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## Original Communications.

### PLACENTA PREVIA.

BY E. G. EDWARDS, M.D., LONDON.

(Read at Meeting of Ontario Medical Association.)

Unavoidable hemorrhage is admitted, I believe, by all to be due to the attachment of the placenta over part, or all, of the os uteri, partial detachment of the same causing the hemorrhage.

Accidental hemorrhage, on the other hand, occurs from placental detachment of a normally situated placenta.

I have met with seven complete cases of placenta previa extending over a practice of thirty years. Out of these seven cases I will dismiss one very summarily, that case having been my own sister:—

I was sent for a distance of about twenty-five miles to see her, but on my arrival she was dead. The doctor who was in attendance had not succeeded in arresting the hemorrhage, from which she died undelivered, near the full term of gestation.

Of the remaining six cases all the mothers recovered. Two of the children were born alive and four dead.

CASE I. Fourth labor; called a distance of six miles to this case. On my arrival, learned that she had had previous floodings within a short time of each other. The doctor who was called at those times could not be found in this instance. Examination revealed placenta covering the os. I separated the placenta as

far as I could from around the os with my index finger. In doing so, succeeded in getting it completely detached from the os. As the os was very dilatable I succeeded in making a diagnosis of head presentation, and, as labor was in progress, I gave ergot and ruptured the membranes. Child soon born alive by natural uterine efforts; mother made a good recovery.

CASE II. Was called upon about 6 p.m. by husband, who told me that his wife had a severe flooding without any known cause, and without any pain. He said that she was in the family-way about, he thought, eight months with first child. Owing to another engagement preventing my going immediately, I instructed him to hurry home and place her in the recumbent position, and keep her head low, and give her cool drinks, and to report at once if the hemorrhage continued. About six hours after he returned, saying, "My wife is bleeding to death," and to hurry as quickly as possible. Upon reaching her, she was truly in a most dangerous condition from loss of blood—pulse almost imperceptible—in short, she appeared dying. Having lowered her head still more, opened the door and windows, then gave 20 drops of laudanum in a little hot water and whiskey. On examination found placenta completely covering the os. I immediately cleaned out the vagina from clots and then plugged. Ordered hot milk and chicken tea to be speedily prepared and given. After she had somewhat rallied, gave her 2½ grains of opium. I did this in consequence of great restlessness and irregular uterine pains, she being, as I

thought, too weak to deliver. The opium caused her to sleep between four and five hours, and quieted pains.

At the end of this time the pains again commenced, and being sufficiently rallied I removed the plug, introduced the hand into the vagina, separated the placenta on one side, then cautiously introduced the hand into the uterus, found a foot, turned, and delivered; but the child was dead, and the mother was almost in *articulo mortis*.

The after-birth came directly away, but the uterus would not contract properly, and ergot seemed to have no effect. After rallying a little, post-partum hemorrhage commenced. I then gave her ʒj of sugar of lead, and half a grain of opium in two tablespoonfuls of vinegar, and some water. I kneaded the uterus, applied cold, etc. In about fifteen minutes she vomited; then the uterus contracted firmly, and the woman made a slow recovery, after wading through phlegmasia dolens.

I may here state that I consider vomiting of great service in floodings, and it may be speedily induced by pushing the finger down the throat.

CASE III. Called to a case of hemorrhage near the full term of gestation. On examination found I had a case of placenta previa completely covering the os.

*Treatment.*—As it was head presentation, I separated the placenta from the os as far as I could reach, and as my finger is long I completely detached it from one side; then gave ergot, as there was some pain, waited a few minutes and ruptured the membrane. The child was born alive, unaided by artificial means. The mother made a rapid and complete recovery.

CASE IV. In this case severe flooding had taken place twice, both of which had ceased before my arrival. Not so with the third flooding, as I found her still flowing, having lost a large amount of blood. Considering her too weak to deliver, and the placenta completely covering the os, I gave stimulants, plugged, and waited, ordering hot milk and chicken tea to be given frequently, then left, leaving orders to notify me should any unusual change take place. In about three hours I returned and found her rallied, as I thought,

sufficiently to deliver. I then removed the plug, separated the placenta as far as I could with my finger, gave ergot, and ruptured the membranes, believing it was head presentation. The placenta, being completely detached, was thrown off; then, on making another examination, to my disgust discovered a cross birth, which necessitated turning the child and delivering by the feet, which was done. The child was dead. The mother made a good recovery.

This case gave me a great deal of uneasiness, as I had my misgivings respecting the treatment which I adopted, which were not in the least soothed by a brother practitioner to whom I related the whole case shortly afterwards. My misgivings were due to two causes:—

*Firstly.*—Had I diagnosed cross-presentation in time, I would have turned either by external and internal manipulation, and before rupturing the membranes, if possible, or by introducing the hand into the uterus.

*Secondly.*—Had I done so the child's chances would have been better.

I may here state that as soon as the after-birth was completely detached and removed, although the child was unborn, there was no further hemorrhage.

CASE V. In this case I was called to assist another doctor, as his patient had lost a great deal of blood; and pains still continuing, and having diagnosed head presentation, I advised detaching the placenta from the os as far as possible, to give ergot and rupture the membranes, which was done. Natural efforts of the uterus, unaided, expelled both child and placenta. Child was dead. Mother made a good recovery.

CASE VI. AND LAST. Mrs. McC., residing on the border of London East, in London township; age 39 years; tall, thin, dark complexion; third confinement. Her husband came to my office on the 5th March, 1883, and said that his wife had lost a great deal of blood that morning, while sitting on the chamber making water, and without any pain or known cause. He thought she was within two weeks or a month of her confinement. Upon further enquiry I learned that he had placed her in bed and that the bleeding had ceased. I did

not then visit her, but explained to him the nature of what I believed the case to be, and warned him not to have her left alone. Ten days from that time he came a second time and said, "Doctor, come with me as quickly as you can. I fear my wife is dead, as she has flooded a vessel full and fainted." Reaching her as quickly as possible, her case really appeared hopeless, and there was a chamberful of red clotted blood. I pursued the usual treatment, such as head placed low, abundance of fresh air, and, she being just able to swallow, I gave her hot whiskey, milk, and a stimulating dose of laudanum. The examination revealed placenta completely covering the os. As I considered that she was too weak to deliver, I immediately plugged; then applied warmth to the body; and upon leaving her, ordered hot milk and chicken tea to be given often, likewise leaving two grains of opium to be given should she become uneasy or restless, telling them I would return in six hours unless sent for sooner. About five hours after a messenger came, saying I was wanted immediately, as Mrs. McC. was flooding again.

I asked the messenger to call upon Dr. McArthur and have him go with him, as I might require assistance. Finding that she had rallied the doctor agreed with me that the sooner we delivered her the better. Having removed the plug, we diagnosed head presentation. I then, after giving ergot, separated the placenta with my finger all around the os. Upon doing so, it became detached from one side, falling into the vagina. I then seized this detached portion with my fingers and pressed it against the opposite side. After a little, the pains returning, I ruptured the membranes, holding the placenta with my fingers to the opposite side until the head stopped by pressure all bleeding. The child was delivered dead by the natural efforts, and the mother made a good recovery.

In conclusion, to sum up. Judging from my own experience, coupled with what I have read and heard respecting the treatment of placenta previa, my own views are the following: That after one severe flooding the sooner you deliver the better, more especially if there are labor pains. In five out of six cases there were more

floodings than one. I recommend, when head presents, to separate the placenta from os uteri all around as far as you can reach, if labor has commenced. Then, if possible, detach the placenta on one side completely, so as to allow you to reach the membranes and rupture, to give ergot by the mouth or ergotine by hypodermic injections, and use a little pressure over uterus externally. In most cases as the water discharges the head descends, thereby plugging, by pressure on the placenta, so thoroughly as to check the hemorrhage. I am in the habit of emptying the bladder by a catheter and having forceps on hand, and a roller bandage around the abdomen in order to give external support if required, and holding a plug against the os with my hand if the flooding is severe. I had no occasion to use forceps in any case of placenta previa so far.

Respecting turning, I should, in cross birth, carefully try to turn by manipulation by finger in the vagina and external assistance.

I might here state that I have thus succeeded in cross births, lowering the shoulders, raising the hips and so bringing the head, feet, or breech down. I see no reason why we should not try, especially in cross-births, in cases of placenta previa. I have notice in the December number of the *Canada Lancet* an article on combined version in placenta previa.

My advice is never to introduce the hand through the placenta and thereby gain entrance into the uterus for the purpose of turning, for thereby violence is sure to follow. In fact I am not an advocate for turning by introducing the hand into the uterus under any circumstances, unless all other means fail; as I consider that procedure very injurious to the mother and very apt to be followed by shock or by inflammatory action of some kind. Possibly in some cases no other mode is practicable, and it must then be had recourse to. Respecting plugging, I have always succeeded in arresting hemorrhage by this means, giving thereby safety and time. It likewise stimulates the uterus, and the os is found more dilated. I would not give ergot unless I knew the bladder was empty, the parts proportionable, the os dilatable, and instruments at hand. Flooding nearly always relaxes the os. My rule in giv-

ing ergot is first to make sure of head, feet or breech presentation, with some pain, and in cases in which I have decided to deliver at once. Ergot would only increase the mischief in placenta previa, unless it was given to assist your efforts at the time of expulsion of the child.

Respecting hot drinks, I am aware that cool or cold drinks are generally recommended in cases of flooding. I do not, however, believe in giving cold drinks in shock or great depression. Opium, in small doses, as a stimulant, I hold very valuable in floodings, and large doses in the cases requiring the plug, to give rest and sleep when time for rallying is necessary.

I once dreaded placenta previa cases as amongst the most dangerous in midwifery; I now look upon them as being very manageable, unless there should be an excessive loss of blood before we see the patient, and even then, in most cases, we can stop the pains by larger doses of opium, plug, then wait until the patient rallies, then deliver.

I am, as before stated, of the opinion, if there has been great loss of blood, that the sooner you deliver the better, provided the hemorrhage continues, and there is pain, and the patient not too weak; but you should not introduce the hand into the uterus if you can possibly avoid doing so, always giving an anæsthetic when you do. I put emphasis on this latter—*anæsthetic* (ether or chloroform). My practice and advice is, in all severe midwifery operations, to give one or the other. My reasons for thus advising are:

1st. It is humane and prevents unnecessary suffering.

2nd. By its use depression and shock are lessened, if not prevented altogether.

Allow me here to say that I, at anyrate, have not, neither do I intend adhering to the old traditional theories and procedures respecting the use of anæsthetics in midwifery.

In conclusion, following up turning in cases of placenta previa, the only argument I can conceive justifying it when the head presents is the speedy delivery of the child in order to save its life. But how often will we be disappointed in this, as it is well known where some floodings have taken place the child is usually

born dead. To compensate for that, by plugging and waiting the shock of introducing the hand into the uterus will be avoided and the maternal parts not injured. I believe the time is not far distant when turning, by introducing the hand into the uterus, will be the exception, not the rule as at present.

I have adopted a procedure of my own, viz., when called to a case of placenta previa near the end of pregnancy, when flooding is in progress, with the pains continuing, and the patient not too weak or exhausted, to separate as much of the placenta as I can on one side, detaching a portion of it completely from one side, bringing it down into the vagina; and if the os is not well dilated, and the pain continuing, to squeeze the detached portion between my fingers, or to press it firmly against the opposite side until the os dilates; then I give ergot and rupture the membranes, still pressing the detached portion of the placenta until the head descends sufficiently to check the hemorrhage.

#### FOUR OVARIOTOMIES, AND ONE LAPAROTOMY.

BY F. R. ECCLES, M.D., F.R.C.S. ED., M.R.C.S. ENG.,  
F.O.S. LONDON.

(Continued.)

The incision was four, enlarged to six inches. There was no pedicle—what appeared at first to be a broad thick pedicle was simply the uterus, and the tumour a prolongation or outgrowth from it, and engaging the right ovary. One part of the tumour was thought to fluctuate, and was tapped with a small-sized ovarian trocar. Blood exuded freely, and the hemorrhage soon became so alarming that I immediately threw the ecraseur wire around the tumour and rapidly tightened it, which procedure controlled the hemorrhage. By the use of the pedicle forceps, and several pairs of Spencer Wells' compression forceps, I engaged the whole connection, and then relaxed the ecraseur to ascertain if the forceps would control the hemorrhage, which they effectually did. I then separated the tumour with the long-handled scissors—cutting through the right angle of the fundus uteri, and removing with the tumour the

right fallopian tube and right ovary. The uterine tissue (close to the forceps) was transfixed twice with a large needle armed with a very large double silk thread,—thus making four segments. Each ligature was then firmly tied as the forceps were removed, the stump was sponged dry, and the remainder of the uterus examined and found healthy. The left ovary was then examined, and it was found that in the haste to control the hemorrhage, in throwing the ecraseur wire around the tumour the left ovary was engaged and its connections injured. Fearing some untoward event as a result of this, I removed it after ligating.

As there had been some considerable escape of blood into the peritoneal cavity, I was extremely anxious that there should be a thorough cleansing. Quite 20 minutes was spent in clearing this cavity of all blood; and not until the sponge came out quite clean were our efforts relaxed. Before the adjustment of the bowels, the stump was again examined and found dry.

