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THE  
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OF  
MEDICAL & SURGICAL SCIENCE.

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Selected Articles.

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CASE OF ŒSOPHAGOTOMY.

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BY A. B. ATHERTON, M.D., FREDERICKTON, N. B.

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On the morning of June 8th, 1870, Annie D., aged 1 year 11 months, swallowed a New Brunswick cent (one inch in diameter). Vomiting came on immediately, and lasted twenty-four hours. From this time up to June 13th, when she was first seen by me, she suffered from slight dyspnoea and choking cough, with hoarseness and indistinctness of utterance. Could only swallow liquids.

*Present Condition.*—Child healthy looking. Some feverishness. Tongue coated in centre and at posterior part with dirty-white fur.

On examination with finger, the edge of the coin, lying transversely in the throat, could be barely touched. The neighboring parts seemed swollen, so as to interfere with the discovery of the foreign body. Chloroform was given, and various attempts made with œsophagotomy forceps (opening both laterally and antero-posteriorly) to extract it. A blunt hook, fastened to a watch-spring and whalebone, could not be

passed down beyond it. In these efforts I was assisted by Dr. Gregory, whose forefinger is considerably longer than my own, but both of us failed to extract the coin.

Want of success was largely due to the continual biting which the patient kept up while the finger was in the mouth. Even when fully under the influence of chloroform, the introduction of anything between the teeth was the signal for the commencement of a constant chewing. A piece of chamois skin around the finger made it scarcely more bearable. There was not room for the use of a gag together with finger and instrument.

Emetics were not tried, for it was thought that, if the severe vomiting which occurred soon after swallowing the coin did not dislodge it, they would not now succeed after its firmer impaction in the swollen soft parts. The operation of œsophagotomy was therefore determined upon.

The operation for removal was performed June 13th, five days after the impaction of the foreign body. Chloroform was given. A fold of skin on the left side of the neck was pinched up and a bistoury pushed through it. This gave an incision from two to two and a-quarter inches in length, lying to the inner side of and parallel to the sterno-mastoid. The upper part of the incision was on a level with or a little below the upper edge of the larynx, the lower end extending down to a point just above the end of the clavicle. On dissecting down, the internal jugular vein was seen on the outer side of the wound. This, with the carotid artery and the anterior belly of the omo-hyoid, was drawn on one side, while the thyroid gland and trachea were held to the other. About the middle of the wound, at its deepest part, the edge of the coin was felt through the œsophagus. A slight touch of the knife brought it into view, and, by means of dressing forceps and some enlargement of the incision, it was extracted.

During the operation, no vessel of any size was wounded, and no more than a drachm of blood lost.

Whole surface of wound sopped with a mixture of carbolic acid and water (1 to 4 or 5). One suture was put in the skin at the upper end of the incision. Wound to be dressed with one part alcohol to three of water. Three or four ounces of gruel, made with milk and strained through muslin, to be administered per rectum three times a day. Nothing allowed by mouth.

June 14.—Speech distinct since operation. Slight cough still. Wound gives exit to saliva and mucus. Enemata remain in rectum four or five hours. Patient is very clamorous for water. May have a teaspoonful occasionally. Continue the other treatment.

15th.—Somewhat restless and feverish. Can swallow a teaspoonful of water while lying on the back and inclined to the right side, with little or none escaping from the wound; the latter red and irritable-looking about the edges, and filled, as before, with saliva and mucus. Enemata come away as soon as given. Three ounces of milk-gruel, or two ounces of beef-essence, to be administered alternately, with the addition of six drops of tr. opii during the day and of ten drops during the night.

16th.—Slept well last night. Enemata now retained. General appearance better. Pulse 112. Omit opiate during the day; to be continued at night. May give a small quantity of milk from a teaspoon this evening.

17th.—Is able to walk across the room. Milk exudes from the wound when given. May have a gill of milk every day; also two or three teaspoonfuls of wine or brandy in water.

19th.—Doing well. Took more than half-a-pint of milk out of a teaspoon during the last twenty-four hours; very little if any escapes through the wound. May omit stimulants and opiate. Only two enemata to be given per day.

21st.—No milk has come from the wound since the morning of June 19th (being six days after the operation). Patient allowed to take a swallow or two of milk for the first time, while in an upright posture, and no increase of moisture noticed in the wound; a quart of it has been taken during the last twenty-four hours. Wound more healthy looking, and is contracting, suture removed. Milk and beef-tea to be allowed *ad libitum*. To be fed with a spoon while lying down. Omit enemata.

24th.—Gaining in flesh and strength. Slight cough still continues. Incision healing down as far as suture. Granulating surface an inch and one-third long and one-third of an inch at its widest part. Granulations touched with nitrate of silver. Omit the alcoholic wash and use the following:—

R. Ung. resinos. ʒij.;

Ung. zinci ox. benz., ʒss.

M. To be applied twice a-day.

Patient may have all kinds of liquid food.

27th.—Cough has entirely disappeared. A mere line of granulations, three-fourths of an inch in length. May return home to country. To have ordinary diet after perfect healing of the wound.

July 9th.—Heard indirectly that the child was doing well.  
—*Boston Med. and Surgical Journal.*

#### CASE OF IMPACTED CALCULUS IN THE URETHRA. EXTERNAL URETHROTOMY. RECOVERY.

BY M. F. GAVIN, M.D., F.R.C.S.I., &c., SURGEON TO OUT-PATIENTS, CITY  
HOSPITAL, BOSTON.

Henry M., a delicate lad, aged 10 years, born in South Boston and always lived there. Has had the diseases usual to childhood. No pump-water on the premises where he lives. About December, 1868, mother first noticed his water grow cloudy and thick, but free from blood, while the act of urinating caused intense pain in the region of the bladder, extending up towards the lumbar region. From January, 1869, until May of the same year, patient's general health failed, and incontinence of urine and severe "attacks of gravel" became frequent, when he entered the City Hospital under the care of my predecessor, the late Dr. Ropes, who failed to detect stone. Under treatment and rest he rapidly grew better, and left the hospital, feeling well. For some time after leaving the hospital he remained free from all symptoms of his trouble, except after severe exercise, when the pain in making water returned, and once or twice he suffered from retention, which was relieved by a hot bath.

Early in the autumn the "fits of gravel" returned, grow more severe, lasted longer, and were not relieved by the warm bath. About this time the patient had a very severe hemorrhage

from the urethra, probably caused by a rupture of a small portion of the urethra from the great straining of the patient during an "attack of gravel."

My first visit to him was in January, 1870, when he was suffering from one of these attacks, of unusual severity, which had lasted more than two days at the time of my visit. Three days before my visit the lad took severe exercise in running and jumping off a shed fourteen feet high to the ground, and that night began to complain of pain in urinating, extending up the urethra, and passing only a few drops at a time. There was constant pulling of the prepuce; no sleep; hot and feverish; appetite gone.

It was evident something should be done, and at once, as the little fellow was in agony; the bearing-down pains were really distressing to bear, hardly leaving the patient for a moment, and unless something were done, the bladder, which extended almost up to the umbilicus, was in danger of being ruptured.

A warm bath was first tried, without any benefit; when I attempted to pass a No. 5 elastic catheter, but failed, owing to the pain and restless condition of the patient. The parents would not allow ether or chloroform to be given, preferring to wait a few hours before any operative measures were undertaken. After trying opiates and the warm bath for a few hours without relief, ether was given, when a foreign body could be felt filling the urethra about an inch in front of the bulb, which was shown, on passing a sound, to be an impacted stone. The parents preferred to have a consultation, when Dr. Thaxter was called in and gave me his valuable assistance during the operation.

An effort was first made to extract the stone with a long narrow forceps, but it failed. Dr. Thaxter held the stem firmly and drew back the scrotum, while an incision was made in the raphe just anterior to the scrotum; the stone was now pressed forward toward the cut and withdrawn by a forceps.

Very little bleeding followed the operation. A No. 5 elastic catheter was passed through the entire length of the urethra and retained by straps; the edges of the wound were brought together by two very firm silk sutures, with the expectation of obtaining union by first intention, as the wound did not differ from any ordinary flesh wound as long as the urine was not



allowed to come in contact. An opiate was ordered in case he became restless.

Jan. 17th, twenty-four hours after operation. Patient had a very good night, slept well; no occasion to give opiate. Free flow of clear urine through the catheter, not any through the wound. Pulse 88; no heat of skin or headache, tongue clean. Cold-water dressing and milk diet.

