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CANADA MEDICAL RECORD

DECEMBER, 1899.

DEVIATED NASAL SEPTUM.

CLINICAL LECTURE DELIVERED AT THE WESTERN HOSPITAL
(DEPARTMENT FOR DISEASES OF THROAT AND NOSE).

By G. T. ROSS, M.D., Laryngologist to the Hospital,
Professor of Laryngology and Rhinology Faculty of Medicine,
University of Bishop's College, Montreal.

In discussing this subject to-day, time will not allow us to deal with the etiology and pathology of the deformity. I will, therefore, briefly refer to the evils caused by it, and the best means taken for its correction, before operating on the case before us.

I would ask you first to remember that the function of the nasal mucous membrane is essentially respiratory. The turbinals secrete normally 12-16 ounces of thin watery fluid in 24 hours, to moisten the respired air and prepare it for the bronchi. If stenosis of one or both nostrils occurs, there is a constant liability to throat and bronchial disease, owing to the physiological function of the nasal passages being arrested. In fact, there is a certainty of throat disease ensuing in some form. Instances have been noted where this function, on being restored, has caused the previous existing throat trouble to spontaneously disappear without other treatment being resorted to.

The treatment of nasal stenosis due to deflected septum consists in straightening the deformity. In some cases where the septum is but slightly deflected from the median line, the main obstruction to the naris on the convex side may be due to hypertrophied turbinals, and not to the slight deflection, in which case the septum should be left untouched. All

crooked septa that cause stenosis on one or both sides should be straightened.

In structure, the septum, you will remember, is composed of bone and cartilage covered by mucous membrane, and liberally supplied with blood vessels, nerves and lymphatics. The broad, thin plate of cartilage is known as the triangular cartilage ; behind it and partly below it is found the bony vomer and perpendicular plate of the ethmoid. The cartilage is of rubber-like resiliency, while the bone is brittle. On account of the thinness of the upper and central parts of the bone, it can be easily moulded into shape. The posterior portion of the osseous part of the septum is rarely deflected, but it is generally recognized that more or less deflection of the anterior portion is associated with deflection of the cartilage in about one-third of the cases. The cartilage cannot be changed in form without destroying its resiliency. That is the first and most important proceeding in this operation. How can this be best accomplished ?

In a paper read before the N. Y. Academy of Medicine last April, this operation was discussed in extenso. *Bosworth* advocated the use of a saw to remove the projecting part of a deflected septum. The advantage claimed was, that the operation was done at one office sitting ; that a new septum was sawed out of an old and crumpled one, the same as a straight board was sawed out of a crooked log. The objection to this procedure is apparent to you by glancing at the various deformities shown on this plate, the septum being as a rule too thin to admit of the "log-cutting" principle without many perforations resulting.

ROE, of Rochester, said : that nearly always the anterior portion of the bony septum is out of line with the cartilaginous part ; he therefore advocates straightening both at one operation. This he does by fracturing the bone at the point of junction, so that a change may be made in the direction of the septum, at the attachment of the cartilage. It is especially desirable to do this without laceration of the tissues, and Dr. Roe has devised special forceps for this purpose. The cartilage is then incised subcutaneously by ver-

tical and horizontal cuts. When this is all done, a pair of flat-bladed forceps is applied, one blade being in each nostril, and by pressure the septum is put in the straight line. He then cleanses the parts with bichloride of mercury solution (1-4000), and inserts anti-septic dressing into the stenosed side, this being left for 3 or 4 days before removal. A second dressing is then done, first irrigating thoroughly, and the wound treated surgically until healed.

WATSON, Phila., claims that the operation should be considered as one of the most important in nasal surgery, when we think how many serious conditions of the respiratory tract depend on nasal obstruction, of which deflected septa are the most frequent cause. He reminds us that respiration may not be so much affected, as that secretions may be penned up in the lower meatus or upper nasal spaces, or it may be deflected enough to block drainage from the accessory sinuses. One or all of these conditions may obtain, and nothing but operation can remove them.

A correct operation should relieve obstructed respiration, ensure proper drainage of the nose and relieve any existing pressure. This author makes an incision on the stenosed side, beginning at the bony septum from behind forwards as far as the deflection exists, forming a bevelled cut, and avoiding if possible any cutting of the mucous membrane of the opposite nostril. Now the whole upper part of the septum is pushed over with the finger into the opposite naris. The bony deflection is moulded with forceps, and dressing is done with or without splints.

GLEASON makes a V-shaped incision to surround the deflection, either by knife when the cartilage alone is affected or by saw and knife if bone interferes. The flap is then pushed through into the opposite side and resiliency thus destroyed. Splints then keep the parts in place for a week or so, cleansing daily. The cut must be made around and not through the deflection.

ASH, of N.Y., devised an operation which meets the approval of most practitioners. He says that neither sepsis, hæmorrhage nor perforation has followed his couple of hundred operations, and the results were a satisfactory restoring

of nasal respiration. As this operation is the one I purpose doing to-day, and the one that has given me most satisfactory results, I will outline it in detail so that you can follow my work. The instruments required are what I show you, viz.: a cutting forceps, a compressing forceps to mould the bony septum and straighten the cartilaginous one, blunt and sharp separators to break up old adhesions, and nasal splints of oval form in sets, made of vulcanite. You also require an atomizer, with some antiseptic solution, such as glyco-thymoline or Dobell's solution, kept in a bowl of cracked ice. The operation is better done with complete anesthesia. The instruments being sterilized, and the field of operation made clean by douches and sprays, the patient's head is drawn over the edge of the table and slightly lowered, to prevent blood entering the larynx. Then the blunt separators are used to free any adhesions that require breaking up. Now introduce the smaller blade of the cutting forceps into the stenosed side, bringing it over the point of greatest convexity. Cut through and extract instrument, then re-introduce the blades at a right angle to first cut, and exactly over centre of first cut make the second cut. There are now four segments, as result of the crucial incision. The forefinger of operator is now passed into the stenosed side, and the segments pushed through to the opposite side, effectually breaking them at their bases.

This part of the operation determines the success or failure as regards results. If the segments are thoroughly broken at their bases, then the resiliency of the cartilage is effectually destroyed, and deviation cannot recur. Here I would remind you that you must not expect these segments to break, as you would bony structure, owing to the elasticity of the cartilage, so that, if you double the segments each on itself thoroughly and press well down, you will have accomplished your object. This I have now completed, and with the compressing forceps proceed to further straighten the septum and force the broken segments to more completely override each other. Now, passing the instrument further into the nostrils, the bony septum is seized and compressed, judging of the force necessary by the amount of deviation

existing. Bleeding is now arrested and the iced antiseptic spray freely used, after which we introduce the sterilized nasal splints. A snugly fitting one is put into the stenosed side and a smaller one into the free side. After further spraying, the patient is put to bed, iced water compresses being applied to the nose externally, and an ice-cold antiseptic solution sprayed into the nostrils every half hour. Twenty-four hours after operation the tube in non-stenosed side is taken out and not replaced; the spray and compresses being continued. Twenty-four hours later the tube in opposite side is removed, thoroughly cleansed and sterilized, the nose well irrigated and tube replaced. Cocaine may be necessary to permit of re-introduction without pain. The same tube should again be used if not too large for comfort. This tube must be taken out and cleaned by the surgeon every day while patient is in bed, which should be for four (4) days. At end of that time patient may be able to do this himself daily, and it should be kept up for 4 weeks, the patient coming once a week to the surgeon's office for inspection. After 4 weeks the straightened septum will be strong enough not to require support in its new position.

It sometimes happens that the lower segment remains thickened after tube is withdrawn, and projects into nasal cavity. This can be remedied by the electro-trephine, saw or cautery, though if left alone it will eventually disappear. The hollow splints permit of free breathing through nostrils, an improvement on other forms of solid supports which have been used after this operation.

In badly nourished, cachectic patients a perforation may occur, but if done when the patient is otherwise physically well, the result is satisfactory.

Instead of forcibly breaking bony deviations of either vomer or ethmoid, as recommended by various authors, Dr. Ash prefers to treat these parts with the chisel or electro-trephine, after the permanent removal of the tubes. He thinks such fracturing are liable to cause dangerous hæmorrhage, sepsis or meningeal complications.

PROCEDURE IN POST MORTEM MEDICO-LEGAL EXAMINATIONS.

By CHARLES A. HEBBERT, M.R.C.P., London,
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CASE II.

In the issue of this Journal for February, the first case illustrative of post mortem procedure in medico-legal investigations was related. It was that of death from a bullet wound in the head. The following case is that of a stab in the thorax by a stiletto, and has several points of interest. The victim was a young man, aged 32 years, who was assaulted by an unknown assassin on the night of Jan. 28, 1896. He was removed to the hospital, where he remained till his death on the 30th Jan., forty-eight hours after his admission.

The post mortem was made at 10 a.m., 30th Jan., '96.

INSPECTION.—The body was that of a young man, 32 years old, 6 ft. $\frac{1}{2}$ in. tall, very muscular and well formed, dark brown hair, face clean shaven, eyes brown, pupils dilated, the left rather smaller than the right. Rigor mortis present. In the anterior margin of the left axilla, opposite the junction of the 2nd rib with the sternum, there was an incised pear-shaped wound with clean cut edges, measuring 3.8 in. long, by 2.5 in. wide. The only other external mark of injury was a circular abrasion on the left knee cap.

THORAX.—In dissecting the tissues from the anterior wall, a large ecchymosis in the substance of the left pectoral muscles was noticed, and a further examination revealed a wound penetrating the thoracic wall in the 3rd left intercostal space. The sternum and rib cartilages were then removed, and the internal aspect of the wound examined. The intercostal vessels in this space were found divided. The upper lobe of the left lung was completely traversed by a wound the upper end corresponding to the pleural incision, and the lower being found on the inner and under surface of the same lobe. The tissue throughout this tract was ecchymosed; the lung was considerably collapsed, some 6-8 quarts of black fluid blood being present in the pleural cavity. There was no blood in any of the divisions of the bronchi.

The right lung was congested at the base, but otherwise normal in appearance.

The pericardium had been opened on the left side by a clean cut wound $\frac{1}{2}$ in. long, immediately below and corresponding to the lower wound of the lung. There was acute pericarditis, with much blood-stained fibrinous deposit on both visceral and parietal surfaces, which were loosely adherent. The heart weighed 12 oz. In the wall of the left ventricle, about $\frac{1}{2}$ in. below the auriculo-ventricular septum and $\frac{1}{4}$ in. to the left of the interventricular septum was an oval wound $\frac{1}{4}$ in. long penetrating the whole thickness of the wall, the outer edges being united by fibrin. On opening the cavity, the inner edges of this wound were surrounded by fibrin and recent soft round vegetations similar to those found in acute endocarditis. The heart substance was healthy, the cavities empty and the walls flaccid, the valves competent and normal. The wound in the heart was opposite the 3rd intercostal space.

The general aspect of the brain was pallid and waxy in appearance, but, on separating the hemispheres, a red strawberry coloured area was noticed, involving those convolutions of the right hemisphere supplied by the terminal branch of the anterior cerebral artery. The section of the brain showed normal but somewhat ex-sanguine tissue. Weight, 44 oz.