Nine deep stitches closed the abdominal wound. Between the lower two a long glass drainage-tube was inserted, passing down to the bottom of the *cul de sac*. This was done because I feared there might be some necrosis of the stump, on account of the large amount of tissue that was strangulated by the ligatures; and it was doubtful whether so broad a stump would tack itself on to the peritoneum, and imbibe enough nourishment for its vitality. The further history of the case proves the correctness of this procedure, and the fatality that would certainly have resulted had no tube been introduced. The wound was dressed antiseptically—dry absorbent pads being used, as in the former cases. Gas and lamp light were needed to complete the operation, which lasted nearly 2 hours. Enema of 20 min. of tincture of opium was administered and patient put to bed, prepared as mentioned in August number. Catheter to be passed every 6 hours, and nothing allowed but occasional sips of ice water or iced champagne for 24 hours after the operation.

21st, 5 a.m.—Patient has had several naps—very little nausea. Temperature 99°, pulse 112.  
11 a.m.—temperature 98½°, pulse 106. 11.30

p.m.—temperature 100½°, pulse 100. Enema of 20 min. of tincture of opium.

22nd, 6.30 a.m.—Temperature 99½°, pulse 96.  
9.30 p.m.—Temperature 101½°, pulse 106. One drop of Fleming's tincture of aconite every hour, until temperature and pulse below 100.

23rd, 5 a.m.—Temperature 99½°, pulse 86. Pumped out 1 oz. of foetid serum and a few blood clots through the glass drainage-tube. I then thoroughly washed out Douglass' *cul de sac* through the drainage-tube, until the water came out clear and devoid of any factor. 11 a.m.—Temperature 99½°, pulse 104. Patient says she feels comfortable—now taking milk and barley water.

24th, 8 a.m.—Temperature 99°, pulse 84. Some discomfort from distension. A large male catheter passed up the rectum and allowed to remain three hours. Flatus frequently passed out through it, and much relief afforded. 8 p.m.—Temperature 99½°, pulse 84. Half an ounce of very foetid serum withdrawn. The pelvic cavity to be washed out through the drainage tube with carbolized water every 8 hours.

25th, 8 a.m.—Temperature 99°, pulse 114. Considerable distress from bloating, and tube again passed up the rectum. The gas passed away so rapidly as to be distinctly audible at the opposite side of the room. 8 p.m.—Temperature 99½°, pulse 114. Foetid serum, looking more like pus.

26th, 2 a.m.—Very restless; enema of 20 mins. 4 a.m.—Vomited; foetid purulent discharge drawn out through drainage-tube; the stump no doubt the cause. The strength of carbolic water increased from 1¼ to 2½ per cent. In the afternoon the distension became enormous, with tendency to vomit. Rectal tube again passed with great relief. Fearing that considerable of the flatulency was due to more or less intestinal indigestion, I ordered B. T. injections, 1 oz. every hour, and nothing whatever by the stomach for 12 hours.

27th, 6.20 a.m.—Stomach better and bloating less. A little iced milk allowed. B. T. injections every 2 hours. Temperature 98°, pulse 106.

I need not continue to narrate the further daily records, but simply state that 2 or 3 drs. of

fœtid pus was drawn out daily, and occasionally a few drops would well up at the side of the drainage-tube, which prevented primary union at that point. Still, by the frequent washings out through the drainage-tube, and the dusting of iodoform on the abdomen around the tube, the temperature never rose above 99°, and the patient continued daily to improve. That although the stump was septic, there were no symptoms of septicæmia affecting the general system. This condition must be largely attributed to the frequent washing out of the pelvic cavity with the 2½ per cent. solution of carbolic acid. In order that it could be as effectually carried out in my absence as in my presence, I extemporized a fountain syringe, using a gallon tin pail with a metal tube at the bottom, to which five or six feet of rubber tubing was attached, the distal end of which slipped over a small silver tube 6 inches long. Through a cork, which accurately fitted the Keith drainage-tube, this silver tube was carried down to the bottom of Douglass' *cul de sac*. This sufficed to carry the carbolized water into the pelvic cavity, whilst a short glass tube, passing just through the cork, and to which a few feet of rubber tubing was attached, served the purpose of carrying away the carbolized water as fast as it entered through the silver tube, and with it the pus and debris, into a vessel at the side of the bed. By raising the pail some 3 or 4 feet higher than the mouth of the drainage-tube, a continuous stream of warm carbolized water douched the pelvic cavity and stump. This was continued three or four times daily for several days, and latterly once daily.

29th.—The nurse informed me that there had been a fœtid discharge from the vagina—doubtless pus—from the line of ligature through the angle of the uterine cavity. Later on I confirmed my suspicions by examining her with the speculum and finding the pus coming through the os. The vagina syringed out with carbolic water twice daily.

30th.—All the sutures removed except the last two, between which was the drainage-tube, and the union was complete down to within an inch of the tube, and here granulation was going on. Bowels moved freely and unaided.

From this date there was no interruption to

the complete recovery, and were it not that the glass drainage-tube had to remain in three weeks, and a small rubber one a further three weeks, she could have returned in twenty days. The pulse and temperature were normal, appetite and digestion good, bowels regular, and seven or eight hours of sleep daily without any hypnotic.

But the large glass drainage-tube saved her life, by keeping the septic influence local. Around the drainage-tube a complete membrane was formed, which extended down to Douglass' *cul de sac*—so that after the removal of the last inch of the rubber drainage-tube, I could pass a probe down to the bottom of the pelvic cavity. From several letters after her return home I learned from Dr. Crawford that there was a slight discharge, as from a sinus. On the 18th of April she came up to London, and I injected the sinus with Churchill's tincture of iodine, producing closure. A letter in May states that there has been no discharge since.

The tumour weighed 6½ lbs., and upon examination was found to be largely composed of the fibrous element. On one side there was fully one-half inch of muscular tissue cut through before coming to the dense fibrous tissue. It was not irregular or nodular, and formed almost a perfect sphere.

CASE IV. Miss B—, age 17, residing in the County of Elgin; widow's daughter; was first seen by me in May, 1884, in consultation with Dr. Clark, and following notes made:—

Early in May, 1883, she first noticed a swelling in the left and lower abdominal region—then about the size of a small cocoa-nut. Dr. Clark, who saw her at this time, thought that it had been growing for a year. She said the growth was gradual and continuous from the first time she discovered it; that it rarely, if ever, gave her pain, and that it was always hard.

Father died of phthisis, and mother has curvature of the spine—Potts' disease.

The patient about 4 ft. 4 in. high, somewhat emaciated, but of a round figure; of a melancholy expression; the skin tawny, dry, and very rough—*unusually so across the abdomen*, which was considerably distended with a firm, unyielding, and somewhat uneven tumour, which

extended from the pubes to the *scrobiculus cordis*, and which moved but very slightly on manipulation. No fluctuation or impulse; no tenderness on pressure; no marked dilated veins; no sounds on auscultation, but dulness on percussion all over the swelling. Resonance over right lumbar region—mammary areolæ of the unimpregnated. On examination, per vaginam, the tumour could barely be reached it was up out of the pelvic cavity. The cervix uteri was far back, and sound passed  $2\frac{1}{4}$  in. The movement of sound *in utero* did not appear to be communicated to the tumour.

Catamenia first appeared at 14; always scanty and irregular; no dysmenorrhœa; no leucorrhœa.

There was a history of constipation for some time, but not obstinate. The appetite and digestion were hardly ever normal; sleeps poorly; has occasional attacks of neuralgia; pulse 90, small and weak; temperature normal.

Urine scanty, acid; specific gravity, 1022; no albumen.

A diagnosis of dermoid disease of the ovary was made, but on account of the weakness of the patient and the bad family history an operation was not recommended. Tonics and diuretics ordered.

I heard no more from the patient until September 26th, when she and her mother came to London to again consult me about the removal. There had been considerable increase in the size of the tumour since May; and although the kidneys were acting better, still the constitutional debility was but little improved, and I discouraged operative interference, and she returned home.

Early in December she requested her family physician, Dr. Clarke, to call on me and to say that she was anxious that I should operate on her, and that she was quite willing to assume all risks, and that she did not want to die with the tumour in her. I then advised the doctor to have her come up to London for operation, which she did on the 18th of the same month. While she had a careworn and anxious look, there were intervals in which she exhibited a mingled sense of joy and fear, and underlying all a good share of hope.

Her sense of modesty was keen in the ex-

treme, and the possibility of her being an object of curiosity or a subject of remark was painful to her tender sensibilities, and made her intensely desirous that she should be relieved of her burden. She was prepared for operation on the 23rd. Dr. Wilson administered the chloroform with a Junker apparatus, and I was assisted by Drs. Fraser and Clarke. The incision was made in the line of the *linea alba*, between the umbilicus and the pubes. The peritoneum was divided to the extent of  $3\frac{1}{2}$  inches, and the hand passed down between the tumour and the pelvic brim, when it was ascertained that the tumour was not connected with any of the pelvic viscera. However, upon raising the omentum and tracing the connections, it was decided to remove it. The incision was then extended upwards, passing around to the left of the umbilicus. The great omentum was raised, and some adhesions of it and the transverse colon to the tumour had to be ligated and divided. The tumour was then carefully rolled forwards, and, with difficulty, brought out through the abdominal opening. The pedicle forceps clasped its connections, which were then divided by the scissors and ligated immediately beneath the forceps. Little time was spent in examining the bed of the tumour. One was unwilling to prolong an operation which necessarily must produce much shock. It was thought, however, that the point of origin was in either one of the lumbar glands or the *psoas* muscle. It was in that region, just below the kidney. There was scarcely any hemorrhage, and very little sponging sufficed to cleanse the peritoneal cavity.

The abdominal wound was closed by eleven deep sutures, and antiseptic pads and dressing applied, secured by broad strips of adhesive plaster, around which a warm flannel binder was fitted. The patient made a temporary rally, but died from shock 17 hours after the operation. The tumour, which weighed 7 pounds, was found to be densely fibrous, with quite a number of irregular nodular elevations. Two large pieces of bone, in shape like the malar bone, with a concavity like the lower half of the orbital cavity, were noticed. The bone could only be separated from the dense fibrous or fibro-cartilaginous tissue by the aid of the



knife. It was the presence of the bony out-growth and the presence of the tumour down to the pelvic brim, and my being able to press the ulnar side of the hand between the brim and the tumour, together with the age of the patient, that misled me. With all the facts now before me, it appears to me that, although not able to make a positive diagnosis, I should have been able to exclude disease of the ovary.

CASE V. The fifth case was that of Mrs. M——, who was 59 years of age, and had been married twice, first in 1845, and to her present husband in 1865; one child, which died at the age of ten months. She resided in London, and was under the care of Dr. Fraser, who recognized a tumour which he believed to be ovarian, and asked me to see the case with him on January 27th, 1885, at which time the following notes were made. Emaciated and somewhat careworn, with a tawny and not fair complexion. The abdomen was largely distended, the skin was smooth, and the temperature normal. There was little or no perspiration, and no œdema of the lower extremities. The girth at umbilical level was 42 inches, and no apparent difference from right and left anterior superior spines to the umbilicus. The tumour was only slightly movable, although there was no history of pains giving rise to adhesions. Fluctuation distinct and impulse carried all over the tumour. Percussion revealed dulness in the median line and resonance at the sides. The action of the kidneys was somewhat interfered with; bladder irritable and urine one pint in 24 hours; acid; specific gravity 1024; no albumen. The finger easily recognized the *tumour* through the vaginal walls, and the *uterus* far back, with a depth of scarcely  $2\frac{1}{4}$  inches. The condition of the os and cervix were normal. The catamenia ceased, without any unusual nervous symptoms, at the age of 50. The tongue clean, appetite and digestion not good, great flatulence at times, and the bowels only acting by the aid of laxatives.

The respiratory and circulatory organs were healthy, and there was nothing unusual to note about the nervous system except that she did not sleep well. Her mode of life had always been active, and she suffered from no previous

illnesses except two or three attacks of cystitis many years ago. Early in September last her friends intimated to her that she was growing much larger, and she herself noticed from week to week she had to enlarge her waist-bands. From her first knowledge of any enlargement, the growth was gradual and continuous, and her symptoms referable to the stomach and bladder became more and more troublesome. There was a history of nausea and occasional vomiting, more or less flatulence, and more or less constipation from the beginning of September.

Dr. Fraser's diagnosis was confirmed and an operation recommended. Diuretics, laxatives and stomachics were prescribed. At this juncture Dr. Fraser very kindly turned the case over to me, and by the line of treatment just mentioned she was put in the best possible condition for the operation, which was done on the 11th of March, Drs. Fraser, Wilson, Belton and some senior students assisting me. After the usual anaesthesia and an abdominal incision of 4 inches, a tumour, composed almost entirely of one cyst, and with but slight adhesions, was found. Its contents were evacuated. The pedicle, which was long, was clamped, transixed and ligated, as in the former cases; the abdominal incision was closed by nine carbolized silk sutures, the usual dry dressing, adhesive straps and flannel binder applied, and a suppository of opium administered.

The patient was a little longer than usual in rallying from the shock. At 7.45 p.m. (four hours after the operation), 8 oz. of urine were withdrawn and enema of 20 min. of tincture of opium given.

March 12, 3 a.m.—Temperature 99.4°, pulse 98; very thirsty; only small sips of iced champagne allowed. 8 p.m.—Temperature 100°, pulse 96.

15th, 8 a.m.—Temperature 98°, pulse 96; bladder irritable; catheter not to be used; lithia prescribed.

16th.—Great irritability from cystitis; hyoscyamus in addition to lithia. 7 p.m.—Temperature 98.8°, pulse 116.

17th, 7 a.m.—Temperature 99°, pulse 116; still great irritability of bladder; washed out with a 5 per cent. solution of hyposulphite of

soda, and ordered suppository of opium, 2 grains every 12 hours.

18th.—Temperature 99°, pulse 116; constantly complaining of bladder, and micturition very frequent; lithia stopped, and dilute nitric acid and hyoscyamus given.

