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Selections: Medicine.

DISEASES OF THE BRONCHIAL GLANDS.

BY RICHARD QUAIN, M.D., R.S.,
Consulting Physician to the Hospital for Diseases of the Chest at
Brompton; etc.

The study of the diseases of those lymphatic glands which are situated at the bifurcation of the trachea is of great interest and importance, not only in reference to the diseased glands themselves, but also by reason of the manner in which they, on the one hand, simulate, and, on the other hand, modify and mask the diseases of other organs in the neighbourhood. Throughout English and foreign medical literature numerous cases will be found described, in which there existed marked disease of the bronchial glands. Little notice, however, has been taken of less striking, but far more numerous, examples of disease. And it is only within a comparatively recent time that the condition has received special attention and been discussed as a disease *per se*. MM. Rilliet and Barthez, in their well-known *Traité des Maladies des Enfants*, have described the disease in infants; and Dr. West, in his work on *The Diseases of Infancy and Childhood*, has fully and clearly described—under the head of “Bronchial Phthisis”—the tubercular diseases of these glands in young subjects. It is, however, to M. Noel Guéneau de Mussy, following up and widely extending the investigations of his predecessors, that we are specially indebted for our knowledge of the effects of these lesions, and to his pupil, M. Baréty, who has published an exhaustive memoir upon them, under the title of *L'Adénopathie Trachéo-Bronchique*. The

subject has attracted my notice since, or even before, the year 1853, and I have kept short notes of nearly sixty cases which I have seen in private practice and which will form the basis of some of the conclusions to be here stated.

Before, however, describing the pathological and clinical history of the diseases of the bronchial glands, it will be well to make a short reference to their anatomical relations. Taking the bifurcation of the trachea as a starting point, we find in the space between the right and left bronchus a group of glands. They are from ten to fifteen in number, and they vary in size from that of a small pea to that of an almond. The glands towards the right bronchus are larger than those towards the left. Glands are also situated upon the tubes; they are few in number and small. The vascular supply of the glands, which is free, is derived from the bronchial arteries, and the blood is returned to the bronchial veins. Afferent lymphatics reach these glands from the lungs, from the pleura, from the neck, and other neighbouring parts. Besides these groups of comparatively large glands, numerous minute lymphatic glands are found in connection with the primary division of the bronchi, chiefly at the back of these tubes, at their bifurcations and those of the pulmonary artery. The central group of glands is in relation in front with the pericardium, the arch of the aorta, and the pulmonary artery; behind, with the pulmonary plexus of nerves, the œsophagus, the aorta, the vena azygos, etc. The glands on the upper, the anterior, and posterior surfaces of the right bronchus are four or five in number, and smaller than those of the central group. Their situation brings them into relation with the arch of the aorta, with the

innominate and subclavian arteries, with the brachio-cephalic vein, and with the vena azygos, the pneumogastric nerve, and its recurrent branch. The glands on the left bronchus are still smaller than those of the right side. Their position gives them relations with the arch of the aorta, the origin of the left carotid and subclavian arteries, the left branch of the pulmonary arteries with the large veins, with the left pneumogastric nerve, and especially with its recurrent branch. Lastly, it should be stated, as a guide in clinical examination, that the bifurcation of the trachea takes place in front of the body of the fifth dorsal vertebra, or between the fourth and fifth, and behind the lower end of the first bone of the sternum. The glands, except when diseased, are proportionately larger in children than in adult or aged persons.

The bronchial glands participate in the pathological conditions which affect lymphatic glands generally. In the present instance, however, those cases will not be noticed in which the bronchial glands, becoming the seat of constitutional disease in association with other glands in the neighbourhood, constitute large and manifest tumours. Nor is it intended to give prominent consideration to the state of the glands when they enlarge in acute disease—such as eruptive fevers; nor in those diseases—such as typhoid—where the glands play a secondary part. The writer has been anxious to describe and to aid in recognising the presence of a condition in which the disease of the bronchial glands constitutes to some extent a disease *per se*, or gives rise to complications which it is important to recognise. The remaining morbid changes to which the bronchial glands are liable may be grouped as follows.

a. The bronchial glands are liable to congestion with enlargement, as are glands in other situations. Hypertrophy may be the result, if the latter condition become chronic. After childhood, the glands in this situation become almost invariably studded with black deposits, the quantity of which may be so considerable as to constitute melanoma.

b. These glands are liable to acute and chronic inflammation. Acute inflammation in this situation, terminating in abscess, is rare, but several

cases of the kind have been recorded. Chronic inflammation of the glands is by no means uncommon. It may lead to permanent enlargement, or to contraction and induration of the glandular textures, with the presence of calcareous particles, or to abscess. The contents of the abscess may be more or less completely absorbed, leaving a partially filled sac or cyst, containing thick pus or cheesy matter. But these glands, when inflamed and enlarged, may form adhesions with surrounding parts, and the contents of an abscess, if it exist, may be discharged by an ulcerative process into the substance of a lung, into the mediastinum, into the trachea, or oesophagus, or even into a blood-vessel. Diffused emphysema has been found in such cases, and the emptied sac has assumed in some instances the character of a cavity connected with the lungs. When the matter is discharged into the air-passages, purulent expectoration is the result. Two or three examples of such cases were noticed in the writer's observation, and the possibility of their being mistaken for the discharge from a cavity in the lungs, or an empyema, was remarked upon at the time. The abscess may discharge into the mediastinum. A remarkable instance of the kind is recorded in the case of the late much lamented Dr. Fuller. A chronic abscess of the bronchial gland had opened into the posterior mediastinum. This led to pyæmia, the formation of abscesses in the brain, and to the loss of a valuable life.

c. These glands are liable to suffer especially from tuberculous or scrofulous disease; from various forms of malignant disease; and in cases of secondary or tertiary syphilis. Of the latter form of disease, some striking examples have fallen under the notice of the writer, in which symptoms closely resembling phthisis existed, but which yielded to treatment directed to the specific disease.

