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WINNIPEG, JANUARY, 1878.

NOTES ON A RARE CASE OF  
BULLET WOUND OF THE  
PELVIS, INVOLVING  
THE RECTUM.

By HENRY HARGOOD, M. D., L. R. C. P., etc., Surgeon  
to the Hospital.

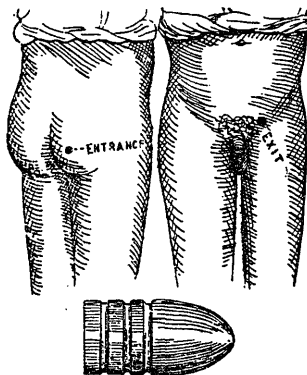
P. J., a married man, aged 21, was admitted into the Princess Alice Memorial Hospital, Eastbourne, under my care, on July 19th last, suffering from a bullet wound of the pelvis and left hand.

It appeared that whilst searching on the sands for a missing tobacco pipe, and taking no particular care where he went, he had wandered ten yards within the line of danger flags, placed behind the rifle butts, at the time the volunteers were practising with the Martini-Henry carbine. He was about 600 yards distant from the firing party, in a line with the butts, and standing at the bottom of a slight declivity; consequently he was out of sight of the marksmen.

Whilst stooping down with his back towards the butts, and his left hand in his trouser pocket, he was struck by a bullet in the right buttock, three inches to the right of the anus, and an inch and a half to the rear of it.

The bullet passed through the great sacro-sciatic notch, through the rectum, at a point about three inches from the anus, then beneath the posterior part of the bladder, and finally out of the pelvis through the obturator foramen

of the opposite side, emerging through the skin at a point one-quarter of an inch to the inner side of the femoral artery. It then passed through the ball of the left thumb, opening the metacarpo-phalangeal joint, thence through the metacarpo-phalangeal joint of the middle finger, the bones of which joint were considerably comminuted, and the soft structures badly lacerated. Hæmorrhage had not been copious.



On admission patient was suffering from shock and loss of blood. Under ether the course taken by the bullet was traced. The wounds of the pelvis differed but little in character. Arterial blood oozed from the wound in the buttock, and venous blood from that in the groin, its margin being surrounded to the width of three inches by venous extravasation. There was no escape of fæcal matter or urine by the wounds. A finger introduced into the rectum detected two large wounds in its walls, at a spot about three inches from the anus; another finger passed through the wound in the groin and down through the obturator foramen, easily met the finger in the wounded rectum. The lower margin of the body of the left pubic

bone was felt to be denuded of periosteum and grooved by the bullet

Patient was found to be suffering from gleet. The injured finger, with the head of its metacarpal bone, was removed. The resulting wound, together with the wounds in the thumb, was dressed antiseptically. The hand and thumb were then put up carefully in splints. A large, soft catheter was then passed through the anterior pelvic wound and obturator foramen as deep as it would go, and the track of the bullet washed out with 1 to 1,000 perchloride of mercury solution. No drainage tube was left in, as it was thought that the posterior wound would drain itself, and the anterior wound would drain into the rectum. A pad of iodoform wool was placed over each wound, and the patient placed on his back, with the knees bent and supported on pillows.

Nourishment to be strictly liquid. An injection of a quarter of a grain of morphine to be given at once, and one grain of opium in pill to be given every six hours, to subdue pain and keep the bowels quiet. Patient rallied well. Six hours after the accident he complained of great pain in the epigastrium. The abdomen was not distended, but there was some tenderness on pressure all over it. Had passed urine freely that showed no trace of blood. Slight hæmorrhage from the anterior wound. Temperature 100°, pulse 120. To have one-third of a grain of morphine hypodermically, and poultices to the abdomen. Iodoform pads to be changed.

Next morning patient was found to have passed a fairly good night. Abdominal tenderness still present; hæmorrhage less; temperature 100°, pulse 124.

In the evening he had much less pain. Temperature 99.4° pulse 104. Took nourishment well, and was much more comfortable. Morning temperature 98°, pulse 90. Had a good night. A tube was passed through the anus

into the rectum, to see if any pus had collected there, but none escaped. From this time he went on uninterruptedly well until the evening of the seventh day, when his temperature suddenly rose to 100°, and it was feared that pus was collecting somewhere in the track of the wound. There had been no rigor. Before I was able to find the situation of the pus it commenced to escape through the anterior pelvic wound. A small drainage tube was passed deeply into this wound; the posterior wound was found to be nearly healed.

Next morning pus was freely escaping from the drainage tube. Patient was quite comfortable, and asked for solid food. Temperature 97°, pulse 72. He again went on well until the evening of the twelfth day, when his temperature suddenly ran up to 101.8°. This was found to be due to orchitis of the left testicle, which had become swollen, hard and very painful. The urethral discharge had ceased. The drainage tube was removed, both wounds being nearly healed. Four leeches were applied to the scrotum, followed by the ice bag. Morphine (one-third of a grain) injected. Patient passed a quiet night. Morning temperature 99°, pain and swelling much less.

From this date he again went on well in every respect. On the fourteenth day the posterior pelvic wound was found to be healed. The opium was now stopped, and on the sixteenth day, as the bowels did not act, a dose of castor oil, followed by a small enema of olive oil, produced a copious motion, that showed no trace of blood, pus, or mucus. Solid food was now cautiously exhibited, and the patient went on uninterruptedly well, getting up on the twenty-eighth day. By this time both pelvic wounds were healed. A few prominent granulations on the amputation wound in the finger required attention. The

wounds of the thumb had quite healed. The splints were removed, and passive motion commenced in the thumb. The bowels were inclined to be costive, and never acted except under the influence of medicine or enemata. The rectum was examined, and found to be intact, but somewhat contracted at the site of the wounds.

Patient left the hospital on the forty-first day, quite well, having fairly good use of his thumb, and complete control over his bowels. At home he went on well, except that he had three attacks of orchitis in a month, started apparently by over exertion, the urethral discharge having ceased for about a month. The diameter of the motions passed, though smaller than usual, showed no sign of further diminution.

REMARKS.—Amongst the other interesting points in this case are the remarkable escape of the patient from almost instantaneous death by wounding of the femoral artery; the absence of faecal extravasation, and the small amount of constitutional disturbance caused by the injury. The experience of military surgeons tends to prove that, as compared with penetrating wounds of the abdomen, wounds of the pelvis are far less fatal; owing probably to the fact that in some abdominal wounds, the reparative efforts of nature can be assisted by art to a very limited extent only. In penetrating wounds of the pelvis it is obvious that if the great vessels and that part of the bladder or rectum covered by peritoneum escape, the risk to the patient is very much lessened.

In military surgical practice, bullet wounds of the pelvis accompanied by wounds of the rectum are not infrequent, though they are rarely uncomplicated. The injury calls for serious attention, as both the safety and comfort of the patient depend upon the result of the treatment employed.