18th.—Slept well; no heat of skin or headache; pulse 70; tongue clean and moist; wound partly united, sutures removed. Catheter withdrawn and larger one (No. 6) put into the bladder, with considerable difficulty.

19th.—Pulse 101, skin hot, tongue moist and coated. No swelling or redness of the scrotum. Some pain in the right iliac region. A few drops of urine come through the wound. Catheter taken out. Cold-water dressing; liquid diet, and a saline purgative.

20th.—Pulse 68; tongue clean and moist. Bowels moved yesterday. Urine all came through the normal passage, without causing any pain.

21st.—Pulse 66; tongue clean; appetite good. Wound not quite healed; a few drops of urine came through this morning.

22nd.—General condition excellent. Passes water freely and without pain, a few drops escaping through the lower angle of wound. No 6 catheter passed and allowed to remain in for ten minutes. Wound touched with nitrate of silver.

From this time forth the patient did well, and was allowed his usual diet. Catheter (No. 6) was passed every third day for two weeks, when the wound was firmly united.

The unsettled state of many minor points in surgery was very well shown in this case.

1st. Was it better to remove the stone from that part of the urethra where its further progress was arrested, or to press it back towards the perineum or membranous portion of the urethra? The latter proceeding is strongly advocated by Mr. Erichsen, who dreads the infiltration of urine taking place if the urethra is opened anterior to the scrotum, and if infiltration does not take place we are apt to have a fistulous opening remain. No doubt Mr. Erichsen's suggestion has the advantage, that if other stones are present Allerton's or the lateral operation for

stone may be done without waiting. On the other hand, if, as in the case reported, the stone is firmly impacted midway in the spongy portion of the urethra, to press it back to the membranous portion must lacerate the urethra, which is quite likely to be followed by infiltration of urine or organic stricture.

2nd. Was it better to pass a catheter after the operation, or allow the urine to come in contact with the fresh wound in the urethra? On this point systematic works on surgery have nothing to say, while practical surgeons differ in practice. In the case reported we think the healing process would have been slower if the urine had been allowed to come in contact with the wound.—*Boston Medical Surgical Journal*.

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#### CASE OF POISONING BY WORM LOZENGES.

BY BENJ. D. GIFFORD, A.M., M.D., GLOUCESTER.

On Dec. 23rd, 1869, I was called to a child three years old, who, two hours previously, had eaten seven "worm lozenges," judged to contain *santonin* as the medicinal ingredient. I found her in clonic spasms of the left side; pupils widely dilated and uninfluenced by light; respiration, much impeded, eighteen per minute; a viscid, frothy *saucus* issuing from the mouth at each expiration. The spasms involved every muscle on the left side of the body. The face was twitched into frightful contortions, and *pleurosthotonos* was developed every other second. Pulse fair, 160 per minute. No ability to speak or move. She had vomited freely before I saw her. I endeavored to produce *emesis* with *ext. ipecac. fl.* and by tickling the *fauces* with a feather, without avail. I then gave her chloroform *gtts. v.* every fifteen minutes; also injections of diluted whiskey. In course of an hour the spasms began to yield and the pupils to respond to light; at the end of two hours she was perfectly quiet. I directed the chloroform to be continued should the spasms return, and left. An hour afterwards they did return, and I was again called. I found her worse than ever. Instead of the muscles of one side, both were involved in the spasmodic

action. The pulse was so fast and fluttering that I could not count it. Respiration was very laborious, with mucous rales throughout both lungs. I continued the chloroform, with an addition of tinct. opii gtt. v., every twenty minutes; also small injections of whiskey. At the end of an hour and a-half the spasms entirely abated, and the patient slept from 8.30 to 11 p. m.; she then awoke conscious, drank some beef-tea, then slept till morning, when she was apparently as well as usual.

A similar case is reported in the *Annale de Thérapeutique* for 1852 (see *U. S. Dispensatory*, eleventh edition, article *Santonin*), after what was considered an overdose of santonin, but which afterwards proved to be strychnia. The symptoms were the same in my case, though instead of cold sweats the body was preternaturally hot and bathed in perspiration. I never suspected strychnia at the time, nor till I had seen the later edition of the *Dispensatory*. I then subjected one of the lozenges to analysis, by powdering it on a clean porcelain surface, drenching it with sulphuric acid, and adding a small crystal of bichromate of potassa. After a few minutes the characteristic purple or violet color was produced, showing the presence of strychnia. The color was of precisely the same shade, though less distinct, as that produced by the same experiment with a specimen of Rosengarten & Sons' strychnia. Hence I conclude that the case was in reality one of an overdose of strychnia, and that the santonin played no part in producing the symptoms. I suppose the admixture of strychnia with santonin is purely fortuitous, but it behooves the manufacturers to carefully test their santonin before sending it out, for in this case it was far from being "positively safe."—*Ibid.*

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**NEW TEST FOR ARSENIC.**—Bettendorf has found a test so delicate, that one part of arsenic in 1,000,000 parts of solution may be detected, and the presence of antimony does not affect it. To apply this test the suspected liquid is mixed with hydrochloric acid until fumes are apparent. Chloride of tin is then added, and a basic precipitate containing the greater part of the arsenic as a metal mixed with the oxide of tin is thrown down.

**A SIMPLE, CHEAP AND EFFICIENT SUBSTITUTE FOR  
THE STOMACH PUMP.**

BY JOHN T. HODGEN, M.D., PROFESSOR OF ANATOMY, ST. LOUIS  
MEDICAL COLLEGE.

About a year ago, I had a case of stricture of the œsophagus, so narrow that my patient could not swallow even liquids. To sustain life I resorted to a small stomach tube (a gum catheter, in fact), as a means of injecting liquid nourishment; to this I fixed the elastic tube of one of Davidson's syringes.

On one occasion the vessel containing the liquid happened to be higher than the patient's stomach, and I observed, while the syringe was not being used, that the liquid continued to flow into the stomach—the action being that of a syphon. I at once, to test the syphon, substituted a simple elastic tube for the syringe, and found the stomach could be as readily emptied as filled. Thus I conceived the idea of using a syphon instead of a stomach pump, and have used the same in a case of poisoning, recently, with the most complete success.

I attach four feet of India-rubber tubing to a stomach tube, fill both with water by simply dipping it in the liquid end first, then compressing the elastic tube between the thumb and finger to keep the fluid from running out, introduce the stomach tube, lower the outer end of the elastic tube, and the contents of the stomach pour out as readily as if from an open vessel. When the fluid ceases to flow, I dip the outer end of the tube beneath the surface of water, elevate the vessel containing it, and the stomach is soon filled; lower again the outer end of the tube, and the stomach is emptied. This can, of course, be repeated as often as is necessary.

The advantages claimed for this simple contrivance are, that it may be almost always improvised, is of speedy and easy application, has no valves to become obstructed or deranged, and is less expensive than a stomach pump.

The same principle may be applied in injecting fluids into the bowels, as indeed it has been for injecting into the bladder, uterus and vagina.—*St. Louis Med. and Surgical Journal.*

## THE TREATMENT OF CARBUNCLE.

Mr. Pagot has given, in a recent clinical lecture, an admirable summary of his opinion on the treatment of carbuncle. He gives an outline of the general mode of treatment, and criticises it severely. With reference to incisions which are made to prevent the spreading of the carbuncle, he expresses a doubt as to the efficacy of this method in early stages, and has little faith in it after three or four days of the existence of the disease. "I have," he said, "seen carbuncles spread in as large a proportion of cases, after incisions, as in cases that have never been incised at all. I have in my mind a striking case that occurred to me early in practice when I followed the routine, and a friend of my own divided the carbuncle most freely. I cut it after the most approved fashion in depth and length and width, and then it spread. After two or three days more all the newly-formed part was cut as freely as the first, and then it spread again, and again it was cut as freely. Then it spread again, and was not cut. Then in a natural time it ceased to spread, and all went on well." . . . "On a very strong general impression, however, I say that carbuncles will spread after cutting, in as large a proportion of cases, as they will spread in without cutting." In reference to the supposed relief of pain by incision, and the alleged acceleration of the healing powers by this operation, Mr. Pagot expresses grave doubts, indeed, in regard to the latter, he distinctly states that the "healing without incisions is very clearly, and certainly a deal the quicker." In regard to very high feeding and the use of stimulants in large quantities, Mr. Pagot states his belief that this practice is mistaken, and he recommends that the patient be allowed instead only about two-thirds of his ordinary supply of food. His method of treatment is briefly as follows, and consists in doing very little at all. In local treatment, the best thing, he says, is, if the carbuncle be small, to cover it with *emplastrum plumbi*, with a hole in the middle through which the pus can exude and the fine slough can come away. For a large carbuncle he recommends the common resin cerate. "this should be spread large enough to cover the whole carbuncle, and over it should be laid a poultice of half linseed meal and

half bread." The carbuncles, too, must be carefully washed with Condy's fluid, or weak carbolic acid, and the cavities may be syringed out with it. Bark, &c., then may be given, but he thinks needless; opium must be given, especially in the earlier stages, and above all things fresh air and exercise must be allowed to the patient. Mr. Pagot does not think the disease a very fatal one, for, out of 400 cases of his own, only four died.—*Lancet*.