With regard to the ætiology of the diseases of the bronchial glands, it will be sufficient merely to allude, amongst predisposing causes, to hereditary predisposition, to general impairment of health, and the like. MM. Rilliez and Barthez have described the frequency of the disease in childhood. My own observations made on young persons and adults, show that in

fifty-nine cases, twenty-one were males and thirty-six females (in one case the sex was not recorded). Of these, two were under 10 years of age, nine were between 10 and 20 years of age, eighteen were between 20 and 30, and twenty-six were over 30 years of age; while in three cases the age was not stated. If these observations justify any inference, it is that females are more liable to disease of the bronchial glands than males, and that the disease occurs with increasing frequency after the age of puberty. Amongst the exciting causes of disease in these glands, I need not do more than mention those general conditions which give rise to disease in glands generally, such as scrofula, tubercle, malignant disease, etc., and will pass on to the consideration of the more immediate local exciting causes. Cold leads frequently to congestion and enlargement of the bronchial glands. But it is to local irritation or inflammatory disease in organs or tissues with which these glands have a connection, that the source of disease may be frequently traced. As we find the submaxillary or cervical lymphatic glands enlarged from irritation or disease in the mouth or throat, or the axillary glands or the inguinal glands enlarged from irritation or inflammation about the hands and feet, so we may find the bronchial glands enlarged temporarily or permanently from inflammatory disease in parts whose lymphatics pass to these glands. They have been observed to be enlarged in the course of or after certain acute specific diseases, such as scarlet fever, measles, and typhoid fever. In whooping-cough, this enlargement has been so frequently observed by M. Guéneau de Mussy, that he believes this disease to be an exanthem of the bronchial mucous membrane, and that this local disease leads to enlargement of the glands, which, again, by pressure on the pneumogastric and recurrent nerves, gives rise to some of the special phenomena of the disease, such as crowing cough, and even to the vomiting frequently observed in this disease. It is right to remark here that the late Dr. Hugh Ley speaks interrogatively, in his work on *Laryngismus Stridulus*, of enlarged bronchial glands being capable of producing a cough like whooping-cough; and he further alludes to some cases of whooping-cough in which the glands by the

side of the trachea were enlarged. He asks, "May it not be that an enlargement of these glands from a specific animal poison, similar to that of the parotid gland in mumps, is after all the cause of whooping-cough?" The same author gives several beautiful illustrations of diseased bronchial glands pressing upon the pneumogastric and other nerves. The black deposit so often found in the glands is the result of its absorption from the lungs.

The symptoms which I have observed as more or less characteristic of the presence of enlargement of the bronchial glands are the following.

1. Cough is noted as being a prominent symptom in thirty-nine cases. In twenty-one of these cases, it was stated to have been the most troublesome of the symptoms present. In six cases, it was described as harsh and laryngeal; in four cases, spasmodic, resembling whooping-cough. In the other cases, five in number, it was characterised as short and hacking, constant, incessant; and in one case, the sound resembled that made by the cough of a sheep.

2. Pain is, in regard to the frequency of its occurrence, the next symptom recorded. It was mentioned as being present in twenty-two of the cases observed by the writer. The seat of pain was almost constantly referred to the situation of the fourth and fifth dorsal vertebræ at one or both sides of the spinal column. The pain was mentioned in a few cases as existing only in front, beneath and at one or both sides of the upper end of the sternum and below the clavicles. The feeling was described in some cases (five) as of distressing tightness, and in one case as a "spasm." Tenderness on pressure over the seat of pain was very frequently observed. The persistence of the pain was very varied.

3. Difficulty of breathing was a noticeable symptom in several cases. In thirteen, it was recorded as being specially so; in four, it had all the character of spasmodic asthma, occurring at intervals and especially during the night.

4. Difficulty of swallowing was noticed in ten cases; in one of these the difficulty was remarked especially in swallowing liquids.

5. Hæmoptysis was present in ten cases. The amount of blood varied in these cases from marked streaks to copious expectoration, lasting two or three days. No case was recorded as presenting this symptom, except on tolerably clear proof that it depended on bronchial gland enlargement, and on no other cause.

6. Congestion and puffiness of the face were noticed as present in three cases.

7. The expectoration of mucus, such as results from bronchial catarrh, was frequently present. Expectoration of pus was present in three cases. In each it resembled the contents of an ordinary glandular abscess mixed with air. In one of these, the discharge was intermittent. The frequent occurrence of cough, without any expectoration, was remarked in many cases. Calcareous particles are mentioned also as having been expectorated.

8. Loss of voice (four cases) and hoarseness (two cases) are recorded as striking symptoms.

9. Vomiting is mentioned as having been present twice.

10. Lastly, the position assumed with least discomfort by the patient when lying down was noticed in forty-one cases. Of these, twenty-three rested on that side on which the glands were mentioned as being chiefly if not wholly affected. In fifteen cases an opposite condition was noticed. In two cases, lying on the back was the most comfortable position. One patient unable to lie down, sat when in bed, and stooped forward. One patient, a little boy, could only rest on his face, elbows, and knees. This case was further remarkable in reference to the clearness with which the disease was recognised and the successful result of subsequent treatment.

It might be mentioned here incidentally that the glands of the right side were noticed as being chiefly affected in twenty-eight cases, and those of the left in twenty-two cases; in four, both sides seemed equally affected, and in four no record was made.

The general or constitutional symptoms connected with the malady under notice are in no-wise peculiar. The symptoms described above have special reference to these glands. The cough and its peculiar characteristics are, no doubt, in a great measure dependent on pressure

or on irritation communicated to the pneumogastric nerves and their branches. So likewise pain and difficulty of breathing, in a great degree, through direct pressure on the air-passages, may also cause or aggravate this symptom. Aphonia especially appears to have relation to the condition of the recurrent nerves. In one of the cases which the writer saw with Mr. Lennox Browne, paralysis of the left chorda vocalis existed. The diagnosis of glandular disease was clear, a conclusion confirmed by the results of treatment. Vomiting is mentioned in two cases. M. Guéneau de Mussy says this result is more frequent when the left pneumogastric nerve is pressed upon. He sees a connection between the troublesome vomiting which occurs in some cases of tubercular disease of the lungs with like pressure on nerves. The puffiness of the face and eyes noticed in these cases is due to the pressure on the venous trunks, a condition which also accounts, not only for hæmoptysis, but for bleeding from the nose, occasionally present. Copious and sometimes persistent hæmoptysis has been traced to the perforation of a vessel (ulceration in connection with disease of the glands).

Physical examination is of great importance in confirming the diagnosis that may be suggested by the presence of the symptoms just described. The following were the physical signs elicited in the fifty-nine cases referred to.

1. Dulness was present in forty-seven cases. It was found between the margin of the scapula and the spinal column at one or both sides, on a level with the fourth and fifth dorsal vertebra. It varied in degree, was more readily manifested when the muscles of the back were made tense by folding the arms across the chest, and was often strikingly distinct when one side was contrasted with the other. Dulness was present in front in eight cases (whether coincidentally with dulness at the back or not is not clearly stated), beneath the top of the sternum and at each side below the sterno-clavicular junction. The dulness here was best elicited by the patient holding the head backwards whilst percussion was being made.

2. Flattening of the affected side in front was mentioned in three cases. Diminished mo-

bility of the affected side, independently of flattening, was recorded in four cases. Prominence in front was not recorded in any case, though, no doubt, it may occur.

3. The respiratory sounds were variously modified. Marked tubular breathing was recorded as being present over the seat of disease in fourteen cases. In ten, the expiratory murmur was described as being very loud, various modifications of the inspiratory murmur being found at the same time. Feebleness of the respiratory murmur as a whole was noticed in fourteen cases. In some this deficiency extended over the whole lung; in others it existed over the upper or lower portion of a lung, behind or in front. The observations made on the voice by the writer were few, but M. Guéneau de Mussy and M. Lereboullet speak of a peculiar and increased reverberation of both the voice and the cough. Dr. Eustace Smith has described a venous hum heard at the root of the neck when the head is thrown back, caused by the pressure of the enlarged glands on the venous trunks in children.