The abdominal organs were apparently healthy, though pallid. The examination of the walls of stomach, intestines and bladder showed no abnormalities.

This case has been thought worthy of record, not only as illustrative of medico legal procedure, but on account of its almost unique character of the healing of a penetrating wound of the heart. The fact that death has not been the immediate sequel of such an injury is no doubt familiar to many medical jurists, but that life should so far be prolonged after such an injury to allow of the progress of the healing process is certainly unusual. The cause of death was undoubtedly due to the hæmorrhage into the pleural cavity. Certainly no blood had recently escaped either from the heart or pericardium, though some bleeding had previously taken place in the pericardial sac as evidenced, by the stained fibrinous deposit.

Some blood may have escaped from the lung into the pleural sac immediately after the stab, but I believe the elastic tissue of the lung prevents any continuous escape from the visceral surface of the pleura. It has been my experience in a considerable number of penetrating wounds of the thorax, both by bullet and knife, that any large amount of blood in the pleural cavities has been the result of hæmorrhage from the^e intercostal vessels. The man in this case lived two days after the infliction of the injury, and sank from exhaustion and anæmia, consequent on the *slow* internal bleeding, which would be more likely to come gradually but continuously from such a source as the intercostal artery than from a vascular organ like the lung, whence one would expect a more profuse and more rapidly fatal hæmorrhage, if continuous.

Another great interest in this case is that a serious injury may be received by the heart without immediate fatal result, or indeed possibly without any fatal result, if only the injury is not in the areas occupied by the automatic motor centres, that is, in either the auriculo-ventricular or interventricular septa. In this case the wound was satisfactorily healing, and as before related was not the responsible cause of death.

Progress of Medical Science.

MEDICINE AND NEUROLOGY.

IN CHARGE OF

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ANTI-PHTHISIC SERUM, T. R. (FISCH), IN TUBERCULOSIS.

Dr. A. M. Holmes (*N. Y. Med. Journal, The Postgraduate*) reports thirty-one cases treated by this method, the time of administration extending over periods varying from one to eight months. In conclusion, he records the following observations :

1. In incipient cases, or in cases with small areas of infection, the serum treatment gives the best results. 2. Patients with well-established tuberculosis lesions require longer time to bring about a cure than has heretofore been considered necessary. 3. A serious mistake is made in dispensing with the use of the serum too soon in any case that improves under its use. I therefore make it a rule to continue the treatment two or three months after all bacilli and other symptoms of the disease have disappeared. 4. All patients who have done well under the serum have continued to improve after discontinuing the treatment. This fact would indicate that the effect of the serum is permanent; that it does not simply act while it is being used, but increases the antitoxin-generating power of leucocytes and tissue cells of the patient to such a degree that the artificial supply can be dispensed with. 5. The number of bacilli in the sputum, when other signs of the disease are diminishing, is by no means a true criterion of the condition of the patient. This has been well shown in each well-established case in which improvement under the serum treatment was observed. In a number of cases, just before the complete disappearance of the bacilli, it was observed that the sputum was almost a pure culture, the stained film showing bacilli in enormous numbers, frequently in large masses too numerous to count. 6. The serum was continued in daily doses as long as nine months, in individual cases, with no deleterious effects.

The longer the serum was used, the more the author was impressed with the necessity of a proper selection of cases. The results obtained from the serum offer no grounds for believing that all tuberculous patients can be cured, or even benefited by it. Yet, notwithstanding the warnings that have been given on this point, reports have been published in which cases of the worst type only were studied—cases of long standing, in last stages, with mixed infection; and, to make such a report even less valuable, the duration of treatment, as shown by report, ranged from a few days to two months and a half. Unfavorable results naturally followed, and by the same reasoning the treatment was condemned.

The author is convinced, after making the foregoing observations, that a failure to obtain satisfactory results in advanced cases does not reflect upon the treatment, but emphasizes the importance of a proper selection of cases and the necessity of beginning treatment early. He also protests against the exaggerated statements so often made for *climate* alone as a therapeutic agent in tuberculosis. Such statements, he says, have created a false impression in the minds

of physicians living at some distance from Colorado, and especially is this true when they emanate from men who have attained prominence in this field.

It is a well-recognized fact, especially in Colorado, that the majority of tuberculous patients sent there from other parts of the country come with the understanding that the climate alone will give the beneficial results desired. The author has given particular attention to this point in the study of his cases. It is true that many of the patients improve, but, says the author, if they are carefully followed, it will be observed that in a large percentage the improvement is temporary or incomplete, and that sooner or later a relapse occurs. Hence, many of these patients, in a short time recognizing this truth, realize that they require more than climate. They feel the need of counsel, and, naturally turning to an expert on "climate," in a short time find themselves under his care. As the disease insidiously makes progress, the patient receives the final information that climate was sought too late, and is ordered to his former home. In this manner many physicians at a distance have already learned that the statements regarding climate alone proving beneficial in tuberculosis have been misleading.

The author would not be understood as opposing properly selected climates in the treatment of tuberculosis. He maintains, however, that erroneous impressions have been given to those who have had no opportunity to investigate this question for themselves. Any well-informed physicians, and even the well-informed laity, will recognize as self-evident that more than climate is necessary to bring about successful results in these cases. Proper tissue nutrition and aids to cell metabolism are essential points which cannot be neglected in the successful treatment of tuberculosis.

It has been the author's experience that there are few diseases which require more careful, conscientious and earnest advice than tuberculosis, even when the patients have the advantage of living in the Colorado climate. The climate, in many cases, aided by a rest from cares and former labors, often checks the active processes of the disease and causes it to remain in a quiescent state. In many cases, however, this latent state is misinterpreted as a cure, and not until the patients return to their former homes do they realize their error, when the disease shows evidence of renewed activity.

TREATMENT OF RINGWORM WITH CHLORIDE OF SODIUM.

This simple remedy is strongly recommended by Perkins, who claims to have used it in every case of ringworm that has come under his observation for the past sixteen years, and in no case did it fail to give relief. In one of these the disease had been of five years' standing and the cure only took three weeks. The chloride of sodium in fine powder is rubbed up with vaseline to make a moderately stiff ointment. The affected part if covered by hair is shaved and the ointment thoroughly rubbed in night and morning. In a few days the part becomes inflamed, after which a simple emolient is applied. Two daily applications of the ointment for three or four days is usually sufficient to destroy the parasite over the area to which it is applied. The simplicity of this method makes it particularly desirable, and it would be interesting to know if other observers reach similar results. There is a possibility that in our search for new and rare chemicals as antiseptics that we are overlooking some efficient and well-known older remedies.—*Medical Review.*

ON THE LOSS OF KNEE-JERK AND ON PERI- PHERAL NEURITIS IN DIABETES MELLITUS.

Karl Grube (*Lancet*, July 22, '99) found that, in 320 cases of diabetes mellitus, the knee-jerk was lost in 84, 25.3 per cent. The frequency of the absence of the knee-jerk was found to vary with age, increasing with advanced age. In those cases, regarded by the writer as slight diabetes, the loss was present in 49.1 per cent., while in the severe form only 23.9 per cent., which shows that the loss of knee-jerk cannot be regarded as a sign of bad prognosis. The writer concludes that three manifestations of nervous disturbances caused by the increase of sugar in the blood are met with: 1. Cramps or acute irritation of nerves, probably not accompanied by any material change in the nerves. 2. Neuritis. 3. A slow degenerative or nutritive change in the nerves which seems to have a preference for the crural, accompanied by loss of the knee-jerks, but also occurring in other nerves, as, for instance, in the optic; impotence, so frequently a symptom in male diabetic subjects, is also probably caused by nutritive changes in the corresponding nervous apparatus.—*Medical Review.*

PALPITATION OF THE HEART IN CHILDREN.

L. D'ASTROS has the following to say on the above subject : While palpitation of the heart in the adult is very frequently induced by causes lying outside of the heart, we find that in children latent or semi-latent affections of the heart frequently make themselves felt for years simply by palpitation ; to these may be added endocarditis, true mitral stenosis. Aside from true affections of the heart, which should be carefully sought for, in the first instance, digestive disturbances may also cause palpitation to a high degree (intestinal parasites), also an incipient (latent) pulmonary tuberculosis in young girls twelve to fifteen years of age at the beginning of menstruation, also chlorosis, and occasionally hysteria. It may, also be induced by physical over-exertion (wheeling), by masturbation, etc. Only after all these causes have been excluded are we justified in making a diagnosis of nervous palpitation of the heart. The treatment is, of course, to be directed as far as possible in the first instance to the cause, in nervous palpitation over-exertion from all kinds of mental or bodily exercise (wheeling) is to be avoided, and hydrotherapeutics of moderate duration and degree should be employed, and not too cold. Next to hygienic advice, which is of great importance, the most useful medicines are bromide of sodium, in doses of 0.5 to 1.0 gr. twice daily, and tincture of valerian in doses of two to three coffee spoonfuls. — *Annales de Médecine et de Chirurgie Infantiles ; Pédiatries* September, 1899.

TREATMENT OF ACUTE RHEUMATISM.

Dr. Favill, in the *Four. Amer. Med. Asso.*, recommends that the bowels be emptied thoroughly, preferably with a mercurial, and that sodium salicylate be administered to its full analgesic effect, or, if it is not well borne by the stomach, oil of gaultheria. If salicylates are contra-indicated by cerebral conditions, antipyrin or some other coal-tar analgesic may be employed, and if these are contra-indicated by circulatory or nervous complication, opium may be used for the relief of pain. As the pain is controlled by these means, perhaps together with heat and immobilization, salicylates should be withheld and the system saturated with alkali until the active process seems controlled. Iron should be given simultaneously or subsequently if the conditions of the bowels and the liver permits. Throughout the attack intestinal hygiene should be promoted by means of a mercurial, cholagogue or saline. — *Medical Record*.

TREATMENT OF SUNSTROKE.

In sunstroke, or, as it is now often called, heart stroke, it should in all cases be remembered that overheat of the body is the very essence, the gist of the disease, and the main indication is to reduce the temperature as speedily as is consistent with safety. What are the most approved methods for reducing the temperature? If a bath tub is obtainable, the patient should be at once stripped of clothing and placed in a bath of a temperature ranging from 80 to 85° F., which may be still further reduced by the addition of ice, at the same time ice cold cloths may be applied to the head. When removed from the bath and put to bed, bottles filled with hot water may be put to the extremities to obviate internal congestions. If the heart seems weak, an injection hypodermatically of the 1-50 grain of strychnia should be given. If a bath tub is not at hand, the "cold pack" should be resorted to, and strong hot tea or coffee, in tablespoonful doses, given every few minutes to promote perspiration. If coma continues after the temperature is reduced, a hypodermic injection of pilocarpine may afford relief. When the more alarming symptoms subside and sweating supervenes, large doses of the bromides of sodium, potassium and ammonium may be given with advantage.