### PROPHYLAXIS OF SCARLET FEVER.

Mr. Amos Beardsley, of Grange, Lancashire, sends us an important note respecting a method of arresting the spread of scarlatina, which he has found very valuable. When a patient suffers from scarlatina, he is to be washed all over, once or twice a-day, with diluted carbolic acid. Mr. Beardsley says that in no case in which he has tried it with the first case in the house, has there been any further spread of scarlatina in the family. For example, about a year ago he had a girl, seven years old, under his care, one of a family of five; she was attacked with well-marked scarlatina, and was immediately ordered to be systematically sponged with carbolic acid—one drachm to a pint of water. Also the rest of the household were desired to put carbolic acid into their washing water. Although there were no means of properly separating the other children from the invalid, none of them took the fever, the one patient was severely ill, and scarlatina was in all the surrounding villages, and in remote parts of the village where the family lived. Mr. Beardsley has now had so much experience, as to be convinced that this plan is most useful in preventing the emanation of contagious influence from patients, especially during the desquamating stage. We shall hope to give a more extended account of the results he has obtained, on a future occasion.—*Practitioner*.

"I suppose," said a quack, while feeling the pulse of a patient who reluctantly submitted to solicit his advice, "I suppose you think me a bit of a humbug?" "Sir," gravely replied the sick man, "I was not aware until now that you could so readily discover a man's thoughts by feeling his pulse."

## NEW METHOD OF TREATING CONFLUENT SMALLPOX.

*L' Abeille Médicale* says:—"M. Chauffard has recently made the following communication to the Société Médicale des Hôpitaux:—"The treatment of which I have to speak consists in the employment of large doses of crystallized phenic (carbolic) acid, a therapeutical agent whose efficacy in the secondary fever of severe confluent smallpox—a secondary period when, as is well known, the majority of patients attacked by severe confluent smallpox succumb—appears to me established.

"To judge the more clearly of the efficacy of this remedy," says M. Chauffard, "I have used it exclusively in five cases of absolute severity, and, to my great surprise, in all these cases I have observed the rapid disappearance of the intense febrile phenomena, and of the symptoms of suppuration. Only one of these five cases died, but at the time of his death he had been convalescent a fortnight."

"The dose of the medicine adopted was one gramme (15·4 grs.) of crystallized carbolic acid in a mixture of four or five ounces, to be taken in the course of the day. The treatment is completed by the application of carbolic acid lotions externally."

Our readers will remember that our Lyons correspondent, in his recent letter, adverted to this treatment.—*Dublin Medical Press and Circular.*

## ACUTE RHEUMATISM AND ITS TREATMENT.

The Hospital Report of the recent numbers of the *British Medical Journal* contains a summary of the methods of treating acute rheumatism, in vogue in the London hospitals. At Guy's Hospital, Dr. Wilks has tried various forms of treatment with nearly the same results, and he believes that the remedy remains to be discovered, the main point, he thinks, for consideration, is the discovery of that treatment which will bring the patient through without implication of the heart, and this has not yet been arrived at. In treating private cases, besides administering aconite, as mentioned in his recent paper in this

journal, he prescribes the saline of acetate and nitrate of potash, with an opiate at night, occasional blisters to the joints to relieve pain, and flannel next the skin. At St. George's Hospital, Dr. Fuller pushes the alkali treatment to its fullest extent, to the point of producing alkalinity of the secretions. Dr. Fuller thinks that the failure of the alkaline treatment has been due to the want of discrimination between true rheumatic fever and rheumatic gout. In the latter the alkaline remedies have little effect; in the former they are beneficial. In the true rheumatic case, Dr. Fuller prescribes both soda and potash, to the extent of two drachms every three or four hours, till the urine is rendered alkaline. Dr. Fuller usually prescribes two ounces of the haustus ammoniæ acetatis of the Hospital Pharmacopœia, with one drachm and a-half of bicarbonate of soda, and half a drachm of acetate of potash; and this he orders to be taken in a state of effervescence, in combination with half a drachm of citric acid dissolved in two ounces of water. When the urine is alkaline, the dose is given only three times in the twenty-four hours, and on the following day only twice. Subsequently two grains of quinine are added to each dose, if quinine cannot be borne, the bark preparations are used. From day to day the urine is examined, and, on the appearance of acidity, alkalies are again administered in sufficient quantity. Solid food must not be given. Dr. Barclay also adopts the alkaline treatment. At the Royal Infirmary, Edinburgh, Dr. Laycock also employs the alkaline method, giving drachm doses of either carbonate or nitrate of potash every three or four hours. Calomel and opium are also administered. At St. Bartholomew's Hospital, Dr. Farro adopts the alkaline method. At St. Thomas's, the same may be said of Dr. Peacock's treatment. At King's College Hospital, Dr. Johnson uses the alkaline remedies in a mild degree, but he insists on the use of opium, and the plan of wrapping the patient in a loose soft flannel dressing-gown; hot-air baths he also thinks of service in some cases. At Middlesex Hospital, Dr. Goodfellow adopts the alkaline method. At Westminster, Dr. Fincham has reliance on blisters, but he also gives alkalies, though to less extent than is recommended by Dr. Fuller. Dr. Basham also adopts the alkaline method, but he gives opiates to relieve the pain, and



urgos attention to the intestinal discharges. In a letter, commenting on the reports which contain the above summary, Assistant-Surgeon A. Myers, of the Coldstream Guards, recommends: (1) That in all cases the patient should wear a flannel garment, and be laid between blankets. (2) That a thick layer of cotton wool should be wrapped round the tender joints, and covered with flannel bandages, and (3) that milk and potass or soda-water should be the chief article of diet.—*Practitioner*.

[We have found a mixture of equal parts of potass-bicarb. and potass-nitras, say three drachmas of each, to the 8 ounce mixture, answer exceedingly well in most cases.]—Ed.

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### FOREIGN BODY IN THE CHEST.

Dr. Snyder, in the *Chicago Examiner*, reports the following strange case of tolerance of a foreign body in the thorax, and its spontaneous removal:—

James Thompson, sixty years of age, stout and robust, usually, of active habits, suddenly commenced declining in health, without apparent cause. When I was consulted, he had been, as he expressed it, "under the weather for five or six weeks." His symptoms were a troublesome, dry cough, furred tongue, loss of appetite, emaciation, hectic night-sweats, and pain in the right side. Previous to the initiation of this train of symptoms, which he attributed to "catching cold," he had always enjoyed excellent health, "excepting," as he said, "occasional twinges of rheumatism, for the last dozen years, under the right shoulder-blade," whenever he exerted himself at any kind of manual labor.

The chest examined, revealed a portion of the right lung, two or three inches in diameter, just below the nipple, entirely impervious to air, and all the organ below that, very dull, on percussion. The left lung was evidently healthy, though over-taxed by its vicarious labor.

The *diagnosis* suggested was *circumscribed pneumonia*, originating, perhaps, in the increasing size and consequent pressure of some isolated tubercular mass. (I will here state that the

patient's wife died a few years before of *phthisis*, and it is possible I was influenced in my conclusion by a vague idea of the contagious theory of that disease.)

The *treatment* ordered consisted of stimulating expectorants, mineral acids, and counter-irritants. For four weeks more the case continued without change, save a gradual aggravation of all the symptoms, increased dyspnoea, and free expectoration, when one day, in a hard paroxysm of coughing, the patient throw up, from the right bronchia, an ounce or two of pus and a hard substance, which attracted his attention, by the force with which it struck the floor. On examining the substance, it proved to be the point of a *knife-blade*, an inch in length, half an inch in width, and weighing half a drachm. The fragment of steel was much corroded and pitted by oxydation.