During the American war, 103 cases

of shot wounds of the rectum were reported, of which 44, or 42.7 per cent, proved fatal. In one instance only was it reported that the bullet passed through the obturator foramen, rectum, and sacro-sciatic notch, but in that case it passed through the obturator foramen first, and the patient died on the thirty-ninth day of secondary hæmorrhage, from one of the inferior hæmorrhoidal arteries.

In forty-six cases concomitant fractures of the pelvic bones were noticed, the osseous lesion being specifically referred to the pubes in eleven cases. By implication, however, the reports indicated the existence of pelvic fracture in a much larger proportion of cases than forty-six in 103.

Pelvic cellulitis, and septicæmia from faecal infiltration, diffuse suppurations, and other consequences of osseous lesions and secondary hæmorrhage from injured branches of the iliac arteries, were the most frequent causes of death. Thirty-four of the cases, of which fourteen proved fatal, were complicated with wounds of the bladder. A large proportion of the cases that recovered resulted in paralysis with incontinence of fæces, or obstinate constipation, stricture, muscular contractions and atrophy, sinuses leading to various parts of the pelvis or recurrent abscesses. Guthrie says, at the close of his classical commentaries, that, "The rectum may be wounded without any other organ being wounded within the pelvis; of this I have seen several instances." Dr. Fehr relates a case that occurred in the Franco-German war, in which a soldier was shot through the right obturator foramen, the bullet traversing the lower part of the rectum and escaping at the great sacro-sciatic notch. Fæces passed through the wound of exit. Death on the eleventh day. Dr. Fehr adds: "The wounded man might perhaps have been saved by the immediate splitting of the external sphincter;

but I never thought of this until after the war, when an analogous case was cited to me which Simon had successfully treated in this manner."

There is little doubt that shot wounds of the rectum have not the grave consequences of injuries of the upper bowels, but are to be compared with injuries of those portions of the ascending and descending colon, uncovered by peritoneum; and though fæcal extravasation outside the peritoneal cavity is not attended with such peril as intraperitoneal effusion, yet it is a grave and ever impending complication in shot wounds of the rectum. In order to obviate persistent fæcal fistulæ following this complication, it is plain that the best possible treatment is to divide the external sphincter at once. In the case I have recorded, this complication was fortunately absent, consequently the operation was not called for.

#### TREATMENT OF TYPHOID FEVER IN THE HOSPITALS OF NEW YORK, BOSTON AND MONTREAL.

##### NEW YORK HOSPITAL.

During the early part of this summer the routine treatment of typhoid fever in Dr. Peabody's wards, if the patient entered during the first ten days of the disease, was a calomel purge immediately followed by naphthaline in doses of ten grains every three hours. The first seven cases died (two having entered the hospital moribund), one of septic infection, one of acute mania, and the three others simply from the intensity of the poisoning, the lesion being very extensive.

Since August 14th we have had but one death in twenty-one cases—two of these are still sick, but doing well—of this number, thirteen have had absolutely no treatment directed to the intestines, eight have had naph-

thaline, and among these the one death occurred.

When the temperature rises high enough to make the daily average about 103°, antifebrin is given, either in large doses at long intervals, or in continuous doses of two grains every two hours during the day, and three grains every three hours during the night. Some patients have had two grains every hour during the day. In no case was any bad result noticed; on the contrary, the patients were quieter, slept better, and temperature, pulse, and general condition were much improved.

Whiskey is given when pulse, tongue, and condition indicate the need of stimulation, the amount varying from three to eight ounces during the twenty-four hours. Fluid extract of digitalis is added occasionally in small doses.

When there is insomnia, it is almost always relieved by morphine, generally given hypodermatically, as so many of the patients have a greater or less tendency to vomiting. In a few cases the bromides, or urethan have been tried, but not with such good results as morphine. In cases of delirium with great restlessness, hyoscin hydrobromate, given hypodermatically in doses of one-hundredth of a grain, has been tried with very good effect. It has been followed by several hours of quiet sleep.

Diet is of milk, patients taking generally from four to five pints daily. If the stomach is at all irritable, milk with lime-water, or peptonized milk is given. Some patients take beef-tea well, and have from one to two pints of this daily in addition to the milk.

In a few cases nourishment by the rectum has been tried for short times, with the effect of relieving an irritable stomach. Laxative enemata are given every other day if patients have no movements from the bowels; and

in almost all of our cases this has been necessary, as patients have been generally constipated, diarrhœa being the exception rather than the rule, during the summer just passed.

Counting three cases not already entered in this report, as they were not here during Dr. Peabody's service, there have been thirty-one cases treated here since last April with eight deaths, a mortality per cent. of almost 26. This very high rate is to be explained partly by the fact that several patients entered late in the disease, and in very bad condition.

#### ST. LUKE'S HOSPITAL.

In Dr. Francis Kinnicutt's wards the treatment is essentially general and symptomatic. During the past several years, when it has been possible to establish the date of the beginning of the disease, occasionally one or more moderately large doses of calomel have been given in the first days of the fever, but never with the result of *aborting* the disease. So many factors are involved, that it is difficult to give a trustworthy opinion in regard to the alleged power of calomel given at the inception of the disease, *at least* to influence favorably its subsequent *course*. Naphthaline given in frequently repeated doses, to the amount of sixty grains daily, has also failed in any abortive effect.

Rest, quiet, fresh air, and a very carefully regulated diet of mixed liquid food constitute the general treatment. Increased fever and intestinal irritation frequently have been observed to follow the ingestion of large quantities of raw milk, and in such cases a reduced amount of peptonized milk has been given.

The symptomatic treatment may be summarized as follows: Urethan is considered by far the safest and most efficient hypnotic. Its not sufficiently well recognized antipyretic properties increase its value. It is given in

doses of thirty to forty grains, repeated in an hour of two, if necessary, to relieve insomnia. Believing that excessive diarrhœa has its source often in the presence of undigested food in and catarrhal inflammation of the bowel in addition to the specific lesion, the stools are carefully examined in such cases. The presence of curds demands a more careful regulation of the diet. A combination of naphthaline and bismuth has been found efficient in controlling the catarrhal inflammation and in correcting fetor.

Recognizing the fact that paralysis of the bowel and thereby obstinate constipation may proceed from a *deep* ulceration, laxatives are not given after the first week or ten days. Small enemata every other day are used to relieve constipation. Since the discovery of the new group of antipyretics, they have been employed, almost to the exclusion of baths in any form, to control what is believed to constitute harmful continuous pyrexia.

The general rule adopted is to give antipyretics only when the temperature reaches 103°. Kairin, hydrochinnon, thalin, antipyrin, and antifebrin have been successively used and their effects very carefully observed. As the result, antifebrin is at present almost exclusively employed. Very exceptionally have any ill effects followed its use.