The physician at the conclusion of such cases should never neglect to warn the patient of the danger of a second attack, to which, as a general rule, he is far more liable than he was to the first.

A NEW SIGN FOR THE DIAGNOSIS OF PULMONARY TUBERCULOSIS.

Murat (Gaz. Hebdom. de Med. et de Chirurgii, March 5, 1899; *Journal of Tuberculosis*), describes the following subjective symptom: An abnormal sensation is experienced by the patient in the early stages of phthisis when he speaks loudly, or when in the course of conversation the voice is raised, the tuberculous lung vibrates, and the sense of discomfort is such that the patient instinctively holds the arm of the affected side close to the trunk. The patient becomes conscious that the vibrations of the voice are propagated on the affected side while he experiences no such sensation on the opposite or healthy side.

In one case in which this subjective sign was present auscultation could discover nothing wrong.

According to the author, this symptom ought to be hailed not only as a sensory symptom of early tuberculosis

of great value when the foci of disease are so seated that auscultation may not be able to reveal them, but as a phenomenon common to phthisis in general at any stage.

To verify this claim, upward of sixty patients have been interrogated and examined in the Winyah Sanitarium within the last month, and in no single instance had the patients previously been conscious of the vibrations referred to; but after their attention was directed to the sensation and being made to speak loudly, the phenomena was observed only in two out of all the cases; in one the disease has reached an advanced stage, in the other it is in an early stage.

From theoretical considerations only, one would suppose that an amount of consolidation sufficient to increase the vibrations produced by the voice, so that the patient shall become conscious of them, would hardly belong to the early stage, or offer any difficulty in its detection by physical examination of the chest.

THE LOCAL TREATMENT OF LUNG DISEASES

BENJ. F. LYLE, M.D., Cincinnati, Ohio, contributes the following instructive article on this subject in the *Journal of Tuberculosis*, July, 1899.

The results we hope to obtain by the application of medicines locally in diseases of the lungs are a cure or amelioration of the local inflammatory, ulcerative and septic conditions with the consequent removal of their local and systemic manifestations.

By this method we secure for the stomach exemption from the effects of drugs which frequently produce indigestion, and save our patients the consequent physical depreciation. These attempts are the result of the wonderful success attendant upon the local treatment of diseases of the upper respiratory tract, the natural inference being that like results would be obtained by the local application of drugs to the trachea, bronchial tubes, and even to the lungs.

The pioneer of the local treatment of diseases of these organs was Dr. Horace Green of New York, who first published his method and results in 1840.

In 1859, after an extensive experience of many years, he wrote: "If I were required to relinquish all known therapeutic measures to topical medication in the treatment of thoracic diseases, I should choose the latter, with hygienic means alone, in preference to the entire class of remedies ordinarily employed in the treatment of these diseases."

Unfortunately, the inability to inspect the lesions in

any particular case compels us to judge of the conditions present by analogy, or by the knowledge acquired by post-mortem investigations and scientific research.

Before considering the practical application of this method of treatment, it will be well to bear in mind the following facts. The air in the bronchial tubes during inspiration meets with an obstruction equal to one half millimeter of mercury, and on expiration of from two to three millimeters.

The inspiratory pressure may reach from nothing to eight m.m. of mercury, and the expiratory pressure from nothing to thirteen and one-half, the higher being due to expiratory dyspnoea. (West.)

Even when the inspiratory and expiratory pressures are high, the respiratory oscillations may be very slight or even absent. West also states that in one instance when the inspiratory pressure was plus nine the expiratory pressure was the same, respiratory oscillation being absent. Where there is no dyspnoea the respiratory oscillations are apt to be small and may be completely absent.

The contractibility of the lungs is not due entirely to elastic tissue, but to a certain extent to muscular tissues; the functional abilities of the latter are quickly affected by any local or systemic disease, the respiratory oscillations becoming deficient. When the parenchyma of the lung is seriously involved, or when the pleura is adherent to any extent to the chest wall, the respiratory oscillations are interfered with to a proportionate degree, sometimes being entirely abolished. When this condition prevails for a considerable period the opposite lung becomes correspondingly hypertrophied.

The lungs are richly endowed with lymphatics which under ordinary conditions rapidly absorb any extraneous or inflammatory material which may be found in the alveoli and smaller tubes. This function depends largely upon variations of pressure in the lymphatic vessels brought about by the respiratory oscillations; hence the term "lymphatic pump."

A like change takes place in the pulmonary blood vessels during respiration. The knowledge of these physiological facts is of importance when considering our subject, and teaches the futility of endeavoring to reach diseased portions of the lungs in which the respiratory oscillations are deficient or entirely absent, by means of medicines in a gaseous state.

These deductions are borne out by the experiments of

Schreiber, who finds that finely pulverized substances may in diseased lungs even find entrance into the alveoli, but in order that this may take place it is necessary to have a combination of pressure with aspiration. While the pressure can be readily supplied, when disease of the lung is present, the aspiratory influence is compromised or perhaps absent. "Thus if the lung has lost elasticity so that new air no longer enters, it follows that substances mixed with air will not enter."

"The diseased processes which so lessen the elasticity are not sufficiently considered. It has been found that in healthy animals exposed to air loaded with coal dust, the larger and smaller bronchi were reached in fifteen minutes; that in animals with diseases of the lungs, as bronchitis and military tuberculosis, substances mixed with atmospheric air enter in greater quantities than in healthy animals. But the distribution of substances is very uneven, for while coal dust can be seen in clumps in healthy lung nothing whatever appears in diseased foci."

"The general law applies not only for infiltrations and scars (that is, where there can be no air), but also for processes accompanied by ulcerated foci and cavities."

In the treatment of the diseases of no other organ has the study of bacteriology produced greater changes than in that of the lungs.

While lung diseases were supposed to be due simply to aberrations of ordinary vital processes, tuberculosis being due to inheritance and colds, and pneumonia and bronchitis to exposure—no indications existed for other than general treatment.

In the light of our present knowledge we realize that something more than inherited or predisposing factors are involved, and for this knowledge we are indebted to the science of bacteriology.

For instance, we now know that consumption is not a simple process, and that the lesions of tuberculosis invite the attack of various septic agents whose activities result in increased local and systemic difficulties. These germs of "secondary infection" and their lesions are what we hope to remove by local treatment. Its advisability and desirability is unquestionable, the only query is: when and how.

During the acute stage of bronchitis when the membranes are dry and congested and the secretions absent, local treatment is contra-indicated. When the stage of secretion is reached local treatment is invaluable. The other conditions in which we derive valuable aid from this method of treatment are: chronic laryngitis with or without ulceration;

tubercular laryngitis, even when extensive infiltration and ulceration is present; chronic tracheitis and bronchitis; asthma; emphysema when accompanied by bronchitis; pulmonary tuberculosis; bronchiectasis; syphilis of the lung when complicated by disintegrating gummatous masses.

By means of local treatment without taking into consideration its incidental constitutional effects, we obtain results that cannot be secured by the devious and uncertain route by way of the stomach. Among the effects produced the following may be enumerated :

ANTISEPTIC.—This is shown by the change in the appearance of the secretions, the purulent, yellow expectoration becoming clear and the fetor of bronchiectasis dispelled. The removal of the contents of cavities, disinfection of their secretions and diminution of their size. The consequent diminution of the septic material absorbed is shown by decrease of fever, night-sweats and physical exhaustion.

EMOLLIENT AND ANAESTHETIC.—Sensitive areas, the irritation of which results in coughing, are rendered less susceptible; hoarseness is diminished, and tenacious secretions are more readily removed. As a result of the removal of these harassing symptoms the sleep of the patient is unbroken, his respirations are deepened, and his general condition is correspondingly improved.

Local treatment also relieves congestion and diminishes the hypertrophy of the mucous membranes by means of its astringent and stimulating influences; and as a result there is an improvement in the vital functions of the parts, conservative processes being also inaugurated in parts not under the direct influence of the drugs.

In consequence of these beneficial changes a larger volume of air is admitted to the diseased area and thus some of the favorable results incident to greater physiological activity are realized. The absorptive functions are increased, deleterious products removed, and drugs given a better opportunity to act.

The medicines employed must be those that are un-irritating and that vaporize slowly at the temperature of the body. The only exception to this rule is Chaplin's creosote method of treating bronchiectasis. Here it is the intention to cause sufficient coughing to expel the secretions and disinfect the cavity walls. For the purpose of reducing congestion and producing anaesthesia, drugs like menthol and camphor are employed; for the antiseptic effects guaiacol and eucalyptol: as aqueous and alcoholic menstrua are too irritating, oils are employed as the vehicle, pure olive oil, the light petroleum oils and cod liver oil being favored.

For experiments showing the antiseptic action of drugs frequently used in intratracheal injections we are indebted to Dr. A. H. Peck of Chicago. His experiments are particularly valuable to us because they were conducted with the fact in mind that "an antiseptic must be regarded as a poison to the vegetable cell; and many of them act also as poisons to the animal cell." The following is a summary of his results with drugs that are of interest to use in connection with our subject:

	Antiseptic Value.	Poisonous to Tissues.		Antiseptic Value.	Poisonous to Tissues.
Oil cassia	1—2233	Yes	Carbolic acid 95 per cent.	1— 338	Yes
Oil cinnamon (Ceylon)	1—2100	Yes	Oil myrtol	1— 357	Yes
Oil cinnamon (synthetic)	1—2133	Yes	Oil cajuput	1— 120	No
Creosote (beechwood)	1—1230	No	Eucalyptol	1— 116	No
Oil cloves	1—1150	No	Oil gaultheria	useless	No
Oil bay	1—1028	No	Eugenol	useless	No
Oil sassafras	1—1000	No	Formalin	—	Yes
Oil peppermint	1— 875	No			

Koch's statistics derived from experience with anthrax spores are:

	Growth Checked:	Growth Ceased.		Growth Checked.	Growth Ceased.
Bichloride of mercury	1—1,600,000	1—300,000	Eucalyptol	1—2,500	1—1,000
Thymol	1— 80,000		Boracic acid	1—1,250	1—1,800
Oil cloves	1— 5,000		Carbolic acid	1—1,250	1— 850
Camphor	1— 2,500	1— 1,250			

The bacteriological experiments of Blaxall have shown the inefficiency of the essential oils in controlling the growth of tubercle bacilli. Inhalations of 6 per cent. solution of formaldehyde seemed to be attended with favorable results.

How to introduce these various medicaments is the next question of importance. For some years occasional mention has been made of injections into the diseased portions of the lungs; this procedure has been followed in some instances by an attempt to increase the influence of the drug by electrolysis. This method is apt to cause inflammatory changes with resultant fibrinous exudation; and from a theoretical standpoint may be regarded as a valuable procedure. However, it has not succeeded in gaining the confidence of the profession.

For the purpose of influencing the pulmonary tissues by local remedies, the tracheal route is the one employed, the medicines being introduced in a state of minute subdivision by means of inhalers, vaporizers, nebulizers and spray apparatus; or in its fluid condition by means of a tracheal syringe. The experiments cited in the early part of the paper will prove the futility of endeavoring to influence diseased portions of the lungs by means of medicines in the form of sprays, vapors or gases if the lesion is situated beyond the second subdivision

of the bronchial tree, and even those parts which can be thus influenced can be better treated if the remedy is used in a fluid state, for the following reasons :

The medicine is exhibited in the only form in which it can be efficacious, the theory that sprays can be carried further into the lungs having proved fallacious.