The patient now remembered a circumstance he had entirely forgotten—that *twelve years* before this, in a street fight, at Beardstown, in which himself and several others had been engaged, he had been "stabbed in the back, about the lower point of the shoulder-blade," but as the wound gave him no pain and soon healed, he had no suspicion that any part of the blade had remained imbedded in his body. The true pathology of the case was now manifest, and the patient rapidly recovered his health.

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ABERNETHY'S DISLIKE TO UNNECESSARY TALK.—People who came to consult this eccentric man took care not to offend him by bootless prating. A lady on one occasion entered his consulting room, and put before him an injured finger, without saying a word. In silence Abernethy dressed the wound, when instantly and silently the lady put the usual fee on the table and retired. In a few days she called again, and offered her finger for inspection. "Better?" asked the surgeon "Better," answered the lady, speaking to him for the first time. Not another word followed during the rest of the interview. Three or four similar visits were made, at the last of which the patient hold out her finger free from bandage and perfectly healed. "Well?" was Abernethy's monosyllabic inquiry. "Well," was the lady's equally brief answer. "Upon my soul, madam," exclaimed the delighted surgeon, "you are the most rational woman I ever met with."—*Jefferson's Book about Doctors.*

## CHLOROFORM VERSUS ETHER.

So many deaths from chloroform have lately been reported that the question. Have we any safer anæsthetic? becomes more and more important both to the profession and the public. Boston unhesitatingly says yes, *Ether*, and as our medical brethren of Boston are honorable men, we might ask why is the use of ether confined almost exclusively to Boston. The fact is that the denunciations of chloroform and the laudatory reports of ether, by Bostonians, are considered by the profession generally, as unfair and unreliable. Nor is ether used exclusively even in Boston. Dr. Storer, in the *Journal of the Gynaecological Society of Boston*, for April, is decidedly in favor of chloroform in obstetric practice. He also gives it as his opinion that the mixture of chloroform and ether, equal parts, is more dangerous than chloroform alone, and goes on to state that he "was not sure but that he should entirely discard the use of ether, as has been done in almost every place in the world save Boston. There might be, there undoubtedly was, a slightly greater risk of life, when we came to examine into tables of thousands of cases, but in comparison with the many other risks, as of increased retching, etc., etc., greater with ether, and very positive oftentimes in their disastrous results, he thought the balance in favor of chloroform."

He instances two cases of death from ether, and promises that in a future number, he will "give an incontrovertible statement of deaths from sulphuric ether \* \* so detailed and presented as to warrant the assertion that, in proportion to the number of instances of their respective use in the world \* \* the inhalation of sulphuric ether for anæsthetic purposes is in reality more deadly and unsafe than that of chloroform."

We believe, however, that it will be found that the danger generally lies in the physiological condition of the patient at the time of administration of the anæsthesia, and not in the particular anæsthetic used, and that fear, the dread of the operation or its consequences, is the agent, above all others, which produces the physiological condition most conducive to death from anæsthetics.

When the patient exhibits no fear for the operation, I have none in administering chloroform. When the patient exhibits

great fear, I administer the chloroform slowly and cautiously, believing that the shock of a full breath of the undiluted vapor of chloroform to a very nervous patient, may and often does produce death, while it would be quite harmless to the same individual, in the absence of the nervous condition which is due to the fear of the operation. We do not wish to be understood to say that there are not pathological conditions in which the use of chloroform or ether would be very dangerous; but, that the majority of deaths from anæsthesia are due to physiological conditions, is evident from the history of the reported cases. For instance many of the reported cases of deaths from chloroform have occurred when the anæsthesia was administered for the extraction of teeth, the subjects being generally females, while few if any accidents, when the anæsthesia is administered in obstetrics. Yet there is no comparison between the suffering and exhaustion accompanying the two conditions, on the other hand the fear and nervous excitement is much greater when a tooth is to be extracted than at the approach of labor.—*Oregon Med. and Surg. Reporter.*

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## HOW TO CURE A COLD.

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The following is from a lecture by Dr. G. Johnson, the Professor of Medicine in Fing's College.

The exciting cause of a catarrh, in the great majority of cases, is a chill, or some unknown atmospheric influence, which tends to suppress the action of the skin. The popular domestic treatment consists in the use of a hot foot bath at bed time, a fire in the bed room, a warm bed, and some hot drink taken after getting into bed, the diaphoretic action being assisted by an extra amount of bed clothes. Complete immersion in a warm bath is more efficacious than a foot bath, but the free action of the skin is much more certainly obtained by the influence of hot air—most surely and profusely, perhaps, by the Turkish bath. The Turkish bath, however, is not always to be had, and, even when available, its use in the treatment of catarrh is attended

with some inconvenience. In particular there is the risk of a too speedy check of the perspiration after the patient leaves the bath. On the whole, the plan which combines in the greatest degree efficiency with universal applicability consists in the use of a simple hot air bath, which the patient can have in his own bed room. *All that is required is a spirit lamp with a sufficiently large wick.* Such lamps are made of tin, and sold by most surgical instrument makers.

The lamp should hold sufficient spirit to burn for half an hour. The patient sits undressed in a chair, with the lamp between his feet, rather than under the chair. An attendant then takes two or three blankets, and folds them round the patient from his neck to the floor, so as to enclose him and the lamp, the hot air from which passes freely round his body. In from a quarter to half an hour there is usually a free perspiration, which may be kept up for a time by getting into bed between hot blankets. I have myself gone into a hot air bath suffering from headache, pain in the limbs, and other indications of a severe incipient catarrh, and in the course of half an hour I have been entirely and permanently relieved from these symptoms by the action of the bath.

Another simple and efficient mode of exciting the action of the skin consists in wrapping the undressed patient in a sheet wrung out of warm water, then, over this, folding two or three blankets. The patient may remain thus packed for an hour or two, until free perspiration has been excited. Let me impress upon you that the sweating plan of treatment, to be successful in cutting short the disease, must be adopted early—I mean within a few hours from the commencement of the symptoms.—*British Medical Journal.*

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The following treatment has been found very useful in Tonsillitis.—Bicarbonate of Potash 1 scruple, Tr. Guaiacum  $\frac{1}{2}$  drachm, Aqua Mucilaginosæ 1 ounce, to be taken with 15 grains of Citric Acid, in a state of effervescence. Tr. Iodine 20 minims to the ounce of water, to be used as a gargle.

## OPERATION FOR RADICAL CURE OF HERNIA.

Mr H. D. S., aged thirty-five, presented himself for operation Nov 10th, 1869. He had inguinal hernia of right side, two years duration, it was not large and did not extend to the scrotum.

Chisholm's plan was chosen and aimed to be followed; but not having his description at hand, an imperfect memory of it allowed considerable departure of the operation from his.

A vertical line is drawn on the skin across the centre of the ring; then a curved hollow or tubular needle is entered at the lower edge of the ring, in this line, and carried under the skin a little past the margin of the abdominal column of the ring. Then the point of the needle dipped down through the wall of the ring, passed from below upwards through the wall again. But as the needle's point came to the skin, this integument was drawn over toward the needle so it should make its exit through the skin in the vertical line. The needle is now armed with silver wire and withdrawn, leaving the wire in the track made by the needle. The motion of the needle under the skin is much like that of the shoemaker's awl when he takes a stitch in leather. The unarmed needle is next re-introduced in the same opening made at first, pierces the opposite column in like manner as before, and passes out at the same second opening through the skin. The needle is again armed with the upper end of the same wire and brought through the needle's track in the poupartie column. These stitches include about three eighths of an inch of the column on either side. The sutures are now tightened, twisted, cut short and retracted under the skin through the opening, and the work is done.

Six months have now passed with no return of the hernia.

A re-perusal of Chisholm's plan shows this difference: He carries the fundus of the scrotum on the finger into the ring, and includes the scrotal facia in the suture. In his operation each column of the ring was only once transfixed, which allowed him more freedom of the needle; mine twice transfixed the columns.

One feature occurred which somewhat embarrassed the expertness of the operation. The needle being passed first through the inner or abdominal side of the ring, is accomplished easily enough. But the poupartie column is so unyielding, and holds the needle so firmly, it prevents the ready manipulation of the point, and bringing out at the upper aperture in the median line of the skin. It is quite likely this difficulty may be avoided by commencing the operation on the poupartie side.

