time to devote to their study. I claim for these every-day diseases a fair share of your attention, for it is they and not the case of extreme rarity which will form the bulk of your practice and the foundation of your reputation.

The subject I have chosen for my first lecture is Hæmorrhoids, or in Anglo-Saxon, piles, and at the very outset let me put you on your guard against a common source of error. Patients frequently make mistakes as to the diagnosis of their complaint, even when the malady is situated in a locality which they can readily observe. Still more is this the case when, as with piles, the disease is situated in a part which it is difficult to see and examine. You will see patients coming here suffering from every different affection the rectum and anus are heir to, and yet, they will nearly all tell you, without any

hesitation, that they are troubled with piles, and many of them will deem it an unnecessary liberty we are taking, when we ask them to let us see the piles. The personal and thorough examination of every case of the kind is a most necessary precaution as will be shown by recalling the following case which many of you may remember:—Pete McN., a e. 19, exceeding pale and weak in appearance, came here a few months ago complaining of bleeding piles. He said whenever he had a motion which was a somewhat rare occurrence, as his bowels were always confined, the piles would come down and bleed profusely, sometimes to the extent of nearly a pint. When they came down he could feel a round lump, which was not very painful, but bled freely. We immediately examined his anus, but found nothing abnormal; neither did the use of the rectal speculum reveal any appearance of internal piles. But on removing the speculum I introduced my finger, and at once detected a pear-shaped polypus about the size of a cherry hanging by a long pedicle from the wall of the rectum about two inches up. I pulled this highly vascular tumor down, placed a ligature around the pedicle, and returned it to the rectum, whence it was passed a few days later. He has had no bleeding since, and having rapidly regained his strength, has returned to his occupation, which he had been obliged to relinquish for over a year.

John R., aet 22, came a few weeks ago complaining of piles, which he diagnosed as of the itching variety. On examining him, however, we could find no trace of piles, but we did find a number of little white squirming worms about half an inch long, and looking like bits of thread endowed with

life. These were the oxyuris vermicularis, or ascaris vermicularis, which give rise to intolerable itching about the anus and even tenesmus.

One other case, Mr. W., aet 40, came to be treated for piles, which however, proved to be eczema of the anus.

Do not be misled either by the patient telling you that they have been doctored for piles for several years. In nine cases out of ten enquiry proves that the doctor was himself and the treatment consisted in the liberal application of the numerous quack ointments so generally advertised, while in the tenth case the M.D. who attended them failed to diagnose the disease before treating it.

Never, therefore, undertake the treatment of a case about the anus or rectum until you have made a thorough examination and certain diagnosis.

With these words of warning let me remind you that piles are essentially enlarged hæmorrhoidal veins, surrounded by infiltrated cellular tissue. They are either situated outside the anus and are covered with skin and called external, or they are situated inside the sphincter, covered with mucous membrane, and are called internal. If you remember the vascular supply of the lower end of the bowels, a great deal of light will be thrown on the nature and cause of piles. The rectum and anus receive their blood supply from three principal sources; the upper third is supplied from the superior hæmorrhoidal, a branch of the superior mesenteric artery; the corresponding vein for which empties into the vein of the same name; the middle third receives its vascular supply from inferior mesenteric artery, and this vein, like the previous one being a branch of the portal system, its blood has to go through the liver; but the lower third, including the anus, receives its supply from the inferior hæmorrhoidal, a branch of the internal pudic, and the blood from it returns by the vein of the same name into the internal iliac and vena cava inferior, and does not go through the liver, not having anything to do with the portal system. From this you will readily understand that anything obstructing the return of blood from the portal vein or any of its branches, such as a hard contracting liver or a plug of hard fecal matter pressing on the delicate walled veins in the internal tube would dam back the blood in the superior and middle hæmorrhoidal veins, which, being distended and subsequently inflamed, would become very painful and bleed when pressed upon

by a hard piece of feces, giving bleeding internal piles. While anything preventing the free return of blood by the inferior vena cava, such as a distended right auricle from heart disease or pressure upon the inferior vena cava from an enlarged liver, or pressure on the internal pudic vein, as it passes over the spine of the ischium by sitting for many months on a soft cushioned chair; the soft cushion following the vein into the protected channel nature had made for it. Any of these cases would produce external piles because they would prevent the free return of blood from the inferior hæmorrhoidal veins.

Bleeding is much more frequent from the internal variety than from the external, because the veins are much better supported and covered by the skin in the latter.

In some of the cases I have had, the bleeding was very profuse, indeed in such large quantities that the pallor of the cheeks, the weakness of the voice and step, and the apathy and general debility, attested that a large portion of their blood had been drawn off, and was only replaced with water, the blood in these cases being generally of a dark color showing that the vein itself had burst.

In a few of the cases the bleeding was also copious but of a bright red color coming from the laceration of one of the enlarged arteries of the inflamed mucous membrane covering the distended vein.

In the remaining and perhaps most frequent cases, the bleeding came from engorged capillaries and was small in quantity.

As piles are nothing more or less than varicose veins of the rectum, they are produced by the same causes as produce varicose veins of the legs. Thus they are both frequent in pregnant women, because the enlarged uterus compresses the internal or common iliac veins; they are also rarely absent from heavy drinkers, both because alcohol changes the normal condition of the liver and because moreover, the walls of the veins and heart are relaxed and weak.

One of the first instruments I would recommend you to purchase in starting practice is a rectal speculum. This one made on the same principle as a Fergusons vaginal speculum, but with a slit down one side is the one I prefer. There is another very good one somewhat larger than this, but with the addition of a glass side in the opening, which

can be with-drawn after the speculum has been introduced.

I shall conclude with a few words as to treatment. This may be either medical or surgical, or both. The medical treatment consists in regulating the bowels, diminishing the engorgement of the liver, and in remedying as far as possible the defects in the general circulation. In over-coming constipation, you must carefully avoid anything approaching a purgative, which in the atonic or relaxed condition of the intestine would cause prolapsus and with intense pain. More especially should you avoid aloes which as you are aware acts more especially on the lower part of the bowels and causes congestion of the pelvic organs. Castor oil and sulphate of magnesia should not be given as they irritate the rectum.

On the contrary only the mildest laxatives should be employed. My favorite in these cases is the confection of Black Pepper which gives almost immediate relief when taken in a dose of 1 or 2 teaspoonful every night. Another very mild laxative is a mixture of equal parts of cream of tartar and sulphur, rubbed into a paste with syrup and taken in the same quantity. The compound liquorice powder of the German Pharmacopœia consisting of powdered senna and powdered liquorice of each 2 parts; powdered fennel and sulphur, of each 1 part and white sugar 6 parts. Where there is congestion of the liver you will find prodophyllin in the dose of  $\frac{1}{4}$  to  $\frac{1}{2}$  a grain in pill form every night, a mild and safe remedy. You can also do much for this class of patients by recommending a suitable diet, in which fruit and vegetables should enter largely; they are nature's laxatives.

You must also warn them against drinking decoctions of tea which containing a considerable quantity of tannin, dry up the secretions of the intestines, allowing those hard plugs of fecal matter to form which press upon the veins and cause them to be distended.

For reasons already mentioned the use of alcohol should be discouraged.

The surgical treatment may be either palliative or curative. The former consists in the local application of anodyne and astringent ointments and injections. The best of these and the one I invariably use is the unguentum gallæ cum opio. It is always soothing, and when employed in con-

junction with remedies which keep the contents of the bowels semi liquid, it will almost seem at times to be curative.

When there is much bleeding a lump of alum cut into the shape of a suppository may be inserted, or an enema of a 20 grains to the ounce solution of persulphate of iron will generally control the hemorrhage.

Among the curative surgical measures one of the best, least painful and safest is the injection of carbolized oil, equal parts of each with a hypodermic syringe into the distended vein which forms the pile.

When piles are internal and not readily brought down, a speculum is employed to uncover them. The operator generally takes only one pile at a time, always selecting the uppermost one first, and injects into its interior from one to four drops. The injection turns the pile white, probably con- gulates the blood in its vessels, and results in its shrinking away, without the inflammation being at any one time severe enough as a general thing to prevent the patient from attending to his business. The well known power of carbolic acid to act as a local anaesthetic antiphlogistic and antisu- purative favors the progress. When the irritation of the first injection has measurably subsided, another pile is attacked in the same way."

Of the two remaining methods, the ligature and actual cautery, the latter is most generally employ- ed. If you have a Paqueline thermo-cautere, you should employ the sharp pointed platinum tip at a little below white heat. By gently pulling the swollen mass down and pushing this into it at one or several points according to its size, the circula- tion in it is stopped and in a few days it shrivels up. If you have not such an instrument any blacksmith could make you an iron cautery con- sisting of a handle, stem, and at the end of that a sphere of metal for storing the heat necessary for supplying the point projecting from it and which does the actual work.

When there are loose flaps of skin hanging around the anus you may snip them off with a pair of scissors, hemorrhage if any being controlled by the ligature or pressure.

I have not been called upon to do any of these operations here, for I have not yet come across a case that did not readily yield to medical treat- ment which as I have already said consists largely in preventing constipation.

## GYNECOLOGICAL REPORT.

By E. H. TRENHOLME, M.D.

Professor Gynecology Bishop's College, Montreal.

Vaginismus is such a serious and at the same time such an intractable affection that we gladly accept any plan of treatment that adds to the means we already possess for its cure. A short paper by Dr. W. C. Peaslee, of Denver, Col., published in the *St. Louis Medical Review* is of such value that we give it in its entirety. He says that to treat this disease in a manner that will be tolerated by the patient, often taxes the inventive faculties of the physician to their utmost capacity, and in many cases patients will not submit a second time to the painful treatment which we ordinarily adopt. Recently cases have come to me for treatment who had been under the care of several other physicians, but the means adopted in each case produced such unbearable suffering, that after several attempts the patients absolutely refused to receive further treatment, which consisted mainly in the introduction and prolonged use of a speculum. This always induced severe and very painful contractions of the sphincter vaginæ muscles upon the speculum, producing a very telling effect upon those muscles which I think are of secondary importance in the treatment. Believing, as I do, that the pathological condition exists principally in the mucous membrane of the vulva and vaginal orifice, which, when irritated, is followed by contraction of the sphincter muscles (as occurs in closure of the eyelids from irritation of its lashes, or spasm of anal sphincter from ulcer or fissure) I directed my efforts entirely toward that membrane. To do away with the suffering incident to the contractions of the sphincters upon an unyielding speculum. I use a large sponge tent which I prepare by passing a piece of small rubber tubing eight or ten inches long, or a catheter (in which I insert a piece of wire to prevent compressing the tube when winding the tent) through a cone-shaped sponge, over which apply a layer of strong twine, compressing the sponge as closely as possible, then lay aside, and when dry insert the tent into a rubber condom (to prevent sponge from penetrating the mucous membrane), fastening the open end of condom firmly around the rubber tube. Lubricate and insert, except about one-half to three-fourths of an inch, which is left external to sphincter for the purpose of pressing against the vulvar portion of the mucous membrane;

then attach a syringe (containing from one-half to one ounce of warm water) to the rubber tube and inject the contents, which will be carried to the internal end of tent, causing it to expand first, which aids materially in its retention. Remove syringe and tie the tube or insert a plug to retain the water; then apply patient's periodical bandage, and after she has remained in recumbent position about half an hour, permit her to get up and go about the house, allowing tent to remain as long as forty-eight hours, if borne well.

This method of treatment affords a very effectual means of overcoming the disease without confining our patients to their beds, and without much suffering, as the sponge readily yields to the contractions of the muscles, yet is sufficiently elastic to exert a firm pressure upon the mucous membrane of the vulva and vagina. I believe this sponge tent is fully as efficacious as the Barnes bag, and much more acceptable to the patient, since the sponge is more readily compressed. The results which I have obtained are so satisfactory that I am convinced this treatment if properly carried out we need scarcely ever resort to the division of nerves. A case or two may not be in appropriate here.