19th.—Removed the upper 7 sutures, where union was complete; one inch at the lower part of the wound was not fully united, and the 2 lower sutures were left.

On the morning of the 20th, while the nurse was napping on the lounge, the patient got up, loosened some of the plasters, and was sitting on the edge of the bed, with her feet on the floor when the nurse awoke. After putting her back to bed, the nurse noticed some oozing of blood from the lower angle of the wound, and immediately telephoned me. Upon examination it was found that nearly the whole wound had opened out and nothing but the peritoneum was intact. A few sutures were put in, iodoform dusted over the wound, and adhesive plasters applied. Whether the patient was crazed with the intense pain in the bladder (which she described as if a red hot iron were run into it), or whether temporarily deranged, on account of the large doses of hyoscyamus, I was unable to make out. She could not offer any explanation of her conduct. I need not give any further details of daily records. Suffice it to say, that the cystitis, despite the washings out of the bladder with hyposulphite of soda, diluted nitric acid, carbolic acid, salicylic acid and other remedies, besides pareira brava, triticum repens, benzoate of ammonia and balsam copaiba internally, continued to grow daily worse—mucous, muco-purulent, and finally purulent discharge. The only relief was by the free administration of opium, either by enema or suppository. The wound healed slowly, on account of the general irritability produced by the vesical trouble.

Several times after the passage of the double channel catheter for washing out the bladder, that viscus contracted so violently that the fetid pus was ejected some 15 or 20 inches from the mouth of the catheter.

In April, while I was ill, Dr. Wilson kindly attended her, and she then apparently had an attack of septicæmia. The temperature ran

up to 103.5°, and the pulse above 130, and the doctor and I had almost despaired of her life; but in 10 or 12 days she gradually grew better, and the temperature again fell to 99°. Still the pulse was weak and frequent, and the pain in the bladder but little improved. At one time I had a consultation in reference to the advisability of opening the bladder through the vagina, or paralyzing the sphincter by forcible dilatation. Dr. Jenks, of Detroit, recommended opening the bladder with a thermocautery blade. Just at this time I began giving her full doses of eucalyptus, and in less than a week there were some symptoms of improvement, which gradually continued, and she was able in 3 or 4 weeks to leave the room and go home several blocks in a cab. She has occasional attacks of irritability of the bladder still; but her appetite and digestion are good, and she is getting quite fleshy and able to attend to light household duties.

There was only one mistake made in the after treatment, and that was in using the catheter at all. I am certain the cystitis was not produced from foul catheter, for I am always painfully particular in reference to the cleansing after each time using—always well washed in clean water, and afterwards in carbolic water, and then left standing in a tall bottle of simple water until required again. I formerly left them standing in carbolized water, but found that the solution, even if very weak, would, in time, affect the gum on the catheter and roughen its surface, so that now I never allow the catheter to remain in it. Knowing that this woman had two or three attacks of cystitis—although many years ago—should have been sufficient notice of what might be expected if the catheter was used. I believe the cases are extremely few, indeed, where the chances of recovery are in any way lessened by allowing the patient to empty the bladder herself. I had many weeks of worry and anxiety, and am not likely to forget it soon.

The operations were all done under the spray (2½ per cent carbolic acid), and the general principles of Listerism carried out. And in reference to this, perhaps the three most important points that require the attention of the operator are—the absolute purity of the

sponges, the cleansing of the instruments, and the thorough cleansing of his own hands and arms, and that of *the* assistant. The sponges in use for ovariectomy or abdominal section, I never use for any other operation. They are cleansed when new, and after each operation under my own supervision, and left standing in a 5 per cent. solution of carbolic acid for several days; then dried and put away. The instruments receive unusual care, especially the compression forceps. The jaws and teeth require most scrupulous attention; and the use of a nail-brush is brought into requisition, to clear away all dried blood or other uncleanness. It is better also that these instruments should never be used in any other operation.

Three or four days before operation, the room that the patient was to occupy was thoroughly cleansed—floor, ceiling, and walls—and a five per cent. solution of carbolic acid sprayed in the room for an hour. For this reason I would not operate in the general surgical theatre, as one cannot insure absolute cleanliness there. The temperature of the room was kept as near 65° as possible, a small fire in the grate *regulating* the temperature, as well as contributing to the ventilation of the room. On the day before the operation, a brisk cathartic was given, and the evening meal restricted to beef tea and dry toast. On the *following morning* the rectum was washed out, and a cup of beef tea, four hours before the operation allowed; no other food.

In Case III. the bowels were not *so thoroughly* moved by the cathartic, and to this I attributed the enormous after-distension; and I am not certain but the foetid character of the pus was partly due to the absorption of gas, from retained feces in the bowel, in close proximity to the stump; and should a similar imperfect sweeping out of the bowels occur again, I should prefer to repeat the cathartic and delay the operation for 24 hours.

I must apologise for the length of this article. What (of details) must of necessity prove wearisome to some, may possibly prove interesting and suggestive to others.

In England the ratio of the sexes is 105.5 females to 100 males.

## Selections.

### TREATMENT OF HICCOUGH BY COMPRESSION OF THE PHRENIC AND PNEUMOGASTRIC NERVES.

BY DR. GROGNOT.

When we examine the different methods of treatment of hiccough called *idiopathic*, one is surprised to find scarcely anything else advocated than a number of remedies popular as well as empiric, such as strong compression of the wrist, and sudden fright, swallowing a large quantity of cold or acidulated water, compression of the chest or pit of the stomach, etc. It is rather odd that, in the treatment of this spasm of the diaphragm, a therapeutic action upon the nerves which preside over its function or influence it in a reflex manner has been so little sought after—we refer to the phrenic and pneumogastric nerves. It is true that the malady being as a rule benign, the above treatment has usually sufficed. However, T. Schortt, Duchenne, Bouchut, and Tripier, each advocate a method in which they had had in view an action on the nerves which appeared to them to be involved. The first three wished to act on the phrenic, A. Tripier on the pneumogastric. The Scotch physician, Thomas Schortt, successfully applied a blister over the phrenic nerve; Bouchut extols the hypodermic injections of morphia in the course of this nerve; Duchenne uses galvanism of the phrenic; the continued current is used by A. Tripier, who advises its application, “the positive pole to the epigastrium, the negative to the front of the neck, in the line of the pneumogastric.”

It will be noticed that, whatever the theoretic idea may be that has influenced the choice of one or other of these nerves, the therapeutic application always involves both. The reason for this is the anatomy of the parts. After referring to the anatomical relations of the two nerves in the neck and to the diffusible nature of electricity applied to the surface, the writer goes on to say: But in a malady usually so mild, and which as a rule lasts but a few minutes or hours, when it is not symptomatic of a serious disease, such as peritonitis, intestinal obstruction by internal strangulation, etc., such a

condition, I repeat, where hiccough is styled *idiopathic*, the treatment employed ought to be as simple and easy as possible. It is true that if one can consider as simple the use of electricity, blisters and hypodermics, one ought to observe that they have been only resorted to where empirical means have failed. We must find, then, a means at once easy of application and effective; such is the treatment of hiccough by digital compression.

It requires no instrument; it is readily applied even by the patient. We have seen just now that four or five centimetres of the inferior clavicular portion of the sternocleidomastoid muscle lie directly over the two nerves. This is the part we select, guided by the pulsations of the carotid. The thumb and index finger are used one on either side symmetrically, applying pressure sufficiently strong to cause the spasm to disappear. One or two minutes as a rule, sometimes less, are sufficient; meanwhile the patient's head must be kept immovable. In our method, as in those that we have cited, the therapeutic action affects equally both nerves.

It follows that if the hiccough arises from the stomach, the pressure which effaces or diminishes the reflex action of the pneumogastric will stop the spasm during the time it is reflexly excited and often even afterwards. If, on the other hand, the cause arises directly from the influence of the phrenic, the calmative action of compression is equally manifested. Whatever may be the pathogeny of hiccough and the therapeutic mode of action of the digital compression, the result is nevertheless remarkable. We have rarely seen this method fail in idiopathic hiccough. Once, however, in a young hysterical girl, who had suffered from hiccough for two days, compression far from calming the spasms, each time it was applied, rendered them on the contrary more frequent. In hiccough symptomatic of a severe general disease we have never successfully used compression. We would in no wise discourage experiments in this line, having only used this method five years.—*Bulletin Général de Thérapeutique, R. Z.*

## SKIN DISEASES RESULTING FROM VENOUS STAGNATION IN THE LOWER LEG, AND THEIR TREATMENT.

This paper is too long and too full of detail to allow of compression into a short abstract; the general principles of the author's treatment may, however, be briefly summarized. The intensity and obstinacy which characterize so many otherwise generally mild affections, when they attack the lower leg, and produce such tedious complications (cyanosis, œdema, tendency to hyperæmia, to hæmorrhage, suppuration and deposit of pigment, ulcers and elephantiasis) are due chiefly to the evil influence of the venous stagnation to which those parts are so liable, and in every line of treatment the main endeavour must be to combat this defect of circulation. Unna discusses the various methods hitherto resorted to, such as cross-strapping with plaster, elastic stockings, and Martin's bandages, but finds in all many drawbacks to their general application. In their place he recommends that the limb should be bandaged from below upwards by a double-headed muslin bandage, the sound portions of the skin having been previously painted with gum or dextrine pastes, or with zinc-gelatine, the bandage-rolls being crossed at each turn over the front of the leg. As they change hands the requisite tension is easily given, and accurately-regulated, firm, but elastic pressure can thus be brought to bear on the limb wherever it is most required, while by the fixedness produced by the rapidly drying pastes or gelatine, a solid and comfortable support is provided, which allows the patient to use the leg with safety. Any dressing required for ulcers, eczema, or other morbid conditions (ointments, iodoform powder, etc.) may be applied beforehand, and the re-dressing renewed daily, weekly, or even at an interval of several weeks, the frequency of the renewal being dependent on the presence and rate of secretion from the skin. In this way a form of support is obtained which, being so easily and cheaply replaced, need not therefore like stockings and rubber bandages be protected from the action of grease and lotions, and being permeable, does not confine the heat and sweat and excite fresh trouble, as these

A case of yellow fever was reported in New York August 19th.

latter are apt to do. The applications which Unna recommends in phlebotomies (hamamelis, ichthol), in œdema (dextrin bandages), to allay pruritis (lot. plumbi, ac. carbol.), and in the various eczemas of the leg (lead paste, salicyl. acid, etc.) are given in detail with great fulness and accuracy. In that *crux medicorum* the "ulcered leg," the author finds in the support of the bandage the greatest possible assistance. Its use, however, is only part of the battle, it is necessary to understand the treatment of the sore itself. The means of cleansing the sore (peroxide of hydrogen), the encouragement of the granulation process, by the use of oxydising agents (carbolic acid, iodoform, pot. chlorat.), and of the skinning process, when this is complete, by the action of reducing substances (sulphur, silver nitrate, &c.), and the importance of their thorough comprehension for the successful treatment of ulcers, are insisted upon. The whole series of papers are exceedingly instructive, and have already given me very good results.—*Dr. H. G. Brooke, in Medical Chronicle.*

### THE WATER SUPPLY OF ANCIENT ROMAN CITIES.

Professor Corfield chose, as the subject of his address at the anniversary meeting of the Sanitary Institute of Great Britain, the Water-supply of Ancient Roman Cities. He gave a most interesting account of aqueducts erected by Roman engineers, not only at Rome, but for certain provincial towns. Rome itself was served by nine aqueducts, and it is a very striking fact, as showing the value which the wise rulers of ancient Rome attached to uncontaminated water, that the third aqueduct, erected over 2,000 years ago by the Prætor Marcus, and hence called the Marcian aqueduct, was no less than 54 miles long. The water-supply of the city was about ten times as great as London receives in proportion to the population; and all the water used for drinking purposes was brought from pure mountain-streams. Small settling-tanks, in four compartments (piscinæ), were interposed, and were so constructed as to be easily cleaned. The channel (specus) of the aqueduct was generally constructed of blocks of stone cemented

together and lined with cement. It was roofed over, and, in the earlier aqueducts, was carried entirely underground.

But these mighty aqueducts were by no means peculiar to the capital, for wherever the Romans built a city, there they provided for a copious supply of clear water; and Professor Corfield gives a most interesting description of the three aqueducts of Lyons, especially of the great aqueduct built by direction of the Emperor Claudius to supply the imperial palace. The sources of a river were tapped at a point 50 miles from the city, and the water brought through a most irregular country, across valleys, one of which is 300 feet deep and about 1,000 yards wide. The water was taken down the sides of the valleys, and across the streams at the bottom, in eight or ten lead pipes, arranged as inverted siphons. Professor Corfield says of this that it was the most remarkable aqueduct of ancient times, reflecting the greatest possible credit on the Roman engineers, and showing that they well understood the principles of hydraulics. Yet this was only one of three aqueducts erected for the supply of Lyons. We cannot do better than quote the moral of such facts as these in Professor Corfield's own words:—

"It is thus seen that the ancient Romans spared no pains to obtain a supply of pure water for their cities, and I think it is high time that we followed their example, and went to the trouble and expense of obtaining drinking water from unimpeachable sources, instead of, as is too often the case, taking water which we know perfectly well has been polluted, and then attempting to purify it for domestic purposes."—*Brit. Med. Journal.*

A NEW METHOD OF RELIEVING A COLD.—A writer in *El Siglio Medico* strongly recommends the following as a certain means of relieving the discomfort incident to cold: Pour about a half-pint of boiling hot water over about a drachm of pulverized camphor, and inhale the vapors arising therefrom ten to twenty minutes. Great relief is at once experienced, and after two or three repetitions the discomfort is said to disappear entirely.—*Medical News.*

## ANOTHER LOCAL USE FOR GRINDELIA ROBUSTA.

As the majority of our readers know, we have referred to the use of *grindelia* a number of times as a valuable application in rhus tox. poisoning, in the proportion of one drachm of the fluid extract to eight ounces of water, to be applied freely and often to the affected surface.