For combating heart failure, alcohol is chiefly relied upon. Where heart weakness proceeds from degeneration of muscle fibre, a minimum effect may be expected from any method of treatment; if failure is chiefly due to impaired nerve force or influence, which is more often the case, the use of alcohol gives the happiest results. Alcohol is rarely given in the early stages of the disease, very commonly in the third and fourth week. Many cases are treated throughout, without its



employment. Its use is restricted to combat *special* symptoms. Sir William Jenner's rule is largely the guide in its administration. "When in doubt in an individual case of typhoid fever, abstain from giving it; where there is a question of the larger or smaller dose, prescribe the latter."

Dr. Beverley Robinson's general treatment of typhoid fever is expectant; he does not believe that there is any known specific for this fever and is very doubtful as to the power of any drug, in use at the present time, to abort this disease. His treatment naturally depends upon the stage of the malady at the time it comes under his care, and whether it has a tolerably mild course without complications, or whether the disease from the beginning is marked by more than ordinary severity and is accompanied by manifest departures from what is usual, and the complications indicate special severity of the attack, or march of the affection.

The cases of typhoid fever which he has treated during several years past, have been, as a rule, of moderate severity. Diarrhoea has not been very frequent, temperature rarely going beyond  $104^{\circ}$  at any time, and then only during brief periods, heart complications have been occasional, pneumonia rare, and nervous symptoms showing either ataxia, or great adynamia, in relatively few instances; he recalls not more than three or four cases of intestinal hemorrhage.

In the incipient stages of typhoid fever a mild saline cathartic preceded by one or two grains of calomel, or double that quantity of blue mass, is prescribed. Later, and so long as the development of typhoid fever appears doubtful, small doses of aconite, ammonia, and spirit of Mindererus, or neutral mixture, are the means he employs to subdue the febrile excitement. If fever still continues, with marked elevation of temperature in

the afternoon, after a few days, and other symptoms point more surely toward the typhoid state, these agents are abandoned for tonic doses of quinine, milk diet, which is insisted upon, and occasional tepid sponging of the trunk and limbs with lukewarm water and vinegar. Complications are treated as they arise, bronchitis, or pneumonia with tincture of iodine, turpentine stupes, or Corson's paint, to the chest walls; chloride of ammonium, moderate doses of digitalis, and moderate stimulation with whiskey internally. If the heart becomes irregular or notably weak and frequent, or a blowing murmur shows itself at the apex, he now orders tincture of strophanthus in five-drop doses every six hours, besides using mustard poultices or dry cups to the chest, and beginning, continuing, or increasing the alcoholic stimulant. Nervous derangements are influenced favorably by ether in the form of perles, by musk, or by a mixture of lavender, chloroform, ammonia, and camphor. Hemorrhage is controlled with turpentine and opium. High temperature is controlled by antifebrin in five-grain doses, repeated two or more times, in the twenty-four hours, or whenever the body temperature goes beyond  $103^{\circ}$  Fah. in the axilla.

The diet is usually limited to milk during the duration of the fever. This is given to the patient every two hours, as much as he will drink; nausea, or disgust for food, being to some extent relieved by the addition to the milk of lime water, Vichy, or Vals water, or by the alcoholic stimulant administered at the time. If nausea persists and the patient becomes very weak and prostrate, dry champagne is given frequently in small doses. Occasionally, *black coffee* has worked wonders in bringing back to life patients who appeared almost moribund. Solid food, as a rule, is

not allowed until all febrile reaction has been absent at least one or two weeks. When begun, he is now using with favorable results what is known as albumenoid food, which seems to be tolerated by the stomach and bowels more readily than beef peptonoids, or other preparations of a somewhat similar character. At a later period, if the albumenoid food and the beef peptonoids have been well supported, and, especially, if no recurrence of the fever take place, farinaceous food is permitted and a small quantity of the light meats once a day.

In very few patients has he found the necessity at any time to treat their febrile condition by means of *systematic cold bathing*, and he regards this treatment as ill-adapted to the large majority of typhoid fever cases met with in New York City, either in hospital or private practice. Whenever hypostasis of the lungs involves these organs in a considerable degree, he believes frequent inhalations of oxygen gas to be a measure of great practical utility in giving to patients some additional chances of preserving life otherwise imminently imperilled.

#### THE MASSACHUSETTS GENERAL HOSPITAL.

The plan of treatment of typhoid fever carried out in Dr. Frederick C. Shattuck's wards has again become chiefly a symptomatic one. This summer he tried in six or eight cases the administration of naphthaline, eighty grains a day in divided doses, ten grains of calomel being given immediately on admission to the ward. It has been claimed by some that early cases may sometimes be aborted in this way. One patient thus treated, presenting the important early symptoms, recovered in three or four days; and so did another who received no medicine whatever.

Among the points in connection with typhoid fever in regard to which

we are still very ignorant is the question of fact. Does the disease ever abort spontaneously, or in consequence of treatment? Dr. Shattuck gave up the naphthaline treatment because he could not see that in cases in which it received a thorough trial it was productive of any good result, while in two cases it caused strangury, in one other hæmaturia.

This year he has also discontinued the systematic use of internal antipyretics, ordering them only when the temperature is very high and the patient very restless, or, in his judgment, suffering in some other way directly from the effects of the temperature. These indications are seldom present.

Diet.—Six ounces of milk are given every two hours. If this is not well borne lime water is added, or the milk is peptonized; or, if there is no diarrhœa, animal broths are allowed. When the evening temperature reaches the normal point, patients who have been on an exclusive milk diet are given broths, then raw eggs, then light farinaceous articles, and meat is permitted toward or at the end of the first week of convalescence. Stimulants are given in such quantities as the pulse, the tongue, and the nervous symptoms may seem to demand.

In cases characterized by constipation, a large percentage the past two years, a plain water enema is given every second day. For sleeplessness and diarrhœa opium is the main reliance. In intestinal hemorrhage opium is given in sufficient quantity to narcotize the patient, stimulants are used according to the pulse, and ergotine is injected under the skin. To moderate the temperature, stimulate the nervous centres, and to promote the comfort of the patient he is sponged with water at a temperature of 60°–75°, every two hours if the temperature is 103° or more; every three, four, or six hours according to circumstances if it be below that figure. Sometimes

alcohol, or alcohol and water, is substituted for the plain water baths once or twice a day.

It will be seen by the above that the aim in treatment is simply to conduct the patient to recovery, safely and as speedily as is compatible with safety. A certain percentage of patients receive neither drugs nor stimulants, a certain proportion stimulants only, and a certain proportion both drugs and stimulants.