Dr. J. R. (initials borrowed) having previously consulted me concerning his wife, brought her before me January 5th, 1882. She had suffered much from occasional attacks of neuralgia. Is of gouty diathesis; twenty-five years of age, had been married three years, and had never had intercourse, she being so sensitive as not to tolerate the slightest touch of anything to the vulvar mucus membrane; had resisted all his arguments for operative treatment. On examination I found two large vascular excrescences protruding from the orifice of the urethra; also several carunculæ around margin of vagina, which I considered the prime factor in this case, but, finding I could not persuade the patient to submit to operative interference for their removal, I made an appointment with them, and on the following day inserted a sponge tent, which the patient retained for two hours with but little inconvenience. I inserted another the following day, which she retained eleven hours. After the use of seven tents the doctor reported a perfect cure.

February 27, 1883, Mrs. M. B., aged 24, slight build; been married two and a half years, and bearing every evidence of sexual starvation, her health having failed rapidly during her married

life. She stated she had not been able to have intercourse with her husband on account of being so tender and sensitive. An examination verified her statement, and disclosed the presence of a severe leucorrhœa, an abundant discharge of viscid mucous, which led me to suspect uterine trouble. I attempted to use the speculum, but she could not tolerate it. I ordered hot vaginal injections for that evening and next morning, at which time I inserted a small tent, which by its gradual distention was borne four and a half hours quite well. I prescribed nerve tonics, and by the use of five tents, gradually increased in size, she completely recovered.

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Dr. W. H. Byford, in an excellent paper read before the American Medical Association, recently, draws attention to the great care required in the treatment of uterine diseases if we would avoid the dangerous consequences that not unfrequently follow examinations and operations. The following conclusions to his paper are worthy of careful study:

1. The sometimes terrible effects of examinations or operations in the pelvis do not often, if ever, take place when there is not a perceptible predisposing inflammation.

2. The inflammation may be so slight as to be easily overlooked.

3. It may be an original condition; the sequence of an acute attack long gone by; or it may be the product of some immediately previous examination or operation, the effects of which have not subsided.

4. To avoid the dangers of acute inflammation we should, in making a first examination for pelvic disease, conduct it in such a way as not to give the patient much pain, and, when she complains of much suffering, desist, at the sacrifice of completeness of diagnosis.

5. Complaints of much tenderness to the touch, or the use of instruments, especially in parous women, is sufficiently diagnostic of inflammation upon which to base treatment for that condition.

6. If, with such tenderness, a thorough examination or an operation is imperative, it should be done under profound anæsthesia. There is no

question, in my mind, that much less danger of ill-effects is incurred in making examinations or operations on susceptible subjects, under the free use of anæsthetics.

7. Examinations or operations should not be repeated until the effects of the first have entirely passed off.

8. As chronic parametritis is a frequent complication of most of the morbid conditions of the uterus, it should be always suspected, and its diagnosis be carefully considered in all cases of metritis.

9. When chronic parametritis is present, it should be the chief, if not the exclusive, object of treatment until removed.

10. It is not safe to use the sound, sponge-treatment, or intra-uterine stem, when there is perimetric inflammation.

11. It is especially dangerous to replace a displaced uterus, when it is bound down by inflammatory adhesions, by any means which will overcome its fixedness by force.

12. The use of pessaries or supports of any kind, which find their lodgment in the pelvis, is generally followed by disastrous consequences when there is even slight primitive inflammation.

13. All local treatment of the uterus must be conducted with the greatest care in all cases where this complication is present.

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Dr. H. C. Howard, of Champaign, Ill., in speaking of iodoform says he finds that in so-called endometritis or uterine catarrh, that a suppository composed of one half-drachm of finely powdered iodoform with one ounce of the butter of cocoa, acts very beneficially.—The ointment will keep in a shallow jar, and 2 to 5 grammes may be introduced by means of a thin silver tube, about one-fifth of an inch in diameter, with a closely fitting piston. This tube is 8 inches long. By contracting the piston to a depth according to the required suppository, it is then filled by forcing it into the ointment. The tube is then passed into the uterine cavity, where the suppository is deposited by simply pushing down the piston. This preparation melts quickly, and causes no pain, in these respects being preferable to the gelatine pencils often used.

*Manganese for Amenorrhœa* has for some time been tried with much success by Drs. Ringer and Murrell. It may be used in solution (B. P.) or solid in 1 or 2 gr. pills. It is best to begin with 1 gr. three times a day, and gradually increase the dose to 2 grs. four times a day. The best time to give the remedy is three or four days before the menstrual period. If this fails to bring on the flow it may be continued steadily for 3 months. Its most noticeable success has been achieved in young persons from 18 to 25 whose usual regular flow has been arrested by cold or wet feet. Especially has it succeeded in those recently from the country. It usually takes about three days for the medicine to produce its effect, but in some cases the flow comes on after the 2nd or 3rd dose. The medicine can be continued during the flow, as it helps its escape. This remedy has succeeded when iron, aloes, nux. vomica, pulsatilla, nitro-glycerine and mustard baths have failed. In scanty menstruation it has been found to increase and prolong the flow. In some cases in girls of 15 or 16, who had never menstruated, it generally brought on the flow. Its value has been proved also in cases of irregular menstruation in married women whose regularity has been interfered with by lactation. The manganese should not be given in cases of gestation; it is useless to induce the flow in advanced phthisis.

The pill form of administration is the best borne by the stomach.

The *modus operandi* of the remedy is not known. It is not by improving the condition of the blood, as it acts equally well in both plethoric and anæmic cases.

Diseases of the Fallopian Tubes has engaged the attention of Dr. Savage, London, and his remarks upon the three forms of Fallopian disease viz., hydrosalpinx, pyosalpinx and hæmatosalpinx, are worthy of attention. It is important to bear in mind the anatomy of the tubes which, like the uterus, is a portion of Müller's duct. The muscular tissue of the tubes being continuous with that of the uterus itself, they also have the same serous covering, and the mucous membrane of uterus and tubes are continuous. This latter fact accounts for the spread of disease from one part to the other, just as orchitis may arise from gonorrhœa in the male. The reason why pus is not formed in the uterine cavity as frequently as in the tubes, is due to obliteration at each end, also to the small amount of areolar tissue in the uterus compared

with that in the tubes. These tubular disorders are more frequent in the married than in the unmarried. The history generally shews that these patients have had some form of pelvic inflammation, or tedious convalescence after childbirth or miscarriage. Gonorrhœa is also a frequent cause, and in its latent form will explain many obscure cases of peritonitis in newly-married women. Intra-uterine pessaries may cause salpyngitis. Pyosalpinx may occur with acute rheumatism. Inflammation of the ovaries frequently occurs with that of the tubes, and is probably due to the same cause or causes. Menorrhagia is a frequent accompaniment of both hydro and pyosalpinx. The first effect of inflammation is to close both the uterine and the finitriated ends of the tube, hence the accumulation of fluid and the sausage-shaped distention. The character of the pus varies from that of a laudable character, to that of a most offensive character. If the tubes are not renewed they give way to repeated inflammatory attacks and cause death.

Cases of hydrosalpinx are not so serious as that of pyosalpinx. Dr. Savage thinks they are sometimes mistaken for a large Wollfian cyst, where a single tapping has been curative.

TREATMENT—Expectant and medicinal treatment are not to be relied upon. The presence of pus is much more serious than when clear fluid exists. The temperature of the patient and condition of pelvic structures point out the need of prompt action. To tap "*per vag*" is dangerous, as pus may escape into the peritoneum; its removal often is very difficult. As spontaneous absorption of two sacs of pus as large as an orange is not to be looked for, one of *three* things must result if left to itself: 1st: Absorption of the fluid, which is not apt to occur in any case, and impossible when the fluid is pus. 2nd. Chronic invalidism, constant pain, frequent high temperature or rigors, etc., etc., and 3rd; bursting the sac, which if it took place into the rectum might result in cure; but if into the peritoneal cavity, it would destroy life. The following cases are given in illustration, also Dr. Savage's concluding remarks in his own words.

CASE I. Patient had menorrhagia, with a small lump on right side of pelvis. Tents were inserted, and the uterine cavity explored: nitric acid being applied to the interior. Died of septicæmia, with abdominal distention. At the *post mortem*, a pyosalpinx on the right side was discovered.

showing distinctly its sac and a point at which it had burst, with the contents free in the peritoneal cavity.

CASE 2. In one of my first operations of this kind I found that the anterior wall of the sac on the right side was composed, at one spot, of only a single layer of membrane, thin enough to be almost transparent, and which must have given way on the slightest pressure; such, for instance, as romping with a little child on the lap, etc., etc.

CASE 3. In a patient recently operated on, the left distention gave vent to a quantity of stinking pus immediately on my touching it with my fingers, using scarcely any pressure at all. Here, a very little external pressure, even examination by double palpation, might have caused a rupture.

The diagnosis of an enlarged and distended tube must be frequently to some extent presumptive, founded upon the clinical history and physical signs. There will be found a tumour of not very considerable size in the position of the Fallopian tube on one or both sides of the uterus or, if larger, it may be felt almost wholly in Douglas's space. A small ovarian cyst, a phlegmon in the broad ligament, or a small hæmatocele, are the affections which would most generally be taken for it; but I have been able in a certain number of cases to say beforehand that the tumour felt was most likely a distended tube, in which the result proved that I was correct. In the acute forms, the parts about the uterus may be felt to be boggy, with more or less fixation of that organ. In the more chronic forms, the uterus may be quite free and mobile; and the tube felt, more or less tender, as a small tumour, floating about apparently quite freely. If the tumour is large, say the size of a small orange or more, and is to some extent fixed by adhesions, the result of previous inflammatory attacks, the uterus is less free, and may be pushed to one or other side. With the patient lying on her back, and especially if thin with a lax abdominal wall, important aid may be also gained by the use of double palpation, *i.e.*, with the finger of one hand in the vagina, and the other hand exercising pressure outside through the abdominal wall. The clinical history, in addition, will give a considerable amount of aid in the diagnosis. In some instances, I feel sure there is nothing to be felt in the pelvis before operation, and we have nothing to guide us but the more or less constant pain and recurring attacks of inflammation; each

attack making the adhesions stronger and more extensive, and rendering the subsequent removal by operation more dangerous.

In performing abdominal section for the removal of these tumors the incision may generally be, say two inches, or just enough to insert the fore and middle fingers of the left hand. It would seem as if an enlarged experience enabled the operator to separate the adhesions with greater facility, and that an increased "tactus eruditus" taught him the more easily to distinguish the line between ovary or tube and the surrounding parts. The omentum is sometimes found to be troublesome, getting entangled among the fingers. If there is any doubt in the surgeons's mind as to the exact relation of the parts, I think it is best to take the fundus uteri as a landmark, and by tracing outwards, on either side, the ovary, tube, and broad ligament can generally be accurately mapped out. If the tumour, after being separated from its bed of adhesions, is large and cannot be brought out through the short opening, it is often a good plan to aspirate it, especially if the contents are serous, when the collapsed tube comes outside readily. If any of the serum or pus escapes into the pelvis, especially the latter, it is of the utmost importance to make a most complete *toilette du péritoine*: in fact the patient's safety depends more upon this than perhaps all other details in the operation put together. I would say, sponge, sponge, sponge! I do not think it necessary to wash out the pelvis; dry sponging is quite as effective. There need be no fear of too much sponging. If there has been no escape of pus, and if I am sure also of no blood being present, I make it a rule to close the abdominal wound completely: otherwise, I insert a glass drainage tube.

I have of late omitted the use of the spray in performing abdominal operations. This doctrine of cleanliness has doubtless been brought about very largely indeed, if not wholly, by the work which Lister has done; and I understand it to include many items, such as abundant use of water, most careful attention to sponging, arrest of hæmorrhage, and drainage where necessary. If there is the slightest doubt, before closing the wound, as to the presence of fluid or the likelihood of much future oozing of bloody serum, you must sponge very thoroughly indeed, and will probably require a drainage tube.

The remarkable and well-known frequency with which both tubes will be found affected with



disease at the same time, renders it necessary to remove both; and I would go so far as to say that, when one has been removed, it is generally best to remove the other one also, even if it be found at the time of operation to be apparently healthy, as the probability is that it would sooner or later become affected in the same way as its fellow.