Dr. Gatchell, in the *New York Medical Times*, commends the same agent highly as a topical application in the treatment of stings and bites of insects.

He says: "For some years I have given to patients bound for countries infested with insect pests, a lotion of *grindelia robusta*, and upon their return they would invariably report that it was all that could be desired as an application to stop the itching and promote the healing of the mosquito or flea bite. One lady told me that while in Florida her children would come to the house in the evening completely 'frescoed' with insect stings, which would nearly drive them crazy, but that after bathing them and applying the lotion, they would quickly drop into a peaceful sleep, to awake in the morning free from any pain or itching, till they had encountered the pests that day, when the same process would be gone through with in the evening."—*Medical Age*.  
—*Medical Summary*.

## TEST FOR ALBUMEN.

BY M. BOYMOND.

Robert recommends the following as one of the best tests for albumen in the urine.

R. Strong nitric acid . . . . . 1 part.  
Saturated solution of sulphate of magnesia . . . . . 5 "

This gives a clear liquid, non-fuming; does not stain nor burn the fingers. It causes little change in the color of the urine, and gives off no gas from decomposition of uric acid.—*Rundschau für Pharmacie*.  
R. Z.

THE PARADOXICAL ACTION OF QUININE.—Merkel ("Dtsch. Arch. f. klin. Med.," "Ctrbl. f. klin. Med.") relates the case of a woman who

had fever which was taken to be malarial. She was given three grains of hydrochlorate of quinine, and in an hour she showed faintness, weakness, and stupor. She then had a chill, and her rectal temperature rose to 104.6° F. The temperature fell gradually without the occurrence of sweating. The same effects were produced whenever a small dose of quinine was given.—*New York Med. Journal*.

## DELIRIUM OF BRIGHT'S DISEASE.

At a meeting of the *Société Médicale des Hôpitaux* (July 10, 1885), M. Dienlafoy read a paper on "Certain Troubles in Bright's Disease, particularly Delirium." Certain cases present troubles of the intellect, which generally appear when these patients have already suffered from other uremic symptoms. Usually the disease is mild and quiet. In some rare cases this delirium is marked; the patient is agitated, has insomnia, gets up every minute, and the straight-jacket has to be resorted to. In others hallucinations of hearing or sight predominate. This delirium of Bright's disease has been long known. It has been well described by Lasèque, in 1852. According to him, the delirium was due less to the renal lesion than to other predisposing causes—hysteria or alcoholism. There are, however, a good number of cases in which uremic delirium came on without other cause, hereditary or personal. These delirious troubles are truly attributable to uremia. When this delirium is associated with other symptoms of uremia, it is an epiphenomenon of secondary importance; but at other times it is a dormant symptom; œdema and albuminuria may be absent, and still we have to do with a case of Bright's disease. This is of great importance, not only in a diagnostic point of view, but also in a point of view as to treatment and as to medico-legal cases. These patients may be committed to an asylum, or be fed with the stomach-pump, or have the cold douche applied—all absolutely contra-indicated in Bright's disease. There is also the question of responsibility, capability of making a will, etc.

M. Dienlafoy gives six cases in support of the above remarks.

I. A female, aged 37, admitted 14th Feb., 1885, to St. Antoine ward. She was completely dumb, haggard, stupid; fingers contracted; refused all food; greatly agitated; no symptoms of hysterical mania; urine slightly albuminous, contained very little urea. Temperature 36°. Treatment: Milk diet, large sinapisms over the kidneys. During eighteen days this patient went through all the forms of mental alienation, ideas of persecution, etc. Tongue dry, abdomen tympanitic, constipation. The albumen disappeared, the temperature rose, improvement. There was never any œdema. She complained of itchings in the back and arms, prickings and cramps in the legs. There was vomiting nearly every day, and copious epistaxis. There was no personal or hereditary cause. The albuminuria, which had reappeared, disappeared again; the urea increased; there was a second amelioration, then the vomiting returned, with recurring epileptic attacks, and death after sixty-five days illness. All the organs were found healthy except the kidneys, which presented the characteristics of Bright's disease.

Five other cases are cited. One, aged nineteen, with acute nephritis, profound stupor, refusal of food. Temperature 35° cent. Cured of nephritis and insanity.

Another, with delirium of persecution and acute mania, cured; died two years later of Bright's disease.

A fourth, aged nineteen, known to have Bright's disease—furious mania cured after four months. Died four years after from Bright's disease.

The fifth, known to have had Bright's disease for a long time. Insane nine and a-half months. Cured, the kidney trouble remaining.

The sixth had all the varieties of delirium—a female—erotic, succeeded by religious mania. She died maniacal, and with Bright's disease.

In these cases the duration was from twenty days to eight and a-half months. The nature of the delirium varied. Sometimes there was acute, violent mania; sometimes lypemania, sometimes erotomania, sometimes religious mania, mania of persecutions, etc., etc. The diagnosis is sometimes very difficult, for there are cases in which we find no other signs of

Bright's disease, neither œdema nor albuminuria, at the time of observation. As to prognosis, these cases are not so grave as the comatose or epileptiform. The treatment is that of Bright's disease. R. Z.

### MULTIPLE ULCERATIONS CAUSED BY MORPHINE.

BY DR. AMEDEV SOURROUILLE.

The following case is reported in the *Gazette des Hôpitaux* of June 13th:

"Mme. X., suffering from uterine cancer, had at intervals very severe pelvic pains. Soothing remedies failing, I had recourse to morphine in pill form. I commenced with progressive doses of 5, 10, 15, 20, and 25 centigrammes. These doses were well tolerated. No vomiting; pains less, and bearable; scarcely felt. The patient, however, was troubled greatly by thirst, dryness of the mouth and throat, difficulty in deglutition, loss of appetite, a distaste for food, constipation; difficult, painful, and scanty micturition. Soon multiple ulcers, superficial and deep, with sharp cut edges, invaded the buccal cavity, pharynx, and very probably the alimentary canal. It was impossible for Madame X. to take any nourishment whatever. Suspecting the morphine to be the cause, I immediately suppressed it. Some days after, and without the slightest intervention, I found, to my great surprise, that the ulcerations in the mouth had entirely disappeared, and permitted the patient to take a little nourishment: the digestive functions had resumed their natural course. Shortly after, the uterine pains became very acute; I again prescribed morphine. The ulcerations re-appeared with more severity, and accompanied with the same symptoms. I stopped the morphine. Mme. X. lived two months longer, without the slightest sign of ulceration in the mouth." R. Z.

A CLINICAL TEST FOR LEAD-POISONING.—Dr. Du Moulin recently presented before the Académie Royale de Médecine de Belgique (*Revue Médicale*) a young man affected with saturnism, whose skin, when painted with monosulphide of sodium or sulphide of ammonium, gave a well-marked plumbic reaction. This sign often appears earlier than the blue line on the gums.—*Druggists' Circular*.

## TWO RARE MANIFESTATIONS OF IODISM.

BY H. HALLOPEAU.

Besides the oculo-nasal catarrh, and the rare bullous eruptions on the skin, due to iodism, there are other exceptional manifestations caused either by very large doses, or by special idiosyncrasy. M. X., aged 30, had syphilis eight years ago. After mercurial treatment, he used, for a long time, large doses of iodide of potassium. In 1875, wishing to rid himself of some lingual tubercles, for six months he took daily 6 to 10 grammes of the iodide. The oculo-nasal catarrh was slight, and there were no digestive troubles. However, there were purpuric spots on the lower part of the legs. In December he was attacked with numbness and swelling of the limbs on the left side. We discovered a paresis of the left limbs, and a slight deviation of the features on that side: the grasp of the left hand was weaker; the features were less marked on the left side of the face; the orbicularis on the left side contracted less forcibly; there was then an alternating paralysis, evidently due to a syphilitic lesion, bulbo-protuberantial. What is the nature of this lesion? Is there syphilitic encephalopathy? Such was our first impression. The patient had hitherto no central nervous trouble, but this might be the beginning. Should the iodide be continued? We thought not. On account of the strange abuse the patient had made of it, we ordered it to be stopped immediately. And we did well, for at the end of a few days the symptoms of paresis vanished and did not return. This caused us to modify the interpretation we had first given. A syphilitic encephalopathy does not shew itself by such fugitive symptoms, especially when it has not been treated: before it disappears it must accomplish its evolution. The hypothesis of a specific lesion being eliminated, what is the diagnosis? M. X. is too young to have cerebral atheroma; and, on the other hand, there was no appreciable source for an embolism; we could then eliminate softening; the rapid vanishing of the symptoms did away with the idea of a tumour; the hypothesis of a small hemorrhage was the most

reasonable, but what could cause this hemorrhage? This accident is very rare, apart from Bright's disease, at the age of 30.

If we consider that our patient had previously several purpuric spots, and that he was still suffering from this at the time the nervous troubles began, we must admit that the lesion of the bulb was of the same nature, and was due to the same cause as the cutaneous lesions; in a word, *there was produced in the mesocephalon, under the influence of iodism, a small hemorrhage similar to the purpuric spots.* This fact shows that it is prudent to avoid, as far as possible, huge doses of iodide of potassium in cases in which purpura has followed its administration. They are only justifiable in extremely urgent cases. The second anomalous manifestation of iodism that we have recently met with is the *appearance of painful nodes in the subcutaneous tissue* in one of our patients, who for several years had undergone successive treatments by iodide of potassium. The doses varied between one and two grammes, and the treatments had not lasted longer than six weeks for several years; each of them caused the development of these nodosities. They appeared a few days after the patient would renew the iodide treatment. There was no other symptom of iodism except, occasionally, purpura: this appeared later, when the cure approached its finale. The nodosities were chiefly situated on the thighs, and particularly anterior. They were from one to two centimetres in size one way and one centimetre the other; generally oval, their long axis corresponding to that of the limb; they seemed to involve the cuticle and subcutaneous tissue; they were reddish at the point, painful on pressure, and hindered walking. After lasting several days they gradually became less painful, smaller, and disappeared, leaving the skin of its normal color; several times during the iodide treatment they reappeared. They regularly appeared each time the patient took iodide, and only at these times. Oddly, the patient, though treated since 1868, only presented this symptom since five years; his idiosyncrasy was therefore acquired.

This affection was mistaken for a syphilitic gumma, but its rapid evolution, its constant



appearance during the first days of the iodide being resumed, and its disappearance not less constant after its cessation, made it sufficiently clear that it was not a case of specific neoplasm.

These nodosities are analogous to those described by Froisier in rheumatism. They differ, however, in being adherent to the skin, being generally situated away from the joints, and being always of a reddish color. Erythema nodosum presents greater prominence and a brighter coloration; it is globular rather than oval, and does not extend so far under the skin. These iodic lesions are probably of the nature of phlegmasia; they always terminate in resolution, and leave no trace; the chief interest in them lies in the difficulty of diagnosis when one is not on his guard.—*L'Union Medicale*.

R. Z.

### EXPLOSIVE PHYSIC.

A list has just been published in the *Union Pharmaceutique*, of accidents which have recently occurred during the preparation or carriage of explosive substances used in medicine. At Strassburg, a chemist's assistant was changing some lycopodium powder from one bottle to another; the particles that escaped mixed with the air, a jet of gas was burning, and a slight explosion occurred. The frightened assistant dropped the jar containing the lycopodium, the room was at once filled with the power, and a violent explosion took place. Chlorate and permanganate of potash are also dangerous. M. Meyet has stated that a tooth powder composed of chlorate of potash and cachou has been known to explode in the mouth of a person engaged in brushing his teeth. A druggist who dried some hypophosphate of lime in a receptacle containing sand was killed by its explosion. Oxalate and citrate of lime are also explosive, but only at a high temperature. Pills of permanganate have been known to explode spontaneously. A mixture of perchloride of iron and glycerine exploded in the pocket of a patient who carried it. An eminent chemist at Paris prepared ozone with powders composed of equal parts of peroxide of manganese, permanganate of potassium, and pulverized oxalic acid. He took every recognized precaution, and the mixture was corked up in a bottle; a few minutes afterwards an explosion took place, and the bottle was reduced to atoms.—*British Med. Jour.*

### INSANITY IN THE UNITED STATES.

The number of insane persons in the United States, in 1865, is shown by recent statistics to have been only 24,042. Five years later it had reached 37,432; and, by 1880, treatment was required for 91,959 lunatics. The increase in insanity during the ten years from 1870 to 1880 was nearly 150 per cent., while the population was only about 26 per cent. But these figures do not represent the actual increase, as during the above period a large number of insane persons previously concealed were brought into public notice by more thorough investigation. Apart from several large county asylums in the United States, there are eighty State and forty private institutions for the care of the insane, with a proper capacity for about 40,000, but containing 53,192, thus leaving about 45,000 lunatics to be cared for elsewhere. The proportion of insane is greatest in New England; but the increase has been most rapid in the Western States. In the State of New York there are thirty-five institutions for the care of these unfortunate people, accommodating 11,343 patients, while it is said that there are 4,000 provided for at home.—*Brit. Med. Journal*.

### CLINICAL USE OF CHRYSAROBINE.

Dr. B. Merrill Ricketts thus writes in the *Cinn. Lan. and Clinic*, May 2: There is perhaps no remedy known to the dermatologist, which has been of more interest and used with more favorable results in the treatment of psoriasis, chronic eczema, and the parasitic diseases, especially those of a vegetable origin, than the active principle of Goa powder—chrysarobine—formerly known as chrysophanic acid.