The symptoms and signs above described will generally suffice for the diagnosis of diseases of the bronchial glands. It is, of course, necessary always to remember that, in the present and all similar instances, means have to be taken for excluding diseases which may produce like phenomena. Thus we may find cough, pain, tenderness on pressure, and aphonia, in a case of hysteria, without any evident structural disease. On the other hand, a small tumour, say a small aneurism, may produce all the signs of pressure which are above given as the signs of bronchial gland enlargement. It is the duty of the physician to recognise these differences and distinctions by tracing the effects to their sources.

The prognosis will in this, as in similar instances, so entirely depend on the nature of the disease, on its amount and its condition, on its relation to and effects on surrounding organs and textures, that each case must be regarded independently. It would be impossible to discuss them fully here—all that can be said is that simple enlargements generally yield to treatment, and within a reasonable period.

In several cases of bronchial gland enlargement, treatment has proved very effective. Such

cases would seem to be those of simple chronic enlargement. Many such have yielded to the use of iodide of iron in the form of pills or syrup, and to the external application of a solution of iodine, composed of equal parts of the tincture and the liniment of iodine, between the shoulders. The same treatment has likewise proved very effective in cases in which a syphilitic origin for the disease could be traced. Symptoms such as cough, difficulty of breathing, pain as well as dyspnoea, loss of flesh, strength, etc., will all require more or less suitable treatment. The cough and difficulty of breathing may in some cases be relieved by simple expectorants or antispasmodics. A useful application, when pain is a prominent symptom, is an embrocation composed of equal parts of chloroform, belladonna liniment, laudanum, and spirits of camphor. A couple of drachms of this composition sprinkled on the surface of piline, and applied on the painful part for a few minutes, often affords relief. Hypodermic injection of morphia may be required when pain is very severe. Under all circumstances, it is necessary to improve the general health by wholesome diet, pure air, and those other conditions which promote good digestion and elimination from the excreting organs.—*British Medical Journal*.

CHLORAL IN RETENTION OF URINE.—Dr. Tidd relates a case of twenty-four hours' retention of urine in a young woman in the eighth month of pregnancy. On account of tumefaction of the genital organs and some deviation of the urethra, all attempts at catheterism had failed; morphia was administered and puncture of the bladder proposed, when Dr. Tidd remembered the success which had attended the administration of chloral in like cases in the hands of some surgeons. He prescribed a solution of 10 grammes (150 grains) of chloral in 60 grammes (3ij) of water, and administered it in teaspoonful doses at first every half-hour, and then every two hours. Deep sleep ensued, in which the patient unconsciously passed an enormous quantity of urine. Excretion commenced five minutes after the second dose of the solution. Seven days later natural labour occurred; child living and healthy; no recurrence of retention.—*Le Practicien*.—*Archives Méd. Belg. Gaz. Hebdom.*

TRACHEOTOMY IN MEMBRANOUS LARYNGITIS.

[Read before the Royal Medical and Chirurgical Society.]

BY ROBERT WILLIAM PARKER.

A paper was read on tracheotomy in membranous laryngitis, the indications for its adoption, and some special points as regards its after-treatment, by Mr. Robert William Parker. The author began by expressing his regret that the surgeon is only too often called in after all therapeutic measures have failed, the more so, because these measures generally include the use of depressants, which if not at once beneficial greatly tend by their continued administration to increase the prostration, so often a predominant feature of the disease. He regards recession of the chest-wall as a more important indication for tracheotomy than a loud clanging cough, for in the most urgent cases voice and cough are all but abolished owing to implication of the vocal cords. He advocates the administration of chloroform previous to the operation, and has never seen any ill effects therefrom. The higher operation is preferred as the more easy, especially in children, and the use of a tracheal dilator is advocated in preference to the immediate introduction of the cannula; in this manner the tracheal wound is kept open. Then the author advises, *as a matter of routine in every case*, that the trachea and glottis be thoroughly cleared of all foreign matters, whether membrane or mucus, before the introduction of the tube. For this purpose a feather is usually employed, but any other means may be adopted which the operator may prefer. The feather may be passed downwards towards the trachea and upwards into the larynx, and through the glottis. The presence, it was argued, of membrane or inspissated mucus in the larynx above the tube after tracheotomy, is often an unsuspected cause of reflex-irritation and cough; the surgeon, therefore, ought every now and then to clear out the larynx, so long as the patient is unable to do this for himself; and while he has to wear the cannula in his trachea the patient is unable to use the natural means—viz., coughing—owing to the fact that all air is directed from the larynx through the tube.

The author advocates the use of the largest-sized tube which can be got into the trachea without the employment of actual violence, and of the shortest that is consistent with safety, and he lays stress on the advantages of the tracheal part of the tube being freely movable. As regards the curve of the tube, it was stated that the outline should approximate to the Gothic rather than to the Roman arch; in other words, tubes made in the form of quarter circles (the usual forms are not recommended, for it can be shown that such tubes must almost necessarily impinge on the anterior wall of the trachea, and so produce mischief). He believes that a large proportion of the troubles which in past years have arisen from the use of "rigid" tubes has been caused by "ill-fitting" tubes. Speaking of Mr. Baker's "flexible tubes," the author is rather inclined to doubt the expediency of regarding "flexible" tubes as less likely to produce ulceration than "rigid" ones; for, unless the flexible tubes are made of a suitable curve, they will most probably lead to ulceration, just as certainly as (though, perhaps, less rapidly than) rigid tubes. The great indication for operation having been the presence of a mechanical impediment to respiration, so the chief object of the surgeon in the after-treatment must be to prevent its recurrence. The use of a feather has already been referred to. Another important aid is the employment of steam; the amount varies with the individual case, but an excess in all cases is to be avoided.* The less there is of tracheal secretion the more is steam needed, and the converse. Creasote, carbolic acid, benzoin, and other medicaments may be added in order to meet the requirements of various cases. The use of "solvents" is strongly recommended, the most important of these being soda. It may be used in solution (from ten to twenty grains in an ounce of water), and ought to be sprayed into the throat from time to time. It is thought to soften the membrane and to help its removal, and also to render its re-formation less possible. The

* The most useful apparatus for this purpose is the ventilating croup-kettle manufactured by Messrs. Allen & Son, of Marylebone-lane. It supplies not only steam, but fresh and warmed air at the same time.

author has seldom seen cases in which a fatal result could be traced to the operation itself; pneumonia and collapse being the commonest causes of death. The paper concludes thus: Bearing in mind that the operation is undertaken, not as a curative measure, but simply with a view to relieve a mechanical impediment to respiration; seeing, nevertheless, the great frequency with which, after tracheotomy, the trachea and larynx, on the post-mortem table, are found covered, not to say choked up, with membranous exudation (specimens of which may be found in almost every anatomical museum),—the author, as a practical outcome of his paper, and with a view to raise a definite issue for discussion, feels justified in enunciating the following dictum: The presence of membrane in the trachea, in a fatal case of membranous laryngitis after tracheotomy, must be regarded as evidence of the want of due care on the part of the surgeon in charge, just as much as would the presence of a piece of gut in the inguinal canal after herniotomy, or a calculus in the bladder after the operation of lithotomy.