There are some cases which have been classified as pelvic cellulitis, or pelvic abscess, which I feel sure would, if their exact relations could be made out, come under the head of pyosalpinx, or pus so contained that it could be removed, and the operative treatment in such cases is gradually throwing a considerable amount of light on pelvic suppuration, so that many hitherto incurable cases may be cured. It does seem to me to be very important that we should recognize the serious position in which patients are placed who are having from time to time recurrent attacks of pelvic inflammation.

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## *Society Proceedings.*

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### MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

*Stated Meeting, February 29, 1884.*

WM. OSLER, M.D., 2ND VICE-PRESIDENT, IN THE CHAIR.

*Unilateral Hyperidrosis and Tabes Dorsalis in a Female.*—Dr. REED read the notes of this case.

Dr. HY. HOWARD said that unilateral hyperidrosis is by no means uncommon in cases of mania in the chronic stage, particularly where there is partial sensory and motor paralysis. It is just what we should look for in these cases, if we bear in mind the experiments of Dr. Isaac Ott, from which he drew the following conclusions:—1, That the sensory fibres decussate in part in the spinal cord; 2, That the vaso-motor fibres also do; 3, That the sudorific fibres follow the vaso-motor and decussate; 4, That vaso-motors run in the lateral columns. Now, seeing that in nearly all cases of mania, particularly in the chronic stage, there is found some abnormal state of the different nerves, producing low temperature, etc., it is but natural that we should find hyperidrosis in these cases; but in the case brought under our notice

by Dr. Reed, as yet there has been no pathological psychosis. But with the hyperidrosis, there is absence of patellary reflex, showing some abnormal or degenerate state of sensory or motor tracts in the cords, with enlarged and fixed pupil, showing a partial paralyzed state of the ciliary nerves. With these symptoms, I should say that there was some abnormal state of the spinal cord, or of the vaso-motor, sudorific and sensory nerves in their course along the sides of the cord, which time will more fully develop.

Dr. OSLER had seen two cases of unilateral hyperidrosis during the past two years, one of which was in a patient suffering from caries of the cervical vertebrae.

Dr. Reed remarked that he, with Dr. R. P. Howard, was treating another case of tabes in a female.

#### PATHOLOGICAL SPECIMENS.

*Actinomykosis.*—Dr. OSLER exhibited the jaw of a cow attacked by the above disease, often called "big-jaw," or osteo sarcosis, and due to a fungus, slides of which were also shown. The yellow color in the centre of the nodular masses was well seen. Dr. OSLER said that this disease was fairly common in Europe and America, and has been known for a long time under a variety of names, such as tubercular stomatitis, scirrhus tongue, scrofula, etc. The tongue, lips and mucous membrane of the nose are often attacked. Actinomykosis is fatal unless removed with the knife. This disease is seen in horse and swine, and even in man, twenty cases being reported, all in Germany. In man multiple abscesses are generally produced throughout the whole body, a fatal issue always following.

*Lack of Development in an Infant.*—Dr. TRINE HOLME exhibited the above, which was born at full time in the Western Hospital. There was entire absence of the genital organs and pelvic bones. The abdominal wall was formed by the posterior wall of the bladder, on each side of which the ureters opened. The anus was covered with integument. The child lived four or five days.

*Local Paralysis Agitans.*—Dr. McCONNELL exhibited this patient and read the following history:—Fred. R., aged 34, was born in Cambridge, England. Since 20 years of age, has been occupied as a railway engineer. Has always enjoyed good health, and he is not aware of any member of his family having suffered from any nervous affection. On the 20th August, 1882, at Sacramento, Cali-

foria, his engine collided with that of another train, and he was thrown violently to the ground, falling on the top of his head. He was quite unconscious for ten weeks. He received a scalp wound on the top of the head, at which point there can now be felt a distinct depression. On returning to consciousness he found his head done up in a kind of harness, which he soon after ascertained was intended to prevent an involuntary lateral and continuous motion of the head. He was treated in California and in various cities throughout the United States. He states that all kinds of treatment have been employed, such as blisters, actual cautery, electricity, trained exercise, &c., and endless medication, with no relief to the movements. *Present condition*—Is somewhat emaciated; very tall (6 feet 3 inches), and of light build, and appears very intelligent, speaking of his affection and the various methods of treatment in a humorous strain. There is a continuous rotation of his head from side to side—very regular when quiet, but increasing in frequency when he attempts to speak or perform any act, and ceases during sleep. When quiet the movements are 103 times per minute. Frequently complains of pain over region of left temple; has occasionally a slight discharge from left ear; for some time after the accident this was continuous. Is usually very restless during sleep, talking much and tossing about. Walks well, except when he has attacks of what, from his description, appears to be vertigo, accompanied with double vision; says sometimes single objects appear as if there were four. When one of these attacks occur, he usually has three or four in succession, occurring daily or every other day, thus a month or two might elapse before again experiencing any. They usually come on suddenly while walking, when he is unable to guide himself, and has frequently been locked up, his condition being mistaken for drunkenness. There are no symptoms of paralysis, as loss of sensation. From the symptoms of this case, have looked upon it as one of local paralysis agitans, possibly symptomatic.

Dr. Ross referred to the article in Ziemssen's Encyclopædia on cases of clonic spasm. The writer there says that cases similar to this one of Dr. McConnell's are generally produced by blows on the back of the neck or head; the operation recommended being to divide the spinal accessory nerve or excise a portion. The prognosis is bad.

Dr. TRENHOLME did not think it ought to be called paralysis agitans, and would suggest trephining over the depression.

Dr. FOLEY had seen nerve-stretching performed for a similar condition.

Dr. OSLER said the symptoms were not unlike those seen after removal of the vertical semicircular canals in pigeons.

In reply to Dr. Trenholme, Dr. McCONNELL said. If not paralysis agitans, what is it? According to the classification of the narration of the disease by Sanders in Reynold's System of Medicine, I certainly think it must come under that title. In regard to the suggestion made of trephining the skull at the point where the depression exists with a view of curing the case, I think that result would hardly be attained. The movement is produced by alternate contractions of the sterno-cleido mastoid muscles, thus indicating some implication of the nervous structures at the origin of the spinal accessorius. I therefore think it a question whether treating the surface of the brain would have much effect on an apparently localized lesion in the upper end of the cord. In reply to Dr. Osler that it would be better classed as a case of multiple sclerosis, I may say that the fact of the affection occurring in one at his age, and being confined to the head, would favor that view; but, on the other hand, the definite movements occurring during rest, as well as during voluntary movements and the fact that no paralysis exists as yet, although the tremor has lasted now a year and a half, are points which are generally supposed never to obtain in multiple sclerosis.

*Stated Meeting, March 14, 1884.*

T. A. RODGER, M.D., PRESIDENT, IN THE CHAIR.

A groom sent by Dr. GURD was exhibited to shew what appeared to be a clear case of accidental inoculation of horse-pock in the human subject. A dark-colored scab, depressed in the centre, was to be seen a little below the outer corner of the left eye and the parts about were red and swollen. One of the horses which he had the care of was suffering from horse pock, so prevalent in the city lately.

Dr. PROUDFOOT shewed a specimen of epithelioma of the lower eyelid removed by him a few days ago.

Dr. KENNEDY exhibited a small *Anencephalic Fœtus*, the deficiency also extending as a spina bifida downwards to the middle of the dorsal region. There are also an abdominal hernia, the protrusion being covered with the peritoneum only. At birth there was evidence that general peritonitis had existed for some time, which no doubt had caused the death of the fœtus some days before delivery. The case was of some interest owing to the difficulty that arose during delivery. Dr. Kennedy gave the following history: The mother had passed through several pregnancies. Her first child was carried to full term, but the labor was difficult and only completed by instrumental delivery. Each successive labor terminated at the seventh month without any apparent cause, none of the children surviving. She came under my attendance with this last pregnancy, and at the time of engaging my attendance for her confinement, stated that a physician who had examined her had found an extensive laceration of the womb. No opportunity was given me of verifying this condition. Anticipating a recurrence of premature labor, rest and other precautions were taken to avoid its induction but without avail. I was sent for about the seventh month, and found she had been in labor about twelve hours. On examination of the abdomen the fœtal body was felt to be lying in an oblique position relative to the mother's body. A vaginal examination showed the os to be fully dilated and a large amniotic sac distending the vagina. As no movements had been felt for some time by the patient and there being occasional discharges of blood, the membranes were ruptured. An immense quantity of amniotic fluid came away, followed by a free discharge of blood. Failing to find any part of the child presenting, and as the loss of blood was becoming serious, the hand was passed into the vagina. The intention was to perform version at once, but, owing to the pain it was thought best to retain the hand in the vagina as a plug to prevent loss and send for assistance. While waiting the placenta and cord were forced down into the palm of the hand, showing that the attachment of the placenta had been very low, and that easy separation had taken place. Dr. Perrigo arriving, gave her chloroform. The hand was introduced into the uterus, which was found constricted in the middle. Dilatation of this constriction was slowly effected, and in the cavity above the fœtus was found and brought down by the feet. Delivery

was speedily effected, the patient making a splendid recovery. This patient would, without doubt, have died from hemorrhage but for the promptness of assistance given her. The low attachment of the placenta may in some measure account for the deficient development of the fœtus.

Dr. TRENHOLME stated that in cases of lacerated cervix uteri the cause of abortion was not due so much to the laceration itself as to the diseased condition of organ induced by the lesion. The uterus was irritable and the altered state of the tissues hindered its normal development. The mere fact of lack of support was not enough to induce abortion, or we would meet with such more frequently than we do in multipara where, as is well known, a considerably dilated os was compatible with normal gestation. The reflected decidua effectually closed the womb, whether the os was lacerated or patulous as already stated.

Dr. HY. HOWARD considered that there must always be a physical cause for a physical effect, and said it was the duty of scientific medical men to get at the cause of such deformities. He related a case in his own family of port wine mark due to a maternal impression.

Dr. TRENHOLME avowed his belief in the transmission of maternal impressions to the fœtus.

Dr. PROUDFOOT reported the case of a child born with one arm and one leg.

Dr. WILKINS remarked that Paget reports a case of a child with deficient fingers, apparently due to the mother having handled a deformed hand during pregnancy.

Dr. GEO. ROSS thought that the only cases of irregularity were the remembered ones. He also reported a case of hydrocephalic fœtus with fusion of the fingers and toes.

Dr. TRENHOLME exhibited two *Dermoid Cysts* each attached to an ovary which he had removed on Saturday last. The left weighed two pounds and the right one pound. Both fallopian tubes were considerably dilated. The uterus, removed *post-mortem* and normal in appearance, was also shewn. The woman was aged 32, healthy, &c. Had suffered for many years, but especially since birth of last child, 5 years ago. Of late was unfit for the duties of life and sought relief. Temperature and pulse continued most favorable for the first 24 hours, when pulse rose to 150, notwithstanding drop doses of *veratrum viride*, which was continued 8 or 10 hours. Twenty minims of *Battley* were given hypodermically in the evening

to quiet the utterances of patient. She passed a quiet night and gradually sank, and died 44 hours after operation. Autopsy shewed limited but insignificant local peritonitis and some slight effusion. Heart was normal. The womb had healed by first intention throughout. The cause of death, while not clear, may be perhaps fairly laid to the veratrum viride, which may have caused the otherwise unaccountable collapse and death.

Dr. KENNEDY remarked that he had seen two patients who seemed to have been affected injuriously by veratrum viride, and objected to its use in a case like this of Dr. Trenholme's.

Dr. RODGER had observed great rapidity of pulse follow the use of veratrum viride.

Dr. STEWART said that cardiac depressants as veratrum viride are contra-indicated in puerperal cases.

Dr. ROSS related cases of great depression produced by veratrum viride in the Montreal General Hospital. Convalleria seemed also to have acted unfavorably in a recent case treated there.

Dr. MACDONNELL exhibited photos of a patient the subject of an internal tumor. The cutaneous abdominal veins appeared excessively enlarged.

*Slow Pulse.*—Dr. MIGNAULT related a case of slow pulse in a dyspeptic—treatment brought the beats from 38-48 to 70.

Dr. WILKINS met with two cases where the rate per minute was only 45.