It was used in the form of an ointment prepared by gradually dissolving in various proportions the powder and simple ointment while being heated.

There being much discoloration of the hair, nails, and especially the clothing with which it comes in contact, and many times producing a violent dermatitis even by the use of a mild ointment, its use was almost entirely abandoned.

However, with these objections its employ-

ment could not entirely be ignored by those who best knew its virtues until a more extended investigation was made to determine the proper method of its application, which has been done within the past twelve years in the following mixture, known as "Pigmentum Chrysarobine Compositum," the credit of which is due Dr. George H. Fox, and which is now extensively used in the New York Skin and Cancer Hospital.

R. Chrysarobine.

Acidi salicylici aa . . . . .	10
Etheris . . . . .	15
Collod. flex. q. s. ad. . . . .	100

There is another which is also extensively employed and with about the same results, but very much more expensive, the gutta percha being substituted for the collodion in the following manner :

R. Chrysarobine.

Acidi salicylici aa . . . . .	10
Liq. gutta perch. ad. . . . .	100

Either of these prescriptions should be prepared in small quantities and kept in dark-colored well-corked salt-mouthed bottles, otherwise it will become of a dark, thick, muddy liquid from decomposition, which renders it entirely useless.

When properly prepared it should be of a light, bright, canary yellow, and about the consistency of olive oil.

Physicians, after using the above mixtures, have found that they furnish the best means of its application, consequently the ointment is rarely used.

The liquid is specially indicated in those cases where the psoriatic condition has existed for any great length of time, or in those cases of a more recent date where the eruption is extensive, with much elevation and induration. It may be used in such cases with almost unlimited success, by applying it with a small brush, after having carefully removed the dry scales, which should always be done just before its application, the number of which should be governed by the amount of induration, elevation, and exfoliation.

Should there be continuous scaling, with a thickened condition, daily applications may be

necessary, accompanied with alkaline baths once or twice a week, as the case may require.

Its employment as a parasiticide is of recent origin, especially in the treatment of trichophytosis, either of the hairy or non-hairy parts. It was thought dangerous until within the past year to apply this remedy to the face or scalp, but now it has been fully demonstrated that its employment in diseases of these parts is not only safe, but a sure cure for trichophytosis (ring-worm), chromophytosis (tinea versicolor), and many others that might be mentioned. Dr. W. T. Alexander (*Journal Cutaneous and Venereal Diseases*) speaks of having successfully treated fifty cases of trichophytosis in one of the public institutions of this city, in which there was an epidemic. Great care should be taken to prevent dermatitis, a condition which often follows its application to the scalp, especially made bare by epilation or shaving, one or both of which should precede its application.

This condition is characterized by a peculiar pink discoloration of the skin, with swelling, congestion, and tenderness. If this extends to near the eyes, there may be slight conjunctivitis.

There is no reason why this remedy, properly managed, with the use of alkaline baths, should not cure ninety per cent. of all cases of psoriasis, also any of the parasitic diseases.

While its use in chronic eczema is not so marked, it is many times followed with favorable results.—*Medical Compendium*.

## RUPTURE OF THE HEART.

Dr. H. Nelson Hardy thus writes in the *British Medical Journal*, April 4: Cases of spontaneous rupture of the heart in young persons are sufficiently rare to deserve recording. In the following case, the patient, a young woman, aged 19, had been apparently healthy when she went to bed on the night before her death. She had had an attack of rheumatic fever when 15 years old, but had not lately complained of feeling ill. She had no fainting attacks, nor was there any arcus senilis present. A slight loss of memory had been noticed quite recently.

On March 17th, 1885, a little before 7 a.m., I was sent for to see the patient, who was said to be dying. I found her lying in bed on her back, insensible, almost pulseless, her eyes closed, and pupils widely dilated. In a quarter of an hour after my arrival, the heart had ceased to beat.

On March 18th, thirty-two hours after death, the necropsy was made. The body was well nourished, and there were no marks of violence. The membranes of brain were adherent to the skull-cap; the brain substance was healthy; and there were between one to two teaspoonfuls of serum in each lateral ventricle. On opening the pericardium, there was seen on the anterior surface, near the apex, a slit fully one inch and a half long, which led into the left ventricle, and extended irregularly upwards towards the septum. Slight pressure on the heart caused fluid blood to pour out through this opening into the pericardium, in which there was previously about an ounce of colored serum. Several of the chordæ tendinæ were also found ruptured, and the aortic valves were incompetent through old adhesions. The lungs were congested, but not diseased; the liver was adherent to the diaphragm; the stomach was healthy, and contained partially digested food; the other organs were healthy, and the uterus unimpregnated. The special points of interest in the case are the youth of the patient, and the almost total absence of any indication, during life, of fatty degeneration.—*Compendium of Medical Science.*

WHITE OF EGG IN OBSTINATE DIARRHŒA.—From the *Allg. Med. Cent.-Zeit.*, we learn that Oelli has recently called attention to the curative properties of the albumen of hen's eggs in severe diarrhœal affections. In a discussion before a medical society at Rome, he advocated its use, and related two cases of chronic enteritis and diarrhœa, which having resisted all treatment, speedily made complete recoveries under the use of egg-albumen. The same diet is strongly recommended in the diarrhœa accompanying febrile cachexia, and in that of phthisis. In two cases of diarrhœa dependent upon tertiary syphilis, it was found of no avail. On

post-mortem examination diffuse amyloid degeneration of the arterioles of the villi was found in these cases. The whites of eight or ten eggs are beaten up and made into an emulsion with a pint of water. This is to be taken in divided quantities during the day. More may be given if desired. The insipid taste can be improved with lemon, anise, or sugar. In case of colic, a few drops of tincture of opium may be added.—*Medical Compendium.*

### HEMORRHAGE DURING SLEEP.

On various other large subjects Dr. Wilks has fertile suggestions to offer. He has spent some time and trouble in confirming his first impression, which was originally judged to be heretical, that hæmoptysis occurs more often in the night after some hours of sleep, than in the day after some hours of exertion. He does not claim to give a full explanation, but remarks that the helps to the circulation given by the respiratory movements is certainly less by night than by day, so that tension might in that way possibly be raised; but, at any rate, he does not hesitate to draw the inference, which is of no little importance to many who are suffering from a tendency to hæmoptysis, that they need not be frightened into preserving that harassing and absolute quiet which is devised to guard against a recurrence of hemorrhage. Certainly Dr. Wilks' inference is supported by some of the many methods of cure, especially in the high Alps; but if it were acted upon in all cases, though it might possibly be justified on the whole by its relief of perpetual discomforts, yet it would occasionally bring a responsibility on the medical adviser from which he would be glad to be free, for the occurrence of fatal hæmoptysis during exertion is certainly not unknown. The rupture of aneurisms and of blood-vessels in the brain is also more frequent by night than by day, and the conditions controlling the matter deserve some of the more elaborate care that Dr. Wilks claims for them. And there are many other observations of interest for which we have to thank Dr. Wilks, and for which we most gladly refer our readers to the address itself.—*British Med. Jour.*

## IODIFORM IN GONORRHŒA.

BY DR. A. OGER.

M. Campana uses injections of iodoform in gonorrhœa, both acute and chronic. He uses the solution in glycerine; but the effect produced is more marked when we apply it in fine powder to the diseased surface. Being insoluble in water, four grammes of iodoform, rendered impalpable by solution in ether and evaporation, are suspended in eighty grammes of water. The mixture being well shaken, a small glass syringe is filled. The patient having passed his water, so as to clean the surfaces, lies on his back and the point of the syringe is introduced into the meatus, the penis being held vertically. Gravity causes the powder to fall into the nozzle of the syringe, and the piston is slowly pressed down. The meatus being closed by the finger and thumb, the liquid is by gentle friction over the urethra distributed over the whole mucous surface. After four or five minutes the injection is allowed to escape *guttatim* so as to allow the powder to remain. This operation should be repeated at least three times a day, and perhaps several times in succession. Whatever the stage of the disease, rapid diminution of pain ensues, the inflammatory symptoms subside, and the pus assumes a healthy character. Cure rapidly follows—in one case it was accomplished in five days.—*Journal de Médecine de Paris.*

HOW TO REMOVE A PLASTER BANDAGE.—Dr. G. Krosz writes that the removal of a plaster-of-Paris dressing is greatly facilitated by first scraping a groove with a knife, and then dropping along it a solution of caustic soda. In a few minutes the plaster becomes pulpy along this line, and the bandage can then easily be cut through. If two lateral grooves be made, instead of one, a lid can be cut out of the bandage, the leg can be lifted up for the necessary inspection and returned, the lid being reapplied and retained with a roller bandage. In this way the plaster dressing is not cracked, and the limb is not jolted in the efforts to remove the bandage. By this method, also, it is a very easy matter to cut any fenestra that may be needed.—*Deutsche Medical Zeitung.*  
—*New York Medical Record.*

## CAROBA.

BY M. BOYMOND.

This remedy comes from Brazil and Columbia. It belongs to the natural order *vegnoniaceæ*. Peckholt found in it a crystalline alkaloid carboline, crystallized arabic acid, and a balsamic resin carabone. It has tonic, diuretic, and sudorific properties, and is vaunted as an anti-syphilitic. It is also used in chronic gonorrhœa, and in various syphilitic, rheumatic, and cutaneous affections. The leaf is used in infusion, or the American fluid extract. A dessert spoonful three times a day.—*Journal de Médecine de Paris.*

LUMBAR NEPHRECTOMY.—Mr. Clement Lucas removed (in Guy's Hospital, on the 14th ult.) a distended floating kidney, filled with large calculi, which could be felt through the abdominal parietes. The operation was performed without difficulty through the loin, leaving the peritoneum uninjured. The patient is progressing uninterruptedly towards recovery, her temperature continuing normal as before the operation.—*Brit. Med. Journal.*

NEPHRECTOMY AND NEPHROLITHOTOMY.—On July 25th, Mr. Knowsley Thornton performed abdominal nephrectomy for cystic kidney at the Samaritan Free Hospital. The patient, aged 22, had been under the care of Mr. Manley Sims. A drainage-tube was inserted into the loin, and removed on the second day; the patient is now convalescent. On July 27th, the same operator removed a smooth calculus, weighing two ounces, from the left kidney of a young woman who had been under the care of Dr. George Johnson. The case was supposed to be an instance of strumous kidney in its earliest stage, and the operation was commenced as in abdominal nephrectomy; but, as soon as the kidney could be touched, it was found to contain a stone, and strong adhesions prevented its removal. The calculus was therefore extracted, and a glass tube placed in the abdominal, and an India-rubber tube into the lumbar incision.—*British Med. Jour.*

THE EMPLOYMENT OF WOOD CHARPIE AND WADDING IN THE DRESSING OF WOUNDS, AND AN ANTISEPTIC POWDER REPLACING IODOFORM.

—At a recent meeting of the Paris Surgical Society, M. Championnière criticised the antiseptic gauze generally employed in the Listerian dressing of wounds, as being almost impermeable to fluids, and as retaining its antiseptic qualities for a limited time only. He also held that it is poorly prepared, and irritates the skin.

M. Championnière further announced that for four months he had used in nearly all his more important operations a new substance, invented in Germany—*wood lint*. This is a preparation of the wood of the fir tree, resembling a paste of paper, and impregnated with a solution of corrosive sublimate of 1 to 4000 in strength. When combined with wadding in a proportion of one-fifth, it receives the name of wood wadding.

The substance is soft to the touch, easily compressed, and capable of readily absorbing large quantities of fluid, so that when placed in contact with a wound, the discharges therefrom do not appear or escape from the dressing.

The amount of corrosive sublimate contained in the dressing is relatively large, and when infiltrated into the discharges of the wound readily prevents putrefaction. Owing to these qualities, it is possible to allow a dressing to remain a much longer time than ordinarily is possible, without removing it.

M. Championnière further remarked that the dressing under consideration sometimes fissures, and that thus, if employed alone, septic infection may thereby result. To obviate this, the wound is directly sprinkled with the following powder: Iodoform, sifted; powdered Peruvian bark; powdered benzoin; and powder of magnesia, saturated with some eucalyptus. This preparation is superior to simple iodoform, both on account of its lack of disagreeable odor and greater cheapness.—*L'Union Médicale—Medical News.*

Solutions of atropine and eserine prepared with camphor water, will keep one or two years.—*Rundschan für Pharmacie.*

NOTES OF A VISIT TO SOME OF THE LYING-IN HOSPITALS IN THE NORTH OF EUROPE.

(These notes were read by Dr. PRIESTLEY, at a meeting of the London Obstetrical Society.)