Large quantities can be used.

Insoluble drugs like iodoform can be administered.

The specific gravity of a fluid enables it to enter portions of the lungs not accessible to sprays, by directing the point of the syringe to one side or the other, or by having the patient recline to one side, the medicine can be directed to the diseased portion of the lungs.

The slow evaporation of the remedies employed prolongs their influence for a considerable time.

The absorption of the remedies extends their influence to portions of the lungs beyond the air passages.

The syringe used for making the injections was devised by Dr. Muir, and is capable of holding one-half ounce ; the tube is of metal and can be bent to any desirable curve.

The technique is thus described by Dr. John A. Thompson :

" There are few technical difficulties in this method. With the parts illuminated as in an ordinary application of medicine to the larynx, the curved tip of a laryngeal syringe is carried back over the glottis. While the patient takes a slow, deep inspiration, the remedy is injected between the vocal cords into the trachea. In the earlier treatments it is sometimes advisable to anaesthetize the larynx with cocaine. Later, when the patient recovers from the nervous apprehension that is so often excited by manipulation about the throat, cocainization of the larynx is neither necessary nor advisable. Where the patient has sufficient self-control to breathe slowly, deeply and regularly with the laryngeal mirror in position, it is easy to inject solutions into the trachea without passing the tip of the syringe below the glottis. This latter method is not advisable in ordinary treatments. There is apt to be some injury to the parts in introducing the syringe between the cords, or in withdrawing it. Where cocaine is not employed, a reflex spasm is excited by the contact of the syringe that makes the treatment disagreeable and sometimes painful to the patient. This is not necessary if physician and patient co-operate, the latter breathing as directed and the former regulating his movements by those of the larynx."

The objections made to this method of treatment are usually theoretical, and are not borne out in practice.

Ewart writes disparagingly of it in Albutt's system of Medicine. My own experience has not, however, confirmed his unfavorable prognostications. It has been used at the Cincinnati Branch Hospital for consumptives daily for the past two years, during which time thousands of injections have been given. No complications have ever caused us to regard its use with apprehension; but on the other hand we consider it an indispensable factor in contributing to the relief of those committed to our care.

SURGERY.

IN CHARGE OF

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SOME CONDITIONS OF HEALING BY FIRST INTENTION, WITH SPECIAL REFERENCE TO DISINFECTION OF HANDS.

The author's conclusions as to the possibility of securing primary union of operation wounds with or without gloves are as follows:

1. *Either*: Do use sterilized rubber gloves for every operation when you wish to be quite independent as to the form of your nails, the touching of everything you like, and the liberty to wash or not to wash your hands, and when you can spend plenty of money. Put your covered hand from time to time in a strong antiseptic solution (best, two-per-cent. sublimate) during a long operation, if you wish to be very careful.

2. *Or*: Do never wear gloves for operations, do what you like between your operations, but poison yourself every time before you operate by brushing and bathing your hands for ten minutes in a strong, hot sublimate solution after thorough washing and cleansing with hot water, soap and alcohol for fifteen minutes. Repeat a short antiseptic ablution frequently during a long operation, when you wish to be very careful.

3. *Or*: Go the golden middle-way; avoid touching with uncovered hands any infective or septic material *between* the operations or wash it carefully away at once, cut

your nails as short as possible, brush your hands thoroughly with hot water, soap and alcohol (85 to 95 per cent), avoiding any poisonous disinfectant before you operate, and, if you wish to be very careful, put cotton, silk, or best, rubber gloves on when you touch the threads for ligatures and sutures, and when you have to tear the tissues much and to rub your fingers into the depth of the wound.

4. But don't forget that the healing of the wounds *per primam intentionem* does not depend exclusively upon your hands, but also upon the same preparation of the patient's skin, upon sterilization of everything else coming in contact with the wound and its surroundings, upon complete arrest of bleeding, exact closing of the wound by sutures, or avoiding accumulation of fluids in cavities, necessarily left, by drainage, and, last but not least, upon the use of *anti-septic* threads for ligatures and sutures, as long as impermeable threads are not yet invented.—*Dr. P. Kocher, Boston Med. and Surg. Jour.; The Post-Graduate.*

NON-TUBERCULAR INFLAMMATION OF THE SPINE.

The author cannot believe that tuberculosis occurs in the osseous system primarily. He has made many autopsies in which this looked possible, but always found enlarged bronchial or mesenteric glands also, showing the path by which the bacilli gained entrance to the system. He does not think, either, that the presence of abscess and extrusion of bone prove an inflammation to be tubercular. He has seen several cases in which a severe traumatism of the spine was followed by abscess formation which did not appear tuberculous, both in the cervical and dorso lumbar region. Tubercular lesions of the bone run a pretty definite, well-known course, and while no sharp lines can be drawn, the author is inclined to doubt the diagnosis of tubercular spondylitis if the cure were effected within one year.

Several practical points, says the author, are suggested by this consideration of the non-tubercular lesions of the spine:

1. Syphilitic treatment should be pushed when there is a possibility of this disease being present. The pain will be relieved, and the progress and extension of the disease stopped generally; moreover, many very brilliant cures are recorded when the symptoms seem to be due to pressure on the cord or nerves from gummata and periostitis.

2. Fractures should be more carefully protected, and

for a longer period to prevent occurrence of deformity and paralysis, and to relieve pain and disability.

3. Rheumatoid arthritis can be rendered less deforming and less dangerous to life, therefore, by securing ankylosis in a good position, if ankylosis cannot be avoided.

4. From a medico-legal standpoint it is important to remember that not all chronic increasing kyphoses are tubercular, and, therefore, exorbitant damages should not be awarded in all such cases. We should also consider the beneficial effect on the mental complexion of the patient and his family of the recognition of this fact.

5. Life insurance should not be refused such subjects. Some of the companies have hard and fixed rules, such as the one referred to, that no risks should be taken on a person with Pott's disease. When a mistake in diagnosis can so readily be made, which would work to the applicant's disadvantage, it would seem most just to consider each case separately.—*Dr. P. Halsted Myers, in N. Y. Med. News; The Post-Graduate.*

VARICOSE ULCERS.

Carl Beck uses a gelatine zinc cast in the treatment of varicose ulcers. The composition of the paste is as follows :

Zinc oxide.....20 parts

Gelatin.....80 parts

Glycerin.....200 parts

Water added to make 200 parts.

—*Med. Review.*

RULES FOR DETERMINING THE NECESSITY OF OPERATION IN APPENDICITIS.

G. D. Ladd, in the *Medical Standard* for July, 1899, has an excellent discussion on the guiding symptoms which determine the necessity of operation. He says that the cardinal symptoms of appendicitis are tenderness and pain, and alterations in the temperature and pulse. These vary in their severity in different cases; in one case there may be repeated vomiting, in another high temperature, in another rapid pulse, or in still another great tenderness and pain on pressure over the region of the cæcum. If any one of these symptoms is very prominent, it indicates more than a simple inflammation of the appendix.

Tenderness is of the greatest value as a diagnostic symptom; it is variable and may not attract attention by its

prominence in all severe cases, or may not be proportionate in its severity to the extent of the destruction going on in the abdomen. Pain, when it is severe or persists, or recurs with considerable severity, is an indication that a more serious condition than a simple inflammation exists—that local, if not general peritonitis is present. Pain may be deceptive in its location or degree, but if severe and continuous, or persistently recurring, it is, taken alone, an indication for operation.

Temperature may be deceptive in appendicitis; it remains comparatively low in grave cases; it may mislead by suddenly dropping at a time when gangrene is taking place or pus is emptying into the general peritoneal cavity. A low or moderate temperature should not be interpreted as proof of a mild or safe case. In undoubted appendicitis a low temperature should be regarded as an indication of severe infection and a need for early operation.

The pulse may remain moderately low and of good quality until late in the progress of a fatal case. A rapid, feeble pulse calls for immediate operation. Persistent recurring vomiting indicates a severe condition; it may, however, be absent in severe cases. Its presence in a persistent and prominent form indicates a grave condition of affairs calling for immediate operation. *Medicine.*

INTESTINAL ANASTOMOSIS.

S. H. Barbat, from a series of experiments on dogs, reached the following conclusions on this question: (1) It is possible to make a safe and satisfactory end-to-end anastomosis. (2) With practice, a surgeon can, with nothing but a needle and thread, sew a divided bowel together, and obtain a result which will about equal that obtained by the use of the Murphy button. (3) The result obtained by the use of the Murphy button is superior to that of any suture method yet devised. (4) The Murphy button and Frank coupler give the same anatomic result. (5) Contraction following end-to-end anastomosis is usually due to faulty technique. (6) The Murphy button is much safer and more reliable than the Frank coupler. (7) A perfect Murphy button, properly introduced, is the quickest, safest and most reliable means of obtaining anastomosis between any two viscera. (8) All devices which are used to support the gut in suture operations are unnecessary, and as good, if not better, results may be obtained without them.—*Four. Am. M.A. Med. Review.*

ENDOSCOPIC TREATMENT OF CHRONIC URETHRITIS.

This rational method is eulogized from practical experience by W. L. Champion in the June *Atlanta Journal-Record of Medicine*. He prefers a tube with a calibre number 26 to 30 F. Glycerin should be used as a lubricator rather than vaseline, since the latter interferes with the action of drugs. These embrace nearly every antiseptic and astringent, applied by means of pledgets of cotton attached to small wire applicators. The writer uses nitrate of silver chiefly, beginning with a solution of 20 grains to the ounce and increasing to three times this strength. It is best not to repeat the application oftener than every six or seven days. The irritation and slight discharge that follows each treatment may be relieved by irrigating the urethra on the following day with potassium permanganate solution, 1,6,000.—*Denver Medical Times*.

SCIENTIFIC TREATMENT OF GONORRHEA.

Valentine has published an article upon "Chronic Gonorrhœa," of which the following is a summary (*Medical News*):

1. There are no incurable cases of chronic urethritis
2. All drugs suggested for the treatment of chronic gonorrhœa are soon relegated to merited oblivion.
3. The only efficacious method of treating chronic gonorrhœa is by dilations, as proposed by Oberlinder, followed by irrigations, without a catheter, of the urethra or bladder, or both.
4. Urethral fever or other disturbance does not supervene after urethral instrumentation, followed by irritation.
5. Carefully conducted dilations and irrigations are not painful.
6. Gradual, careful pressure by dilators is preferable to the use of sounds in the majority of cases.
7. The effect of dilation is to stimulate absorption of the infiltrations.
8. Functional disturbance and nervous symptoms are improved very early in the treatment.
9. Chronic urethritis can be exceptionally diagnosed and successfully treated, but never pronounced cured without aid of the urethroscope.—*Medical Compend*.