Dr. STEWART had a case of 25 to the minute, which, under atropine treatment, went up to 100.

Drs. MACDONNELL and ARMSTRONG also mentioned having seen cases of abnormally slow pulse.

*Meeting held March 28, 1884.*

The President Dr. RODGER in the chair. The following is an abstract of Dr. Jas. Bell's paper on "Some Cases of Fracture of the Femur, treated by plaster-of-paris splint."

Three cases were reported all occurring in children. The first, a little boy 1½ years of age, with simple fracture in the middle third. The second, a boy four years of age, with fracture just below the trochanter from direct violence,—being run over by a heavily-laden cart.

The third case was that of a strong, healthy boy, aged 8 years, with fracture at the junction of the upper and middle thirds. In all these cases the treatment was the same. Ether was given, the limb extended, and the fragments brought in to

position, and held there until a plaster splint had been applied, extending from the toes and including the pelvis and loins. Co-aptative splints of paste-board were moulded to the leg and applied between the layers of plaster bandage. In none of these cases has there been the slightest trouble of any kind, and in each case when the plaster was removed the union was found to be most satisfactory. In the first case there was no appreciable shortening. In the second about a quarter of an inch, and in the third a little over a quarter, but less than half an inch. These cases were exhibited, as also an old man aged 62 years who had had a bad compound fracture of both tibia and fibula just above the ankle joint. The fracture of the tibia had been oblique and about three-quarters of an inch of the protruding fragment had to be removed with the saw before it could be reduced. The limb was then permanently fixed with plaster-of-paris, leaving the wound exposed through the small opening in the bandage. The wound was dressed with Listerian precautions and the patient was discharged at the end of eight weeks with a sound leg. He is now doing his regular work (six months after recovery), and has been for some time, without any inconvenience.

The writer, in summing up, thought that in a great many cases the plaster-of-paris splint was the best that could be applied to a fractured femur, notably in children, in nervous and fidgeting people and in fractures complicated with delirium tremens, also among the poorer class of patients, where a suitable bed and good nursing (which are so essential in the ordinary treatment of extension) could not be secured. He also thought that the objections urged against it for fracture of the femur were very much overrated.

Dr. GURD said that he would not like to risk treating an adult's fractured femur in this way, as he feared that before union had occurred there would be no pressure around the limb, owing to the rapid atrophy which follows disuse and bandaging, thus allowing displacement of the fractured ends.

Dr. BLACKADER said he had broken the femur of an infant with the blunt hook in a difficult breech case and, assisted by Dr. Sutherland, a gutta percha splint was applied, which answered admirably.

Dr. SUTHERLAND said he was going to use plaster-of-paris splints in these cases in the future.

Dr. SHEPHERD quoted Heath as saying that there was no necessity to take in the joints where plaster-of-paris was employed.

Dr. Rodger had lately used plaster-of-paris splint for fracture of the femur in child aged 5 years with excellent results. He always uses this method of treatment for fractures of tibia and fibula.

#### CASES IN PRACTICE.

Dr. BELL said that this evening he had been sent for by the Coroner to make a post-mortem examination on a young man, aged 28, who had been found dead in his bed. Death was found to have been caused by the bursting of a small aneurism into the pericardium.

The aneurism arose from the lower and back part of the transverse portion of the arch. The young man had been treated as an out-door patient at the Hospital for pains in the back. Aneurism had not been detected.

*Meeting held, April 11th, 1884.*

The President, Dr. RODGER, in the chair.

Dr. TRENHOLME exhibited two pairs of ovaries and tubes lately removed. One case was operated on 22nd March. Both ovaries were much diseased and enlarged to about four times their normal size. The patient was 32 years old, and had always suffered much at her monthly periods. Her sufferings have gradually increased year after year up to about November last, when she began to manifest symptoms of insanity of a melancholy religious character, with a suicidal tendency. Her monthly sufferings abated with the advent of the mental infirmity. The patient had been under the care of Dr. M. in Ontario, who suspected some disease of the internal organs of generation and sent her down to me. On examination both ovaries were found to be enlarged and tender, the uterus congested, and tender, but otherwise normal. The operation was made with the hope of benefiting her mental condition. The wound healed by first intention throughout, and the sutures removed on the 5th day, not a drop of pus being present. The patient made a rapid recovery, and returned to her home before the end of the third week. But little could be determined as to the result of operation upon her mind, but, so far as could be judged, she seemed somewhat benefited. The future of this patient will be watched with interest and reported to this society at another time.

Case 2.—Patient, aet. 22, has suffered much for several years from pelvic pains, aggravated at each

menstrual period. Both ovaries tender and enlarged, uterus congested and very tender and also retroverted. Attempts at replacement and the use of a pessary had been followed by pelvic cellulitis; even with greatest care could not tolerate a pessary. Rest and local treatment relieved for a time, but when she attempted to work was again laid up.

3.—As the girl had no friends or means of support, and her health precluded service, I removed the specimens now before the Society. Both ovaries (as you see) are much enlarged, undergoing cystic changes. The tubes also very much congested. This patient has so far made a most unsatisfactory progress towards recovery. There seem to be no healing power in her, and, while no dangerous symptoms threaten life, a tedious convalescence is looked for.

Dr. HY. HOWARD considered the first to be a case of acute dementia, and said that peripheral irritation, especially from the organs of generation, will some times be followed by dementia in both sexes, often taking the form of religious dementia. Dr. H. mentioned two or three cases where young men on the first night of their marriage became insane.

#### PURPURA HÆMORRHAGICA.

Dr. KENNEDY mentioned that lately he had had under his care four cases of this disease, all in young children of different families. He asked if other members had seen an unusual number of those cases.

Dr. REID said he had been treating one case at the Dispensary.

#### NITRO-GLYCERINE IN EPILEPSY.

Dr. F. W. CAMPBELL spoke of the continual good results he is having with nitro-glycerine in the treatment of epilepsy. None of the patients whom he has so treated have been entirely cured, but with all, the attacks are milder and much less frequent. The usual dose which Dr. C. gives is one drop of a one per cent. solution three times a day.

Dr. TRENHOLME asked for the modus operandi of this treatment. Dr. Campbell said he was not as yet prepared to say.

Dr. HY. HOWARD congratulated Dr. Campbell on his success in this treatment of epilepsy and said that the Germans classified the forms of epilepsy as follows :

1st Those due to contraction of the cerebral vessels from irritation to the vaso-motor nerves. Here bromide of potassium is very useful.

2nd. An abnormal condition of dura mater. Bromide useless.

3rd. Due to irritation of the anterior pillars of the spinal marrow. Ether spray best for this.

4th. Lesions of different parts of the brain or cord Of course the difficulty is to be sure of the cause.

## Progress of Science.

### PHLYCTENULAR DISEASE OF THE EYES.\*

BY OLIVER F. WADSWORTH, MD., BOSTON.

The affection to which I desire to call your attention to-day is characterized by the eruption of vesicles or pustules on the conjunctiva or cornea, and often attended by much apparent photophobia. It is one with which you are doubtless all more or less familiar under some of the many names given to it. Phlyctenular, pustular, scrofulous, lymphatic ophthalmia, conjunctivitis or keratitis; herpes or eczema of conjunctiva or cornea; fascicular keratitis; ulcer of the cornea,—such are some of the designations it has received,

The extended statistics collected by Cohn show that affections of the conjunctiva and cornea make up half the sum of eye disease. Horner found the same to be true as regards children alone, with this difference, that whereas when all ages are considered, the conjunctival affections outnumber much those of the cornea, with children the proportion is reversed; in them the cornea being implicated in 27.2 per cent., the conjunctiva in 21.7 per cent. of all cases. Moreover, according to Horner, phlyctenular conjunctivitis and keratitis comprise more than half of the disease of these membranes in the child. Arlt also says this is without question the most frequent of inflammations of the eye.

The very frequency of its occurrence makes its discussion appropriate before an assemblage of general practitioners. But its frequency is by no means the greatest of its claim to our interest. Its habitual obstinacy; its tendency to relapse or recur on the least provocation; the variations in form which it manifests; the fact that its appearance is of itself evidence, almost invariably, if not wholly without exception, of some deterioration or imperfection of the general health; and, finally, the frequent permanent impairment and occasional destruction of sight that it causes, are sufficient reasons for its careful consideration and study. According to Birch-Hirschfeld, six per cent. of the inmates of the blind asylums of Saxony lost their sight from this disease. Such a percentage is undoubtedly higher than would be found in this country. The number made blind by it bears,

however, but a small proportion to the number of those whose sight, in one or both eyes, is more or less seriously and irretrievably injured.

While the vast majority of those afflicted are young children, adults are not wholly exempt, though with them the disease is comparatively rare. In my experience, also, the course is usually mild in adults, even if sometimes prolonged.\* It is in children chiefly that severe forms are seen and disastrous effects produced.

Unfortunately, by the laity the malady is very generally looked upon as a troublesome but innocent accompaniment of teething, safe to take care of itself, and to pass away so soon as the irritation attendant on dentition has subsided, or as a sequela of measles or other exanthem, not specially requiring treatment. In consequence of this opinion the child is only too often made the subject of experiment with "household remedies," or allowed, even aided, to aggravate the disorder by following its own inclinations.

For the physician the understanding of the affection is made somewhat more difficult than need be by the prevailing habit in text-books of treating of eye diseases according to their anatomical situation. There is justification for this method of division, but as a result of it diseases of the conjunctiva and of the cornea are separated more or less widely, and where, as in the present instance, the disease is essentially the same whether its habitat be conjunctiva or cornea, the identity does not always appear with sufficient clearness. Other reasons for confusion are to be found in the multiplicity of titles, some of them implying a relationship with other diseases which does not exist, and in the fact that by some authors certain variations of the diseases have been described under different names and as if distinct affections, by others different affections have been grouped under the same name.

The term herpes applied here is a misnomer. There is no evidence that the eruption has any such special connection with the sensitive nerves as is the case with herpes generally; the lesion of the cornea which may accompany herpes zoster is quite other in character than the phlyctenulæ, and the same is usually at least true when corneal or conjunctival affection is coincident with the ordinary herpes febrilis.

Eczema, on the other hand, is a frequent accompaniment of phlyctenulæ as it is also a common affliction of young children. But a considerable proportion of the eczema observed in this connection is a secondary condition, due to irritation of the skin by overflow of tears and rubbing, or, on the lip and alæ nasi, by the catarrhal flow from the nostrils often present at the same time. The ocular changes do, indeed, resemble in some degree those found in eczema, yet there seem hardly grounds enough for adopting the title of eczema of the conjunctiva and cornea which Horner has proposed.

The main characteristic of the disease is the eruption of vesicles or pustules; these may be

\*Read at the Annual Meeting of the Massachusetts Medical Society, June 1, 1883, and recommended for publication by the Society.

single or multiple, may vary in size from that of the head of a small pin to a diameter of several millimetres; the process may be exhausted with the eruption of one phlyctenula, or successive crops appear at irregular intervals; they may be situated on the conjunctiva, or cornea, or both, either successively or simultaneously, or may extend from one to the other. The duration of the individual efflorescence depends in the main upon its size and its situation; on the cornea the course is slower than on the vascular conjunctiva. The amount of irritation is far from being in definite relation to the severity or danger of the disease.

On the conjunctiva the eruption develops almost invariably in the near neighborhood of the cornea, and shows itself in two forms, the typical cases of which are sufficiently distinct in appearance. The more common is that of an isolated efflorescence. Beginning as a localized, elevated congestion, the centre soon becomes grayish-white or with a tinge of yellow, due to an agglomeration of lymphoid cells. The epithelial surface is thrown off, the mass of cells beneath escapes, and there is left a depression with raised edges which gradually flattens and is again covered by epithelium, while the congestion fades. Around the pustule both conjunctival and sub-conjunctival vessels partake in the congestion; toward the fornix, where the conjunctiva passes from globe to lid, the conjunctival congestion extends, diminishing in amount, but often increasing in breadth as it recedes from the focus of inflammation, so that the whole congested region assumes a fan shape.