The hospitals visited were those at Copenhagen, Helsingfors, and St. Petersburg. At Copenhagen, the new system began in 1870. In the Maternity Hospital, in the fifteen years from 1850 to 1864, the mortality was one in 24; between 1822 and 1843, it had been one in 19—that is, only slightly lower than the mortality in the Nightingale Charity of King's College Hospital, which compelled the author to close the ward. From 1865 to 1874, the mortality from puerperal fever was one in 51; from 1870 to 1874, it was one in 87, the improvement coinciding with increasing strictness in antiseptic precautions. The hospital was constructed in the most elaborate and expensive way to secure hygienic perfection, including ventilation, isolation of each part of the building (if desirable), and even a separate room for each patient. Moreover, the rooms were only used alternately, which was equivalent to halving the number of beds. The attendants were under strict rules of periodical purification, and were not allowed to pass directly from the convalescent to the lying-in wards. If a patient had been ill, the nurse was fumigated with sulphurous acid gas by an elaborate process. The same was used for disinfection of the rooms. The personal precautions included careful antiseptic hand-washing, soaking of catheters, etc. No sponges were used. The vagina was injected twice a day with carbolic acid lotion. The beds were of canvas, filled with chopped straw, which was destroyed after use. Each bed had its own basins, syringes, catheters, etc. The placenta and dressings were burnt. On suspicion of infection, the patient was carefully isolated. The medical officers were not allowed to attend necropsies. The director lived in the hospital, of which he was absolute master. As in other hospitals, there was an undue proportion of difficult cases and of primiparæ, and the primiparæ had a large share in the mortality. The midwives of Denmark were compelled to use antiseptic precautions, and this had sensibly

reduced the mortality. At Helsingfors, the hospital was arranged on the pavilion system, one block being devoted to the diseases of women, including wards for operations and rooms for out-patients. The wards for lying-in patients contained about 42 beds; the beds were in the middle of the rooms. The mattresses were sacks of fresh rye-straw for the non-paying patients, and with horse hair or bark of the lime-tree for paying patients, all being cleaned, baked, and remade for each new patient. Some patients lay on the bare boards of the bottom of the bed, as was usual in Finland. Antiseptics were not as minutely carried out here. Midwives and nurses were made to wash their hands and arms with soap, and afterwards to rub them with hypochlorite of lime, before examinations. Abnormal cases were isolated. The medical officers were forbidden to attend necropsies, or to touch infectious wounds, without taking antiseptic precautions afterwards. Catheters were carbolised, and the wards periodically closed and cleaned. After labour, a single injection of carbolic acid was given, and often when specially indicated. The linen was simply washed; the blankets were fumigated by burning sulphur. Professor Pippingsköld trusted largely to the excellent hygiene of the hospital (built on a rock high above the town), and to the clean habits of the people; but the external genitals were always washed before delivery, otherwise the object was to guard against external morbid influences, more minute care being thought unnecessary under the circumstances. Before the new maternity was opened in 1879, the total mortality averaged 1.83 per cent. From 1872 to 1884, the total mortality was one per cent. In the Grand Duchess Catharine Maternity Hospital in St. Petersburg there were arrangements for isolating the various parts. Scrupulous cleanliness, the disinfection of rooms, concrete floors draining into a central gully, and the careful use of antiseptics, were included in the system. In the last three years there had only been one death from puerperal fever, though six had occurred from other causes.

## REMOVAL OF MEMBRANES.

I have, therefore, adopted the following plan to insure complete removal of the membranes. The left hand is laid over the fundus, in readiness for expression at the proper moment; the right hand, previously rendered aseptic, is placed in front of the vulva, and, just at the moment of expression, two fingers of the latter hand are projected into the vulva, in order to impede the too rapid descent of the placenta. The latter is now caught by the hand and held within the vulva or partly within the vagina until the uterus recedes. It is now gently removed until the membranes are put upon a stretch. In this position it is held by the thumb and four fingers, while the index finger gently presses against the membranes, near their placental attachment, until the uterus relaxes its hold upon them and the whole mass drops. Twisting of the membranes is objectionable, inasmuch as it is a clumsy manoeuvre which endangers the integrity of the membranes and when successfully accomplished, it encourages energetic traction. Not rarely slight traction even induces reflex spasm which grasps the membranes tightly. Patience is here a virtue. A few minutes' delay will save tearing, and consequent retention of the membranes. The important point to be noted is that, while for the removal of the placenta we act during a pain, the opposite course is necessary in the removal of membranes, for which a relaxation of the uterus offers the auspicious moment. The simple reason lies in the fact that in the one case expression is sought, while in the other extraction is required.—*Baruch: Amer. Jour. of Obstetrics.*

## CHERON'S TREATMENT OF CHRONIC PELVIPERITONITIS.

The treatment of chronic inflammation of the pelvic peritoneum is in many cases tedious, and often very unsatisfactory. The pain, the tenderness, and the inflammatory deposits—the last in some cases simulating new growths, and not unseldom mistaken for them—are very slow in disappearing in many cases under methods of treatment hitherto employed. In consequence of these facts, we look with great

The Corporation of Hamburg, Germany, has decided to permit cremation.

interest upon a plan of treatment which Chéron has employed with remarkable success, and which he publishes in the June number of the *Revue Médico-Chirurgicale des Maladies des Femmes*. He uses hypodermatic injections of the crystallized phosphate of soda. The solution, which should be freshly prepared and carefully filtered, is made of one part each of crystallized phosphate and of sulphate of soda to twenty parts of distilled water. The quantity used for an injection is one drachm; it should be injected into the subcutaneous connective tissue, not into the subdermic. The injection should be made slowly, and massage of the part made for a minute or two. The injections are to be repeated every six or eight days.—*Medical News*.

APPLICATION OF CORROSIVE SUBLIMATE AND GLYCERINE IN EPITHELIOMA OF THE CERVIX UTERI.—Dr. Biddle (*Brit. Med. Journal*) states that but few things in the way of palliative treatment have given him greater satisfaction than the use, in a case of epithelioma of the cervix uteri, of a lotion or injection, containing one-fourth of a grain of corrosive sublimate and half an ounce of glycerine to a pint of water. Before using it, a patient of his had, for seven or eight months, been subject to paroxysms of agonizing pain and to frequent hemorrhages, which were occasionally profuse. Immediately upon its employment, and for the last three months of her life, the hemorrhage became merely nominal; and, instead of agonizing pain, there was simply the distress consequent upon irritation (by the tumor) of the bowels and bladder, the latter of which became perforated a week before death. He attributes the beneficial change to the very marked reduction in the amount of infiltration. The lotion was used continuously, with very few exceptions, twice a day during the three months, and he shall certainly adopt the same treatment in the next case he has, even before recovery is despaired of. In the case referred to, it was not tried until the curative effects of chromic acid had been tried in vain.—*Weekly Medical Review*.

## Therapeutical Notes.

It is suggested to color morphia salts so that they may readily be distinguished from quinine.

ETHER IN TETANUS.—Bontellier, *Progrès Medical*, reports a case of traumatic tetanus cured by applying ether spray to the back every two hours.

GLYCERINE IN ACUTE NASAL CATARRH.—Cotton saturated in glycerine and introduced into the nares relieves the congestion at once.

Squibb recommends the use of a half of one per cent. solution of boric acid to dissolve cocaine, this amount being needed to prevent decomposition.

IRRITABLE BLADDER.—Lionel S. Beale, in his work on urinary and renal derangements, recommends liq. potassæ for the relief of irritable bladder depending on very acid urine.

Flake manna, kaoline, or cocoa butter, are recommended as excipients for pills of permanganate of potash. One pharmacist uses cocoa butter with one drop of castor oil.

BRAZILIAN TREATMENT OF HICCOUGH.—Dr. Maxwell Ramos, in a letter to Dr. Dujardin Beaumetz, speaks highly of cooling the lobe of the ear in obstinate hiccough. It is not necessary to refrigerate, a cold lotion suffices.

HERPES (ZOSTER).—

R Camphoræ.....

Chloralis ..... āā ʒj.

Morph. sulph..... gr. x

M. Sig.—To be painted over affected part.

SALICYLIC ACID SUET IN HYPERIDOSIS.—Our Berlin correspondent writes:—All the reports of the German army surgeons on experiments recently made with salicylic acid suet, agree in recommending its use as a remedy for extreme sweating of the feet. It is composed of two parts of pure salicylic acid to 100 parts of best mutton suit. The War Minister has, therefore, permitted the introduction of this pre-

paration into the army medical stores, for the benefit of soldiers suffering from sweating feet, or soreness from riding.

**RINGWORM.**—Dr. R. W. Taylor, *Western Reporter*, claims good results from painting ringworm twice a day with tinct. myrrh, in which four grains of bichloride of mercury are added to each ounce.

**A DRESSING FOR PHAGEDENIC CHANCRE.**—The *Union Médicale* attributes the following formula to Terillon :

Pyrogallic acid . . . . . 1 part.  
Powdered starch . . . . . 4 parts.

Mix carefully. In cases of ragged phagedenic chancres, with multiple prolongations, the powder is to be blown into the deep parts with a bellows. The application should be repeated twice a day. The preparation should be freshly made, and preserved against moisture in a well corked bottle.—*N. Y. Med. Journal*.

#### A DIURETIC MIXTURE.

Dr. Joseph Mullone, of Lyons, Ind., writes to us that he has treated a number of severe cases of anasarca, most of them of distinctly malarial origin, and has been much pleased with the action of the following formula :

℞ Compound spirit of juniper . . . O j.  
Sulphate of iron . . . . . ℥ ij.  
Acetate of potassium . . . . . ℥ ss.  
Fluid extract of digitalis . . . fl. ℥ ij.  
Syrup of squill . . . . . fl. ℥ ss.

Dose, a tablespoonful three times a day. In severe cases the patient is to drink also a cold infusion of elder root.—*N. Y. Med. Journal*.

**A DIURETIC MIXTURE.**—The same journal credits Billroth with the following formula :

Acetate of potassium, } each . . . . . 5 parts.  
Nitrate of potassium, }  
Distilled water . . . . . 200 "  
Syrup of raspberry . . . . . 20 "

A teaspoonful to be given night and morning in cases of acute articular rheumatism. The affected joints are to be painted with tincture

of iodine, covered with cotton, and kept absolutely motionless. If pericarditis occurs, a blister is to be applied over the precordial region.—*N. Y. Med. Journal*.

**SCABIES.**—The *British Medical Journal* recommends the following :

℞. Flowers of sulphur . . . . . 100 parts.  
Quick lime . . . . . 200 "  
Water . . . . . 1000 " ℥.

Boil, stirring till incorporated ; cool ; decant into bottles and hermetically seal. After a warm bath, paint the patient with the solution, and put him to bed in a flannel night-gown or blanket. A warm bath more, and the patient is usually cured.

The following is an excellent lotion for subduing inflammation, and reducing the œdema of the inflamed parts :

℞ Tr. opii camph. co . . . . . ℥ij.  
Tr. tolutani . . . . . ℥ij.  
Liq. plumbi diacetat . . . . . ℥iv.  
Glycerine . . . . . ℥ij.  
Aqua, ad. . . . . ℥xxx. ℥.

A piece of lint, or old linen, to be well wetted with the lotion, and to be applied to the inflamed part. The wetting to be repeated at frequent intervals.

Internally, it is useful to combine the following mixture with the foregoing lotion :

℞ Potass bicarb. . . . . ℥iss.  
Tr. nucis vom. . . . . ℥xl.  
Ferri am. cit. . . . . ℥iss.  
Sp. am. aromat. . . . . ℥iss.  
Aqua, ad. . . . . ℥viii. Liq. ℥.

"℥j. three or four times a day."

I have found this treatment especially useful in those cases in which intense inflammation in the arms follows re-vaccination.—*Dr. Martin, Med. Press and Circular*.

**PROPER TIME TO TAKE MEDICINES.**—Local irritants, e. g. salts of iron, copper, zinc, or arsenic, in large doses should be taken directly after meals on a full stomach. Small doses, to act on the mucous membranes, should be taken



on an empty stomach. Silver oxide and nitrate should be taken during a period of rest. Iodine and iodides should be taken on an empty stomach. Acids to overcome acidity and prevent fermentation must be taken before meals. Alkalies are given during meals when they are to act on the acids of the stomach, and before meals when they are to be absorbed by the blood. Some of the metallic salts (especially mercuric chloride) also alcohol, tannin, and others, modify or destroy the digestive powers of pepsin, and must therefore be given on an empty stomach. Cod liver oil, phosphates, etc., may be taken during meals. Small quantities of dilute alcohol (as in wines, etc) have no injurious effect on pepsin.—*Bull. Gen. de Therap.*

INCOMPATIBILITY OF CHLORAL HYDRATE IN THE PRESENCE OF POTASSIUM BROMIDE AND ALCOHOL.—Prof. George F. H. Markoe, in the *Druggists' Circular*, calls attention to the above incompatibility. He found that the addition of potassium bromide, sodium bromide, sodium chloride, or magnesium sulphate, to strong solutions of chloral hydrate, together with the presence of alcohol, determined a separation of the liquids into two layers. Ammonium chloride, ammonium bromide, and calcium bromide, did not disturb the same solutions. The practical lesson to be learned is, that alcoholic preparations (tincture, etc.) should not be prescribed with chloral hydrate, especially in connection with the bromides of potassium or sodium, because if the solutions used be at all concentrated the chloral will separate as an alcoholate and float on the surface, and a great risk will be incurred of giving a large overdose, the patient having received no caution to shake the bottle.—*Druggists' Circular.*

THE DANGER OF BEING AN ANTI-VIVISECTIONIST.—M. Magnan cites a number of cases of madness among anti-vivisectionists. One woman first renounced animal food, then took in all stray dogs, and finally went round to the butchers, begging them not to slaughter any more cattle. She became finally mad, and was received as a patient at Charenton.—*New York Medical Record.*

THE

## Canadian Practitioner.

(FORMERLY JOURNAL OF MEDICAL SCIENCE.)

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

TO SUBSCRIBERS.—Those in arrears are requested to send dues to Dr. W. H. B. Atkins, 40 Queen St. East.

TORONTO, SEPTEMBER, 1885.

## BINIODIDE OF MERCURY AS A DISINFECTANT IN OBSTETRICS.

The bichloride of mercury has come into common use as an antiseptic in surgery and obstetrics, and has proved very satisfactory. Lately the biniodide has been brought into prominence, and is said to be three times as strong as the other.