The President wished to add a few remarks, because the greater part of Mr. Parker's experience had been gained in the Hospital for Sick Children during the time when he (Dr. West) had the happiness of being connected with that institution. He believed he had seen more tracheotomy operations than most surgeons, but he had stood by as a critic, and had probably, therefore, observed points which escaped the individual operator. In the whole course of his practice he never regretted having tracheotomy done; he had often regretted that it had not been sooner performed. Retraction of the soft parts during inspiration was the most trustworthy indication for its performance, and in every case he was accustomed to expose the abdomen and chest, and, according to the degree of this retraction, to draw conclusions as to the expediency or not of having tracheotomy done. Mr. Parker's suggestions as to the operation were sound and wise, and he could bear out what he said about venous bleeding. Then as to the size of the tube; he had seen evil result from the use of too small tubes; and he recollected hearing Trousseau in

one of his clinical lectures illustrate this by instancing the difficulty of inhaling through a small tube as compared with one of larger calibre. He was struck to find that Mr. Parker had not mentioned how Trousseau was accustomed to swab out the trachea, holding it to be of considerable importance; and he also advocated dropping in solutions of carbonate of soda, and even nitrate of silver. He had seen what Mr. Parker described, a cannula pushed aside false membrane in its introduction, showing the importance of clearing the trachea before the tube was introduced. He believed the tube with a movable collar was the invention of M. Roger, late physician to the Hôpital des Enfants Malades. Then he was sure that the chances of success in treatment were small without the aid of an exceedingly competent nurse. He could confirm the statement of the grave indication of a dry state of tube, and in any case where the inner tube is dry he advised moistening with water or solution of carbonate of soda. He doubted if tracheotomy was to blame for the pneumonia which so often complicated membranous laryngitis. — *London Lancet.*

BULLOUS SCARLET FEVER.—An interesting case of bullous scarlet fever is narrated by Bramwell. The patient a week before admittance, having previously been exposed to scarlet fever, complained of headache, sore throat and aching in the bones. When examined at the hospital several spots which presented the characters of pemphigus were found on the skin. In some places the vesicles were broken and an ulcerating surface presented itself. On the left hand and arm there was considerable loose epidermis, and on both legs there were many small ecchymoses. On the nates a number of red angry-looking spots presented themselves, some being covered with scabs, these latter were chiefly situated in the fold between the nates and around the anus. The tongue was perfectly clean, moist, and abnormally red. The throat was considerably inflamed and there was an ash coloured slough on the uvula and back of the pharynx. The temperature was 99.8° Fahr.; the pulse 68. The temperature never exceeded 101.5° Fahr.; nor the pulse 90. A mixture of iron and quinine was prescribed, and the throat was brushed over with a solution nitrate of silver. — *Medical Times and Gazette.*

DIARRHŒA IN CHILDREN.

Diarrhœa is essentially a clinical disease. Pathology shows no lesion sufficient to account for the gravity of the symptoms. For the purposes of prognosis, the appearance of the stools may be classed as—(a) Homogeneous in character and consistency—prognosis good; (b) Heterogeneous—semi-solid, lumps of undigested aliment coated with mucus and tinged with bile—prognosis not so favourable; (c) Heterogeneous—mucoid, watery and abundant—prognosis less favourable; (d) Heterogeneous—mucoid, very watery; copious gushes of fluid, preceded by pain or convulsions—prognosis bad. The appearance of blood in the stools may or may not be of serious moment.

For clinical purposes, diarrhœa may be divided into three periods, according to the age of the patient.

1. Indentional, six months and under.
2. Dentitional, from six to twenty-four months.
3. Post-dentitional, from two to twelve years.

In the indentional period, the most frequent cause is improper feeding. In this relation Dr. Sansom gives some rules how to bring up a child: 1st. Keep it warm, clean, and give it plenty of fresh air. 2nd. Feed it with its mother's milk, or, if that is insufficient, give diluted cow's milk or Swiss condensed. Begin to wean at seven months old. 3rd. To bring up by hand, give it at first cow's milk and water, equal parts, or Swiss condensed milk, two teaspoonfuls to a bottle of warm water, increasing the proportion of milk as the child grows older, keeping the feeding-bottles and tubes perfectly clean. 4th. Feed regularly every two hours during the day; after six weeks old, every three hours,—not so often at night. 5th. As the child grows older, supplement the milk by milk thickened with well-baked bread, or some of the made farinaceous foods, once or twice in the day; and at one year give one meal a day of broth or beef tea. 6th. Prevent its taking improper food, stimulants, and medicines without medical advice.

Diarrhœa from this cause may be cured by having resort to a proper diet. Do not take the child away from the mother's breast until the very last. Rather improve her secretion.

He recommends very highly the plan of making the mother take, a short time before nursing, a half-pint of milk, which will cause a secretion of healthy milk.

Other frequent causes are dyscrasia, as rickets, and especially congenital syphilis; direct and reflex irritation of the central nervous system, such as blows on the head, falls, herniæ, exposure to the sun and heat; also the onset of acute febrile diseases.

The treatment consists in a return to a proper dietary. A preliminary aperient of rhubarb, magnesia, castor oil, or calomel is good if there has not been too much water withdrawn from the blood by the flux. The vegetable astringents combined with bismuth or chalk; sedatives, as bromide of potassium in one or two-grain doses, are very serviceable; chloral, one grain, with or without the bromide, when there is much wakefulness and irritability; opium disagrees by interfering with the processes of nutrition; starch enemata are very serviceable. In the most chronic cases we must have resort to artificial nutriment, as cod-liver oil or the raw meat plan.

The dentitional period is conveniently subdivided into the *incisor*, from six to nine months, in which occurred 7.6 per cent. of cases; chief *molar*, from nine to fifteen months, with 58.2 per cent.; *canine*, from fifteen to twenty-one months, 28.1 per cent.; *posterior molar*, from twenty-one to twenty-four months, 5 per cent.

The chief cause is here the disturbances arising from the eruption of the teeth; other causes are as before, though not so frequent, and worms. The medicinal treatment is about as before. The irritation of the gums may be relieved by friction over the gums with the finger moistened with honey or glycerine. Incision is not called for except in rare cases.