Comparatively seldom, however, does the patient present himself with this typical form of congestion. Oftener, other pustules appear in various positions simultaneously or before the first has healed, and the congested area thus becomes a wide one with reddening of the lid conjunctiva also. If the individual pustule is small and superficial it may run through its whole course in a very few days. From this there is every graduation to the sluggish, somewhat deep ulceration, three or four millimetres in diameter, its base ragged, grayish, infiltrated, which may be a fortnight in healing over.

The other, less frequent, type consists in the almost simultaneous development of small, often very minute, phlyctenulae, studded along a part or the whole of the limbus conjunctivae, close to the corneal border. The attending congestion is more general, though greatest in intensity here also at the site of the eruption. The duration of the individual phlyctenulae is short, but successive crops follow each other more or less rapidly, and extend the time indefinitely. Both forms begin with a sensation of burning or smarting as of a foreign body, more marked in the latter variety.

So long as the affection is confined to the conjunctiva alone the subjective symptoms are comparatively light, and the prognosis is positively favorable, even if the course be somewhat pro-

longed. Yet, until convalescence is fully established, the danger that the cornea too may be implicated is always threatening, and when that occurs the situation becomes more serious.

The manner in which the cornea becomes involved varies. A pustule may fall astride of the corneal edge, half in conjunctiva and half in cornea. Should the pustule be small it will generally heal readily and do no damage, but a large pustule in this position may give rise to a deep, funnel-shaped ulcer and to infiltration of the cornea beyond it. It is not so very uncommon for such an ulcer to extend in depth and cause perforation. The so-called fascicular keratitis commences as a pustule in this position. Here, instead of following the normal course, the infiltrated raised edge of the ulcer is pushed farther and farther into the cornea, the tissue breaking down and leaving a groove in the corneal substance behind it. At the same time a bundle of new-formed vessels extends from the conjunctiva, keeping pace in its growth with the progress of the infiltration, filling, or more than filling, the groove, while only a scarcely perceptible depression separates its corneal extremity from the gray, crescentic wall which precedes it. Usually the infiltration moves at first toward the centre of the cornea, but it generally swerves a little from a straight line. It may stop at any part of its course, or cross nearly to the conjunctiva on the opposite side. It never perforates, but the vessels disappear when the process is at an end, leaving a grayish cicatrix, which is exceedingly persistent and characteristic.

Different, again, is the behavior where there are numerous small phlyctenulae along the edge of the cornea in the limbus. Then, if the condition persist some time, vesicle following vesicle, the irritation excites the growth of vessels from the edge into the cornea clove beneath the epithelium. The progress of the vessels depends on the degree of the inflammation at the site of the efflorescence, and they extend farther where this is greatest, but the regularity with which a fringe of straight vessels is formed along the whole circumference of the cornea is sometimes very striking. With the subsidence of the inflammation in the limbus the corneal vascularity vanishes without leaving a trace. More than a superficial ulceration of the cornea, hardly extending deeper than the epithelial layer, I have never seen with this form, but an infiltration, leading to annular ulceration of serious amount, is described as a very rare complication.

If the cornea is affected independently the pustules show the same variation in their behavior as on the conjunctiva. There is the same difference in size and number, the same irregularity in the time of their successive appearance and in their duration. They may present themselves at any part without distinction. There seems to be no place of least resistance. Congestion about the pustule is, of course, wanting

but there is circumcorneal congestion, chiefly on the side nearest the inflammatory focus, and fading toward the fornix. A small pustule may be absorbed without coming to ulceration, but this is uncommon. From the superficial, grayish subepithelial swelling, which, losing its covering, readily heals without leaving any sign, there is every degree to the extensive, deep, yellowish infiltration, causing deep destruction of the corneal tissue, even perforation, healing slowly, generally with the assistance of vessels growing out from the conjunctiva to its edge, and only by the formation of permanent cicatricial tissue. Through this tendency to the formation of vessels on the cornea there is sometimes, when the eruption has been repeated and long continued, a sort of pannus developed. Such a pannus mostly may be distinguished by the greater irregularity of its form and distribution from trachomatous pannus, which latter almost always starts from above, while its lower edge is approximately horizontal. Seldom indeed, a sluggish, deep infiltration is complicated by hypopion and a low form of iritis. When it is borne in mind that, besides all the variations that have been indicated, a catarrhal conjunctivitis, with even considerable swelling of the membrane and mucous secretion, may be superadded, the possible diversity in the appearances presented is manifest.

The degree of injury to the eye as an organ of vision depends chiefly upon the situation of the lesion; a considerable opacity near the circumference of the cornea may be of little moment in this respect, yet, without directly interfering with the entrance of light to the pupil, it may still do harm by changing the proper curve of the cornea. The growth of vessels toward the ulceration is always a welcome manifestation, since the reparative process is hastened by their means, and it may be said in general that the perfection of recovery, the eventual freedom from opacity and changes of curvature, is the greater the nearer the ulcer is to the circumference and the shorter the time till healing is accomplished.

Of the subjective symptoms the most prominent and most troublesome is usually photophobia, so called. With an isolated eruption on the conjunctiva or a single pustule on the cornea this symptom may be but little pronounced. As a rule, however, it is present, and especially if the efflorescences are numerous and repeated does it often reach such a degree as of itself to become almost a distinguishing characteristic of the disease. A child thus affected may never open its eyes even in a moderate light for days or weeks; it buries its head in its hands, in the pillow, or in the clothes of its attendant, resisting violently any attempt to turn its face toward the light. It seems sometimes as if there were an effort to drag all the features, forehead, cheeks, lips, to one common centre and heap them up over the eyes. To some extent in accord with the amount of the photophobia is the quantity of

watery secretion poured out, which, by keeping the lids continually moistened, causes excoriations and increases the irritation. Yet it would be a mistake to suppose that the severity of the ocular affection is to be accurately gauged by the photophobia. Rarely, indeed, where this is pronounced, is the conjunctiva alone involved; there may, however, be but few pustules on the cornea and those small and near the periphery. Precisely the worst cases, those with large, sluggish infiltration, extending deeply and causing large loss of substance (dense permanent cicatrices), or perforation with its consequences, have this symptom usually but little marked.

The title scrofulous ophthalmia, though it affirms too much, yet indicates rightly the general direction in which the cause of the disease is to be sought. Not that all individuals afflicted are scrofulous, even when the most extended application is allowed to the term; many are so, and it is in such that the most serious and persistent cases are to be found, notably the sluggish form, as well as those with great blepharospasm. But a condition of health below the normal, which carries with it an impaired power of resistance to harmful influences, is always present. Exposure to rapid changes of temperature while imperfectly protected by clothing, followed by the onset or exacerbation of catarrhal inflammation of the mucous membrane of the nasal passages and fauces, too often coincides with the beginning or increase of the ocular symptoms to be denied an influence as a causative factor. The exanthemata—measles, scarlet fever—may be regarded as acting to depress the tone of the general system, while the congestion of the mucous membranes they cause, in which the conjunctiva shares, may well prepare the ground in some measure for the local affection.

To form a definite diagnosis we must obtain a view of the eye. In many cases this presents no special difficulty, in others the ingenuity and patience of the physician are taxed to the utmost if he wishes to avoid the use of forcible measures and often in vain. If the child can be coaxed to open its eyes, this is, of course, preferable; occasionally the application of cold to the lids will relieve, temporarily at least, somewhat obstinate spasm. Yet whatever means are employed they will fail in many instances, and then the only resource is the elevator of Desmarres, the child being placed on its back, and its head fixed between the knees of the operator. The use of the fingers to raise the lids in such case can never be as effective, and must produce painful and sometimes dangerous pressure on the eye.

Inspection of the eye is also necessary for the formation of our prognosis. Hesitation or mistake as to this may forfeit the confidence of the parents, a confidence often tried at the best by the persistency of the disease, and without which careful attention to the details



of the treatment is scarcely to be expected. It is not to be forgotten, however, that only a provisional prognosis can be given from the condition at the moment, and the state of the general health is always to be taken into account. Although the central portion of the cornea may have escaped hitherto, no one can safely predict that it will not be affected later. Moreover, we do well to warn the parents before dismissing the case from treatment that, for several years, with any depreciation of the general health, the disease may reappear.

The treatment may be divided into general and local. What has been said of the ætiology indicates both the importance and direction of the general treatment. It should never be neglected even in the lightest cases. The diet should be easily digestible and nourishing and attention to it in detail is always advisable; healthy action of the skin is to be promoted by frequent bathing; iron, malt, and cod-liver oil to be prescribed according to the case. The advantage of fresh air and light can hardly be overestimated. Even in the coldest weather it is usually better that the patient, properly clothed, should be taken out for a time daily, and this is the more needed the poorer are the hygienic surroundings at home.

Blepharospasm, so-called photophobia, is to be feared, not for itself, but for the prejudicial consequences it entails. The violet action of the orbicularis irritates still farther the already inflamed cornea, incites to friction and consequent excoriation of the skin of the lids with the result to increase the general nervous excitability, and prevents the free bodily movement so necessary, in children especially, for the preservation of health. In considering the means for its relief, we should constantly remember that the stimulus that excites it starts from the irritated terminations of the trigeminus, not from any hyperæsthesia of the retina. The indication then is to relieve the abnormal sensibility of these terminations. It is the irritation of the corneal nerves that chiefly excites the blepharospasm, and so far as they are concerned the local narcotic effect of atropine makes this our most reliable agent. The alleviating effect of even the first application is sometimes very great. A two-grain solution may be employed every other day, or two or three times daily, and if the case is seen early the spasm may thus be kept within bounds. But should the photophobic habit, if I may be allowed the expression, be once firmly established, relief is more difficult. When the lids are persistently kept closed it is commonly useless, or worse than useless, to intrust the application of this or any collyrium to the parents or attendants. In the efforts to force open the lids of a struggling child with the fingers, more harm is likely to be done than the atropine will counteract, and the increased flow of tears excited by the struggle will rapidly remove the small amount that has

been instilled. The elevator is hardly safe in untrained hands. The application may, perhaps, be made when the child sleeps, but otherwise in such cases it is better left to the physician. Sometimes, however, reliance must be chiefly placed on less direct treatment. The benefit of cold applied to the lids has already been referred to. All friction of the lids must be prevented. Excoriations of the skin about the eyes may be washed with a solution of silver nitrate, or an ointment, containing ten grains of zinc oxide, or three or four grains each of zinc oxide and white precipitate to the drachm, be applied. The same treatment may be employed for eczema of the upper lip and *alæ nasi*, or elsewhere about the face, if present. Irritants are harmful. Darkness only aggravates the symptom. Within doors the light should be moderate and even, and be increased as the condition improves, but sudden changes of light, producing, as they do even in a state of health, contraction of the orbicularis, are to be carefully avoided. In the open air a dark shade, large enough to protect both eyes, though only one be affected, and arranged to stand out free from them, with a veil or smoke-glasses if required, are of use. It is by attention to details that success is to be attained.

When the eruption is limited to the conjunctiva a simple collyrium of borax in water or camphor water is often all the local treatment needed. Calomel, dusted lightly upon the conjunctiva from a camel's hair pencil, every day or two, till congestion has disappeared, seems to have a good effect in preventing relapses. But it must be employed with precaution. It should be pure and dry, only a very thin film of it should be formed on the conjunctiva, and the lower fold should be inspected after a moment or two, that if any have collected there in a clump or thread it may be removed. The action of calomel was for a long time unknown; now it has been demonstrated that it is soluble, to a slight extent, in salt water, and it probably acts as a weak solution of bichloride. In the presence of iodine there is produced a biniodide of mercury, and it should, therefore, never be used when the patient is taking any preparation of iodine, else a troublesome eschar may be the result. Properly used it is painless, and I have myself never seen any ill effect from it.

In general, astringents are to be avoided, but when the condition is complicated with a catarrhal inflammation of the conjunctiva, mild collyria of alum, zinc, or silver nitrate are in place. Yet these should be employed cautiously and their action watched if any fresh eruption exists.