Twenty-four hours after the operation, the pulse rose to 120, with a white tongue, some local tenderness and hardness.

Water dressing and half a grain of morphine every six hours relieved these symptoms, and in twenty-four hours more the frightful foreboding of peritonitis disappeared. No motion of the bowels occurred for eight days, when an enema secured it.—*California Gazette.*

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### EXTRA-UTERINE FETUS EXTRACTED BY THE OPERATION OF LITHOTOMY.

BY JOSEPH BOSSUETT, MEMBER OF THE MEDICAL SOCIETY  
OF MASSACHUSETTS.

In the month of October, 1807. Mrs. Coleman, of Braintree, found herself in a state of pregnancy, attended with uncommon distress, and some pungent pains shooting from the hypogastric to the epigastric regions. She continued in that way until the latter part of the ensuing spring, when she had all the symptoms of a true travail. She sent immediately for an accoucheur, who, not being able to come at the child by the natural passage, ordered large doses of opium, with the injunction to repeat them as often as the pains recurred. A fortnight after that the pain abated \* \* \* the time I suppose the child died in the abdomen. She was for two months afterward very much troubled by a disagreeable sensation, which she called drawing.

The abdomen swelled to a very large size, which after some time gradually subsided. The three succeeding years she passed without much distress, but at the end of that time she began to experience very acute pains attended with evacuations, by the

urethra, of a matter sometimes of a yellow cast, sometimes bloody and of a very fetid smell, and voided in the same time, by the savao canal, some very small bones. A communication also took place between the bladder and rectum, so as to let the feces and urine pass either way.

During five years before my first visit to her she experienced the most excruciating pain night and day. Having been informed of my recent arrival from Martinico, with my family, and that I resided in Hingham, she sent for me the 20th of May, 1816. I visited her the same day, and after a critical examination found the child in the bladder (mostly in the bladder and partly in the abdomen), crusted over with a calculous matter. Considering her in a dangerous situation, I advised her to submit to the operation of lithotomy as the only means of relieving her from her suffering. She readily consented to it, and the operation was performed by me, the 17th of June, 1816, attended by Doctors Noah Fifield, of Weymouth, and Robert Thaxter, of Dorchester, two respectable members of the Medical Society, in whose presence one hundred and forty-six bones of a fetus, about seven months old, were extracted, together with a stone about the bigness of an olive. She has since entirely recovered, and enjoys at present a perfect state of health, without any pain whatever, but the communication between the bladder and the rectum is not yet wholly obliterated — *Medical and Surgical Reporter.*

#### DIGITAL COMPRESSION.

On the 21st June at the request of Dr Drake, the following gentlemen, students of McGill Medical Faculty and at present attending the practice of the Montreal General Hospital, kindly volunteered their services in the trial of digital compression for the cure of aneurism, viz. Messrs. Morrison, Reid, Johnston, Locke, McConkey, Mathieson, Wright, Webb, McLaren, Duncan, Sutcliffe, Walton, Nelson and Gunsolus. It was arranged that they should attend in pairs to be relieved every two hours, and each man to exercise compression for fifteen minutes at a time.



The work was begun at 6 p.m., Wednesday, June 21st, each Student being fully instructed as to how to proceed. The patient at times for the first thirty hours suffered most agonizing pain in the tumour or calf of the leg, and had to be given repeated opiates to keep him quiet. After this, however, the pain quickly subsided, and at 9 o'clock Friday morning the pulsation was found to have entirely ceased, the compression being then in operation thirty-nine hours. It was continued on for thirteen hours longer, making in all fifty-two hours, when it was thought unnecessary to proceed further, a cure having evidently been effected. The most careful examination of the tumour failed to discover the slightest pulsation, though there is very little difference in its size from the first, but as dense and resisting to the feel as a fibrous tumour.

June 24th.—Patient rested well for the past two nights, can move the leg about with the greatest ease, knee, however, stiff and cannot be extended, no pain at any time, health improving; appetite good, thigh tender from the pressure, patient anxious to sit up.

July 1st.—Discharged from hospital, tumour apparently not decreasing in size, no pulsation, health and spirits of patient improving rapidly; ordered to use stimulating liniments and the cold douche to the knee, which continues stiff and slightly bent on the thigh.

July 17th.—Reported himself to-day; is rapidly gaining full use of the leg; looks greatly improved in health; is told that he may resume his work to-morrow.—*Canada Medical Journal.*

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### METHYLIC ETHER AS AN ANÆSTHETIC.

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At the Medical Society of London, Dr. Richardson made a second communication on the application of methylic ether as a general anæsthetic. Methylic ether is made by mixing one part of sulphuric acid with two of pure methylic alcohol, and applying heat. The ether passes over as a gas, having an ethereal odor, and a vapor density of 23, taking hydrogen as unity. To

fix the gas, Dr. Richardson passes it slowly through pure ethylic ether, of specific gravity .730, and boiling point of 95° Fahr.: the gas is being absorbed for several hours, and the result is an ethylic ether saturated with methylic. This is the fluid employed for anæsthesia. Two drachms of the fluid are poured upon domette in a simple mouthpiece, which also covers the nostrils, and the vapor from the surface of the domette is directly inhaled. Dr. Richardson reported eleven cases of tooth extraction in which he had successfully anæsthetized with methylic ether, at the National Dental Hospital; and since Monday, March 14, Mr. Gregson has used it at the Dental Hospital of London, also with great success. Two peculiarities, at least, may be mentioned, as pertaining to the action of the new narcotic: (1) That it produces quick relaxation of the muscles; (2) That while the patients under its influence are unconscious of pain, they are capable of performing what appear to be conscious acts, which acts, on recovery, are entirely forgotten. The anæsthetic sleep is induced usually within a minute and a half, recovery being perfected as quickly; in no period of the anæsthetic sleep is there asphyxia, and the pulse undergoes little alteration. In short, from the experience as yet obtained, there is promise that, for short operations at all events, methylic ether will fill an important place in our list of remedies. The chemical composition of the ether is  $(\text{C}_2\text{H}_5)_2\text{O}$ .—*British Medical Journal*.

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### COMPOUND FRACTURES.

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At a meeting of the Medical Society of London, held December 6th, Mr. Sampson Gamgee read a paper on compound fractures.

He preferred to our own the French division into simple and complicated fractures, the latter including swelling and wound. A fracture with a penetrating wound may be and often is a less important injury than what is commonly called a simple fracture, though accompanied with much bruising of the soft parts, and consequent swelling. In all cases if the limb is to be saved, the author recommends adherence to the same principle

of treatment, immediate reduction, immobility and compression; *soft pasteboard splints are the agents chiefly relied on, but to be efficient they must cover indeed the joint above as well as below the seat of fracture—a principle firmly inculcated by Percival Pitt, who was erroneously held to be the advocate of position against splints.* On the great value of pasteboard splints, the sound practical teaching of Jean Louis Petit was contrasted with the fanciful objection of Malgaigne. The fallacy of John Boll's objection, and the use of compressing bandages in fractures were fully exposed, and a number of cases were adduced to illustrate the author's practice, amongst them one of compound fracture of the ankle-joint, in which complete recovery followed excision of the astragalus and the application of a compressing pasteboard apparatus, only opened for the dressing of the wound once in nine days. Referring to Professor Lister's carbolic acid treatment, Mr. Gamgee said. "Until the distinguished surgeon whose intimate friendship during the whole of my studentship I shall deem one of the greatest happinesses of my life, thinks well to publish his views and experience in a collected form, it will not be possible to examine them with that completeness and impartiality which his character and position, no less than the importance and difficulty of the subject deserve, but having read all that the Edinburgh Professor has hitherto published, and having seen his practice, with the advantage of his personal exposition in the Glasgow Infirmary, I do not hesitate to say that, so far as I am able to judge, the practice of introducing pure carbolic acid into the innermost recesses of a compound fracture is a mistake."—*Medical Press & Circular.*

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TREATMENT OF CROUP.—Dr. Fabius, of Amsterdam, employs neither antimony, calomel, nor blood-letting in Croup. The chief object is to avoid debilitating remedies as far as possible. Ipecac is as good an emetic as antimony, other purges are equally efficacious with calomel, bleedings are unnecessary. An emetic, a warm poultice to the neck, and a quantity of warm steam in the room, are his "abortive" measures.—*Lancet and Observer.*

## REDUCTION OF PROLAPSED FUNIS BY THE POSTURAL METHOD.

The following case is narrated by Dr. Brunton:—

“On October 26th, 1869, I was called to attend Mrs. H., aged twenty-seven, in labor with her first child. She had been ill for ten hours, and her pains were active, occurring every few minutes. On examination, I found the os uteri dilated to the size of a crown-piece, the head presenting, a bag of membranes protruding, and in this bag was a loop of funis. This I deemed it proper at once to reduce, in case pulsation still existed, though I had not detected it through the membranes. Placing the patient on her knees in bed, with her head as low as she could put it, I partly introduced my hand into the vagina, ruptured the membranes, and just as pain came on I pushed up the loop (now about six inches long) alongside the head, and, as the head was pushed down by the pain, the cord was reduced. No prolapse afterwards occurred. Some hours afterwards, I delivered the child by forceps on account of a very narrow pelvic outlet. The child was dead. The mother had not felt any fetal movements for several days. The placenta was calcareous, and in some parts fibrous, during labor, as the liquor amnii escaped, it was thick with meconium. The mother made a good recovery. By withholding fluid, and allowing a liberal supply of ice, to allay her thirst, little or no milk formed in her breast.”—*British Medical Journal*.