At a recent meeting of the Obstetric Society of Philadelphia, Dr. Bernardy related his experience of the use of the biniodide of mercury as an antiseptic in obstetric practice. He had found it more satisfactory than the bichloride. He uses it for external washings, as well as vaginal and uterine injections when required; and employs a solution not stronger than 1 to 4000, which he finds non-irritating. His method is: take three and a half grains of the salt, well triturated in a mortar, and rubbed with one quart of boiling water, slowly added, giving a solution of 1 to 4390.

## TORONTO SEWAGE.

August is notoriously a dull time for news of all kinds. It is the lull between the meetings of clerical and other associations and the exhibitions of agricultural societies. It is the period of the year in which the intelligent citizen is yachting, or fishing, or sea-bathing, and the period when the sea-serpent always makes his appearance. This season is no exception to the rule. The rebellion in the North-West has been quieted, and even the unseemly squabble over who led at Batoche has dragged out its weary length. Toronto

sewage was a fine subject for arousing the jaded attention of the public, particularly as it had been so ably dealt with at the late meeting of the Provincial Board of Health; even it seemed to fall flat, until our attention was drawn to an important interview with a distinguished sanitarian from a neighboring province, which occupied three columns of a daily contemporary. The interview is decidedly "airy," and must have taxed the patience of the reporter sadly; for our part we laid down the paper regretting the precious time lost in its perusal. The question of the Combined *vs.* Separate Sewer System, is far from being solved, and the battle rages as strongly to-day as ever it did. So far as Toronto is concerned, it would be impracticable to introduce the separate system. We must cope with what we have, and on this point the distinguished sanitarian failed entirely to advance a single new point. A *rechauffé* of Col. Waring's reports on Memphis sewers, and various Government reports, with some twaddle on house-drain ventilation, is such palpable self-advertisement, that for our part we wish the other bore would make his appearance; for no two appearances of the sea-serpent ever agree, and in him there is at least some freshness.

#### MEDICAL MEN IN THE ENGLISH PARLIAMENT.

A number of physicians and surgeons are presenting themselves as candidates for the next election in England. Among the more distinguished might be mentioned the names of Mr. Erichsen, Dr. Balthazar Foster, of Birmingham, and Mr. Ernest Hart, the able editor of the *British Medical Journal*.

Mr. Erichsen's name is so well and favorably known throughout the medical world, that it is not necessary to say more than that the constituency which elects him will do itself honor, and send to parliament one of the best men.

Dr. Balthazar Foster is a man of forty-five or fifty, active, of fine address, and possessing great energy and administrative ability. He will, if elected, soon make his mark in politics, and as he is the Chairman of the Executive Committee of the British Medical Association,

will be able to speak with authority on matters which affect the welfare of the medical profession in Great Britain.

There seems to be some doubt as to Mr. Hart's course if elected to parliament. This is caused by a sudden change in that gentleman's views with regard to the Contagious Diseases Act. Mr. Hart, in the *British Medical Journal*, has for years favored the extension of the Act so as to include other than garrison towns. The following quotation will explain his present position: "The electors of Mile End (Mr. Hart's constituency) have not only made up their own minds, but they have even changed the mind of Mr. Ernest Hart, who last night pledged himself to vote for the unconditional repeal of the obnoxious measure." There is no doubt, however, that if Mr. Hart is elected he will make one of the most active and successful politicians in England. His great success in connection with the *British Medical Journal*, and his clever management of the Association itself, are sufficient guarantees for his future career. After the meeting of the Association in Belfast, last year, we had a conversation with a shrewd American brother on the management of the British Medical and Mr. Hart's connection with it. Our American friend expressed the opinion that if he were a member of the Association he would, if possible, not oppose Mr. Hart, but "would get right up into the waggon with him." We think many have found the latter very much the better policy to pursue.

We are glad to see the profession in England is likely to be so well represented. In Canada the number of medical men in parliament is very large, but, unfortunately, when matters affecting the profession arise many of them become very weak in the knees. It was with great difficulty that one could be found who would take charge of the new Anatomy Act last winter. Dr. Baxter, a notable exception, stood nobly by the profession, took charge of the bill, and carried it successfully through.

If medical men, when elected to parliament, would follow a strict line of duty in these matters, and not pander to the superstitious fears of their constituents, they might not be such successful politicians, but they would be of far greater service to their country.

## RECURRENT SCARLATINIFORM ERYTHEMA.

Two articles have recently appeared treating of this very interesting subject. One by Dr. L. Brocq, of Paris, France, appeared in the August number of the *Journal of Cutaneous and Venereal Diseases*; and the other, by Dr. Penet, in a July number of the *Lyon Medical*. It will be remembered that in the April number of the PRACTITIONER a case was reported by Dr. Graham under the heading of "Recurrent Exfoliative Dermatitis.

We are convinced that these cases occur much more frequently than one might suppose from the number reported. By the general practitioner they are put down as scarlet fever, when they have no etiological connection whatever with that disease. It has been the rule among English dermatologists to classify this disease as a dermatitis; whereas the French authorities, who have written more upon the subject, consider it as a pseudo exanthem, and not in any way related to that chronic form of dermatitis known as pityriasis rubra. When one takes into consideration the regular and uniform course in which the symptoms follow one another in the several cases, and the constant presence of an elevated temperature, one is led to think that perhaps the French observers are correct in their views.

The general practitioner, however, is now particularly interested in the distinction between this malady and scarlatina. The diagnosis in most cases is extremely difficult, and generally the true nature of the affection is not made out until a second, third, or fourth attack has taken place.

On this point we will quote from Dr. Brocq's article already mentioned:

*Diagnosis.* — To distinguish desquamative scarlatiniform erythema from *scarlatina* is at once easy and extremely difficult—easy when the eruption has already made repeated appearances; difficult when we have a first visitation of the malady to deal with. Frequently, in the latter event, we imagine that a case of eruptive fever is on our hands, until the redness is seen to continue after the eighth day of the exanthem, and desquamation has occurred several times and become exceedingly abundant,

when we are compelled to a diagnosis of desquamative scarlatiniform erythema. The onset of the latter, also, is less abrupt than that of scarlatina; the febrile reaction is perhaps less severe; the angina not so marked, or possibly absent altogether. On the other hand, the redness of the skin is much more pronounced; miliaria are of rare occurrence; desquamation is far more abundant and frequently repeated, and exhibits much more of a lamellated character. The local symptoms, too, are very decided, while constitutional symptoms are trivial or wholly wanting. The complications (buboes, endocarditis, renal congestion, etc.) so frequent in scarlatina, are never observed in scarlatiniform erythema. Finally, the latter affection is non-contagious. Notwithstanding all these distinctions, desquamative scarlatiniform erythema was confounded with scarlatina, even down to recent times, and this fact affords an explanation of certain anomalous features which have been ascribed to the more familiar affection (long duration, relapses, etc.)

## AMERICAN MICROSCOPICAL ASSOCIATION.

The ninth annual meeting of the American Microscopical Association was held in Cleveland, commencing August 18th. The high standing of the society was illustrated by the fact that every part of the country was represented, some of the members having travelled thousands of miles in order to take part in the proceedings. There were nearly a dozen ladies in attendance, and they were among the most interested of the members. The meeting was called to order by O. M. Vorce, F.R.M.S., President of the Cleveland Microscopical Society, who, after delivering an address of welcome to the visiting microscopists, vacated the chair in favor of Prof. H. L. Smith, the President of the association. The convention continued its session four days, and most effective work was done, which will add lustre to the society's past history and further progress. The papers were varied and instructive, among the most interesting being those of Dr. Eastman, of Baltimore, on "Some Remarks on Fatty Infiltration of the Liver." "Butter and Fats, or how

to Distinguish one Fat from Another by means of the Microscope," by Thos. Taylor, M.D., of Washington, Microscopist of the Agricultural Bureau. This paper was particularly valuable for public analysts. He explained his methods of examining lard, beef, fat, and butter, and described the appearance of their pure and impure conditions under microscopic treatment.

"Poisonous Dried Beef," by H. J. Detmers; "The Cultivation of Bacteria, with Special Reference to Cholera," by Dr. Lester Curtis; "On Some Improvements in Accessory Microscopical Apparatus," by E. H. Griffith; "Improved Methods of Manipulation," by R. M. Reynolds; "Methods of Preparing Chicken Embryos for Microscopic Examination," by W. P. Manton, M.D.

Among the attractions of the third day was the *working session*. All the points in preparing, staining, cutting and mounting of sections were demonstrated by expert manipulators, including the exhibition of special lines of work, culture of bacteria, application of electric light to the microscope, etc.

The exhibits of Drs. Duffield and Manton, of Detroit, received great attention. In the evening a grand reception was given to the members of the association, which reflects the greatest credit on the hospitality and sociability of the microscopists in the Forest City of the United States.

#### THE BRITISH MEDICAL ASSOCIATION.

The recent annual meeting of the Association, which took place at Cardiff in the latter end of July, appears to have been a very successful one. There was a large attendance of the leading physicians and surgeons of Great Britain and Ireland.

The annual address was delivered by Dr. W. T. Edwards, of Cardiff, the President of the Association. After some discussion the Association decided to erect for itself a building to consist of offices, council chamber, reading rooms, and rooms for printing and publishing the *Journal*. It will cost about \$150,000.

Owing to the enterprise of the *New York Medical Record*, its report of proceedings was published on this continent as soon as in England.

#### CANADA MEDICAL ASSOCIATION.

We are pleased to learn that the prospects for a successful meeting of the Association to be held in Chatham, September 2nd and 3rd, are exceedingly bright. The members of the profession in Chatham are making arrangements to extend a right royal welcome to the visitors. It has been arranged that the Association shall be opened at 10 a.m., on the 2nd, when the members from a distance will be formally received by Dr. J. L. Bray, Chairman of the Local Committee. A short address will then be read by the Mayor on behalf of the City Corporation. A dinner will be given by the local profession on Wednesday evening. The regular sessions will be held in the Christ Church Sunday-School House. A number of invitations have been sent to Buffalo, Cleveland, Chicago, and other American cities, and several have been accepted. We must congratulate the physicians of Chatham upon the great energy which they have displayed in perfecting their preliminary arrangements. The following papers have been promised:

1. Dr. William Osler (Philadelphia): "The Clinical and Pathological Relations of the Cæcum and Appendix."
2. Dr. James A. Grant (Ottawa): "Aortic Aneurism, with the exhibition of a specimen."
3. Dr. W. B. Geikie (Toronto): "Retroversion of the Gravid Uterus."
4. Dr. Burt (Paris): "Internal Urethrotomy."
5. Dr. Holmes (Chatham): "Observations on Puerperal Mania."
6. Dr. Kerr (Winnipeg): "Fractures in the Neighborhood of Joints."
7. Dr. Fenwick (Montreal): "Amputation of the Breast, with cases."
8. Dr. Bethune (Wingham): Exhibition of Specimens, 1. "Parasite from an Abscess in the Thigh." 2. "Aneurism of the Pulmonary Artery."
9. Dr. Worthington (Clinton): "Epidemic Cerebro Spinal Meningitis."
10. Dr. Fulton (Toronto): "Subperiosteal Amputation."
11. Dr. Campbell (Seaforth): "An Account of a Case of Trephining the Mastoid Bone."

12. Dr. Rutherford (Chatham): "Supra Pubic Urination."

13. Dr. Stephen Lett (Homewood Retreat, Guelph): "Inebriety, a Disease the result of Physical Causes."

14. Dr. A. H. Wright (Toronto): "Phlegmasia Dolens."

15. Dr. McKeough (Chatham): "Observations on the use of Pilocarpine in Puerperal Eclampsia."

16. Dr. J. E. Graham (Toronto): "Case of Dissecting Aneurism of the Thoracic and Abdominal Aorta, with Specimen."

17. Dr. Shepherd (Montreal): "Excision of the Tongue with Preliminary Ligature of the Linguals."

18. Dr. Alloway (Montreal): "Micro Organisms in Puerperal Septicæmia, Prophylaxis and Treatment."

19. Dr. Ryerson (Toronto): (1) "Surgical Experiences in the late Rebellion;" (2) "Atrophic Nasal Catarrh."

20. Dr. Atherton (Toronto): "Notes on two cases of Abdominal Section for Uterine Myomata."

21. Dr. Nattress (Toronto): "Field Hospitals and Climate in the North-West Territory."

22. Dr. Gardner (Montreal): "The History of a case of Double Uterus, with the exhibition of the Specimen."

23. Dr. A. E. Hanna (Lansdowne): "Enlarged Prostate."

24. Dr. Oldright (Toronto): "A few notes on a case of Pernicious Anæmia."

25. Dr. Ames (Brighton, Ont.): "The Bite of a Rattlesnake."

26. Dr. Wilkins (Montreal) "Exhibition of Specimens (Macroscopical and Microscopical) illustrating the infective nature of Tuberculosis."

27. Dr. Stewart (Montreal): "The Curability of cases of the Chronic Form of Infantile Paralysis."

There is no truth in the report that Dr. Egerton Y. Davis was killed by jealous braves in Sphincteric Cove, North-west Territories. He is alive and well, though slightly maimed.

## THE INTERNATIONAL MEDICAL CONGRESS.

The prospects for the next meeting of the Congress are still very gloomy. The resignations of prominent members of committees, including a large portion of the ablest and best known Surgeons and Physicians of the United States, have assumed such proportions that it appears at present impossible to make the meeting successful.

The leading members of the profession in Great Britain and the Continent regret deeply the position of affairs, and it is hinted by the *British Medical Journal* that they may withdraw their acceptance of the invitation to hold the congress in Washington.

The *Medical News* proposes that the matter be settled in the following way: by dropping the code question entirely, confirming all the appointments of the original Committee, and leaving to the enlarged Committee which it created the work of making additional appointments, completing the organization, and carrying out the work to its completion.