With an eruption on the cornea I rely, with most oculists, on the action of atropine. Its soothing influence has already been alluded to. The frequency of its application is to be governed in the main by its effect on the pupil, and it is to be continued till the ulceration is again covered by epithelium. Here, also, calomel is apparently of benefit, but is in contradistinction to the

conjunctival affection, only to be applied after epithelial regeneration is well under way. Yet I would make one exception to this last statement. In the fascicular form of keratitis it has seemed to me that calomel, applied somewhat freely during the progress of the band across the cornea, has sometimes checked its course. So erratic, however, is this variety, and the opportunity for studying it so comparatively infrequent, that I am willing to admit it may have been coincidence rather than effect that I observed. With the ointment of yellow oxide of mercury, much used in the same conditions as is calomel, my experience has been limited, and it has appeared to me at least less agreeable to the patient.

The sluggish, deep infiltration, whether at the edge of the cornea or more central, showing little or no tendency to the formation of vessels, demands, besides atropine, the application of hot fomentations, continued half an hour or an hour three or four times daily. These help to relieve the pain, sometimes considerable, and invite the vascular outgrowth from the conjunctiva needed to furnish material for repair. Should perforation occur, pain usually ceases as by magic, and the reparative process begins. The subsequent care after perforation does not differ from that required in similar circumstances arising from other cause.

Many and various have been the remedies recommended to promote the absorption of corneal opacities left by this or other diseases. My own belief is that none of them are of special value, and that the opacities are best intrusted to nature to reduce, as she certainly will in part. Our task, after the immediate attack has passed, is to see to it that measures to improve and preserve the general health are continuously carried out and thus recurrence prevented.

## RINGWORM: ITS PATHOLOGY AND TREATMENT.

By R. M. SIMON, B.A., M.B., Cantab.

THE disease is undoubtedly contagious, but its contagion varies in strength at different epochs of life, and the ringworm of childhood is not the ringworm of maturity. The disease is essentially the same, but very different in its situation; in childhood the head, in mature life the body or rarely the hairy parts of the face are liable to be affected, and the cause in every case is the trichophyton consurares.

The best way to find the fungus is to extract one of the broken short and thick hairs, and after maceration for an hour or two place it under the microscope.

On the body, where ringworm especially affects the face, neck, or chest, it commences with small

red circular spots, and is often associated with the formation of minute vesicles. These circular spots, gradually increase at their circumferences, while the centre becomes more or less normal, the subsidence of the original vesicles being followed by desquamation. The advancing edge is raised, and red, and is an important element in diagnosis, for the patch might, but for this elevation, be taken to be one of eczema. Should there be any difficulty about the diagnosis, the point may be settled by scraping some of the epithelium from the inner border of the advancing ring, and the finding of the characteristic mycelium. I may at once discuss the treatment of this condition, as it is quite distinct from that of the hair and by far more easy; any parasiticide will be effectual, but I have been in the habit of using a preparation of equal parts of sulphurous acid and glycerine with good effects; a free use of soft soap and water is important, and it will be advisable in every case to examine the hair to see if there be a coincident patch there also. If fortunate enough to catch a case as its commencement, we find a small ring of minute vesicles, on a red base; the fluid which is between the rete mucosum and the epidermis is quickly absorbed and there results, a brauney desquamation which spreads rapidly and we soon have round patches of a greyish colour, covered with scales, and but sparingly with stumps of hairs. There is a great amount of grey debris surrounding the base of the hairs, which are thick and stubby, with a fracture like the end of a broom, and full of fungus; they come out very easily, more often breaking in epilation, but without pain, and this is important. If you find a child objecting very decidedly to epilation you may be moderately sure that there is no ringworm in the hairs you are handling.

For practical purposes ringworm of the head may be divided (1) into recent cases; (2) cases of disseminated disease, where the head is practically covered; (3) cases in which there remain one or two old patches which are most intractable. The cardinal feature which underlies all indication for treatment, is the tendency of the fungus to penetrate deeply into the hair follicles. Bearing this in mind, it will easily be seen how useless is the application of medicamenta merely to the surface. Over much washing must be avoided, for if the scalp be soddened by water, ointments cannot sink deeply into the follicles.

For recent patches I use glacial acetic acid, painting it on to the affected parts, but I do not think it better than blistering fluid. I never shave the head in these cases, preferring to clip the hair all over where the disease is widely distributed, and for half an inch round the patches, where there are but few. One cannot so easily distinguish the diseased hair from the sound, where they first emerge above the surface, and I have repeatedly seen cases where a child has been most unnecessarily tortured by the extraction of healthy hair, which would have been avoided had the

hair been only closely clipped. Sometimes this treatment repeated once or twice will effectually cure the disease, but as a rule more treatment is necessary. It will be necessary, with the aid of a good lens, to every day extract a few of the diseased hairs, and to rub an ointment on the patches themselves, whilst it will be wise to employ for the rest of the hair a combination of carbolic acid with glycerine or oil. Mix carbolic acid with either of these in the proportion of 1 to 12, and let it be applied every morning. For the patches themselves you may use carbolic acid and glycerine in equal parts if the patient be about ten years old, and the skin not tender; but for infants and younger children it will be necessary to use a larger quantity of glycerine. Glycerine penetrates well into the follicles, and after its use you will find the hairs getting loose and very easy to extract. This preparation must be used with a sponge and thoroughly rubbed in night and morning, care being taken that it does not run down the face, which it very easily irritates. The best remedy consists of ungu. sulphuris as a base, and varying proportions of ungu. hydrarg., nitratis, citrine ointment, and carbolic acid. For a child of ten you may use equal parts of all three; for a child of two, 1 part of carbolic acid and ungu. hydrarg. to 5 of ungu. sulphuris, and increase the proportion of the two more active agents in a direct ratio with the age of the child.

For the treatment of chronic cases of ringworm we have two modes and must be guided mainly by the extent of surface affected; where this is large we have a valuable remedy in the oleate of mercury. This should be mixed with acetic ether, in the proportion of 1 part of the latter to 7 of the oleate; the oleate being of the strength of 5 or 10 per cent according to the age of the child. In such a case you may commence by cutting the hair to about a quarter of an inch from the head, and washing well with the spiritus saponis alkalini of Hebra. This is prepared by mixing 2 parts of soft soap with 1 of rectified spirits of wine; allow the mixture to stand 24 hours, then filter and use the filtrate as a lotion. Dip a sponge first into hot water and then into this lotion, and rub on the head until a free lather results. Leave the lather on for a quarter of an hour, and wash off again with water. Rub the oleate thoroughly well into the patches night after night, and whenever the epithelium reaccumulates have recourse to the spir. sapon, alkalini.

In a majority of cases this treatment will be successful, but occasionally, while the greater part of the surface recovers itself, there will be left one or two isolated patches which resist all treatment. For these there is no help for it but the production of artificial kerion by the use of croton oil, which must always be applied by a medical man and closely watched. Alder Smith directs that it should be painted on a small patch every day until the part becomes swollen, tender, puffy, and boggy: during the intervals of the use of the oil, poultices should be kept constantly applied. After a varying number

of days of this treatment, the patch will be found covered with a thick yellow crust which is easily removed and leaves a red tender surface, and causes a purulent discharge from the follicles, which either carries with it the diseased hairs, or leaves them loose in the follicles and renders their extraction a matter of ease. Take care not to cause a slough of the skin, as thereby the hair follicles are destroyed, and a patch of permanent baldness remains; also do not attack too large a portion of the surface at the same time. Never declare a case well so long as there are visible minute black dots which are the orifice of diseased follicles: these must be treated by inserting a needle with a drop of croton oil far down into the follicle, as in the production of kerion this will be followed by local swelling and pustulation and the extrusion of the diseased hair. There generally remains after an attack of ringworm a large amount of scurf on the head, and this may be effectually treated by the spir. sap. alkal.—*Birm. M. Rev.*, Aug.

#### THE MANAGEMENT OF ABORTION.

Dr. Walter Coles, in a paper published in the *St. Louis Courier of Medicine* for August, objects strenuously to the practice of removing the secundines in all cases of abortion after the expulsion of the fetus. That such procedure is not always necessary, and that it may do serious mischief, we think all experienced obstetricians will admit. We make the following extracts:—

“Let us suppose that we have been called to a case in which the embryo has just escaped during the third month and the secundines are retained. Under such circumstance there is generally considerable hemorrhage going on, and the first thing in order is to check it. Of course the most effectual and desirable method of so doing is to empty the uterus and cause it to contract. A teaspoonful of fluid extract of ergot is administered, and the accoucheur at once examines the uterus. If it be practicable by digital manipulation, or the aid of forceps, to deliver the placenta, this is a fortunate circumstance which should be availed of on the spot. But if the os is too contracted to admit the finger, or even if patulous and the membranous placenta is so adherent as only to be detached in fragments, it is better not to disturb it for the time being rather than resort to immediate and forcible extraction. We should, however, be equally far from pursuing a *passive* policy; the hemorrhage should be controlled by means of a tampon, aided by ergot supplemented by a full dose of tinct. of opium—the latter being especially beneficial as a soothing stimulant after blood loss. A tampon ought always to be applied with the aid of a speculum, that of Sims being the best. There is a great deal in the method of tamponing; it should be carefully packed over the os and around the cervix. The best material is old cotton muslin torn into strips; I prefer to put

it in dry. Sponge is of very little service as a tampon; it absorbs the blood and permits it to flow through.

"In most cases thus managed the physician will find on removal of the tampon twelve hours later that the secundines have either escaped entire, or else are presenting at the os, whence they may be readily removed by very slight manipulation. But in case this cannot be done without violence, it would be proper to wash out the vagina and again tampon, with the expectation that under the excitation of the plug and the continued influence of ergot the uterus will, by its contractions, detach and expel its contents. If at the end of twenty-four or thirty-six hours there is no indication of dilatation, it will be quite time enough to consider the propriety of artificial dilatation and extraction. If the internal os continues closed it is pretty conclusive evidence that the placenta is still adherent, and hence not extensively decomposed. Lusk recognizes this condition of the internal os as a valuable indication—a fact pointed out by Huter. He remarks that 'when decomposition has once set in, the os internum will, as a rule, allow the finger to pass into the uterus.' Such being the case, we have less reason for being in a hurry when the uterus is closed than if the inner os were lax and the discharges offensive; under the latter condition of things the practitioner should lose no time in emptying the uterus of all decomposing material, provided he can do so without inflicting too much violence on the organ itself." \* \* \* \*

"We are assured by the advocates of immediate removal that this feat is very easy of accomplishment—a thing which the merest tyro may perform—but most of our leading obstetrical authorities entertain a different view of the difficulties and dangers involved. Playfair, while admitting the desirability of emptying the uterus when feasible, goes on to say: 'Cases, however, are frequently met with in which any forcible attempt at removal would be likely to prove very hurtful, and in which it is better practice to control hemorrhage by the plug or sponge tent and wait until the placenta is detached, which it will generally be in a day or two at most. Barnes reiterates the same advice, and cautions us that we must not persevere too pertinaciously in the attempt at removal, lest we inflict injury upon the uterus. The same author, recognizing the fact that the placenta after abortion quickly undergoes retrograde changes, whereby its adherence to the uterine wall is weakened, thereby facilitating its removal, remarks that 'The consulting practitioner here occasionally reaps credit which is scarcely his due. He is called in perhaps on the third day, or later, when the adhesion of the decidua to the uterus is breaking down. He passes in his fingers and extracts at once. But had he tried the day before he might have failed like the medical attendant in charge.'"