GOOD ADVICE.—In a trial at the Old Bailey, the other day, a Surgeon was indicted for having feloniously assaulted a woman whilst she was under the influence of chloroform. The evidence rested mainly on the statement of the woman herself, and the jury were evidently against the prisoner. The judge, however, fortified by Medical evidence, summed up in his favor, and the prisoner was acquitted. On leaving the bar, his lordship advised the prisoner never to administer chloroform to a patient unless in the presence of a third person, a piece of advice applicable to all members of the profession.—*Medical Times and Gazette*.

### AMPUTATION AT THE ANKLE-JOINT.

Stephen Smith, M.D., of New York, in the *Physician and Pharmaceutist*, reports two successful cases of this operation, and remarks that amputation at the ankle-joint has not received that consideration from surgeons in this country which its real merits deserve. Unless the conditions are entirely favorable for a Syme's or a Pirogoff's operation, we too frequently amputate above the knee-joint. The great virtue of the operations bearing these distinguished surgeons' names, does not lie in the peculiarity of the flaps, but in the fact that, by disarticulation, the stump has for its base the broad extremity of the articular surface of the tibia. This bone, whether covered by the integuments of the heel, or sides of the ankle, or dorsum of the foot, or united to a fragment of the os calcis, is adapted to direct pressure in locomotion. In this fact alone we have the intrinsic merit of ankle-joint amputations. It should be a fixed principle in surgical practice, therefore, that whenever the integuments in the vicinity of the ankle-joint can be so shaped as to cover the end of the bone, amputation must be performed at, rather than above, the joint.—*Compendium of Med Science.*

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### AMPUTATION AT THE KNEE-JOINT.

In the January, 1870, number of the *American Journal of the Medical Sciences*, Dr. Stephen Smith, of New York, recommends a very ingenious form of incision in this operation. He says:—

It is evident from the results of the different methods of operation, that the long anterior flap and the lateral flaps combine the advantages which we seek, both in drainage and the position of the cicatrix, and yet each has certain disadvantages. In several recent amputations at the knee-joint, I have endeavored to combine the good features of the long anterior flap and the lateral flaps, without their objectionable points. The operation is performed as follows. The incision is commenced about one inch below the tubercle of the tibia, and carried downward and

forward over the most prominent part of the side of the leg, until it reaches the under surface, when it is curved toward the median line. When that point is reached, it is continued directly upward to the centre of the articulation. A second incision begins at the same point as the first, and pursues a similar direction upon the opposite side of the leg, and meets it in the median line on the posterior part. The following precautions should be remembered, viz. the incisions should incline moderately forward down to the curve of the sole of the leg, to secure ample covering for the condyles, and that upon the internal aspect should have additional fullness for the purpose of insuring sufficient flap for the internal condyle of the femur, which is longer and larger than the external. In the dissection, the skin, fascia, and cellular tissue are raised, and the ligamentum patellæ divided, allowing the patella to remain. The ligatures are all drawn out of the posterior angle of the flaps.

In the appearance of the flaps, immediately after disarticulation, it will be noticed that the extremity of the femur is already completely covered, and the line of union of the flaps will be between the condyles and over the inner-condyloid notch. When cicatrization is complete, the cicatrix sinks into this notch and disappears from the face of the stump, and offers no point of contact with the artificial appliance. The appearance of the stump on recovery is good.

In the process of repair, it will be found that the drainage is so perfect, that all the anterior portion of the wound remains dry, and frequently heals by immediate union.—*Ibid.*

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Dr. Charlton, of the Newcastle Infirmary (*Brit. Med. Journal*), has found Creasote so uniformly successful in checking the vomiting which sometimes occurs in Bright's disease, that he has diagnosed this malady where other symptoms were absent, by the cessation of vomiting under that remedy. As another diagnostic sign, he states that "tenderness on pressure of the pneumogastric, in its course through the neck, is evidence of inflammatory disease of some of the organs to which it is distributed, whether it be stomach, lung, spleen, liver, or kidneys." If only one side be affected, the nerve on that side will alone be tender.—*Lancet and Observer.*

### ITCHING (PRURITUS) OF THE ANUS.

Prof. Van Buren, in a clinical lecture (*N. Y. Medical Gazette*, March 12, 1870), says:—There is a form of eruption, called by Von Hobra "eczema marginatum," with elevated edges and well defined margin, which has existed in the most obstinate cases of pruritus of the anus I have encountered. If you rub these scurfy margins with a little glycerine thoroughly, and then scrape off a drop with the edge of a dull scalpel and place it upon a slide under the microscope, you will recognize the spores of a parasitic plant, which is growing like a weed in the diseased scarf skin. If you kill this vegetable growth, the chronic inflammation of the skin will straightway get well; and to do this, use the solution of Sulphurous Acid as prepared by Squibb, for sulphur is the best of all parasitocides, and this is the best form in which it can be applied. Sop it on two or three times a-day, at first diluted with an equal quantity of water, afterwards stronger if well borne, and within a week the obstinate disease will have taken its departure.

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WOMEN NURSES IN THE PRUSSIAN ARMY.—The Grand Duchess of Baden has, says a lady writing from Heidelberg, begged all the ladies who offer themselves as nurses to come in plain dresses and caps—no curls, chignons, etc. This has put a stop to the romantic young ladies and those who do things from vanity, etc. Plain night caps, without even lace on them, are not becoming. You see ladies in dark blue linen dresses going about, only a white collar; sleeves loose, wide, but buttoned at the wrists. Those who belong to the *Kuchen- und Krankenpflege* have a small bow of narrow satin riband, with "Frauen-Verein Krieg, 1870," printed on it, pinned to their left side. Those who belong to what is called the Reserve, who will be made use of in either capacity, nurse or cook, etc., wear a green bow, the nurses a blue one, and those who attend the linen department a white one. Each hospital has a white flag with a red cross, and the regular hospital nurses, men and women, doctors and dressers, wear a white band around the left arm, with the red cross on it.—*Med. and Surgical Reporter.*

## Editorial.

### PROGRESS OF THE "JOURNAL."

On taking charge of this periodical, in January last, we informed our subscribers that, if properly encouraged, we would "alter the shape, increase the size, and, if then considered advisable, change the name" of the *Journal*. We have, on the whole, met with a fair share of encouragement; nothing like what it ought to have been, when we look at the Medical Register for Ontario; but still the list of subscribers has very materially increased, quite enough to justify a considerable outlay, which we have made with the new volume. To give the *Journal* a more portable form, the size of each page has been slightly reduced, but their number has been increased, so that our readers will be supplied with a much greater amount of reading matter than heretofore, in each number, and as the DOMINION MEDICAL JOURNAL sinks into oblivion, the CANADA LANCET will rise from its ashes with a new lease of life.

We are conscious of many defects in the past volume, and especially of irregularity in the day of publication. This is to a certain extent unavoidable, when the Editors are busily engaged in private practice at the same time; but to remedy it as far as possible, we have increased the editorial staff by the addition of Dr. Fulton, who, with the present volume, will assume the immediate control of the *Journal*. Dr. Fulton's well-known business abilities are a sufficient guarantee for its efficient management, while his high professional attainments will ensure a careful selection of its contents.