SOME OBSERVATIONS ON THE EARLY USE OF PURGATIVES AFTER ABDOMINAL SECTION.

O. G. Ramsay from observations made on a series of cases, draws the following conclusions : (1) It is important to attend carefully to the diet and to the thorough emptying of the bowel before any abdominal operation. (2) The bowels should be moved and the distention relieved soon after operation, both for the comfort of the patient and to avoid possible dangerous complications. (3) In the simpler groups of operations, and in uncomplicated hysterectomies, the administration of calomel and enemata on the second day is followed by a perfectly satisfactory convalescence. (4) In cases of beginning peritonitis, in cases where numerous adhesions have been broken up or large raw areas left, where the intestines have been freely handled or left exposed, and in emergency operations where no previous preparations can be made, Dr. Byford's method of immediate purgation is indicated. This consists in the administration of drachm-doses of Epsom salts hourly as soon as the patient recovers from the anesthetic; after the sixth dose a small glycerin and warm water enema is given; salts are continued after this every hour, with enema every three hours, until the bowels move and flatus passes spontaneously.—*Am. Jour. of Obstet., Med. Review.*

THE HEALING OF VACCINATION SORES.

A. K. Bonn, in the *Maryland Medical Journal* of July 1, 1899, says: That in view of the anti-vaccination movement it is well to examine our work, to see that we are doing all that can be done in the prevention of accidents and suppurations following vaccination. While the glycerinated virus is rarely followed by suppuration, it occasionally occurs. The suppurating vaccination sore does not heal readily under the ordinary antiseptic dressings, but a single application of a solution of nitrate of silver, eighty grains to the ounce, and over this a dressing of absorbent cotton with bismuth, will heal almost any case within a week. He questions whether all vaccination vesicles ought not to be at once opened and the application of the nitrate of silver made to the interior. If the whole protective influence of the vaccinia has already been received when the papule begins to swell into the vesicle, the prompt treatment of it is desirable, and no good reason can be given why it should not be carried out.—*Medicine.*

DIAGNOSIS OF TUBERCULOSIS IN THE FIRST YEAR OF LIFE.

Despite much progress in this direction, the diagnosis of tubercular affections in young infants is still in a very unsatisfactory state. Commenting upon this fact, an editorial in *Pediatrics* refers to the work of Bulius, in the *Berlin Pediatric Clinic*. Aside from the presence of the specific bacilli or lesions, Bulius lays much stress upon a history of daily contact with a tuberculous parent or attendant. Change in disposition, he says, is also a trustworthy symptom. A simple affection, such as eczema or furuncle, running a torpid course, is very suspicious. The association of good appetite and digestion, with progressive weakness and wasting, also points to tuberculosis. Cervical adenopathy, unless quite marked, is of no diagnostic value, but slight enlargement of the supraclavicular glands speaks for tuberculosis. Cough may be present or not, and fever is of no significance. Transitory collapse in apparently healthy children should awaken suspicion. In the more acute forms of the disease, striking disquiet or jactitation, with occasional convulsions, are noted. Excluding meningeal and mesenteric cases, the bronchial glands are the usual focus of infection, from which may arise an acute tuberculous pneumonia, a multiple peribronchitis, and a more or less diffuse miliary tuberculosis.—*Denver Medical Times*.

TREATMENT OF GONORRHEA IN WOMEN.

In view of the frequency of gonorrhœal affections of the genito-urinary tract, especially in married women, and their well-known obstinacy to treatment, it may be of interest to give a review of some recent and instructive experiments made by Dr. Fuerst, of Berlin (*Therap. Monatsch.*, April, 1898), with a new remedy in gynecological practice. The drug referred to is protargol, which has already been extensively tested by Neisser, Finger, Benario, Goldenberg and other well known authorities in gonorrhœa in the male. Fuerst has treated thirty-six cases of gonorrhœal infection in females with protargol, comprising fourteen cases of gonorrhœa of both the cervix and corpus uteri, eight of gonorrhœa of the cervix alone, five of urethro cystitis gonorrhœa, three each of vulvitis and Bartholinitis gonorrhœa, two of endometritis gonorrhœa and one of colpitis. He thinks the bactericidal property of protargol, its freedom from irritation, non-precipitation by the secretions and consequent marked

penetrating power, has rendered it easier to limit the seat of the primary infection, to destroy the gonococci without irritating the uterus or adnexa, and prevent extension of the process. In the treatment of uterine gonorrhœa, he employed irritation of the uterus with 0.5 per cent. protargol solution, gradually increased in strength to 2.5 per cent., followed by insertion into the cervix of a solution bougie of protargol, 5 to 10 per cent.; after this had melted the vagina was irrigated with 10 per cent. protargol solution and a 10 per cent. protargol-glycerine tampon inserted. After the second week astringents were resorted to, and at the end of the third week the gonorrhœal process was usually completely cured.—*Hot Springs Medical Journal; Lancet-Clinic.*

RULES FOR THE PRACTICE OF INTUBATION WITHOUT CONSTANT SUBSEQUENT SUPERVISION.

Dr. M. E. Escate (*Archives internationales de laryngologie, de rhinologie et d'otologie*, xii, No. 2, 1899; *St. Paul Medical Journal*, September) lays down the following rules under which intubation may be practised without constant subsequent supervision. 1. Intubation may be practised among one's *clientèle* when the patient lives within such a distance that the physician could be called and reach him within two hours in case of accident. 2. The superiority of intubation over tracheotomy in cases of croup is such that, if we were called into the country to see 1 case of croup in the period of asphyxia, we would not attempt tracheotomy unless the resisting powers of the patient were such as to guarantee a successful operation. On the other hand, if syncope were imminent, we should perform a provisional intubation; and when the child had rallied somewhat, and been placed in a better condition to continue the fight, the question of a tracheotomy might be discussed. 3. Intubation may be performed whenever the dyspnœa becomes threatening. If called to a case toward night where the dyspnœa is only moderate we may intubate and thus avoid a sudden and pressing call later on. 4. In the choice of a tube one should act with reference to the apparent rather than the real age of the child. Try to use the tube next larger than the one indicated by the gauge. The tube should glide and not fall into the larynx; if it slips in too easily, take the next larger size. It is an advantage to perceive the cricoid resistance as the tube passes in, for this

assures us that it will be held firmly in place. If by reason of œdema we are obliged to use too small a tube, this should be changed for a larger size at the end of twenty-four hours; or one might leave the thread attached. 5. Before introduction, the tube should be coated inside and out with mentholated oil. 6. The patient should be kept in an atmosphere charged with moisture, either with a spray or steam apparatus supplied with some antiseptic solution. 7. When the cough becomes dry and expectoration difficult, threatening an obstruction of the tube, an intralaryngeal injection of several drops of mentholated oil may be made, or, better still, the tube may be changed. 8. One should not leave the patient until satisfied that the tube is well placed. This may be accomplished by causing him to swallow a few drops of liquid from a teaspoon. This at first invariably brings on an attack of coughing. 9. The patient should be visited twice a day. One of the visits should be made as late as possible. 10. The patient should be considered as in a grave condition, and the family warned of possible accidents. 11. In case of sudden suffocation, from obstruction, a pharyngeal injection may be made. This will bring on an attack of coughing which may bring up the tube, provided that the downward flow has not removed the obstruction. If this does not succeed, the patient should be tipped over the side of the bed with the head hanging very low. This position favors the expulsion of the tube. 12. Extubation should always be done in the morning, as one may find it necessary to re-introduce the tube some hours later. 13. After extubation the physician should remain at least half an hour. A sudden and threatening dyspnoea (spasm or paralysis), such as would render a re-intubation necessary, will always appear very shortly after the tube is removed; whereas a slowly increasing dyspnoea (œdema or the persistence of false membranes) would give ample time for the physician to be called to the house. 14. The physician should always be ready to come to the case at once, and should keep the family informed, as far as possible, just where he can be found at any given time.—*N. Y. Med Journal.*

A DISTINCT VARIETY OF HIP-JOINT DISEASE IN CHILDREN AND YOUNG PERSONS.

Edmond Owen (*Medico-chirurgical Transactions*, vol. lxxxii; *St. Paul Medical Journal*, September) says that, after acknowledging the frequency of tuberculous disease of the hip joint, traumatic synovitis or arthritis, and admitting the rarity of syphilitic and osteo-arthritic inflammation,

there still remains a very important group of hip joint diseases which should be recognized and distinguished from the foregoing diseases, with which they have not infrequently been confused, viz., septic disease of the upper end of the diaphysis of the femur, spreading into the synovial cavity and rapidly involving the hip joint in an acute and devastating suppuration. In children there is no disease more sudden in its onset or disastrous than acute arthritis of the hip originating from septic osteomyelitis. The peculiar anatomy of the parts makes the joint especially prone to be attacked by the micro-organisms of septic myelitis, as well as by the bacilli of tuberculosis. The invasion of the germ follows injury to the limb or any condition which lowers the vitality of the tissue, and thereby renders it less capable of resisting the invasion of the staphylococci; thus scarlet fever, measles, typhoid fever or influenza may forerun the attack of acute suppuration of the hip.

In many cases in which the surgeon opens the hip joint and finds the solid head of the femur detached from the neck and scarcely affected by carious disintegration, the cause of the separation has been septic inflammation just below the junction cartilage. The sound detached epiphysis and its even contour are proofs that the separation occurred early in the course of the disease and before the joint was occupied by granular tissue. This condition is very different from the "worm eaten," irregular shaped appearance in tuberculous disease.

The symptoms of this acute condition of the joint differ widely from those of the tuberculous form in that the onset is sudden, in a few days the symptoms attaining allarming intensity, the child having all the appearances of sepsis, even at times delirium, temperature as high as 104° F., or showing depression instead of elevation. The low temperature is explained by assuming "that the dose of toxic material elaborated by the growth of micro-organisms may be so intense that the heat-producing centre, like every other area, is profoundly affected; this general depression may end in a fatal collapse." The local symptoms are similar to those of tuberculous disease—that is to say, pain in the hip, though more severe and intensified by motion, and night cries. The onset is decidedly different from the slowly developing symptoms of tuberculous hip-joint disease, where there is in the beginning only a slight limp, a little pain now and then, and gradual increase of stiffness, etc.

The disease might be mistaken for an acute rheumatic affection or for unusually acute symptoms of a tuberculous

inflammation, but the importance of early diagnosis is apparent, for upon this depends the prognosis.

The indication for treatment in these cases can not be questioned, nor should we wait until the abscess is demonstrated by fluctuation, but it should be opened up, thoroughly washed out, disinfected with a hot solution of zinc chloride (ten grains to the ounce), and thoroughly drained. If the septic focus is entirely removed the patient is not only completely and promptly restored to comfort, but may make an immediate recovery. A detail of the operations and treatment of cases demonstrates the importance of early distinguishing his acute condition of the hip joint from tuberculous disease of that joint.—*N. Y. Med Journal.*

OBSTETRICS.

IN CHARGE OF

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THE VALUE OF ANTISTREPTOCOCCIC SERUM IN THE TREATMENT OF PUERPERAL IN- FECTION.