Dr. R. H. Fitz during the past summer made a few attempts in his ward to attest the value of naphthaline in checking or overcoming the progress of typhoid fever. The remedy was used in three grain doses, every two hours during the first week of the fever. There was no evidence that any benefit resulted.

Although given in capsules, nauseating eructations were, at times, complained of, and the size of the capsule was inconvenient. The disadvantages being conspicuous, without any evident corresponding gain, the use of the naphthaline was soon discontinued.

Of the newly discovered antipyretic drugs, antifebrin was the one usually employed when there were special indications for their use. The artificial maintenance of a low range of temperature throughout the course of the disease was not deemed important. If an elevation of 105° F. was reached, a sufficient quantity of antifebrin was given to lower the temperature four or five degrees. The production of chilly sensations was considered undesirable. A single dose of five grains often sufficed, if necessary this dose was repeated at intervals of an hour until fifteen grains were taken. Doses of three grains were found of great benefit in relieving the headache so frequently occurring in typhoid fever. There was no necessarily simultaneous falling of the temperature.

The routine treatment of all cases

consisted in a carefully regulated diet and the use of cold sponge-baths every two hours. The diet was chiefly milk, as nearly four ounces every two hours as possible. If the milk was not well borne, it was pancreatized or mixed with lime water. The use of the exclusive milk diet was maintained until the temperature remained normal for at least a week. Beef tea, strained soups, and broth were then added, and, in the course of three or four days, soft puddings, eggs, and bread.

In the third week of normal temperature there was no restriction as to diet, with the exception that the most nourishing and easiest digested foods were ordered.

Wine or brandy was given after the first week whenever a weak pulse or excessive nervous debility is present.

Dover's powder or morphine, urethan, and chloral were used as hypnotics, the former, where sleeplessness was accompanied with pain, the latter, where pain was absent.

Constipation was a frequent symptom, and was invariably relieved by enemata as often as once in three days. In one case, irrigation of the colon, twice daily, became necessary. During convalescence a change of diet was often an efficient means of insuring a normal evacuation.

Profuse diarrhoea was controlled by liquid preparations of opium, and intestinal hemorrhage was checked by ten minims of laudanum every two hours.

#### THE MONTREAL GENERAL HOSPITAL.

The cases of typhoid fever treated in Dr. George Ross's ward include a larger proportion of severe and very severe than perhaps elsewhere—the reason being that, owing to the great prevalence of the disease in Montreal at certain seasons, and to the limited accommodation, it is a necessity to refuse a considerable number and receive only those most urgently requir-

ing care. If we come, therefore, to look at the mortality, this important fact must be borne in mind. Here, any method of treatment which will give results approaching the average in other places, must deserve confidence, seeing that we deal with carefully selected bad cases.

The treatment is based upon what might be called an "intelligent expectancy." The diet is composed exclusively of milk and rice water. The amount of milk consumed daily is not considered immaterial. It is not deemed prudent to allow, as is often elsewhere done, milk *ad libitum*. On the contrary, the daily quantity is strictly limited, in the case of adults, to three pints *per diem*. This amount is found sufficient to meet the wants of the economy, whilst the ingestion of more leads to the danger of accumulation of feces and aggravation of symptoms. The milk is frequently diluted with rice water, or, if thought well, with lime water. When the stomach is weak, benefit is obtained by artificial digestion of the milk, but the great majority drink pure milk and appear to assimilate it without difficulty. It is a rule to nurses to supply cold fresh water or ice water to typhoid fever patients freely, and, during the height of the fever, pellets of ice to suck. When a patient is delirious or unable to make known his wants, he is still to have cold water given him frequently and freely. It is believed that strict attention to this apparently simple item is really a matter of considerable importance. It is a fixed rule to allow no change from a milk diet until the patient's temperature has been normal both night and morning for at least eight consecutive days. During the early stages, and until a material fall in the temperature has taken place, cold sponging of the entire body is carried out every three or four hours, as the case may require; and constant cold

is applied to the head by means of a coil through which ice water flows. These measures are relaxed as the temperature falls and the symptoms improve.

In the mild cases, or even in those of moderate severity but running a course approaching to the type, alcoholic stimulants are not given, except in small quantities during the latter stages; but in all those showing a higher grade of fever, as marked by an elevated temperature and signs of vital depression, whiskey and brandy are employed in amounts varying with the special indications of the case. When the prostration is marked, and the nervous symptoms severe, stimulants are given freely.

As regards medicines, a favorite prescription is one containing gr. ij each of acid. carbol. pur. and tinct. iodin., well diluted in water every two hours. It is a rare occurrence to meet with discolored urine from this remedy. No striking results follow its administration. In the later stages, quinine in tonic doses, with or without digitalis, is given. When a case is seen sufficiently early, a full purgative dose of calomel is found to be useful in unloading the *primæ viæ* and preparing for the siege. We find a large proportion of our patients constipated rather than suffering from diarrhoea. The bowels are never allowed to remain quiescent for more than three days at most. More generally two days only are allowed between evacuations, which, if necessary, are obtained by means of enemata. These are greatly preferred to laxative medicines. In approaching convalescence, great caution is exercised in administering a purgative, since rapid elevation would seem sometimes to follow directly after even a dose of castor oil. The presence of prominent symptoms often leads to the medicinal treatment being, for the time, entirely directed toward counteracting them.

For instance, if there be marked gastric irritability, bismuth, bicarbonate of soda, and such like drugs, with effervescent, are given. If the case be especially marked by bronchitis and pulmonary congestion, turpentine in emulsion is relied upon. If tympanites be considerable charcoal is found very useful, sometimes turpentine, together with limitation of the food for a time, and attention to the bowels. If muscular tremor, delirium, and insomnia are a marked feature, such remedies as camphor, valerian, and ammonia are given at frequent intervals. Of the complications, hemorrhage is treated by ice, gallic acid, digitalis, or lead and opium, and the external application of an ice-bag. In peritonitis (without perforation) opium is given in moderate doses, and without any bad effects. When perforation is known to have occurred, hypodermatic injection of morphia and hot applications.

The use of quinine in antipyretic doses, during the active stages of fever, has been entirely abandoned. In some of those unaccountable "excursions" of the temperature which we are apt to witness during commencing convalescence, full doses of quinine are used with very good effect. Of other antipyretics, antifebrin has had a moderate trial in this disease, by some members of the staff. The conclusion arrived at seems to be that the sudden depressions of temperature produced by the drug do not in any way modify the course of the fever, which only subsides at the same time as if this had not been employed. In some cases, decided antipyretic action could not be obtained from it. In others, its ill effects, cyanosis and cardiac depression, were witnessed, but not to an alarming degree.—*Medical Surgery.*

#### DR. KEITH'S REMARKS CONCERNING THE METHODS OF TREATMENT OF UTERINE TUMORS.

The discussion which has been going on about this question for the last few years, culminating not unfitly in a short paper, by Dr. Keith, has done much good, and there seems to be now a tendency towards certain agreements greater than there has been at any time before.