The post-dentitional period. Intestinal worms are the most frequent cause in this period, principally the thread worm (*oxyuris vermicularis*) and the round worm (*ascaris lumbricoides*). These are a frequent cause of blood in the stools and of prolapse of the rectum. The natural effort of the bowel will, at times, be sufficient to expel them. Santonine is specific for the round worm. We have none

for the thread. Improper diet, rickets, and syphilis are also causes, but less frequently in this period. After worms, the next most frequent cause is *zymotic disease*. The question is briefly discussed whether, other than typhoid, there is a specific contagium inducing diarrhoea. Dr. William Johnston, of Leicester, made a series of observations, and discovered numerous bacteria in the excreta of infants suffering from diarrhoea; in the air, from sewer emanations; and in the juice of over ripe fruits in the summer months. He failed, or found only few of them in the winter months, and in the excreta of healthy infants. Hence, he concludes that in Leicester, in the summer months, diarrhoea is caused by these bacteria, which are inhaled with the air or swallowed with the food, giving rise to putrefactive changes in the bowel correlative to the development and multiplication of these microscopical organisms.

Dr. Sansom does not entirely agree with these conclusions. He says that bacteria have been found in health in all parts of the gastrointestinal tract; and even if they were greatly increased in number during the diarrhoea, a causal relation was unproven, for in all conditions of mucous catarrh, a suitable nidus is provided for the propagation of low organisms. That the *air may* be a cause, he admits; but considers contaminated water to be a much more frequent cause. He thinks that, excluding cholera and typhoid, there is no specific contagium giving rise to diarrhoea. The diarrhoea produced by these germs is a putrefactive diarrhoea, and strictly analogous to that caused by the ingestion of food in a state of decomposition. This septic diarrhoea has in most cases a high temperature, and yields generally to antiseptic treatment, especially with the sulphite of soda.—(Dr. A. Ernest Sansom in the *Obstetrical Journal*.)

ACHING KIDNEY.

BY J. MATTHEWS DUNCAN, M.D., LL.D.

This disease is sometimes, both in men and women, very easily recognized. There are aching in cases of what is called floating kidney. The patient can put her hand on the lump, and say, "Here is the pain," and there is no difficulty in recognizing the disease. But there are some cases in which the disease is very difficult to identify. In pregnancy, for instance, right or left hypochondriac pain is very frequent. In many cases I have been able to be quite sure, from the history before and after pregnancy, that the disease was not to be classified in the vague way that is implied in giving it the name of hypochondriac pain, but that it was really a case of aching kidney. In pregnancy you have the very opposite conditions to those in floating kidney. If pregnancy is advanced, you cannot get at the kidney to feel it and identify its position. Here I may remark that, while the disease often occurs in pregnancy, yet some women who are liable to it do not suffer while in that condition.

The disease in women is not a rare one, and its characters are the following: One or other kidney is the seat of pain. It is not a neuralgic pain; it is a heavy, wearing pain deep in the side. It is in the region of the kidney; and in many cases, as I shall presently tell you, you can easily identify it as being in the kidney itself. It is not generally that kidney-pain which is a familiar symptom of calculus. In such cases the pain is the pain of the pelvis of the kidney. You have in the region of the small ribs a boring or a nail-like pain. Patients with aching kidney generally point to the hypochondriac region, not to the back, as they often do in cases of calculus in the kidney. This pain is frequently accompanied by pain in the corresponding lower limb, referred most frequently to the course of the sciatic nerve, sometimes to the course of the anterior crural. The pain is often accompanied (and you will find this of importance throughout all the subjects of this lecture) by irritability—I do not say disease—of the bladder; and it is frequently accompanied by pain in the region of the ureter corresponding to the kidney affected. This pain is not rarely present only

CONVULSIONS OF YOUNG CHILDREN.—Dr. Engel (*Phil. Med. Times*) recommends that when the usual remedies—hot bath, chloral, bromide, etc.—have failed, resort be had to hypodermic injection of morphia and inhalation of nitrite of amyl. He reports several successes and no failures.

during the monthly periods. When it is present only during the monthly periods it may be classed with that disease, which is very ill defined, called dysmenorrhœa. It should never be placed there unless you wish to use the word dysmenorrhœa in a very wide sense. If we use the word as including aching kidney, we might as well use it as including headache—a use which would be in accordance with what is extensively done by writers. This disease, however, often eludes the examination of the physician, because it occurs in many cases only during the monthly periods. In all cases it is then aggravated. I do not think I have ever seen a case in which the patient did not volunteer the statement that the pain was worse at the monthly time.

It is not usual to find both kidneys aching; and I guess—I can use no stronger word—that the left kidney is much more frequently the seat of disease than the right one. You are not left in your diagnosis in all cases merely to identification of the seat of the pain, although that may be sufficient. Frequently in the region of the pain you can find distinct fulness; that is a very important condition that I have not time to explain to you. It can scarcely be made out in a fat woman; but in many cases this condition of fulness over the affected kidney is easily recognized. In addition, swelling of the kidney or of the suet, or of both, is not rarely to be made out. The physical examination of the kidney is too much neglected. It is not in floating kidney only that you can feel the organ. In many women who are not nervous, yielding themselves freely to examination, and who are not fat, you can feel the kidney with distinctness; and in cases of this kind you can frequently make out, as I have said, that there is a swelling of the kidney or of the suet, or of both. There is also generally tenderness, sometimes great tenderness.

The treatment is to be conducted on the general principles applicable to the therapeutics of neuralgia or slight hyperæmia; and these two conditions are not so very remote from one another as may at first sight appear. A neuralgia sounds as if it were something quite different from a hyperæmic condition; but that

has to be proved. The remedies I have found of most service in simple cases of this kind are tonic regimen and tonic medicines, especially iron in the form of the tincture of the perchloride combined with mild diuretics in small quantity, and especially the common sweet spirits of nitre.—*Louisville Med. News.*

PARALYSIS FOLLOWING DIPHTHERIA.

BY N. S. DAVIS, A.M., M.D., LL.D.

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In studying the nature of the paralysis itself, you must remember that impairment and loss of muscular power in any particular muscle or set of muscles may be caused by either of the following morbid conditions: 1st. Disease in the central part of the nervous system involving the origin of the nerves supplying the paralyzed part. 2nd. Disease of some part of the nervous cord between the centre from which it emanates and its peripheral distribution. 3rd. Disease of the peripheral extremity of the nerves in the paralyzed part. And 4th. Loss of the susceptibility, or what Haller called *irritability*, in the muscular structure itself. The condition last named is deserving of more attention than it has received from most of those who have given special attention to the study of paralytic affections.

The members of our profession have come to look so directly to the nervous structures for explanation of all changes in sensibility and motor power, that the existence of a property or susceptibility inherent in muscular or any other structures, by which it is capable of being impressed or acted on by exterior influence has been apparently overlooked. Yet no physiological fact is more easily demonstrated than that such a property exists, not only in the atoms constituting muscular, but also those of all other living structures. Indeed without such a susceptibility in the muscular structures, no amount of nerve-force or intensity of electric currents would elicit the slightest muscular action or motion. This property can be impaired or suspended, by retarding or suspending the molecular changes constituting nutrition and disintegration, and by contact with certain toxæmic agents, such as carbonic

and hydrocyanic acids and other sedative poisons. If, while keeping these physiological facts in mind, we return to the study of the morbid phenomena preceding and accompanying the existence of diphtheritic paralysis, we shall be compelled to look to the muscular structures involved rather than to any part of the nervous centres for the essential seat of the disease.