(*Report of the Committee of the American Gynæcological Society,
May, 1899.*)

This committee was appointed to consider the above subject, and was composed of Drs. J. W. Williams, W. R. Pryor, H. D. Fry and E. Reynolds. Although the experiments commenced by the committee had not been concluded at the time this report was made, and will be given later, they have concluded from a careful study of the literature upon the subject as well as their personal observations as follows:

“Your committee would sum up the results of their studies and observations in the following conclusions:—

“1. A study of the literature shows that 352 cases of puerperal infection have been attended by many observers with a mortality of 20.74 per cent.; where streptococci were positively demonstrated, the mortality was 33 per cent.

“2. Marmorek's claim that his antistreptococcic serum will cure streptococcic puerperal infection does not appear to be substantiated by the results thus far reported.

"3. Experimental work has cast grave doubts upon the efficiency of antistreptococcic serum in clinical work, by showing that a serum which is obtained from a given streptococcus may protect an animal from that organism, but may be absolutely inefficient against another streptococcus, and that the number of serum which may be prepared is limited only by the number of varieties of streptococci which may exist.

"4. Thus far the only definite results of Marmorek's work is the development of a method by which we can increase the virulence of certain streptococci to an almost inconceivable extent, so that one hundred billionth of a cubic centimetre of a culture will kill a rabbit.

"5. The personal experience of your committee has shown that mortality of streptococcus endometritis, if not interfered with, is something less than 5 per cent., and that such cases tend to recover if nature's work is not undone by too energetic local treatment.

"6. We unhesitatingly condemn curettage and total hysterectomy in streptococcus infections after full term delivery, and attribute a large part of the excessive mortality in the literature to the former operation.

"7. In puerperal infections a portion of the uterine lochia should be removed by Döderlein's tube for bacteriological examination, and an intra-uterine douche of four to five litres of sterile salt solution given just afterwards. If the infection be due to streptococci uterus should not be touched again, and the patient be given very large doses of strychnia and alcohol if necessary. If the infection be due to other organisms, repeated douches and even curettage may be advisable.

"8. If the infection extends towards the peritoneal cavity and in gravely septicemic cases, Pryor's method of isolating the uterus by packing the pelvis with iodoform gauze may be of service,

"9. The experience of one of the members of the Committee with antistreptococcus serum has shown that it has no deleterious effect upon the patient, and therefore may be tried if desired. But we find nothing of the clinical or the experimental literature, or to our own experiences to indicate that its employment will materially improve the general results in the treatment of streptococcus puerperal infection."

Amer. J. of Obs.

ECLAMPSIA TREATED BY SALINE INFUSION.

Allen (*Am. Jour. of Obst.*) reports 3 cases treated by this method. Case I, a secundipara, aged 23, had been in convulsions seventeen hours when first seen, and had had about twenty-five attacks. When brought into hospital she was comatose. Under chloroform the cervix was incised to the vaginal vault, internal podalic version was done and the child was extracted—time, seven minutes. Free hæmorrhage from uterus and from cervical incision; tamponnade of uterus and vagina with sterile cotton pledgets. As soon as possible an injection of saline solution was made into the cellular tissue under the mammary glands; 1,000 c.cm. were used, strength 6 grams to one litre. Nine hours after delivery a second injection of 1,400 c.cm. was given. On the following day the tampon was removed, the uterus was washed out with sterile salt solution and 1,400 c.cm. injected subcutaneously. On the third day 1,400 c.cm. were injected, making 5,200 c.cm. in three days. After each injection the change for the better was marked. Medicinal treatment was used also, mostly eliminative. The patient was discharged perfectly well on the twenty-first day. The child was practically dead when born, and all efforts failed to resuscitate it. Case II. A primipara, aged 18, was seen after having had five convulsions. Delivery was effected under chloroform in the same way as in Case I, and occupied eight minutes. Half an hour after delivery 600 c.cm. of sterile salt solution were injected under the mammary gland and 1,200 c.cm. six hours later. On each of the two following days 1,400 c.cm. were injected, making 4,600 in all. The patient was well on the twenty-third day except for a breast abscess caused by the needle. The child was born asphyxiated, but was revived, and is now living and healthy. Case III, a primipara, aged 18, had had four convulsions before admission to hospital. Under chloroform the cervix was dilated with the fingers, forceps applied and delivery completed. Pulse immediately after delivery 130. Twenty minutes later 1,100 c.cm. salt solution were injected; fifteen minutes after injection, pulse 104; thirty minutes after injection, 97. One hour and a quarter after labour a convulsion occurred; the cephalic vein was opened, and 656 c.cm. of very black and thick blood allowed to flow out; at the same time 700 c.cm. salt solution were injected; pulse 98. Six hours after labour another convulsion; vein opened again and 192 c.cm. of blood drawn. Morphine, $\frac{1}{6}$ gr. hypodermically; chloral hydrate 40 gr. and potassium bromide 60 gr., *per rectum*. After this no more convulsions occurred,

and the patient was quiet; there were no more indications for salt injections, and the patient was discharged on the nineteenth day perfectly well. The child was asphyxiated; but revived after a time, and seemed in fairly good condition. About two hours after delivery a convulsion occurred, resembling very closely those of the mother. The ligature was removed from the cord and 2 ounces of blood allowed to flow; 6 drachms of salt solution were injected under the skin, after which it did well, until, five hours later, the convulsions returned, occurring every ten minutes. Three ounces of salt solution were injected into the rectum, and the child put into a continuous warm bath, but it gradually became worse and died nine hours after birth. The author gives the following excellent summary of the treatment of eclampsia: *Pre-eclamptic stage*.—Purge the bowels, stimulate the skin by warm baths twice a day; use a milk and water diet and give sedatives. Examine urine quantitatively for urea; if the quantity is insufficient, stimulate, and keep the patient under close observation. If there is no improvement, induce premature delivery. *Eclamptic stage*.—Give morphine hypodermically at once, and inject into the rectum 40 gr. chloral hydrate and 60 gr. potassium bromide. As soon as possible put the patient under chloroform and complete delivery; this usually necessitates forceps or version, more often the latter. Use force if necessary. The disease cannot be treated till the cause is removed. After delivery do not stimulate the uterus to contract, but let it remain relaxed and bleed until the patient's symptoms show that she has had enough. If sufficient hæmorrhage does not occur, open a vein. As soon after delivery as possible, inject sterilized salt solution subcutaneously; as much as 700 c.cm. can be injected under each mamma. Continue this at intervals for two or three days. Stimulate elimination; for the bowels the best is croton oil—2 drops in 2 drachms of olive oil. As soon as the patient rouses sufficiently, give drachm doses of Epsom salts every hour. The salt solution usually acts wonderfully in stimulating the kidneys; but, if necessary, use dry and wet cups with a half-ounce of infusion of digitalis every four hours. The diet is exclusively milk. To stimulate the skin the hot-air bath or the wet pack is used. Tonics during convalescence.

SORE NIPPLES.

Painting the nipples several times a day with the white of an egg is stated to be a most successful treatment for the sore nipples of nursing women.

NON-ECBOLIC HÆMOSTATIC REMEDIES.

Bossi (*Rif. Med.*) complains of the abuse of ergot as a uterine hæmostatic on account of its ecbolic properties. *Hydrastis canadensis*, *hamamelis virginica*, *stipticin* and *antifibrin* each in their degree act as uterine hæmostatics without having any ecbolic action. When metrorrhagia occurs in the course of pregnancy, and it seems feasible to avoid interruption of the pregnancy, the author has found a mixture of ext. fl. hydrast. can., fl. ext. hamamelis, tinct. piscidia erythr., fl. ext. viburn and liq. opii the most useful. When abortion seems inevitable, he recommends a mixture of *hydrastis*, *hamamelis* and *stipticin*. At the same time quinine should be given. Sugar in doses of 50 to 200 grams dissolved in 150 to 500 grams of water is also spoken of as a valuable adjunct.

INFLUENCE OF MATERNAL INEBRIETY ON THE OFFSPRING.

W. C. Sullivan (*Four. of Ment. Sc.*) has investigated the history of the offspring of chronic drunkards (women) in the Liverpool prison, and has tried to eliminate the cases in which the alcoholism was complicated by other degenerative factors. Among the many interesting points which the enquiry brought out were the following: The death-rate among the infants of the inebriate mothers was nearly two and a half times that amongst the infants of sober women of the same stock. In the alcoholic family there is a decrease of vitality in the successive children; for instance, in one family the three first-born children were healthy, the fourth was of defective intelligence, the fifth was an epileptic idiot, the sixth was deadborn, and the seventh pregnancy ended in an abortion. There was a sensibly higher death-rate in cases where the maternal inebriety was developed at an early period. Sober paternity had little influence, and in face of maternal drunkenness might be almost neglected as far as the vitality of the offspring is concerned. Conception in drunkenness had a distinct influence, as was shown by the fact that in the seven cases in which the condition was noted; in six the children died in convulsions in the first months of life, and in the seventh case the infant was still-born. On the other hand, imprisonment during pregnancy, if the imprisonment began early in the pregnancy and lasted nearly all the time, seemed to diminish the evil effects; but the difficulties in drawing conclusions regarding this point

were great. Of the children of drunken mothers that survived beyond their infancy, 4.1 per cent. (a very high percentage) became epileptic (9 out of 219). These results show the danger to the community of the female drunkard.

PELZER'S METHOD EMPLOYED BY THE PATIENT ON HERSELF.

C. Jewitt (*Brooklyn Med. Four.*) relates the case of a woman pregnant for the second time, and possessing some knowledge of gynæcological methods, who determined to bring her gestation to an end. She injected a few drachms of glycerine into her uterus, and on the next day the ovum was expelled. Within 24 hours after the injection she was seized with chills, and the temperature rose to 103° F. After the second day there were frequent vomiting and diarrhœa. On the third the teeth were covered with sordes and a profuse hæmorrhage occurred from the nose, which was controlled only by plugging. The urine was from the first almost wholly suppressed, and was of a dark red colour from the presence of hæmoglobin. Death occurred on the sixth day.

INDICATIONS FOR CÆSARIAN SECTION.

FANCOURT BARNES.

The most recent statistics give the following figures :

	Maternal Mortality.	Fœtal Mortality.
Symphyseotomy.....	10.8 per cent.	14.5 per cent.
Cæsarian section	7.6 per cent.	7.6 per cent.

The conclusions he says at which I arrive are :

(1) As regards symphyseotomy I consider that the operation has not justified its existence, and I cannot help thinking that in a few years the eminent obstetricians who have been advocating it will abandon its use.

(2) Induction of premature labour within certain limits will always hold a recognized and useful position among obstetric operations.

(3) And, lastly, we are forced to the conclusion, after a careful study of the latest figures which have been published on Cæsarian section, that it is a scientific and justifiable operation, and that it will be more widely resorted to in the future as the science of obstetrics advances than it has been in the past.—*Annals of Gyn. & Ped.*

Therapeutic Notes.

FOR NASAL IRRIGATION.