In the following paragraph Dr. Coles expresses his decided preference of the tupelo tent over other dilators of the os:—

"Whenever there is serious and persistent hemorrhage threatening to exhaust the patient, active interference is of course demanded. Or, if there is an offensive discharge and an elevated temperature together with rigors, we have good reason to apprehend blood poisoning from the absorption of putrefying elements within the uterus. Under such circumstances it would be proper to explore the interior of this organ, dilatation being resorted to if necessary. For this purpose the tupelo tent is certainly far superior to the sponge or sea-tangle. It has all the dilating qualities of sponge, while it is cleaner, and can be introduced more readily, even without a speculum if desired. It has also the advantage over the seatangle in that it can be procured in larger sizes and is less liable to slip out of position. Whenever full dilatation is required the tupelo is preferable to all other tents. The uterine cavity having been exposed, all fragments of secundines should be carefully dislodged, with either the finger or curette, after the manner so well described by Lusk and Mundé, and the organ washed out with some disinfectant fluid. Where there is a tendency to bleeding, tincture of iodine answers an excellent purpose, and is cleaner than perchloride or persulphate of iron as recommended by Barnes. Where the disintegrating fragments are small, repeated irrigation of the uterine cavity (the os being patulous) will generally suffice, as they usually melt down and come away with the discharges. It is not safe to scrape the uterine surface more than can be avoided, for fear of opening up fresh avenues by which septic materials may reach the system, since we know that nature interposes a bar to infection by glazing over denuded surfaces and closing gaping vessels. For this reason Lusk remarks that 'Fatal results are, however, rare, as decomposition is usually a late occurrence, setting in, as a rule, only after protective granulations have formed upon the uterine mucous membrane and after the complete closure of the uterine sinuses.'"—*Pacific Medical and Surgical Journal*.

#### PELLETIERINE, A NEW TÆNIFUGE.

By JOHN L. DICKEY, A.M., M.D.

(Class of 1882.)

Of Wheeling West Virginia.

A recent valuable addition to the remedies used against tænia in pelletierine. It is an alkaloid derived from the root-bark and stem-bark of granatum. It was discovered in 1878, by Tanret, and was named in honor of another eminent French chemist, Pelletier.

The powder is grayish-yellow in color. The dose is given by one authority as two and a-half grains.

by another, fifteen. The preparation most largely used is gotten up in a proprietary form by a Tanret, under the name of "Tanret's, Pelletierine." It is of the color and consistence of maple syrup, and has a sweet and pleasant, but slightly astringent taste. Each bottle contains an ounce, which is the adult dose. An objection to it is the price, three dollars a bottle. Following is a case in which it was used:—

Percy M., æt. 10, had been suffering from a tapeworm for three or four years. While the family lived in Cleveland he had been treated by several physicians at different times; large portions of the worm had been expelled, but the head still remained. Over a year ago the family removed to this city and the boy had been treated by a physician, who succeeded in getting large sections of the worm, but not the head. The case came into my hands, and half a bottle of "Tanret's Pelletierine" was administered on an empty stomach, but owing to the impossibility of getting the boy to take a sufficient cathartic we failed to get the whole worm. Several weeks later, another and more successful attempt was made.

The boy was given a glass of milk only, for supper, and the next morning for breakfast he took another glass of milk containing the remainder of the bottle of pelletierine, about half an ounce, without knowing he had taken any medicine. Half an hour later he was given a full dose of compound cathartic elixir, but his sensitive stomach rebelled, and the elixir was vomited. A still more palatable cathartic was given, in the shape of half a bottle of citrate of magnesia, and at two o'clock I called and found him on the *pot de chambre*, having passed a large, watery stool and about half of the worm. Without removing him or breaking off the worm, I gave him an enema of about twenty ounces of tepid water and soap-suds, containing a drachm of common table salt. In a few minutes the injection was expelled with more of the worm and taking hold of it and drawing it gently away hand over hand, the whole worm was soon withdrawn, the small head and suckers being nearly visible to the naked eye. It measured about sixteen feet in length. Under a microscope, the four suckers and central fringe of hooklets proved it to be a *tænia solium*.

The advantages of this preparation of pelletierine over other tæniifuges are its quick action and its pleasant taste and easy administration. I had seen it successfully used last winter, by Prof. Da Costa, at the Jefferson College Hospital clinic, in a case that had resisted all the well-known remedies.

Giving the injection and gently drawing away the worm I consider important parts of the treatment in the above-mentioned case. It is probable that very often tænia are expelled as far as the lower bowel and that a part of the tangled mass is retained by the sphincter, thus giving the head a chance to reattach itself. The worm did not

once break in drawing on it, but was tough and elastic. After a few minutes exposure to the air, however, it became brittle and broke easily.—*Medical News, March 29, 1884.*

### CHRONIC NASAL CATARRH.

Dr. Addison Hickey thus closes an interesting article on this subject in the *Medical Herald*:

In the treatment of this disease the first thing to be done is to thoroughly cleanse the parts. This is of paramount importance. The means employed to accomplish this should be mild and non-irritating. Anything which produces pain which lasts longer than a few seconds should not be used. I usually use for cleansing purposes the following mixture, which is a modification of "Dobell's solution":

R	Sodæ bicarb,		
	Sodæ bichloride,	aa	3 ss,
	Glycerine,		ij,
	Listerine,		j,
	Aquæ,		ss.
	Ft. sol.		v. M.

This solution, when used slightly warmed, produces a very pleasant sensation, and is excellent for cleaning and disinfecting the nasal cavity.

It should be used in the form of a spray, and Rumbold's, or preferable Sass's spray-producers are the best instructions for accomplishing this purpose. Unless there is a large accumulation of mucus or mucu-purulent matter in the nasal passages (or vault of pharynx) a detergent is unnecessary. In many cases the passages can be thoroughly cleansed by blowing the nose vigorously.

I propose now to very briefly review the method of treatment employed in each of the varieties of nasal catarrh alluded to.

1. Chronic Coryza (catarrh). In the treatment of this variety, as well as most of the others, I use, with some modification, the method originated by Dr. Rumbold. This consists in using in the form of a spray vaseline and ext. pinus canadensis. Unlike the distinguished author alluded to I have added to my armamentarium many other remedies besides the two mentioned. I use vaseline as a menstrum for the remedies employed, and it is the best, I think, that can be used in the treatment of diseases of the upper air-passages, for the following reason: First, it is soothing, hence non-irritating; second, it softens the hard, dry crusts of adhering mucus, and renders cleansing easier and more efficacious; third, it adheres to the parts and thus keeps the remedies in contact with the diseased structures longer and better than an aqueous solution can; fourth, it does not cause the fullness and unpleasant sensation in the head that is usually complained of when an aqueous medicament is used; fifth, it can be applied warm.

The various cleansing and astringent (or curative?) solutions that are generally used produce such pain and discomfort that they are never resorted to except when the annoyance and pain caused by the disease compel the sufferer to resort to something for relief. I have altered somewhat the formula used by Dr. R. of pinus canadensis, and use the following:

℞ Ext. pinus canadensis,	3 j,
Acid carbolic, C. P.	grs. iiss,
Glycerine,	3 vj,
Aquæ fervens,	3 ij, M.

Of this mixture from one to three drops in half a drachm of vaseline, "applied by means of such spray-producers as will make direct application to the whole diseased surface," used every other day, will soon relieve this trouble. I am frequently asked how I convert vaseline into a spray, it being a semi-solid? The answer is easy enough. First convert it into a liquid by heat. The whole spray-producer should be made warm, almost hot by placing it over the gas or spirit-lamp, before the vaseline is put into the bowl. If this is not done the vaseline will not flow into the tubular portion of the instrument, consequently no spray will issue on passing compressed air through it. In order to mix the medicants after they have been placed in the bowl of the instrument, "you simply place your finger lightly on the point where the spray comes out, and allow a small quantity of air to pass through the instrument. The pressure on the point turns a part of the air into the upper tube, causes air bubbles in the bowl. The rising bubbles cause the two kinds of liquid to mix."

I spray, first, the vault of the pharynx; second, the post-nasal opening; third, the ant. nares using the same medicament in each instrument.

2. Hypertrophic Nasal Catarrh. This is the most difficult and intractable variety of the disease with which we have to deal, a surgical operation (removing the hypertrophied membrane) frequently being necessary to effect a cure. After thoroughly cleansing the parts with the solution alluded to, I use, generally, glycerole tannin, two to six drops, in half drachm of vaseline, in the same manner as in treating chronic nasal catarrh. When this does not produce the desired result, great good can be accomplished by using alternately either zinc chlor. or zinc sulph., one part to four of glycerine; of the latter from one to three drops in half drachm of vaseline, and used in the same manner as above described.

I have obtained better results from the use of tannic acid, in the form of the glycerole, in the treatment of this form of catarrh, than from any other remedy. I have occasionally used with good results iodoform as recommended by Dr. Beverly Robinson, of New York, by means of the insufflator, alternating this with the above mentioned treatment.

Atrophic Nasal Catarrh. In this form of the disease a detergent is always necessary in the be-

ginning of the treatment. After thoroughly accomplishing this, use of dinus canadensis mixt. two to five drops, eucalyptol half drop, in half drachm vaseline, and spray the entire nasal and post-nasal cavities. I have found this combination to give very gratifying results in the majority of cases of this variety of catarrh. I have frequently had cases in which pulv. sanguinaria had a very good effect. This was used with the powder insufflator, according to the method and formula of Dr. F. Bosworth, of New York.

Fetid Nasal Catarrh. In this variety I make use of the same treatment as in atrophic nasal catarrh, increasing the eucalyptol to one or two drops, and using the iodoform powder once a week alternately, instead of the sanguinaria.

Ozena. This being a disease of the accessory sinuses of the nasal cavities, and due as a rule, to syphilis or struma, the cause is first ascertained and if possible removed. The nasal cavities are to be kept cleansed, and the vaseline and eucalyptol used twice a week.—*Medical Digest.*

## PALATABLE DRUGS FOR CHILDREN.

By FREDERICK CHURCHHILL, M.D., F.R.C.S.

We owe it, probably, much to the persistency with which practitioners of the sterner sort have impressed their rhubarb and black draughts upon rebellious children, in defiance of the protestations of nurses and mothers, that "the tasteless globule" has found such favor with the weaker sex. I could tell of several cases where the children have been entrusted to the care of a homœopath, while the parents luxuriate under the usual heroic treatment of the orthodox practitioner. We must not forget to swim with the tide. Children of this enlightened age are far more pampered and spoiled than those of the previous generation. Mothers seem unable to control their feelings; or, it may be that, with a smattering of physic lore, they find that there is no longer any necessity to cling to the once inevitable and nauseous potion. We must say a word, too, for the children. None of us like compulsion. It must not be forgotten that there is often more harm done to a child's nervous system, by cramming the draught down its throat than all the good the nauseous drug was supposed to effect. Children will often take days to recover their equilibrium after a protracted encounter with the medicine-glass in the nursery, under the stern discipline of a would-be conscientious nurse. Judging from the varied susceptibilities and dispositions of the children under my care, some of them having very resolute wills, others possessing—I cannot say endowed with—mothers of a pronounced æsthetic-temperament, to whom everything is a bore, except a novel to read and a sofa to lie upon, it becomes most important to formulate a line of treatment that will satisfy such requirements.

This class of children are generally ruled by a domineering old woman they call "nurse," displaying a maximum of "tall talk," with a minimum of what she delights to call "common sense" (and very common indeed it proves to be). The medical man must cultivate a habit of attacking such a stronghold of prejudice and conceit by a series of carefully-planned flank movements, in such a way that the nursery magnate may be drawn, against her own convictions, into a pliable frame of mind, sufficient to enable the medical man's physic and regimen to stand a chance of being attended to.

To attempt to invade the sanctum of a nursery where the lady-paramount is cajoled into the idea that "nurse is a treasure" and prefers rather to foster the notion than to care to have her eyes opened to the actual state of reigning ignorance, requires all the practical art of the medical man gradually to overcome and remedy.

Undoubtedly the ailments under which children for the most part suffer belong to the preventible class. They are due sometimes to overfeeding; very often to neglect, especially of the calls of nature; and very much to general bad management. With this view, it may be well to presume that the best and most approved mode of treatment for habitual torpidity of the bowels is not medicine, but an enema of soap and water, with occasionally a little castor or olive oil added to the injection. If this do not succeed, and the child's appetite begins to fail, it is an indication for administering medicine by the mouth.

Fortunately, the art of the apothecary comes in to our aid, and we are now enabled to give the most nauseous of drugs—castor oil—absolutely free from taste and smell, while it retains the aperient properties of ordinary castor oil. Messrs. Allan and Hanburys themselves advise that it should be shaken up with three or four times its bulk of hot milk. The viscosity of the oil is thus avoided, and the emulsion produced is scarcely distinguishable from warm rich milk.