The decidedly asthenic character of the primary disease; the aplastic and degenerative quality of all its morbid products and changes, leaving the processes of nutrition and metamorphosis enfeebled during the convalescence; the gradual manner in which the paralysis supervenes; the coincident impairment of the electro-excitability of the affected muscles; the tendency to affect the muscles of different parts of the system in succession, those of one part recovering, while those of another are increasing, while the nerves supplying the muscles thus successively attacked have no common or closely approximative origin in the cerebro-spinal centres; and the absence generally of all direct symptoms of cerebral or spinal disease coincident with the failure of muscular action, all point, in my estimation, to an impairment or loss of susceptibility and contractility in the muscular structures involved. This impairment of the primary property and function of the muscular structures may depend on an inadequate supply of arterial blood through feebleness of the capillary circulation in the part; or on the toxic influence of the products of the retrograde metamorphosis of such exudations as had taken place in the structures during the progress of the primary diphtheritic disease, or on both combined.—*Med. News and Library.*

RAPID AND CERTAIN TREATMENT OF SIMPLE HICCUGH.—Dr. Grellety once saw a mother as tender, as full of affection for her children, give them a morsel of sugar dipped in table vinegar whenever immoderate or too rapid repletion of the stomach, or any other cause, had induced hiccough. The latter ceased as if by magic. Since then the Vichy physician has very frequently employed this means on his own account, and has never found it without avail.

SLEEPLESSNESS.

The question of the effects of spasmodic contraction of the arteries and arterioles of the extremities, especially in connection with cold weather, presents itself in an interesting aspect in relation to *sleeplessness*. It is now widely known that a condition of cerebral anæmia is essential to sleep, and that if the arterial vascularity of the brain is kept up sleep is out of the question. If, then, the extremities be cold, sleep cannot be successfully wooed. An old theological writer, when weary with long writing, kept sleep at bay by immersing his feet in cold water: by so driving the blood to the head he could continue his labours: whether they were worth much after such expedients may be open to question. With many women cold feet are their bane; they are miserable when awake, and they can scarcely get to sleep. If they can get their feet warm, they can sleep, but not otherwise. But how to get their feet warm is the question with them. Hot bottles to their feet are but partially effective, and often are a complete failure. Now, Dr. George Johnson has pointed out that with the dry imperspirable skin of certain persons with chronic Bright's disease, perspiration cannot be induced by warm baths. But if a person be first wrapped in a cold pack, so as to drive the cutaneous arterioles into spasmodic contraction, subsequent paralysis readily follows on the patient being placed in a warm bath; the vessels become thoroughly dilated, and then perspiration follows. The spasmodic contraction is essential and necessary to the consequential dilatation; and the same holds good of the cold feet of women. Tight boots prevent the flow of arterial blood through the feet during the day, and the subsequent dilatation which follows with some persons does not occur with others. Indeed, it would seem that the anæmia caused by the pressure remains, and the feet are stone cold. Putting them to the fire gives temporary warmth, and so does the hot bottle in bed, so long as it remains itself hot; but as it cools the feet again become cold, and sleep cannot be wooed successfully.

What should be done is to dip the feet momentarily into cold water and then have them well rubbed with hair gloves or a rough towel

until they glow. This seems a very unattractive plan to many minds; but it is just the story of the snowballer's hands. At first the contact of the snow makes the fingers very cold; but perseverance is rewarded by a glow which may become almost a burning heat; the primary contraction of the vessels is followed by secondary dilatation. This is what we will accomplish by the immersion, for a brief period only, of the feet in the cold water, followed by friction. By such means the cold feet become warm, and after this a hot bottle to the feet will keep them warm effectually. With my patients at the hospital the complaint of bad nights now evokes the question, "Are your feet cold?" And the answer very commonly is, "Oh, dreadful!" And it will be found that all narcotics, draughts, pills, or lozenges are futile to procure sleep as long as the condition of the feet is not attended to. Subject the feet to appropriate treatment, and then the sleeping-draught will be successful and attain the end for which it is administered. Macnish said of sleep, "Sleep which shuns the light, embraces darkness, and they lie down together most lovingly under the sceptre of midnight." Very true; but cold feet will upset the whole arrangement very thoroughly.—J. MILNER FOTHERGILL, in *Philadelphia Medical Times*.

WESTPHAL'S DIAGNOSTIC POINT IN LOCOMOTOR ATAXIA.—Professor Westphal about a year ago asserted that he had discovered a pathognomonic sign of sclerosis of the posterior columns. It is a very simple one. When in health, sitting with one knee across the other and the foot of the uppermost leg freely suspended, it is well known that a smart tap with a narrow instrument, such as a ruler, delivered on the tendon of the quadriceps, just below the patella, will cause the foot and leg to spring up with a jerk. Well, Dr. Westphal maintained that this jerk does not occur in posterior sclerosis, and that its absence is a sure sign of the presence of that formidable disease. His conclusions were attacked by several observers at the last meeting of the British Medical Association; and it seems pretty clear that

his statement requires modification. No doubt the absence of this involuntary act is a significant sign of some important organic change. A new study of it has been made by Dr. S. Tschirjew in the *Archiv für Psychiatrie*, and with great accuracy. The clinical result he reaches is that the absence of the reflex motion in man points to degeneration of the posterior spinal roots and columns at the level of the third and fourth roots of the crural plexus: but that in degeneration of the columns which does not reach so low as this the reflex phenomenon may appear. This very interesting result vindicates the symptom as of great importance.—*Med. and Surg. Reporter*.

The presumption is that every medical man should be and is a man of liberal culture prior to and collateral with his medical education. It is impossible, as we said lately, to pass an evening at any of our great metropolitan societies without being quickly assured that such an assumption is far from being always warranted by the fact. Very rarely can an evening be passed there, especially when the subjects of discussion are such as to invite chiefly surgical speakers, without palpable evidence being forthcoming that a man may hold a prominent position in leading hospitals without having the ordinary culture of an educated gentleman. This is much less frequently the case when physicians are the speakers. But if this be so at all, as it undoubtedly is, in the higher ranks of the profession and in the chief centre of professional distinction, it is probably hardly less true in the general mass. The preliminary education of the medical practitioner has not, until lately, been such as was required by the bar or the church. It is even now, on the average, of a much inferior standard. This is largely the fault of the great Universities of Oxford and Cambridge, which have repelled instead of inviting the young aspirants to medicine to take their place alongside of the great body of English gentlemen educated at those Universities, and have exiled the profession of medicine from the *almae matres* of the arts and sciences.—*British Medical Journal*.

Surgery.

TREATMENT OF STRICTURE.

BY S. MESSENGER BRADLEY.

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And now a word or two before we part upon the subsequent treatment—that is, the treatment of urethral strictures after you have restored the passage sufficiently to pass a No. 4 English catheter. There are three plans open to you—gradual dilatation, immediate dilatation by divulsion, and internal urethrotomy.