One conclusion is certain, that we have finally got quit of the old idea that uterine myoma is a disease that may be safely left to itself, requiring no treatment. Women, "deaf and blind from anæmia," will no longer, I trust, be told that they have only a lump in their womb, of no consequence. I begin to suspect that myoma is increasing in frequency, and is a more serious disease than it was forty years ago.

Another conclusion, indicated as being arrived at in common, is a dislike to hysterectomy. For a long time I had a heavy mortality in this operation—I could get no instruction from the master, and I condemned it. Now I have found out how to do it, and my mortality is less than Dr. Keith's; yet I do not love the operation any the more, and I never undertake it without the greatest reluctance. I have already placed on record the fact that my mortality was largely due to efforts made to develop the intraperitoneal method of dealing with the pedicle, and my recent success is due to using the clamp entirely. Here Dr. Keith and I differ.

In one other matter Dr. Keith and I differ *toto celo*. "In abdominal surgery responsibility seems to have become old-fashioned and gone out of date." On this side of the Tweed we find responsibilities fixed upon those who practice abdominal surgery, and canons of criticism applied to them

which are not imposed upon any other department of the art of surgery.

Another difference between us is the importance upon which Dr. Keith insists for the removal of the ovaries for the treatment of uterine myoma. I find removal of the tubes quite enough, and I often leave the ovaries altogether, getting a perfect and permanent result. There must be some explanation of this curious discrepancy, and I think I have found it. The evidence on which the whole discussion rests will be given at length in a book now getting ready for the press.

Dr. Keith's success in enucleating uterine tumors comes as a surprise to me. He says "there is a secret in the doing of it," but so far he does not tell us anything about it we do not know. What is the secret?

But the great point of Dr. Keith's important paper is the evidence he gives for at least the primary success of Dr. Apostoli's treatment. With such a witness the conclusion is inevitable, that the treatment must be tried, no matter what difficulties may be encountered in the task. It has, however, become to me again clear, since I wrote last on the subject, that it is not a method to be applied as indiscriminately as its author advises, and it is quite certain that it is not every case of myoma that is suited for it. I have recently operated on two cases (in addition to one previously alluded to) which have been made much worse by electrolytic treatment.

Finally, there is the difficulty indicated by Dr. Keith, that the benefit may not be permanent. Probably this will be the case in a proportion more or less extended, and we know that for them there remains the removal of the appendages, which, when effectual, has always a permanent result.

LAWSON TAIT, F. R. C. S.

## POISONING BY COCAINE ADMINISTERED SUBCUTANEOUSLY.

BY BERNARD PITTS, M. C.

With reference to the annotation in *The Lancet* of Dec. 3rd, on Poisoning by Cocaine, the following case may prove of interest. I am indebted for the careful notes to Mr. Calvert, assistant house-surgeon to St. Thomas's Hospital. My attention was called to the case in the out-patient room by Mr. Calvert as one of cocaine poisoning. At first sight the patient's condition suggested the probability of a nervous attack, but it was soon obvious that this was not a sufficient explanation. The symptoms shortly afterwards became alarming, and gave rise to grave apprehension as to the result. There is no reason to suppose that the injection in this case was made into a vein, and the preparation of cocaine was the same as had been used in other cases in the out-patient room. The drug is now in very general use for minor operations, and few cases have been recorded where toxic effects have ensued. I have several times noticed slight indications of constitutional effect, but used the drug oftentimes much more freely than in this case, without anxiety. I can now no longer regard the drug as free from risk, and shall be more cautious for the future, especially when the patient has not had the drug tried on him before, for there must doubtless be some peculiar idiosyncrasy in the subject when such marked symptoms arise.

The patient, a boy aged thirteen, came to the out-patient room at St. Thomas's Hospital on Saturday, Oct. 22nd, suffering from a suppurating sebaceous cyst situated in the middle of the forehead. This had previously been opened by a local practitioner some time prior to his application at the hospital, but the incision having

healed the matter had reaccumulated. It was therefore decided to evacuate the contents and scrape out the interior of the cavity under cocaine. For this purpose two grains of hydrochlorate of cocaine were dissolved in thirty-five minims of water, and of this solution twenty-five minims were injected through two punctures, one on each side of and close to the abscess cavity. The solution was injected at 2:30 p.m. Within five minutes of the injection, the patient became pale and very restless, with hurried respiration and a rapid pulse (120). The abscess was quickly incised, the contents evacuated, the interior scraped, and the wound dressed. The symptoms shortly afterwards became alarming. The patient was exceedingly restless, constantly shifting his position, throwing his arms and legs about, and wringing his hands. The heart's action became tumultuous; the pulse at the wrist was irregular, rapid, weak, and almost imperceptible; the respirations were rapid, shallow and irregular; and the pupils were dilated. The patient appeared in great distress; removed his collar and unbuttoned his shirt, so as to expose the chest. Meanwhile, half a drachm of aromatic spirit of ammonia was administered, and, the symptoms continuing, the dose was repeated a few minutes afterwards. Nausea and retching, with eructations, set in at 3:15 p.m., the patient complaining of great pain in his "stomach." This pain was markedly increased on firm pressure over the epigastrium, but was relieved by friction. Half an ounce of brandy was administered, and friction applied to the epigastrium. The patient's condition improved: the pulse, though rapid, became stronger, and the respiration slower and more regular. The dose of brandy was repeated, and a mustard poultice applied to the epigastrium for fifteen minutes. The symp-

toms at 4 p.m. continued as before, but were less marked. The patient still complained of pain in his stomach, and lay on his left side with his legs drawn up. He said "he felt better," and was not so restless. At 4:45 p.m. he was removed to the ward, placed in a warmed bed, and hot bottles applied to his feet. He now improved rapidly. He was sick and vomited before 6 p.m., after which there was little to record.

The patient never lost consciousness, and was quite rational when spoken to throughout the persistence of the symptoms. The local anæsthesia was certainly not well marked at the time of the operation; afterwards it was not tested. Taking twenty-five minims of the solution as injected, this would give one grain and a half of cocaine, but owing to some of the solution being spilled and some escaping from the punctures on withdrawal of the syringe, it is in excess of the amount actually injected.

#### THE ILLNESS OF THE CROWN PRINCE.

BY SIR MORELL MACKENZIE.