- R Sodium bicarbonate.
Sodium baborate.
Sodium chloride..... āā gr. xxx.
Sodium salicylate..... gr. xl.
Oil of bergamot..... ℥ iij.
Listerine ʒ ss.
Glycerin ʒ i.
Distilled water, enough to make ʒ viij.

M.

—G. STERLING RYERSON.

PRURITUS OF THE SCROTUM.

- R Hydrarg. bichlorid..... gr. viij.
Alcohol.
Aquæ chamomil..... āā ʒ vi.
Chloroformi..... gtt. v.
Aquæ camphor..... q. s. ad. ʒ iij.

M. S. Apply as a lotion.

—LEISTIKOFF.

DYSPEPSIA WITH INSUFFICIENCY OF MOTOR ACTION.

Mathieu (*La Presse Médicale*, April 5, 1899) considers ipecac in small doses as one of the best excito-motors for the stomach. It can be prescribed in the following way:

- R Tinct. ipecac.
Tinct. calumbæ.
Tinct. gentian..... āā 5 gm.

M. S. Fifteen to thirty drops two or three times after a meal at intervals of from one-half to one hour.

Or:

- R Tinct. ipecac..... 6 gm.
Saccharin 0.10 cgm.
Menthol..... 0.25 "
Alcohol..... 40 gm.
Simple syrup..... 120 "

M. S. Two to four teaspoonfuls in coffee after meals.

Or:

R	Tinct. ignatiæ.....	6 gm.
	Tinct. ipecac.....	1 "
	Tinct. anisi.....	5 "

M. et. ſilt. S. Take six drops in a little Vichy after each meal.

Or:

R	Powdered ipecac.....	0.02 cgm.
	Sulphate of potassium.	
	Nitrate of potassium.....āā	0.05 "
	Bicarbonate of soda.....	0.30 "

M. et ft. Tablet No. i. S. Take in a little water five to ten minutes before a meal.

CATARRHAL LARYNGITIS.

R	Chloralis	gr. lxxv. (5 gm.)
	Potassii bromidi.....	gr. xlv. (3 ")
	Ammonii bromidi.....	gr. xxx. (2 ")
	Aquæ cinnamomi.....	ʒij. (62 ")

M. S. Teaspoonful, and repeat in twenty minutes if not relieved. This is for a child of five years of age.

—JOSEPH HOLT, of New Orleans.

SCARLET FEVER.

J. Lewis Smith recommends the following "diaphoretic, diuretic and laxative" mixture for scarlatinal nephritis:

R	Potassi acetatis.	
	Potassi bicarbonatis.	
	Potassi citratis, āā.....	ʒ ii
	Infus. tritici repentis. ad.....	ʒ viii

A teaspoonful every three or four hours for a child of five years.

Whitla gives the following diaphoretic mixture for the early stages of scarlet fever:

R	Spiritus ætheris nitrosi.....	ʒ ii.
	Potassii citratis.....	ʒ i.
	Liq. ammon. acet.....	ʒ iss.
	Syrupi simplicis.....	ʒ i.
	Aquæ camphoræ, ad.....	ʒ iv.

M. Sig. A teaspoonful every three hours.

Widerhofer recommends the following for scarlet fever, with throat affection :

R	Potassi chloratis.....	gr. xx.
	Syrupi aurantii.	ʒ iii.
	Decoct. cinchonæ, ad.....	ʒ iii.

M. Sig. A teaspoonful every two hours.

THROAT SPRAY.

Whitla uses the following spray for the throat in scarlet fever :

R	Glycerini boracis.....	ʒ iv.
	Glycerini acid. carbolicæ.....	ʒ iii.
	Aquæ rosæ, ad.....	ʒ x.

SKIN LOTION.

J. Lewis Smith recommends the following lotion for the itching of the skin in scarlet fever :

R	Acidi carbolicæ.....	ʒ i.
	Tinct. camphoræ.....	ʒ ii.
	Aquæ puræ.....	O i.

M. Shake well, and apply over surface when needed for pruritis.—*four. Am. Med. Association.*

In cases of scarlet fever I have during the past thirty years never failed to give immediate relief to an itching skin by rubbing the body with cocoa butter.—F. W. CAMPBELL.

PALATABLE QUININE MIXTURE FOR CHILDREN.

(1) R	Quinine hydrochlorate.....	gr. v-gr. x.
	Alcohol.....	ʒj.

M.

(2) R	Oil of cinnamon, } each.....	ʒ xxx-xl.
	Oil of anise,	
	Magnesia.....	q. s.
	Water.....	ʒj.

M. Let stand for some hours; filter.

(3) Mix 1 and 2 and add :

	Simple syrup.....	ʒiij.
	Carmin or cochineal solution.....	gtt. v.

Dose, one or two drachms, as directed.

Saccharin in small quantity helps to disguise the larger dose of quinine.

Small doses of Fowler's solution may be added, if indicated, or sodium bromide for children made irritable by quinine.

Druggists will make this in quantity and keep it in stock if requested. It is simple, easily made and inexpensive. Moreover, children like it.—DR. GREANELLE, *New York Med. Jour.*, Oct. 28, 1899.

PILLS FOR THE HEADACHE OF NEURASTHENICS.

The *Riforma Medica* for July 24th gives the following formulæ:

I R Zinc phosphide 0.23 grm.
 Reduced iron..... 3 grm.
 Extract of nux vomica..... 1.8 grm.

M. Divide into eight pills. Two or three to be taken daily.

2 R Zinc valerianate,
 Iron sulphate,
 Extract of rhubarb,
 Asafoetida. } each... 18 grains.

M. Divide into twenty pills. One to be taken three times a day.

A HYPNOTIC.

Dr. F. Marz (*Province Médicale*, September 2) gives the following combination :

R Trional 15 grains.
 Powdered codeine..... ½ grain.

For one powder. To be taken at bedtime.

TREATMENT OF BALDNESS.

Dr. Whitla gives this as one of the best combinations in the treatment of baldness :

R Pilocarp. hydrochloratis..... gr. 5
 Otto rosæ..... m. 8
 Ol. rosmarini..... dr. 4
 Linimenti cantharidis..... dr. 4
 Glycerini puri..... oz. 1
 Ol. amygdalæ dulcis..... oz. 3
 Spts. Camphoræ..... oz. 3

M. Sig. To be rubbed well into the scalp night and morning.

MUSCULAR RHEUMATISM.

R	Sodii salicylatis.	
	Potass. acetatis āā.....	dr. 4
	Glycerini	oz. 2
	Aquæ q. s. ad.....	oz. 4

M. Sig. One teaspoonful in one-half glass of water or milk every two hours.

CHILDREN'S EMETIC.

R	Pulv. ipecacuan.....	gr. viiſſ.
	Antimonii et potassii tartratis..	gr. ⅙
	Oxymel scillæ.....	ʒ iiss.
	Aq. distill..... q. s. ad.	ʒ i.

M. S. One teaspoonful every ten minutes.—BAGINSKY.

INHALATION IN TUBERCULOUS LARYNGITIS.

R	Menthol.	
	Ether. sulphuric.	
	Ol. pini sylvestris.	
	Tinct. iodii.....āā	ʒ ij.
	Tinct. benzoin. co.....ad.	ʒ ij.

M. S. Ten drops on an oro-nasal inhaler which is worn as much of the time as possible.—W. FOWLER.

FOR ALKALINE URINE.

R	Acidi borici.....	ʒ iiss.
	Ext. uva. ursi fluidi.....	ʒ iv.
	Ext. hyoscyami fluidi.....	ʒ iv.
	Ext. lupulini fluidi.....	ʒ iv.
	Syrupi zingiberis.....	ʒ ii.
	Aquæ, q. s. ad.....	ʒ vi.

M. Sig. Two teaspoonfuls in water after meals.—*Ex.*

Jottings.

There is said to be a recognizable danger point in anesthesia. As the anesthesia progresses the corneal reflex is abolished and the pupil contracts to a point. The moment the pupil reaches this point, says the *Four. de Med. et de Chir.*, the anesthesia is profound and the chloroform should be suspended. If the pupil begins to dilate again slowly and gradually, more chloroform will reduce it again to a point. But if it suddenly dilates rapidly, this is a signal of impending immediate collapse, and every effort should be made to facilitate respiration.

Lime frequently causes great pain in the eyes; yea, it sometimes destroys the sight. A simple remedy, which at once removes the pain, is to wash out the eye with sugar water. The lime, in this case, enters a chemical combination which soon takes away its corroding action.

Dr. J. Howe Adams (*Medical Times*, September) records six cases of phthisis in which the congested pharyngeal "sore throat" was treated by the administration of the fluid extract of ergot in twenty-minim doses three times a day with excellent results, the sore throat subsiding in from three to five days. Ulceration was present in two cases. All the cases but one were those of patients in an advanced stage of phthisis.

There is a certain form of incontinence of the urine, most often seen in elderly or nervous females, in which there is a frequent desire to pass water, or the patient cannot hold it long, or it gushes away in the act of coughing, sneezing or laughing. In all these cases the incontinence is due to want of power in the vesical sphincter. In such cases the tincture of cantharides is the proper remedy, but it should be given in small doses—one minim well diluted three or four times daily, or put half a drachm in four ounces of water and give a teaspoonful every hour or two.

In rigid perineum Dr. Southworth says that "he who tries the following will never be disappointed. I consider it indispensable and infallible": Chloroform, 2 drachms; ether, 1 drachm; spirits cologne, 1 drachm. Mix and apply locally.

The *Medical Press and Circular* (Dublin) of July 5, 1899, says that in the constipation of infants the first step must be to regulate the habits and life of the mother. She must be placed on a diet of fresh meat, fresh vegetables and freshly cooked fruit, with due provision for regular exercise and restriction in the matter of tea-drinking and other dietetic irregularities. This *regime* will diminish the proteid and increase the fatty constituents of the milk, and will go far to rid the infant of the tendency to constipation. Should it fail, the best treatment for the child is the administration of cream in doses of from one to two teaspoonfuls in warm water from time to time just before the periodical meal.

Horn is strongly in favor of the dry treatment of the umbilical stump, with the use of earth powder, and no baths until after the cord has fallen off. He allows the children to be bathed once, immediately after birth, and then the cord is dressed with dry cotton and the powder. In 160 consecutive cases so treated there was no case of suppuration, the powder being antiseptic and not irritating to the child's skin. The falling off of the stump cord is slightly delayed, but the umbilicus is left in such very good condition that the method is well worth using.

All that is necessary in epistaxis is to fashion with a pair of scissors a dry plug of prepared sponge, in size and length comparable with the little finger of a twelve-year old boy. This should be carefully soaked in boiled water, to free it from grit, squeezed dry to free it from unnecessary fluid, and inserted its full length, gently, along the floor of the bleeding nostril. No styptic is necessary. The expansive pressure of the soft sponge against the bleeding side, increased by the coagulation of a few drops of blood in its interstices, will check the bleeding at once. It should be removed in twelve hours; under no circumstances should it remain longer than twenty-four. Melted vaseline containing 5 per cent. of carbolic acid, applied with a medicine-dropper in liberal quantities, is the only local treatment called for afterward.—B. CORNICK, in *Canada Lancet*.