In favour of gradual dilatation we can say much; it is perfectly safe, it is not necessarily tedious, and though, like every other plan, it is followed by relapses and reconstrictions, it is probably less liable than the others to this serious drawback. If employed, the best method is to keep the patient entirely in bed, and almost constantly to keep a catheter in his bladder, only taking one out to put another and a larger in its place. In this way a tight stricture may generally be dilated up to admit a No. 12 or 14 English size in a fortnight. Beyond this degree of dilatation I do not care to go, in spite of what the Americans say in favour of much greater dilatation. Personally I do not tell my patients that they are cured of a stricture, but, on the contrary, urge them to learn to pass an instrument for themselves or to present themselves for examination three or four times a year. Gradual dilatation practised in the manner now mentioned is certainly calculated to promote the absorption of exuded lymph and even organized fibrin, but that urethras so treated may yet relapse is sufficiently attested by the history of a case in Mosley ward, in which we followed out this plan *de rigueur*, and yet where the stricture re-contracted, so as not to admit a No. 3, in less than three weeks.

In favour of immediate dilatation a good deal may be advanced. When the kidneys are healthy, it is, I think, quite a safe procedure. It is not a very painful one: e.g., I constantly perform it, and never give chloroform; the patient is not confined to bed more than a day or two, and it is of course speedy. My own experience goes to show that relapses are rather

more frequent than from gradual dilatation, but that with proper instructions as to having an instrument passed at stated intervals, and perhaps with a few lessons in catheterism so as to enable the patient to look after himself, this should not lead to future difficulty. In many cases the stricture is confined to the submucous tissue, and this, being naturally more brittle than the elastic mucous lining, will be ruptured by the divulsor without any lesion taking place in the lining membrane; in other cases, where there has been, from ulceration, loss of mucous membrane, of course *both* will be torn. In the former case no hæmorrhage takes place in the latter there is a little bleeding, but always very trifling, and soon ceasing if left alone.

Of internal urethrotomy, gentlemen, I have no personal knowledge; but, although I am aware that abler and more experienced surgeons than myself practise and speak highly of it, I cannot but regard the operation with extreme suspicion and disfavour. In boldly criticising it, then, as dangerous and unsatisfactory, I would have you remember that it is the criticism of one who has never performed it, and who, I think I may add, never will. I dislike the operation for the following reasons: it is perilous at the time, for I have known death to follow from hæmorrhage in a few hours; it is pregnant with danger for a considerable time after the immediate risk is over, for I have known death from septicæmia to follow ten days after its performance; and it is not attended with any advantages over immediate, and still less over gradual, dilatation, in being less prone to relapses, for I have known a case twice operated on by internal urethrotomy which yet resisted the passage of any instrument a few months after the second operation. I quite fail, then, to see, gentlemen, what there is to commend this elegant operation. It is true we hear of "organization of the blood-clot," and of the "cicatricial splice" thus fashioned being more elastic than ordinary scar tissue. Is not this nonsense? Imagine the crowning glory of antiseptic surgery—the organization of the blood-clot—taking place in an incised urethra; that is to say, in an incision washed every few hours in urine! The greater

elasticity of the cicatricial splice, again, however it be formed, is mere matter of assertion; there is nothing to show *why* this should be so, and there are no reliable comparative statistics to prove that it is. In those cases of tight, or it may be impermeable stricture, where the perineum is riddled with fistulae, the remedy is not, as it appears to me, internal but external urethrotomy; and I myself anticipate the day when internal urethrotomy shall be relegated to the limbo of discarded surgical operations, and when we shall be content to treat strictures of the urethra without this modern improvement.—*London Lancet*.

EXTIRPATION OF THE RECTUM.

The difficulty in the treatment pertains to the establishment of efficient drainage of the wound, combined with oft-repeated antiseptic injections, or even permanent irrigation with an antiseptic solution. In relation to the operation itself, malignant growth of the rectum may be classed as follows:—

I. The circumscribed tumour, easily removed by excising a segment of the rectal mucous membrane.

II. The diffuse infiltration of the rectum, including the mucous membrane of the anus.

III. The diffuse infiltration beginning about the sphincter of the anus.

In cases of the first class, the field of operation being exposed by forcible digital dilation, or by the introduction of Sim's speculum, the tumour is caught and drawn down towards the anus and excised. The next step of the operation consists in introducing a long narrow bistoury on the afflicted side near the margin of the anus, and pushing it upwards underneath the mucous membrane until its point is perceptible in the wound occupying the former seat of the tumor. Through the channel, thus made, a drainage tube is passed, after which the lips of the wound in the rectum are accurately united by sutures. If union by first intention ensues, the cavity without the rectum, can be easily cleansed, with antiseptic injections through the drainage tube. Malignant diseases of the rectum which begin at the anus, necessitate the extirpation of the entire viscus. Before dividing

the tube between the healthy and diseased portion, silk sutures should be drawn through the former in order that it may subsequently be united to the healthy skin. After this operation, also, a number of drainage tubes are inserted along the rectum, the entire length of the wound. If the peritoneal cavity was first opened during the first act of the operation, the wound in it is closed, after thorough disinfection, with catgut sutures. In cases where the disease diffusely infiltrates the rectal mucous membrane above the sphincter, the affected portion is removed, after having been anteriorly and posteriorly divided in the median line; the upper portion being then drawn down is united by sutures with the mucous membrane, lining the sphincter, drainage having been provided for as in the previous cases. The advantages of the operation are greatest, when the lower portion of the gut is sacrificed, because in relapses, there is no such painful impediment to defecation as invariably supervenes when the sphincter of the anus is divided.—*R. Volkman, S. Klin. Vorträge.—Hosp. Gazette*.

SUGGESTION FOR TREATING SWOLLEN FINGERS.

—A correspondent writes to the *Medical Times and Gazette*, London: Allow me to suggest to your readers the use of the material in the treatment of the swellings of the fingers, which are often tedious and painful, in persons of rheumatic or gouty constitution. For two or three years past I have used a piece of an india-rubber finger-stall, in fissures and slight cuts of the fingers; and for twelve months or more I have used it in cases of thickening or deposit around the joints of the fingers after injury, with great relief to the patient. It has seemed to me that the brown finger-stalls of pure rubber are better than black or vulcanized. A piece of tubing may be cut into lengths of about an inch or an inch and a half. One of these can be slipped over the joint by the patient himself, after he has been taught how to do it. It should be worn constantly, day and night. The patient will soon learn how to roll it off and re-apply it after washing his hands. When it has become too loose to give the necessary support another length can be taken.

REMOVAL OF SUPERFLUOUS HAIRS.

BY L. DUNCAN BULKLEY, A.M., M.D.

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The method to be described is founded upon the idea of reaching down into the follicle, after extracting the hair, and thoroughly breaking up its bottom and sides, thereby exciting an inflammation which seals it from its base to its orifice. This is accomplished in the following way: A small, three-sided, straight, surgical or glover's needle is firmly inserted at its blunt extremity in a convenient handle; the smaller the better. The one which I use was made for holding a needle to be employed in manipulating microscopic preparations. The edges of the needle should be sharp, and may require grinding, even when new. A good pair of epilating forceps are also required; their edges should be well fitting, and such as will not cut the hair, and the spring should be rather weak, that it may not tire the hand unnecessarily.