## FOREIGN BODIES LEFT IN THE ABDOMEN AFTER LAPAROTOMY.

In a recent number of the *Transactions of the American Gynecological Society*, Dr. H. P. C. Wilson, of Baltimore, contributes a paper on this most important subject. He is convinced that the accidental inclusion of forceps, sponges, etc., in the peritoneal cavity after laparotomy, is a much more frequent cause of death than is generally supposed. Dr. Wilson has been able to collect 21 cases, of which six, including his own, have been published. This shows that more than two-thirds of all the known cases never come to light; and, from the want of necropsies, the unknown must be very much more numerous. Six of the 21 cases occurred in the United States, Dr. Wilson's being the only one that has been published. Out of 15 in Europe, five have been published. Of the six American cases a sponge was left behind in five, and a pair of forceps in the sixth. Two of the six died, and four recovered after the timely extraction of the foreign body. In three

the error was detected at or immediately after the close of the operation. In one a sponge, and in one a pair of forceps, were discovered after the patient's death. In one (Dr. Wilson's), the presence of the sponge in the abdominal cavity was not suspected till it worked its way to the surface months after the operation, and was successfully removed from an abscess-cavity near the umbilicus by Dr. G. H. Hocking. Of the 15 European cases 10 have never been published, and are mentioned by Dr. Wilson on the authority of Mr. Lawson Tait, who added an eleventh in his own practice, where the error arose through the sponge having been torn in halves. The same accident occurred in one operation performed by Dr. Kocher, of Berne, and is published in a paper on Ovariectomy in Switzerland, which appeared in the *British Medical Journal* of January 28th, 1882. In two cases in Sir Spencer Wells' operative experience, a foreign body was left in the peritoneal cavity—a sponge in the first, and a pair of forceps in the second instance; in both the patient recovered after remedy of the oversight. In the fourteenth of the European cases a sponge was found at the necropsy of a patient of Dr. Carl Braun; and in the fifteenth, a case of Dr. Gustav Braun, a bull-dog forceps was found under similar circumstances.

### Meetings of Medical Societies.

#### MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

(From our own Correspondent.)

At the last meeting of this society, under the title of "A few notes on Gynæcology," Dr. Laphorne Smith related what he had observed during a few weeks spent at the New York hospitals and dispensaries for women this spring. He began by referring to the great frequency with which the operations for lacerated cervix and lacerated perineum were performed. The necessity for these operations having been called in question by some English writers, he stated that the American operators were fully justified in their practice by the great relief to the patient from reflex symptoms in distant organs, brought about by the re-

moval of cicatricial tissue from the angle of the wound and the union by first intention of the sides of even a slight laceration.

He noticed that the operation was often performed rather as a speedy method of getting rid of the hypertrophied tissue of the subinvoluted uterus and of the cervical glands which had undergone cystic disease, than merely for the sake of uniting the laceration; and he instanced one case where Dr. Hunter had removed the uterine tissue nearly as far as the internal os, leaving only a small shell of the cervix to serve for the flaps.

The operation for lacerated perineum was also performed for the purpose not only of affording support to a prolapsed uterus and for the cure of rectocele, but also for the purpose of rendering coitus more satisfactory to the husband, as well as to favor conception by increasing the depth of the seminal lake at the upper and back part of the vagina.

In these operations the reader remarked how completely the tenaculum and scissors had replaced the forceps and knife.

In an operation for removal of the uterus for fibroid, by Dr. Hunter, he noted the extraordinary precautions taken to avoid the entrance of a single drop of blood into the peritoneal cavity, a result obtained by wrapping the edges of the abdominal wound in warm carbolized towels which were changed as soiled. All cases of abdominal section at the Women's Hospital were performed in detached cottages.

He was glad to state that notwithstanding the great experience and skill of the surgeons, and the almost unlimited means at their disposal, the results attained by our Montreal surgeons would compare favorably with any attained there.

Coming to minor details, he showed Wylie's dilator, and pointed out its advantages over all kinds of tents and metal bougies; the principal being that the dilator was exceedingly easy of introduction and all the force used is expended in dilating, while with bougies a great deal of power is lost in pushing the womb, in order to force the instrument in. The mechanical dilator is also more speedy, and free from dangers of septic absorption.

The reader then referred to the frequency

and freedom from danger with which Thomas' blunt curette was used as a diagnostic and curative agent, in cases of menorrhagia due to retained placental tufts and to polypoid vegetation.

The extent to which the medicated cotton tampons have taken the place of pessaries was noted, the value of glycerine tampons and hot water douches in the treatment of subinvolution were briefly touched upon.

The paper concluded by the relating of a case of chronic cystitis in a female patient under Emmet's care, which was cured by having a vesico vaginal fistula made so as to give the bladder perfect rest.

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#### HAMILTON MEDICAL AND SURGICAL SOCIETY.

July 7th, 1885.

The President, Dr. White, in the chair.

Specimens were shewn by Dr. McCargow of two kidneys containing a number of gummatous growths, the following report being given of the case by Dr. J. Cochrane:—When the patient entered the hospital there was no history of syphilis to be obtained. Soon afterwards two growths like horns appeared on the forehead, evidently of a fibroid nature. Afterwards chest symptoms appeared, there being effusion, which, after a small amount of fluid was withdrawn by a hypodermic needle, seemed to subside. There was also noticed a gradual hardening of the glands of the body. Specific treatment was adopted but was of no benefit, the patient dying of exhaustion. Post mortem—there were thickening of the pleura and general adhesions; the cavity contained between eight and twelve ounces of fluid; there was also effusion into the pericardium. The left lung was healthy, but there was great fibroid thickening of the right, there being a fibrous band passing through it from pleura to pleura. Liver and spleen were healthy, but the kidneys were enlarged and congested and contained a number of large yellow gummata. The peritoneal glands were enlarged, while the glands of the groin were broken down. In reference to this case, Dr. Woolverton, under whose charge the patient had been, stated that

at first she had indefinite pains in her legs; the growth on the right frontal region had increased in size up to the time of the patient's death. Two months before she began to have a cough and continued elevation of temperature, the dulness extended rapidly and the chest was seen to be enlarged; after the exploratory aspiration the effusion seemed to decrease, and friction râles were heard, so further operation was postponed; the symptoms improved for a while, but afterwards enlargement again took place, and death at the last was rather quicker than expected. The disease of the lungs he considered to be syphilitic.

Dr. Malloch thought that it was a case of tertiary syphilis, and that the swellings on the scalp were not properly interpreted, for if their softness had been considered, they would not have been thought secondary, as they had been suspected to be.

The other specimens shown were a uterus with a growth attached to the fundus of the size of a strawberry, and two intermuscular growths, and a portion of cancerous liver. The history given by Dr. Cochrane was as follows: There was no definite symptom at first except an inability to retain anything on the stomach, which was thought due to alcoholism; afterwards the condition of the liver was diagnosed. The patient's illness was not of long duration. Post mortem—the liver was found to weigh over five pounds and was studded with cancerous masses, some of them as large as half an orange. In regard to this case, Dr. Mullin inquired if there was any primary seat of the cancer, and was inclined to think it might be in the uterine growths. Dr. McCargow thought it was in the liver itself, and that all the symptoms pointed to malignancy. Dr. Mackelcan inquired if there was any ascites, as in his experience it was generally present in cancer of the liver. Dr. Griffin asked if there was any disease of the pancreas, but none had been observed.

Dr. Hillyer then read a paper on "Typhoid Fever," giving an account of an outbreak of an epidemic character which occurred in the County of Norfolk, in April, 1860. At the time there was a good deal of discussion as to the nature of the outbreak, some of the local physicians calling it typhus, some pernicious,

some typho-malarial, and others typhoid, there being such a variety of symptoms as to warrant the differences of opinion. The epidemic extended over an area of from ten to twelve square miles, amongst a poverty-stricken and hard-working backwoods population. The disease was first noticed amongst lumbermen who had come from Illinois, where a similar epidemic had been raging. Out of five members in the first family attacked, the mother and three children died. The second family attacked were relations, and had visited the infected dwelling while they themselves lived in a one-roomed badly ventilated house. The symptoms presented by those attacked first were typical of the epidemic, and were as follows: epistaxis occurring early with decided chills, followed by fever, flushed and dusky complexion, accelerated pulse, furred tongue, and general feeling of languor and debility. After the first few days when there was an intermission, the fever gradually became continuous. Nervous symptoms also were present, viz: restlessness, aching of the back and limbs, headache and insomnia. The bowels were loose with the characteristic discharge. As the disease advanced, the pain increased in the right iliac region, abdomen became tympanitic, tongue dry, swollen and of a brownish color, which gradually increased to black. A petechial eruption appeared over the body, with sudamina on the neck and portions of the chest; black scordes appeared on the teeth and gums, and delirium with a general typhus condition supervened, while there was a pungent and penetrating odor from the body. The patients evinced great feebleness, while the skin showed great lack of vitality, sloughing taking place on blistered surfaces. Finally the pulse gave way and became excessively frequent and fluttering, the extremities cold and clammy, and the abdomen enormously distended. After referring to some cases which presented different symptoms, and more of a typhus character, there being no enteric symptoms, costiveness being present from the outset, while in others gastric symptoms were most prominent, he proceeded to speak of the contagiousness of the epidemic, instances being noted where those who had gone away to escape the disease had been stricken down with

it, while on the other hand, those who had been constant in their attendance had in some cases escaped. Another feature of the epidemic spoken of, was, that for months, wherever its taint extended, all forms of inflammatory action assumed an asthenic type, and typhoid symptoms were sure to develop. The writer then took up the nature of the epidemic, after which he gave an account of the treatment adopted. This was chiefly of an expectant nature with special treatment of an ordinary kind for the ordinary symptoms. A discussion followed, the general idea being that the epidemic was one of typhoid. Some conversation also took place on the question of what constituted typhoid fever, and whether it could exist without the special enteric symptoms.

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### Obituaries.

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#### DR. WM. G. METCALF.

It was a sad shock to the Profession of this country when it became known, on August 13th, that a savage attack had been made on Dr. Metcalf by a murderous lunatic. A severe wound had been inflicted in the abdomen with a knife, and death ensued on Sunday, the 16th.

He was born in Uxbridge in 1847. In 1870 he commenced his medical studies in the Toronto School of Medicine. During his student's course, he became a clinical assistant in the Toronto Asylum under Dr. Workman. He graduated in Toronto University in 1874, and for a short time practised in Windsor. He was there offered the position of Assistant Superintendent in the Toronto Asylum, which he accepted. In April, 1878, he went to Kingston, to take the place of the Superintendent, Dr. Dickson, who had a year's leave of absence on account of poor health. As Dr. Dickson was never able to resume his duties, Dr. Metcalf received the permanent appointment in 1879, and remained there till the time of his death. In 1876 he was married to Miss Bustin, of Uxbridge. She died in 1880, leaving two daughters. In 1883 he was married to Miss Clarke, a daughter of the present Speaker of the Ontario Legislature. He leaves his young wife and two daughters to mourn for him.



It was a matter of surprise to many that his advancement was so rapid; but this did not extend to his numerous friends who knew him well. His untiring industry and sterling worth had rendered him eminently fit for the position, and his appointment proved in all respects satisfactory. He was one of the best examples of a young Canadian who rapidly attained a distinguished position by his own unaided efforts. On his private character we cannot dwell, excepting to say that it was such as to make him truly beloved and trusted by all with whom he came in contact.

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DR. W. H. MACDONALD.

It is with extreme regret that we have to announce the sudden death of Dr. W. H. Macdonald, who had been practising in Toronto during the last three years. He graduated in Trinity Medical School, and after spending a year as resident assistant in the Toronto General Hospital, and another year in Great Britain he settled in this city. He possessed good abilities, was very popular both with the profession and the public, and his prospects were unusually bright. He was twenty-nine years of age.

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DR. R. S. KING.

Dr. R. S. King, of Port Robinson, died August 6th, at the age of 68. He was born in the County of Wexford, Ireland, graduated in Medicine in Dublin, and came to Canada in 1844. He went to Port Robinson in 1847, and was successful in building up a large practice. During the Fenian Raid of '66 he was Captain of the Welland Field Battery, and in an action at Fort Erie he was wounded in the leg, which was subsequently amputated.

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Personal.

Dr. G. S. Ryerson has returned from the North-West. We are glad to know that he is in excellent health, and has already resumed practice in his speciality.

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Miscellaneous.

Dr. Bartholow's work on *Materia Medica and Therapeutics* is to be translated into French.

The *New York Medical Journal* says that a variety of anthrax prevails among cattle at Bloomington, Illinois.

A marble bust of Sir James Paget will be placed in the building of the Royal College of Surgeons of England.

Prof. Von Fehling, of Stuttgart, well known as the originator of "Fehling's Solution" for testing grape sugar in urine, is dead.

The new committee of the American Medical Association for the International Medical Congress will meet in New York, Sept. 3rd.

The old code is suffering severely from wounds received at New Orleans, where she was stabbed in the back by some of her own adherents.

The Meeting of the British Medical Association for 1886 will be held in Brighton, Dr. Withers Moore of the same city being President.

Mr. Erichsen will run as the Liberal candidate, at the coming election, for the representation in Parliament of the Universities of Edinburgh and St. Andrews.

Drs. Tilt, Fancourt Barnes, Bantock, Heywood Smith, A. Wynn Williams, and Mr. Knowsley Thornton have been elected corresponding members of the Boston Gynecological Society.

Dr. Protheroe Smith, who was one of the English visitors at the Canada Medical Association meeting last year in Montreal, was the founder of the Soho Square Hospital for Women, in London, England. After 43 years of active work in that institution he has resigned the position of Senior Physician, and has been appointed a consulting physician.