If it be desirable to administer an aperient that will act more directly on the liver, and to avoid the unpleasant effects which often arise after taking "oil," the compound rhubarb pill will be found a serviceable aperient. Of course, some new method for its administration will be desired, which I shall now detail. Either an ordinary five-grain pill may be cut up, and a portion of it broken in small pieces may be buried in a chocolate-cream, which the youngest child will take with avidity; or, for children of, say, five years and upwards, I have given one-half and one-fourth of a grain of this pill, thinly coated. Half-a-dozen or so may be taken, like "hundreds and thousands," and washed down with milk and water.

The medicated fruit lozenges are very useful, *e. g.*, tamar indien and laxora lozenges. Podophyllin is probably one of the active ingredients in these lozenges. Only a small portion of a lozenge must be given to a child. The objection found with these is that they sometimes "gripe" the little patient.

Next to these, perhaps, in efficiency and palatability is the compound liquorice powder containing senna powder. About a teaspoonful stirred up with warm milk may be taken at bedtime, and a little chloric ether added (about ten to twenty drops). Very few children will object to take fluid magnesia or the calcined magnesia, especially if flavored with the syrup of mulberry or orange.

I have succeeded in masking the taste of many powders by the addition of powdered "rose" lozenge. I very seldom prescribe Gregory's powder, on account of its nauseous character and bulk. I prefer to combine the rhubarb with bicarbonate of soda, about five grains of each. This makes a much more miscible and manageable powder. Given in jam, honey or golden syrup, the taste is altogether covered.

Children will sometimes take the "baume de vie," or decoction of aloes, without objecting much. A little of this rubbed into the stomach of infants will suffice sometimes to procure an action of the bowels. The extract of liquorice may be added to the decoction until the bitter taste is sufficiently masked. Children have not really such an aversion to it, for I have known them to lick off the aloes from their fingers when put on to prevent them from sucking them. Powdered aloes, about half a teaspoonful, may be given mixed with brown sugar. The electuary of senna is taken without difficulty by some children, also the syrup of senna and the infusion with prunes. The effervescent purgative lemonade is a very agreeable drink, as also half a seidlitz powder flavored with lemon juice.

Turning now to febrifuge mixtures, there is not much need of flavoring to mask the flavor of these. Sweet nitre, acetate of ammonia, spirits of chloroform, are all pleasant drugs to take. The nitrate and chlorate of potash are rather saltish, but the sal prunelle and Wyeth's compressed tablets will be taken by the bigger children without much protest. The syrups of orange, lemon, and mulberry will come in as agreeable and cooling adjuncts. Cough-mixtures can generally be made very pleasant by the addition of syrup of squills of tolu, etc.

As regards tonics, some considerable skill will be necessary efficiently to cover the bitter flavor. Children will take the saccharated carbonate of iron very well, and also steel wine; but if we attempt to give the bitter infusions, there is sure to be rebellion in the nursery. Quinine—one of the most valuable medicines for children—can be given without difficulty, either in the form of pill or, which I prefer, dissolved in syrup of orange, without the addition of any water. This effectually covers the flavor. Quinine wine is useful for the elder children.

Chemical food is, of course, taken with relish, and if recently made is a serviceable tonic; but the phosphates, from their insolubility, throw down very much. The compound solution of the hypophosphites, in ten-minim doses, and the hypophos-

phite wine, forms a perfect substitute for Par-  
rish's food. Besides having iron, in a form which  
is easily absorbed, the hypophosphite of magnesia  
serves as a useful antacid and stomachic in this  
combination.—*British Med. Journal.*

SOME THOUGHTS CONCERNING OLD  
REMEDIES NOW CONSIDERED  
ALMOST OBSOLETE BY PHYSI-  
CIANS,—TARTAR EMETIC,  
FOR EXAMPLE.

By HARVEY L. BYRD, M.D.

President and Professor of Obstetrics and Diseases of  
Women and Children in the Baltimore Medical College,  
Baltimore, Md.

Whilst the present age may be considered gen-  
erally as a progressive one, and in a great many  
respects is really such in fact, as may be seen in  
the numerous accessions that have been made in  
various arts and in many departments of science  
likewise, which are seemingly permanent addi-  
tions to what was known before, and, therefore,  
calculated to benefit mankind in various ways, yet  
so far as it relates to the medical profession it can-  
not be properly regarded as a utilitarian one, cer-  
tainly not in the broad acceptance in which some  
have thought proper to apply that term to the ad-  
vancements taking place in the latter half of the  
nineteenth century. Hence we pause to consider  
that it is lacking in conservatism, in our calling at  
least, in a conspicuous degree.

The adaptation of means to ends that so gen-  
erally marks discoveries as they are utilized from  
day to day at the present time, in a manner and  
to a degree probably never equalled before in the  
various arts and sciences, including medicine,  
would seem to indicate that an attempt like this  
to revive an old remedy and bring it prominently  
before the profession would be truly "a work of  
supererogation."

But when the thoughtful mind reverts to the  
great benefits it has seen result from *tartar emetic*  
and contemplates and compares the action of the  
remedies that have been substituted for it and the  
results obtained, there will be found sufficient  
reason to "give us pause," and to ascertain  
whether our great zeal in behalf of *new remedies*  
is not causing us to drift away from that which is  
good to that or those remedies which are no bet-  
ter at least than it is, and whether or not the  
tendency of the profession is to ignore many other  
old remedies and useful experiences of past ages,  
and press them to the rear, where they have not  
been actually forgotten, when making plans for  
new discoveries or new facts in the healing art.  
Again, it may be observed of a few modern reme-  
dies even, or those of comparatively recent intro-  
duction, that the tendency in some instances is to  
permit them to fall still-born ere sufficient time is  
given for their proper development or utilization,

because unsupported by the sanction of a great  
name, in order, seemingly, to afford larger space  
for others that appear to offer more brilliant pros-  
pects of usefulness to the profession or a wider  
fame to the discoverer.

Whilst always ready to remove obstructions and  
to facilitate progress and discovery by all proper  
means, I often think that more enduring and sub-  
stantial results would be certainly reached if we  
could delay just long enough to "prove all things  
and to hold fast only to that which is good" in  
medicine, as is done in almost all the other de-  
partments of human affairs.

I am emboldened to step to the front in the  
advocacy of *tartar emetic*, from seeing the good  
effects upon the profession that followed an article  
I had the temerity to publish in the *Medical and  
Surgical Reporter* of Philadelphia, in 1872, en-  
titled "Blood-Letting in Disease."

I am thoroughly satisfied, after four decades of  
experience as a physician engaged in active pro-  
fessional work, that, next to blood-letting, the  
tartrate of antimony and potash is absolutely  
without a peer or rival as an antiphlogistic agent  
in our therapeutic resources, and that it may in  
some cases be substituted for blood-letting, even,  
without detriment, when certain circumstances or  
conditions do not absolutely demand the use of  
that old and peerless remedy in inflammation.

I am conscious of the import of the language I  
am using, and desire that I may not be misunder-  
stood in regard to it. And I wish to add, still  
further, that, like blood-letting, the *necessity* for its  
use in practice is now as great as it ever was at  
any time in the history of the article. After vene-  
section, in acute inflammatory affections, I have  
found it produce its most strikingly marked bene-  
ficial effects, and feel fully warranted in saying  
that the most sceptical member of the profession  
would not doubt its wondrous power for good  
could its action be observed in a single case. But,  
as already stated above, its field of usefulness  
covers absolutely all cases of febrile and inflam-  
matory affections that are unattended with inflam-  
matory or considerable irritation of the gastric  
mucous membrane. Those conditions only con-  
tra-indicate its internal employment in any form  
of disease whatsoever, or in any pathological con-  
dition attended with a full or even moderately  
tense and quick-pulse, with dry skin and paucity  
of the secretions generally. It will be seen from  
these statements that, with the single exception of  
calomel, it is capable of doing good in a larger  
number of diseases than any other remedy in the  
hands of the medical practitioner. With these  
remarks I might conclude this paper, and, were I  
not aware of the fact that there are a large number  
of practitioners who have never used the article at  
all, would probably be inclined to do so. But for  
the use of such, and of those who have permitted  
other and more recent articles to monopolize its  
place in their therapeutic resources, I feel that the  
interests of science demand that a few more words



should be added regarding its mode of administration, etc.

In doses of from one-eightieth to one-tenth of a grain, alone or in conjunction with opium or one of its salts or preparations, I expect good results from it when given as an antiphlogistic or antipyretic, expectorant, diaphoretic, diuretic, or as an alterative. I never prescribe it as an emetic, unless no other article of that class is convenient, and am not prepared to speak of its *tolerance*, as mentioned by Rasori many years ago, in acute diseases from personal experience. Thus, I find it a valuable agent in most forms of fever, in bronchitis, in pneumonia, in croup and laryngitis, in torpid conditions of the liver, in certain chronic cutaneous diseases, and in sick-headache, etc. It is as valuable in lessening the force and frequency of the circulation as veratrum or aconite, and, being tasteless in the proper dose, is almost absolutely free from disagreeable or unpleasant effects, and thus is generally preferable to either of them.

The foregoing strong commendation of tartar emetic in this paper will be endorsed, I feel quite sure, by those practitioners who would preserve the old landmarks in our therapeutics, and are unwilling to drift too far away from the moorings of well-tried experience, merely to follow fashion or for the sake of novelty in practice. And, if it should prove the means of adding a most valuable and trustworthy article to the therapeutic repertory of a physician unaccustomed to or inexperienced in its use in the treatment of his patients, another most important object will have resulted from its preparation and its publication in the *Medical Times*.—*Phil. Medical Times*.

## THE CANADA MEDICAL RECORD

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MONTREAL, MAY, 1884.

### PERSONAL.

The *Panama Star* of April 15th says:—

Dr. George Nelson, (C.M., M.D., Bishop's College, 1880) late doctor of the Central Hospital of the Canal Company at Huerta Galla, leaves today by the *San Blas* for Santa Barbara, California. He has made many friends in the service and among the public, and carries with him the heartiest wishes of all his friends that he may return to his post in a few months in renewed health. It also says: we learn that Dr. Wolfred

Nelson (C.M., M.D., Bishop's College 1872), has declined the appointment tendered him by the State Government as a member of the Board of Health.

Dr. Frank Nelson (M.D., Savannah Medical College, 1884), and late a student of Bishop's College Faculty of Medicine, left Montreal early in May to join his brother George in California. His health is, we regret to say, far from being robust.

Dr. Roddick, Professor of Clinical Surgery McGill University and one of the Editors of the *Canada Medical and Surgical Journal*, has returned to Montreal after an absence of more than six months in Europe.

Dr. James Bell (M.D., McGill, 1877), late Medical Superintendent of the Montreal General Hospital has commenced practice in Montreal.

Dr. Gray (M.D., McGill, 1883) has been elected Medical Superintendent of the Montreal General Hospital. His appointment is for a year.

Dr. John Gardner (M.D., McGill, 1883), late one of the interiors of the Montreal General Hospital, has commenced practice at Point St. Charles, Montreal.

Dr. Wm. Stephens (M.D., McGill, 1881) has resumed practice in Montreal. He passed the Winter in Vienna.

Dr. Buller of Montreal became a Benedict on the 16th of April last and Dr. G. T. Ross of Montreal followed suit early in May. Both please accept an Editor's congratulations.

Dr. Dickinson (M.D., McGill, 1846), of Cornwall, Ont., is dead. He was one of the noble men who served at Grosse Isle Quarantine Station, during the terrible epidemic of typhus fever in 1847. His career subsequently was a most honorable one, and he died beloved and respected by all.

The following changes have taken place in the Medical Faculty of Bishop's College, owing to the removal of Dr. Young to China, and the resignation of Dr. Kennedy of the chair of Obstetrics and of Dr. Foley of the chair of Anatomy:

Dr. D. D. Gaherty (C.M., M.D., Bishop's, 1879) has been appointed Professor of Anatomy.

Dr. H. L. Reddy has been appointed Professor of Medical Jurisprudence.

Dr. Cameron has been appointed Professor of Obstetrics and Diseases of Children.

Dr. McConnell will combine Therapeutics with *Materi Medica*, and is now Professor of both these branches.

Mr. J. T. Donald, M.A., F.C.S., has been appointed Professor of Chemistry.