So many misstatements have been made in various quarters as to my views concerning the case of His Imperial Highness the Crown Prince of Germany, that I have not thought it of any use to attempt to correct them. The *Journal*, however, has hitherto been so accurate in its reports, and has always placed the facts of the case, and my own position, so fairly before the profession, that I must ask you to allow me to correct a serious, though doubtless unintentional, misrepresentation which appeared in your note under the above heading, at page 1292, in your issue of December 10th. It is there stated that "It is quite permissible to entertain hopes that the clinical opinion first formed by Sir Morell Mackenzie, based on the ap-

pearances of the throat, when he first saw the Prince in Berlin, and during His Imperial Highness's residence in England, may yet prove to be correct." The fact is that when I arrived in Berlin, I gave it as my opinion that the appearances were negative; that is, that they were compatible with the growth being either malignant or benign. I therefore suggested that a portion should be removed *per vias naturales*, for microscopical examination, and the treatment which I finally recommended was based on the clinical aspects of the case, plus the results of Professor Virchow's microscopical examination.

I may add that as after Dr. Virchow had made his report the proposed line of treatment was unanimously agreed to by those present at the consultation, all my colleagues were equally responsible for the views entertained at that period. There is no reason, therefore, why I should be singled out as having formed a "clinical opinion," or indeed as having arrived at any opinion different from that of my German colleagues. The only difference which existed was the different opinion held by my *confreves* before my removal of a portion of the growth and reception of Dr. Virchow's report thereon.—*British Medical Journal*.

#### COMMUNICABILITY OF SYPHILIS THROUGH THE SALIVA.

With regard to this, von Zeimssen, in his recent work on *Skin Diseases*, says, in speaking of tattooing: "Repeated infections with saliva have occurred, in consequence of the habit of moistening the needle with saliva, so as to make the pigment stick." It is not, I presume, to be inferred from this that in every case of constitutional syphilis the saliva is infective, but rather that, in all cases where the disease has been communicated

through the saliva, "mucous patches" exist either on the mucous membrane of the mouth or on the tongue, the "highly contagious" secretion from which, mingled with the saliva, is directly inoculated.

D. LECKIE, M. B., Surgeon-Major, M. S.

With reference to the case described by Surgeon Porter, in the *Journal* of December 10th, it may be interesting to him to know that there is at present an exactly similar case under my care in the Station Hospital, Glencourse, except that the tattooing was done on both forearms, and on each forearm there is a large chancre, about the size of half-a-crown. In this case the axillary glands on the left side became inflamed, and suppurated, from the primary irritation, before there were any local signs. Both men, privates in the Seaforth Highlanders, were in hospital together—the one with well-marked tertiary symptoms, since discharged; the other, his victim, a robust young soldier, who never had venereal disease in his life before, still remains under treatment. The same process of communication was shown to have taken place, the operator having spat upon the punctured part during the tattooing. No doubt was entertained as to the nature of the disease when the history was ascertained. The sores are healing kindly under specific treatment. Such evidence of communicability through the saliva points to measures of prophylaxis.

P. M. CARLETON, M. D., Surgeon, M. S.

#### COW DISEASE, AND ITS RELATION TO SCARLET FEVER IN MAN.

BY PROFESSOR EDGAR CROOKSHANK,  
M. B.

Of the Bacteriological Laboratory, King's College,  
London.

Though the investigation which I bring before you to-night is not yet complete in many details, I feel that,



as the subject is of such great public importance, and information is awaited with keen anxiety in the agricultural world, it is right that an account of what has so far been done should at once be published, especially as the evidence which has already come to hand has forced me to come to definite conclusions. I would add, I feel strongly in investigations which are so strictly pathological, that the assembly to whom the results should first be made known is this Society. I desire, therefore, most cordially to express my indebtedness to Professor Brown, of the Agricultural Department of the Privy Council, for giving me permission to lay this matter before you, and to you, sir, for having enabled me to do so without any delay.

*Origin of the Investigation.*—I will ask you first of all, sir, to allow me to remind you of the circumstances which have led to a searching inquiry being instituted by the Agricultural Department of the Privy Council into a disease in cows and its relation to scarlatina in man.

*Scarlatina in Marylebone.*—On December 18th, 1885, Mr. Winter Blyth reported to the Local Government Board a sudden and extensive outbreak of scarlatina, which was associated with the distribution of milk by a particular retailer in South Marylebone. The retailer procured his milk from two farms, and there can be little doubt that the milk responsible for the outbreak was derived from a certain dairy farm in Hendon. Mr. Blyth and the medical officer of health for Hendon, Dr. Cameron, were unable to obtain any clue as to the source of infection, and Mr. Power was deputed by the Local Government Board to make an enquiry into the matter.

*Mr. Power's Diagnosis.*—Mr. Power having come to the conclusion that

the milk had not become infected from any human source, proceeded to investigate the condition of the cows. A careful examination was made, with a view to detecting any disease among the cows, and it was discovered that there were several on the farm which were suffering from a disease characterized by the appearance of vesicles and ulcers on the teats and udders. At this stage Dr. Klein became associated with Mr. Power in the inquiry, and we are told that their belief in the existence of a constitutional disease among the cows on the farm, capable of producing scarlatina among human consumers of the cows' milk, became unreserved. Dr. Klein took with him samples of milk, contents of vesicles, and discharges from ulcers, and afterwards two cows were purchased and conveyed to the Brown Institution. At this stage of the inquiry a cowman pointed out to Dr. Klein that he had seen the disease on a certain cow, which was one of a batch that had been imported on Nov. 15th from Derbyshire.

*Dr. Cameron's Account.*—In a paper before the Epidemiological Society, Dr. Cameron gave a detailed description of this cow disease. He pointed out that it was a specific contagious and infectious disease, capable of being communicated to healthy cows by direct inoculation of the teats with virus conveyed by the milker from a diseased animal. Further, he pointed out that the disease was communicable to man.

*The Disease in Man.*—A trusty informant received the virus into a recent scratch on the forefinger while milking a diseased cow. General weakness, *malaise*, and loss of appetite resulted, and after about four or five days a vesicle or small blister appeared on the finger. This broke, and several others formed on the back of the hand. The whole hand and

fingers became swollen and inflamed, the inflammation extending in broad lines as far as the elbow. The general disturbance lasted a fortnight.

*Symptoms in the Cow.*—Dr. Cameron regarded the disease in the cow as constitutional, and he pointed out the occurrence of initiatory fever, cough, sore throat in severe cases, discharges from the nostrils and eyes, eruption on the skin round the eyes and on the hind quarters, vesicles on the teats and udders, and visceral lesions.