In making these efforts, we trust that we will be cordially seconded by the profession at large. We want our country friends to send us in their experience. We are sure there is as much talent in Canada as in either the United States or Great Britain, and quite a large enough clinical field for its development. If practitioners in the country would only keep their case-book half as faithfully as they do their day-book and ledger, the contribution of an interesting paper would be a matter of no difficulty; and such a course would add greatly to the standing of the Canadian profession in the eyes of the world.



PROSPECTUS OF THE CANADA LANCET.

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Having assumed the management of *The Canada Lancet*, and having in view the interests of our many subscribers, and the medical profession generally, we have in the first place enlarged its capacity to nearly double that of the former edition. We are fully aware that we have assumed great responsibilities, but we will endeavour to discharge our duties faithfully. We think it is very desirable to have in Canada a good, reliable, practically useful medical journal, and it will be our constant effort to meet that view by enlarging and improving this periodical from time to time, and making it more and more worthy of the confidence and support of the medical profession. There is undoubtedly a good field in Canada for a well conducted medical journal, and we intend to make a persevering effort to occupy it. There is also talent enough and material enough, and we intend, if possible, to bring it out. And while we will endeavour on our part to make this journal as useful and instructive as possible, we must ask the cordial co-operation of the profession. There are many medical men in the Dominion who could send us very interesting and practical cases which occur in their daily practice, and which might be very important if they would but spare the time. Such original communications would be most heartily welcomed and would be placed in the most prominent part of the journal. The shorter, the more practical, and the more to the point—the less historical and verbose, the better, but this must be left to the individual judgment of the contributor. We have an intense dislike to communications so long that they have to be continued in a subsequent number.

Our pages will always be open to correspondence on medical and scientific subjects, and we trust that our medical friends throughout the country will avail themselves of the opportunity thus afforded them. We would most earnestly solicit original communications on all medical and scientific subjects and reports of cases occurring in professional practice. We also intend to give such reports as we may be able to obtain, of the most interesting and instructive cases that occur in the Toronto General Hospital. These will of necessity be very much condensed; but we will endeavor to make them practically useful to the

busy practitioner. We receive a large number of British and American medical journals, from which we intend to make careful and judicious selections. This we will be able to do in a more satisfactory manner than heretofore, as our list of exchanges is large and varied, and the space at our disposal much increased.

Our reviews and notices of books will be carefully attended to.

The future numbers of the *Canada Lancet* will be issued promptly on the first of every month.

With a view to increase our circulation, a specimen copy of the *Canada Lancet* will be sent to every medical man in the Dominion, who is not already a subscriber, whose name we can obtain. A polite note will be enclosed in each, with a form of application attached, and we trust that all those who have the welfare of the profession at heart will do us the kindness to send their names.

#### AXILLARY THERMOMETER, USES OF.

The exact temperature of the skin can only be obtained by means of the thermometer, the sensation communicated to the hand being very unreliable. The instrument, however, requires to be especially adapted for that purpose. The bulb of the instrument is placed in the axilla and the arm folded across the chest. It is allowed to remain ten or fifteen minutes, and the temperature read off before being removed. The natural temperature of the body is about 98° or 99° F. but in disease it may rise to 110° F. If the thermometer does not indicate abnormal heat, there is no febrile condition present, so that the physician may be materially assisted in his diagnosis in otherwise doubtful cases. When the thermometer indicates 100° or 101° F. the fever is of a mild type, when 105° very severe, and if it rises to 108°, 109° or 110° death is almost certain. The temperature has been found very high in fatal cases of scarlatina and tetanus. When convalescence begins the temperature gradually declines, but in some cases there are remarkable fluctuations, as in typhoid fever, and hence the thermometer should be used twice a day.

A decrease of the temperature in the morning is favorable, but an increase denotes danger, and if at any time, the temperature, reaches  $109^{\circ}$  or  $110^{\circ}$  the disease may be looked upon as inevitably fatal. In any fever or acute disease a sudden increase of temperature (not so high as in fatal cases,) denotes the occurrence of some severe complication or intercurrent disease. Diminution of the natural temperature of the body is very rare; but it has been observed to precede hemorrhage from the bowels. In the stage of collapse in cholera, the temperature falls 3 or  $4^{\circ}$  below the normal standard. The axillary thermometer is a very useful and reliable instrument, and is of inestimable value to the physician in diagnosis and prognosis, and its low price places it within the reach of all.

**NOTE**—By reference to our advertising columns, it will be seen that Mr. Potter, of Toronto, offers a very reliable instrument for \$3. If any of our subscribers should wish one, they may enclose the amount to us and we will make a selection and forward it by post or express.

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### THE MEDICAL SCHOOLS OF TORONTO.

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It will be seen by the advertisements in our columns, that both Toronto schools have very materially increased the number of lecturers, so as more fully to meet the requirements of the Medical Council. We think that Toronto affords as good facilities for Medical education generally, as any other city on the continent. Students will receive a thorough course of instruction, and there is no necessity for their going elsewhere. A new and interesting feature in the programme, will be the delivery of regular Clinics at the Toronto General Hospital, by the several lecturers connected with the Hospital staff.

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As will be seen from the advertisement, in another column, subscribers at a distance wishing to try the new anodyne, hydrate of chloral, can have a supply for 75c. Owing to the immense demand for it, the price has come down to something like a reasonable figure.

## THE CANADA MEDICAL ASSOCIATION.

This meeting will be held in Ottawa, on the 14th inst., and we trust that there will be a large attendance of delegates and others from the different Provinces, as some very important matters are likely to come up for discussion. The committee appointed at last meeting to prepare a Bill for the establishment of one uniform system of Medical Education applicable to the whole Dominion, will, in all probability, be prepared with a report, and we trust that it will receive that amount of careful consideration its importance demands. It is to be hoped that the state of the finances are not such as to cripple the usefulness of the Association. Complaints are being made that many of the members have not paid their annual subscription. This is not as it should be, and we think it only requires to be mentioned, in order to insure its immediate payment.

We will give a condensed report of the proceedings of the Association, in our next number, which will be published on the 1st of October, punctually. The meeting of the Association has been duly advertised, and arrangements have been made by which return tickets, at half fare, may be secured for all members and delegates who may be desirous of attending.

Application for return tickets should be made to Dr. De-Grassi, Toronto.

## SALAD OIL AS A REMEDY.

For some time past Dr. Knaggs, of England (*Lancet*), has been testing the value of anointing the surface of the body, in infantile diseases, such as Atrophy, Bronchitis, Convulsions, Diarrhæa, febrile disturbances, and all diseases of children in which there is an unnatural state of the skin.

The treatment consists in the application of warm Salad Oil to the entire surface of the body, and wearing a flannel gown or wrapping the child in warm blankets. It may be repeated, say every 4, 6 or 12 hours, according to the urgency of the case. By its use the action of the skin is restored, and the danger of reaction avoided. It is no doubt in part absorbed,

and seems to prevent waste of tissue, and also to increase the bulk of the patient. The above affections are said to yield readily to this course of treatment, and signs of improvement may be noticed in from 20 minutes to 48 hours.

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### ONTARIO MEDICAL COUNCIL.

The examination for Matriculation will take place, in Toronto and Kingston, on the last Wednesday and Thursday of this month (September), at the Grammar Schools of the respective places.

Candidates are requested to give notice of their intention to present themselves, 6 days prior to the examination, such notice to be sent to the Examiner appointed for the place at which the candidate intends to present himself.

Examiners, { A. Wickson, M.A. &c., Toronto.  
S. Wood, M.A., Kingston.

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### OBITUARY.

It becomes our painful duty to record the death of our fellow citizen and brother practitioner, Dr. King. He had been complaining of ill health for some time past, and died after a short and severe illness on Friday the fifth of August, at the early age of 32. The immediate cause of his death was disease of the liver and jaundice. Dr. King was educated in Upper Canada College, and subsequently entered upon the pursuit of medical studies under his father, and finally graduated in the Toronto University. Shortly afterwards he went to England and passed a most successful examination before the Royal College of Surgeons, London, and was highly complimented for his attainments. He was for a short time connected with the Medical Department of Victoria College as clinical lecturer. He has been in practice in the city of Toronto for upwards of ten years, and had established a large and lucrative practice. He will be missed very much by his old friends and many poor patients in the city.

## Original Communications.

(To the Editor of the Canada Lancet.)

SIR,—In accordance with your request, I send you the following cases.

Yours faithfully,

W. R. BEAUMONT, F.R.C.S., Eng.,

Senior and Consulting Surgeon to the Toronto General Hospital.