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Editorial.

Insurance medical specialists on the other side of the Atlantic, especially on the continent, would seem to have very crude ideas of their work. Not only do they adhere with tenacity to the old-fashioned detailed form, but, when they attempt improvements, it often seems as if they were unnecessarily increasing their own work. As it is, the medical forms of many English Life Insurance Companies are altogether too voluminous. Compared to those on this side of the Atlantic, and especially with most American companies, they ask for an amount of detail which, in the opinion of Insurance underwriters, is entirely useless; in fact, the tendency of the present day is abbreviation. Indeed as a matter of fact, one of the great Insurance corporations of this continent has, within a few months, reduced the writing of the Medical Examiner. It is, of course, well known that in all Medical Examiners' reports, it has been the habit to ask the examiner to classify the risk. He is asked to state whether it is a first class risk, a good risk or a bad risk, or, if this is not the form, then he is asked if he recommends the risk "yes or no." The company to which we refer has eliminated all this. The examiner is not asked either to advise acceptance or rejection. He is simply required to

give as clearly as possible all the information asked for, and on these the Medical Directors at the Home Office decide how they will deal with it. We have been induced to make these remarks from an article which appears in the *Post Magazine and Insurance Monitor* of the 25th November. This periodical is published in London. From it we gather that, quite recently, an International Congress of Medical Examiners was held at Brussels. It is said to have been a thoroughly representative gathering of the Medical Insurance world (European), and that one of the objects of the Congress was the simplification of the Medical Examination form or blank, as it is called on this side of the Atlantic. How well they have succeeded our readers will understand when we tell them that the new form, which this Congress has evolved, occupies six closely printed pages of foolscap. There are fifty-two questions to be answered by the proposer alone, independent of those relating purely to his family history. The Medical Examiner himself has to report on a further list of one hundred and thirty-two items. Then there are "anthropometrical" tables to be filled up and "abdominal charts" to be sketched in. It is, we think, safe to say that this new model has not the slightest chance of being adopted by any Life Insurance Company. The work such forms would necessitate could not be performed for twice the highest fee now paid by any Insurance Corporation, and, moreover, is quite unnecessary. The tendency of the age everywhere is to make smooth and easy the pathway of the medical examiner, and not to confuse him in the performance of a most important duty. "What's the length of your left ear?" is one of the questions suggested to be put in the new medical blank. What information an answer to this question is supposed to evolve passes our comprehension. It is said that the Belgian Minister of Agriculture presided over this Congress. Were it not that we know such was not the case, one might imagine that it was a veterinary assemblage. Then this question of the ears might be held to apply to those members of the animal world which are now playing so important a part in the war in South Africa.

OPERATIVE TREATMENT OF APPENDICITIS.

Medicine for October says: "In the last edition of Osler's Practice it is stated that all cases of appendicitis are essentially surgical. He condemns the use of cathartics and other medicinal means of treating the disease, and states that even a suspicion of this disorder should look to its reference to a surgeon. The statistics collected by F. W. McRae for the address on surgery before the American Medical Association were exceedingly interesting and instructive, in view of Osler's authoritative condemnation of the medical treatment of appendicitis. The collected statistics of McRae include 2,903 cases published during 1898 and 1899. Eight hundred and seventy-four cases were operated upon during the acute attack as soon as the diagnosis was made, with 170 deaths, a mortality of 19.45 per cent.; 896 were treated in a medicinal way without surgical intervention, with 106 deaths, a mortality of 11.83 per cent., and 457 were operated upon during the interval—in these there was only one death. If reliable deductions can be gathered from the foregoing, it rather militates against universal operation. The figures are in the main correct, at least against the advisability of early operation, because if they err in any direction it is in a failure to report the unfavorable cases. So far as these statistics go, they tend to support the views of many, notably Keene of Philadelphia, who does not regard every case of appendicitis as suitable for operation, but thinks that many make a good recovery under medicinal or no treatment. The symptoms of severe appendicitis, such as pain, rigidity, vomiting and rapid pulse are sufficiently indicative of danger to furnish definite rules regarding the necessity of operation. It would be interesting if comparative studies could be made of the mortality of severe cases when operated upon and when treated medicinally. The statistics of McRae leave us in no sort of doubt as to the most favorable time to operate for appendicitis, namely, between the attacks. The mortality is reduced at this time almost to the vanishing point, and every recurring case of appendicitis should have the benefit of operation in the interval."

PHOTOGRAPHING THE STOMACH.

The *New York Medical Jour.* says a device has been made by Dr. Fritz Lang, of Munich, Germany, by which the inside of the stomach can be clearly photographed, so that it will give a very accurate means of diagnosing a class of diseases which has heretofore been attended, in some cases, with great difficulty.

The camera is constructed on exactly the same principles as all cameras for taking moving photographs, although, of course, there is no attempt made to combine them so as to project the actual operations of the stomach. It is doubtful, however, if a camera has ever before been fashioned which is as compact as this one, or which has been put to as strange a use.

This camera is actually swallowed by the patient, and no sooner does it reach his stomach than the walls thereof are illuminated by a small electric lamp attached to the apparatus. At the bottom of the camera is wound a photographic film twenty inches long and a quarter of an inch wide, and one end of this film is fastened to the cord, which runs freely in the tube. Of course the cord and the conducting wires must be swallowed with the camera itself, for in order to draw the film past the lens the cord must be pulled.

As soon as the camera reaches the bottom of the stomach, the work of photographing may begin. All the surgeon has to do is to pull the cord and thus run the film past the lens. The electric light is then turned on and after the sensitive film has been impressed with the image the current is turned off and another section of the film is brought into play until the requisite number of pictures have been obtained. When this is done the entire apparatus is withdrawn from the stomach, and the films are carefully developed and enlarged.

TO PREVENT ETHER NAUSEA.

In the *Philadelphia Medical Journal* of September 23 Dr. Samuel Edwards of Baltimore reported four years' experience with vinegar as a preventive of the nausea which follows the administration of an anesthetic. The vapor of

vinegar is given by inhalation immediately upon the discontinuance of the anesthetic. It is said to prevent both the nausea and vomiting and also the intense thirst which commonly follow. He reports that in four years' use, success has followed the employment of this method in 97 per cent. of the cases. No suggestion was given as to the method of operation of the remedy, but so definitely observed an empiric fact is well worthy of further trial by others. Certainly if the remedy is successful in anything like the proportion of cases that is reported, it will prove of the very greatest value to the operating surgeon, as the nausea following the use of the anesthetic is very often one of the serious complications of the first days after an abdominal operation.

Book Reviews.

Progressive Medicine—A quarterly digest of advances, discoveries and improvements in the Medical and Surgical Sciences. Edited by Hobart Amory Hare, M.D., Professor of Therapeutics and Materia Medica in the Jefferson Medical College of Philadelphia. Vol. III., Sept., 1899. Lea Brothers & Co., Philadelphia and New York, 1899.

In our August number we acknowledged the receipt of the first two volumes, and then expressed our appreciation of its object and the very satisfactory manner in which that object had been carried out. We can but reiterate the same opinion regarding the volume now before us, and in an especial manner draw our readers' attention to it. Its cost is but an infinitesimal fraction of its value. The present volume deals with diseases of the thorax and its viscera, including the heart, lungs and blood vessels; diseases of the skin; of the nervous system; obstetrics.

The Physician's Visiting List (Lindsay & Blakiston's) for 1900; forty-ninth year of its publication. Philadelphia: P. Blakiston, Son & Co.

We have to thank the publishers for a copy of this well-known and thoroughly tried visiting list. We do not think that we can better endorse this publication than by saying that we have used it for thirty-seven years, and it has given us perfect satisfaction. In years past, we have tried once or twice to use others which reached our Editorial table, but, not finding the same satisfaction, was glad to fall back on Lindsay's. We presume it may be possible to improve on it, but that improvement has not yet appeared, and to-day it undoubtedly holds first place.

PUBLISHERS DEPARTMENT.

EDITORS PLEASE NOTICE.

The *Living Age* for 1900. During the fifty-six years of its existence this sterling weekly magazine has steadily maintained its high standard. It is a thoroughly satisfactory compilation of the most valuable literature of the day, and as such is unrivalled. As periodicals of all sorts continue to multiply, this magazine continues to increase in value; and it has become a necessity to the American reader. By its aid alone he can, with an economy of time, labor, and money otherwise impracticable, keep well abreast with the literary and scientific progress of the age and with the work of the ablest living writers. It is the most comprehensive of magazines, and its prospectus for 1900, which appears in another column, is well worth the attention of all who are selecting their reading-matter for the new year. To new subscribers remitting now for the year 1900 the intervening numbers of 1899 are sent *gratis*. The *Living Age* Co., Boston, are the publishers.

The December issue of *The Art Amateur* is really and truly what it is called—a Christmas Number. From the charming cover—"Madonna and Child"—to the end of the magazine with the Colonial hall decorated with holly and smilax the Christmas spirit is everywhere evident. The color plate should be highly prized, for it is a direct reproduction from the original "old master" "Virgin and Child," by Raphael del Colle, a contemporary of the great Raphael. The beautiful cover in color, and the frontispiece, "Madonna and Child," are from the painting by Mme. Demont-Breton, which created so much favorable comment at the Paris Salon this year, because of the tenderness and reverence with which the subject is treated. The illustrations in the number are of exceptional merit, including "The Crusty Old Bachelor's Christmas," by Frederick Barnard, and "The Cosy Old Maid's Christmas," "Christmas in Old Virginia," by W. A. Rogers; "Madonna and Child," by Van Dyck; "Preparing the Christmas Music," by Cederstrom. The Note Book and Collector are, as usual, replete with the important art news of the day. The practical illustrations include Drawing for Reproduction, Christmas Lettering, Painting in Oil Colors, Painting in Water Colors, the Arts of Metal, Dining-room in an Artist's Bungalow, Colonial Hall decorated for Christmas, Artistic Arrangement of Bric-a-Brac, the Art of Mineral Painting, Figure Painting, etc. Price, 35 cents. (John W. Van Oost, Publisher, 23 Union square, New York City.)

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Have you a case of indigestion, acute or chronic? If so, write Messrs. William R. Warner & Co., of Philadelphia, for complimentary copy of their book, "The Clinical Application of Ingluvin," by John V. Shoemaker, M. D., Professor of Therapeutics, Medico-Chirurgical College, Philadelphia. It is a very interesting book, beautifully printed on coated paper. Messrs. Warner & Co. are also issuing exceedingly interesting booklets, "The Acid Diathesis," "The History of Sugar Coated Pills" (of course you know that W. R. W. & Co. were the pioneer manufacturers of Sugar Coated Pills), "A Study of Rheumatism," "A Study of Constipation," etc. Any of them will be sent free upon request. Of course each of the books will tell you why it is desirable to specify "W. R. W. & Co." when ordering any of the remedies suggested in the booklets, and the reasons are very good ones, manufacturing, as they do, the highest quality of pharmaceuticals. Physicians certainly secure first-class remedies when they specify Wm. R. Warner & Co.