*Character of the Eruption.*—The condition of the teats is described as follows: The teats became enlarged, swollen to nearly twice their natural size, and œdemateous. On fingering them there was no feeling of induration. Vesicles or bullæ then appeared on the swollen teats and upon the udder between or near the teats. These varied in number from two to four on a teat and in size from a pea to a horse-bean. The vesicle contained a clear fluid. The vesicle, Dr. Cameron adds, was not preceded by a hardened papule, but was in the first instance a vesicle or bulla. The vesicles were rubbed and broken on milking and left raw sores, sometimes red, in other cases pale in color with raised ulcerated edges. Sometimes a few accessory vesicles formed around the margin of these ulcerated sores. After the rupture of the vesicle a brown scab formed, which might remain attached for five or six weeks or fall off in ten days or a fortnight, a smaller one forming afterwards. A thin watery fluid exuded from under the scab, and the sore ultimately healed. Many scabs varied in size from a shilling to a florin; they were about one-eighth of an inch thick in the centre, thinning off towards the edges. When picked off the recently-healed skin was of a pearly-blue color, with slight tendency to bleed when the scabs were forcibly detached. According to Dr. Cameron, there was no depression of the vesicle

or pitting of the skin. The swelling of the teat gradually subsided.

*The Micrococcus of Scarlatina.*—To search for micro-organisms, Dr. Klein removed the crust from an ulcer on the teat, scraped off the most superficial layer, squeezed the ulcer, and made cover-glass preparations with the exuded lymph. Tubes of nutrient gelatine and nutrient agar-agar were also inoculated. Dr. Klein succeeded in isolating a micrococcus which, after three to six days at 20° C., formed at the line of inoculation small points or granules, whitish in color, and tolerably closely placed. In the depth of gelatine the channel of inoculation was visible as a whitish streak, made up of smaller and larger droplets. The gelatine was not liquefied. Cultivated in milk and incubated for two days at 35° C., the milk was turned solid. Microscopic examination of a culture showed that there were micrococci, diplococci, and shorter and longer chains. In both, after two or more weeks' incubation, very long chains were formed. The micrococci showed a peculiar mode of division. The chains showed branchings, and here and there in a chain the presence of a large element amongst the smaller ones.

*Inoculation with Cultivations.*—Dr. Klein inoculated two calves in the groin with the cultivated micro-organism. One calf died in twenty-seven days. No ulcers resulted, as after inoculation with the scraping of the sores; but at the necropsy there were found peritonitis, hæmorrhagic spots on omentum, congested liver, kidneys and lungs, petechiæ under the pleura, and pericarditis. In the second calf, on the nostrils and lips, and in the hard palate and gums, numerous irregularly outlined patches were seen. They were discolored, brownish, with a very slightly raised margin, and a paler centre. This animal was killed, and at the necropsy there were con-

gested lungs, kidneys, and hæmorrhagic patches on the spleen. Thus in neither of these cases was a real ulcer produced as the result of the inoculation of the cultivated organism, but the *post-mortem* appearances and anatomical features recalled to Dr. Klein the lesions of scarlatina. In the kidney, for example, there were congestion of the cortex, hæmorrhages and glomerulo-nephritis, and granular or opaque swelling of the epithelial cells and infiltration with round cells. From the blood of the heart, the micrococcus which had been used in the inoculation was recovered. In view of this evidence, Dr. Klein concluded that the streptococcus was identical with the virus of the cow disease, and that it produced a disease very closely resembling that of scarlatina. In a paper read before the Royal Society, Dr. Klein describes how the work was carried on during 1886-1887. Dr. Klein found in the blood of human scarlatina that a micrococcus was present in four out of eleven cases. The micrococcus proved to be identical in its microscopical appearances and its characters on cultivation with the micrococcus found in the Hendon cow disease. And by inoculation with a cultivation of the scarlatina micrococcus, he states that a cutaneous and vesical disease resulted, which was identical with that produced in the calves infected with the micrococcus from the Hendon cows.

*Dr. Klein's Conclusion.*—In conclusion, Dr. Klein says, "it must be evident from these observations that the danger of scarlatinal infection from the disease in the cow is real, and that towards the study and careful supervision of this cow disease all effort ought to be directed to check the spread of scarlet fever in man."

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MANITOBA, NORTHWEST AND BRITISH COLUMBIA LANCET.

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By the departure of Dr. Kerr to practice his profession in the city of Washington a blank occurs in professional and social circles in Winnipeg which will take a long time to fill up. Dr. Kerr, though a comparatively young man, has attained a position among the surgeons of the Dominion which in the centres of Europe is only accorded to those who have long toiled among the juniors of the profession and won their way step by step with advancing years to positions of prominence and trust. Competing with those of his own age, he outstripped them all, and has been long regarded as the most skilful surgeon in this portion of the Dominion. The assiduity and unwearied enthusiasm which he devoted to his professional work won for him the respect of his confreres, while he evoked a warmer feeling from the students of Manitoba Medical College to whom he was not only a painstaking teacher, but a kind and generous friend, anxious for their educational advancement and desirous of promoting their professional and social welfare. His loss to the Medical School as described by one of his colleagues is well nigh irreparable. A series of banquets was given to Dr. Kerr on the eve of his departure, and the eulogistic terms in which every one present at these gatherings spoke of him, must be to him a pleasant, never-to-be-forgotten reminiscence.

A man may well be proud who can command such sincere testimony, not alone to his abilities as a professional man, but to his moral and social worth. His future career will be watched with keen interest by his many friends in Manitoba, who are all confident that those talents which he gained for him the high position which he held in this Province will bear him

onward to greater honor in the land of his future labors. Dr. Kerr, after graduating from the Queen's University, Ireland, in 1870, was appointed surgeon to No. XII. transport employed in the Gold Coast expedition. After settling in Winnipeg he was appointed Surgeon to the Canadian Pacific Railway, Superintendent of Health for the Province, Health Officer for the City of Winnipeg, Dean of the Faculty of Physicians and Surgeons of Manitoba, Professor of Surgery, Surgeon to the Winnipeg General Hospital, and Consulting Surgeon Indian Department.

### THE MANITOBA MEDICAL COLLEGE.

The students of Manitoba Medical College gave a banquet at the C. P. R. dining rooms during the Christmas recess to a large number of guests. Ample justice having been done to an excellent menu, toasts and speeches became the order of the evening. So numerous were these that the small hours had long passed before the festive gathering broke up. The hosts were indefatigable in their endeavors to make the evening as pleasant as possible to all present, and most successful were their exertions. It was a pleasure to see the *entente cordiale* that existed between teachers and students, who seemed never to weary in praise of each other. It augurs well for the future of the profession in this Province that these young gentlemen have thus early grasped the fact that the promotion of sociability and interchange of kindly feeling is a duty we all owe; the closer the profession is knit together the greater will be their success and the more certain the advancement of its members. The school is to be congratulated on the class of students now composing it. The teachers have excellent material to work with, and if they fail

not in their duties the future surgeons and practitioners of this Province graduating at Manitoba University need not take a back seat when meeting with conferees of other colleges.