## CASES OF STONE IN THE BLADDER—LITHOTRITY.

Thos. G—, aged 35, from Lucan, Ontario, was admitted into the Toronto Hospital, under my care, on the 3rd of February, 1870, suffering from very acute symptoms of Stone, which began seven years ago by frequent micturition attended at times with pain, the pain, as usual, being greatest after micturition, and more by day than by night, and felt chiefly along the urethra and in the glans. Another strongly marked symptom was the occasional stoppage of the stream of urine when the bladder was but partially emptied, and another was hæmaturia after riding over a rough road, which occurred several times about two years ago, but not since. On admission, there was some chronic cystitis (ropy mucus in the urine). The urino reddened litmus, and contained no albumen.

I directed him to remain recumbent, and to take three times a-day Pot. Bicarb. 1 scruple, Tinet. Hyosce  $\frac{1}{2}$  drachm.

Feb. 8th —A small calculus lodged this morning immediately behind the meatus externus, which I cut, in order to extract the stone, being unable to break it with a small urothral lithotrite. It had caused complete retention of urine for many hours. The incision of the meatus had the double advantage of allowing the removal of the small calculus impacted behind it, and also of preventing fragments lodging there after lithotripsy. I have twice had to incise the meatus before performing lithotripsy, and the best instrument for the purpose is a small lithotomic cache.

On Feb. 12th, I performed lithotripsy, the patient having held his urine between 3 and 4 hours. I used the flat bladed lithotrite, recommended by Sir Henry Thompson. It is made by Weiss, of London, and seems as perfect as a lithotrite can be, the sliding movement being instantly changed to the screw movement, and, *vice versa*, the screw to the sliding movement; but it has not sufficient power to crush a rather large and hard stone. It was as much as I could do, in this case, to crush the stone, which measured  $\frac{7}{8}$  of an inch in the diameter seized. I then crushed six fragments. There was not a tinge of blood,

and he suffered no very great pain during the operation and none afterwards, nor was it followed by any rigor or acceleration of the pulse.

I directed him to take immediately *Liq. opii. sed. M* 10, and to remain in bed, voiding his urine whilst lying supine for two days, to prevent fragments passing whilst the urethra might be a little tender.

Jan. 19th—(second operation)—I used the same lithotrite, crushing ten fragments, two of which measured nearly  $\frac{7}{8}$  of an inch in diameter. There was no tinge of blood, and no rigor followed.

Feb. 24th—(third operation)—I again crushed ten fragments (not so large as the others). He had passed many pieces and pulverised stone, and said he had been much easier, and could hold his water longer.

Feb. 26th—(fourth operation)—I again crushed ten fragments. There was no tinge of blood, and less pain than during the first operations.

March 2nd—(fifth operation)—I crushed ten very small fragments, the largest  $\frac{3}{4}$  of an inch in diameter. There was no blood, and scarcely any pain. The urine for some time past had been free from mucus, and micturition not abnormally frequent.

March 5th—(3 weeks after the 1st operation)—I examined him with a lithotrite, but could detect no fragment. He said he was quite free from any uneasiness about the bladder, and his strength much improved. Before the operations he was afraid to make an incautious step; at this time, three weeks after the first operation, he had no pain from violent concussion of the body.

Between two and three months after leaving the hospital, he wrote to say that he remained quite well.

Considering the size of the stone, its long continuance in the bladder, and its hardness (most of the fragments looking like oxalate of lime), this was one of the most satisfactory cases of lithotrity one could have.

CASE 2—Another very satisfactory case of lithotrity I had in the hospital in September, 1868. Joseph P—, aged 22, an out patient, had a small calculus lodged in the urethra, near the neck of the bladder, which several times caused total retention of urine, which was relieved almost daily for about a week by Dr. Hampton.

On September 28th I was asked to see him, when I pushed the stone back into the bladder, and crushed it, using a small lithotrite (the old fenestrated form, as I had not then Weiss's improved instrument). There was no tinge of blood, and no pain. He walked home immediately after, passed the fragments the next day, and remained well a long while afterwards when I last heard of him.

CASE 3.—Wm. T.—, aged 58, a private patient in the Hospital, was admitted Feb. 13, 1869, having had severe symptoms of stone for about two years or rather more. The urine reddened litmus, and contained a little mucus, but no albumen. The meatus of the urethra was so small that I had to divide it, and then a large lithotrite passed easily into the bladder. In this case I had to operate 15 times, and crushed about 100 fragments most of them seemingly phosphatic. After the second operation he complained so much of pain that I had to give him chloroform, and a most enormous quantity was used, usually 4, 5 or 6 ounces, before he became insensible. He is the only patient to whom I have ever found it necessary to give chloroform when performing lithotrity. The first operation was on the 22nd of February, and the last on September 29th, 1869, (seven months from first to last) but this arose from his leaving Toronto several times, and staying away a long time. It was, owing to the great irritability of the bladder, a most troublesome case, but he left the Hospital a few days after the last operation, saying that micturition was no longer frequent or attended with pain.

He wrote to me about four months after, saying that he was "quite smart, and thought there was no stone left."

#### TORONTO HOSPITAL REPORTS.

During the past two months, there has been a good deal of Typhoid Fever in the Toronto General Hospital.

The disease has not presented any very special features, being rather low in type in a few instances, and in all requiring liberal support and more or less stimulation. The Diarrhœa has been found troublesome in a few cases, and in one, no doubt from ulceration of a blood-vessel, death took place from Hemorrhage.

Milk diet, with beef-tea, rice and corn starch were the principle means of support; and whisky judiciously given with the food, in quantities varying from  $\mathfrak{z}\text{iv}$  or  $\mathfrak{z}\text{vi}$  to  $\mathfrak{z}\text{xii}$  or even  $\mathfrak{z}\text{xviii}$  in 24 hours, according to the necessities of peculiar cases.

As medicine, Tonics have been freely used, combined with Anodynes and Diaphoretics, Quinine, in gram doses, with Nitrate of Potash or Chlorate of Potash; and Tinct. of Opium, in doses of v. to x. drops, is a favorite plan with some; while in cases evincing much ulceration of the bowels, *Ol Terebinth* is often added, in 4 or 5 drop doses to the mixture. This stimulates gently, and appears to promote the restoration of a healthy state of the mucous membrane, besides acting beneficially where there has been congestion of the vessels of the lung, as not unfrequently occurs.—*Cor.*



# VICTORIA UNIVERSITY.

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S. S. NELLIS, D.D., PRESIDENT.

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THE NEXT SESSION  
OF THE  
MEDICAL DEPARTMENT  
WILL OPEN  
THE 1st OCTOBER, 1870.

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## Faculty:

- W. CANNIFF, M.D., M.R.C.S., England, Principles and Practice of Surgery.  
NORMAN BETHUNE, B.A., M.D., Edinburgh, M.R.C.S., England, and F.R.C.S.,  
Edinburgh, Principles and Practice of Medicine.  
CHARLES VALANCE BERRYMAN, A.M., M.D., Materia Medica and Medical  
Jurisprudence.  
JOHN N. REID, M.D., Physiology and Microscopy.  
JOHN HERBERT SANGSTER, A.M., M.D., Theoretical and Practical  
Chemistry.  
JOHN FULTON, M.D., M.R.C.S., England, and L.R.C.P., London, Associate in  
Physiology and Lecturer on Sanitary Science.  
ELI JAMES BARRICK, M.D., M.R.C.S., England, L.R.C.P., London, L.R.C.P.  
and L.R.C.S., Edinburgh, Lic. Mid. R.C.S., England,—Midwifery.  
J. N. AGNEW, M.D., Diseases of Women and Children.  
RICHARD A. REEVE, B.A., M.D.—Botany.  
JOHN A. MULLIN, M.D., Descriptive and General Anatomy.  
J. ALGERNON TEMPLE, M.D., M.R.C.S., England, General Pathology and  
Medical Diagnosis.  
ARCHD. E. MALLOCK, B.A., M.D., Glasgow, Demonstrator of Anatomy and  
Lecturer on Surgical Anatomy.  
A. M. ROSEBRUGH, M.D., Diseases of the Eye and Ear.  
S. P. MAY, M.D., Pharmacy and Curator of the Museum.  
Clinical Medicine, Surgery, and Ophthalmology, by the Faculty.

For further information apply to Dr. Canniff, 111 Church St.; or the  
Secretary, Dr. BERRYMAN, William St., Yorkville.