### MISCELLANEOUS.

**NAPHTHLIN, C<sub>10</sub> H<sub>8</sub>.**—To most fungi naphthalin has been found to be a powerful poison, and has proved very valuable as an antiseptic, being applied in the same manner as iodoform. Professor Rossbach, of Jena, first administered it internally in cases of acute and chronic enteric catarrh, in typhoid fever and acute gastro-intestinal catarrh. It has since been extensively applied, but not with absolutely uniform results. It is given as a powder in wafer in doses of 2 to 8 grains, to which a drop of oil of bergamot is added to obliterate the peculiar smell of tar belonging to it, which makes it otherwise impossible for some patients to take it. For example the following formula may be adopted:—

Naphtalin.

Sacch. alb. . . . . aa 30 gr.

Ol. bergam. . . . . 1 gr.

Make a powder and divide into ten doses, one to be taken three times a day. Naphtalin is a crystalline body forming colorless, resplendent scales; it tastes pungent, is insoluble in water, but sparingly soluble in cold alcohol and fatty oil, but readily if these agents are heated. The solution in oil and the ointments should be made to contain ten per cent. of naphthalin, which must be added to the warm fatty matter. Melting point 176° F., boiling point 424.4°.

**PHOTOXYLIN**—A substance in use among photographers, was recommended some time ago by Dr. Krynski as a suitable material for mounting microscopic specimens, and more recently still it has been utilized

by Professor Wahl, of St. Petersburg (*Lancet*, June 18, 1887), in surgical practice. A five per cent. solution in equal parts of alcohol and ether he finds preferable to collodion, as it adheres more firmly to the skin, not being so easily rubbed off in washing. It is absolutely impervious to liquids, and exerts a perfectly even compression on the tissues.

*THE Gaz. des Hopitaux* publishes a communication from Dr. Sollaud, of the French Navy, on the beneficial effects of a sulphurous atmosphere in pulmonary phthisis. The test was made on a sergeant having pronounced symptoms of this disease, to whom was intrusted the fumigation of the rooms of two large barracks occupied by marine infantry. Part of the operation consisted of burning large quantities of sulphur in each of the dormitories, all orifices being hermetically closed. After thirty-six hours the sergeant with a couple of soldiers proceeded to open the doors and windows; which had to be done rapidly, for the air within was thoroughly saturated with sulphurous fumes. At first the fumes caused much distress and aggravation of the cough, with a burning sensation down the throat and windpipe; but, on persevering, the painful symptoms gradually disappeared, and the sergeant was able to move about, without inconvenience, in the densest sulphurous atmosphere, and soon derived great benefit, with amelioration of all the symptoms.

M. Blondel proposes, in the *Gaz. des Hopitaux*, the employment of albuminate of iron in certain cases of dyspepsia associated with anæmia. The combination of iron and albumen seems well suited to correct the alteration of the blood which is characterized by a decrease in quantity of its albumen. M. Blondel administers this medicament in the form of *liqueur de Leparade*, in which the syrup of orange, itself useful in relieving

atony of the stomach, is the vehicle in which the albuminate of iron is mixed. The dose is one tablespoonful (containing five centigrams of the metal) after each meal.

ARSENATE OF LITHIUM is recommended by Dr. Martineau, in diabetes in the following form: carbonate of lithium, 3 grs.; arseniate of sodium, 1-10 grs.; carbonic acid water, 2 pints. Solution is effected under pressure. The effervescing liquid is taken mixed with claret, the foregoing dose to last for at least three days, being taken at the two principal meals of the day customary in Paris. No change of diet is necessary. Dujardin-Beaumetz and others are skeptical about the value of this treatment, but it is simple and easy, and when the patient is not dangerously ill, it will do harm to try it.—*Technics*.

SUPRAPUBIC LITHOTOMY. — Dr. T. Svensson, of Stockholm, having practised all the recognized methods of operating for stone in the bladder, has had complete success since he commenced to perform the suprapubic operation for large stones and in severe and complicated cases. He has performed this operation with various objects, and he considers it by no means dangerous in itself if it is only executed with the necessary precautions (in two sittings, with antiseptic methods, a cautious injection into the bladder, &c.). Thus he removed by suprapubic lithotomy, or epicystotomy as he terms it, a stone nearly as large as a hen's egg, from an old man, who was extremely weak, and who was suffering at the time from senile gangrene affecting the foot and the lower part of the leg. A few weeks later amputation had to be performed through the thigh; but the patient was afterwards sent to his home (which was at a considerable distance) completely cured. Dr. Svensson does not invariably perform the operation at two sittings, and he

does not resort to it, of course, in all cases of stone. Lithotripsy at a single sitting, litholapaxy, as well as median lithotomy, always, he considers, present their own indications, which is not the case with the lateral operation. In the performance of suprapubic section, he agrees with Petersen that plugging the rectum, while at the same time the bladder is filled, contributes in a marked degree to facilitate the operation and to render it free from danger. Complete suture of the wound is not generally desirable, but the application of some sutures to the bladder serves to check posterior hæmorrhage, and may be requisite for this purpose. Usually before opening the bladder Dr. Svensson passes a running noose of thread through the wall of the bladder so as to include the line of incision, thus providing a remedy in case hæmorrhage should occur. His experience is that posterior hæmorrhage occurs in an eighth of the cases if sutures are not applied to the wound in the bladder. He endeavors to show that the suprapubic operation is safer than other methods, the patient recovering more rapidly than after litholapaxy, the pain also being very slight. An additional advantage is on the side of suprapubic section; it is available for other affections of the urinary passages, and without some of these diseases would be incurable. He hopes in a subsequent paper to give an account of his experience in the Sabbatsberg Hospital.—*Lancet*.

**EXTENSIVE CONTRACTION OF THE LARGE VESSELS.**—Professor C. Wallis, of Stockholm, reports an interesting case of stricture or contraction of the large vessels. The patient was a girl of thirteen, who was admitted into hospital with chronic nephritis and hypertrophy of the heart. She died suddenly after having left the hospital, where she had been fairly well. She went home on foot, a walk of

about twenty minutes. Before her death she suffered from violent choking sensations. At the post-mortem examination the heart was found to be enormously hypertrophied—as large, indeed, as that of a man. There were no valvular lesions, but there was a marked narrowing of almost the whole of the aorta and of the pulmonary vein; that of the aorta, which was the more marked of the two, was continued into its principal branches, and attained its greatest degree in the abdominal aorta, where a thrombus was found which entirely occluded the vessel. The narrowing was due to chronic arteritis affecting all the arteries to a variable extent. This arteritis consisted principally of cellular infiltration, but also partly in the formation of a firm cellular tissue. No calcareous deposits were found. Professor Wallis is not able to speak positively as to the cause of the affection, but he is disposed to consider it as probably of syphilitic origin on account of the amyloid degeneration which was present in the liver, for which no other cause, as tuberculosis or malaria, appeared to exist. It is, however, right to say that no confirmatory evidence of the existence of a specific taint could be made out.

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