The needle in its holder being taken in the right hand, as one holds a pen, a hair is seized with the forceps in the left hand, and the point of the needle is engaged in the orifice by the side of the hair, before the latter is extracted. Gentle traction is then made upon the hair, and at the same time slight pressure upon the needle, and as the former slips out the latter readily enters the follicle for a little distance. It is then thrust in, to a little greater depth than that occupied by the hair, as shown by the root-sheaths on the extremity of the latter, and with a delicate touch it may be readily perceived when it has gone to the bottom, or rather when it has penetrated the latter a little, and its sides are closely embraced by the follicle. A little experience soon shows this, and the error can be made of not having the needle penetrate deep enough far more easily than that of going too deeply. A clean needle can do little if any harm even when piercing the entire thickness of the skin.

When the needle is fairly in the follicle, it is given a number of turns or twists, by rotating the handle between the thumb and forefinger, and when it is withdrawn the sharp edges of the needle are seen to be filled with epithelial debris scraped from the sides of the follicle, and very shortly after a drop of blood or serum is

seen to issue from the orifice of the recently irritated follicle. Occasionally blood will follow immediately, and if it is not controlled, in considerable quantity, but this need never give trouble, for it is readily arrested by firm pressure with the finger, with a little ordinary picked cotton or styptic cotton. I have considered it better when but a little blood followed the needle, or when only serum was observed after a few moments, because when there is a larger flow of blood it indicates rather that the needle has missed the follicle, and either gone one side of it, or penetrated its walls, and has failed to reach the bottom, where the new hair takes its origin; though of course it is quite possible to penetrate through the base of the follicle, and pierce a little artery below. In by far the larger number of insertions of the needle I do not draw any blood, but only observe the serum exuding soon after each puncture.

Dr. Bulkley goes on to say that at first he dipped his needle in carbolic acid before each insertion, in order to make sure of exciting inflammatory action, but latterly has repeatedly omitted it, because he doubts the necessity for the extra irritation caused by its use. The procedure requires tact and patience, and also several sittings. It is difficult to treat more than twenty-five to forty hairs at a sitting. At the first trial the needle does not enter every follicle at which it is aimed, or it may not penetrate deep enough to destroy the base and the papilla, or the inflammation excited may not be active enough to close the follicle. The Dr. has operated successfully on four patients, and in no case have the hairs returned, although one of the operations was performed nearly two years ago.

CASEOUS CORYZA.—This disease, which is as yet but little understood, and must not be confounded with fetid ulcerous rhinitis, is characterized by the accumulation in the interior of the nasal cavity of a caseous material analogous to that contained in certain sebaceous cysts, and that may reach such an amount as to cause deformity and produce anosmia. The disease frequently manifests itself after an attack of erysipelas. In the first stage the patient is annoyed by an abundant and fetid sero-purulent secre-

tion mixed with caseous lumps, the expulsion of which affords temporary relief. Little by little the obstruction of the nasal fossæ and consequently the anosmia becomes more complete, and the features in the vicinity of the nose commence to show deformity. The diagnosis of caseous coryza presents great difficulties because of the danger of confounding in its different stages either with periostitis of the jaw, or with a polyp, or with a malignant tumour of the jaw or nasal fossæ, or lastly with caries of the bones of the face; and yet an accurate diagnosis is very essential, since in cases of malignant growth very grave surgical operations even to removal of bones may be indicated. The treatment consists in abundant and frequently repeated irrigations, and in the cleaning out of the nasal fossæ and the removal of visible portions of the tumour, by means of the proper instruments. The patient must aid the operator by making efforts to blow through the nose.—*Giornale Internazionale delle Scienze Medicale.*
—*Le Mouvement Medical.*

Dr. C. T. Poore, in the *N. Y. Medical Record*, draws the following conclusions in regard to hip-joint disease:—1st. That the causes of death directly traceable to coxalgia are amyloid degeneration, tubercular meningitis, and exhaustion. 2nd. That there is an intimate connection between the tubercular diatheses and amyloid degeneration, so that those of this predisposition seem peculiarly liable to this complication subsequent to suppuration in connection with diseased bone. 3rd. That exsection does not, as a rule, increase the amount of suppuration. 4th. That death is not as a rule due to, or hastened by exsection. 5th. That the removal of carious or necrotic bone from the hip-joint is followed by an improvement in the general condition of the patient, and that the chances of his recovery are improved thereby. 6th. That in patients of a tubercular diathesis, the question of excision should earlier be taken into consideration than in those of a non-tubercular diathesis. 7th. That repair in a joint after excision is no proof of the non-existence of amyloid degeneration.

Midwifery.

Hôpital de la Pitié.—(Service de M. Le Dr. Gallard.)

TREATMENT OF CANCER OF THE UTERUS.

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The only method of treatment which can be efficaciously employed in cancer of the uterus so as to avoid relapse is its destruction *in loco*. . . . Recamier's operative intervention consisted in practising ablation of the uterus; but this method ought to be most formally proscribed, for it cannot avoid injury to the peritoneum.

Surgical interference will be most efficacious at the beginning of the affection, for at that time the cancer is not of too great extent, and only affects the neck of the womb. In such case, operation will afford relief, for it will free the patient of a focus of infection and of an excessive secretion—grave causes of debility. . . . A first general and absolute rule is to operate in the depth of the vagina, great care being taken not to draw the uterus down to the vulva. In view of a liability to hæmorrhage, cutting instruments should be employed as little as possible. Chassaignac's *ecraseur* is, on this account, an excellent instrument, but its application is extremely difficult, and its introduction constitutes one of the most delicate steps of the operation. Maisonneuve's loop, or the galvano-caustic wire, will prove the better instrument whenever it is possible to completely seize the tumour and surround it in its totality. . . . When the wire-loop of the galvano-cautery is employed, care must be taken not to allow the platinum wire to attain too great a heat; and an intermittence of the current of short duration, should from time to time be made. If the platinum wire be fine, you can succeed in directing it with the fingers, and thus seize the neck of the womb perfectly. The whole difficulty consists in maintaining the loop in an axis perpendicular to the cervix, so as to obtain a complete section: this will be obtained with difficulty, in proportion to the friability of the cancerous tissue. It will therefore be always necessary to be prepared to employ some other operative procedure should you not succeed with the first. It is never necessary to leave an operation uncompleted.

Specula are commonly employed to find the cervix; but these instruments present great inconvenience, because they hinder operative manœuvres, or even render them impossible. The univalve speculum is almost the only one of any utility, or, at all events, of much advantage.

The mode of treatment will vary according as we are concerned with the fungating form or the ulcerating form. For this latter form, recourse will not be had to caustics, but to the application of the red hot iron, which will often be followed by success. I have also had an idea, in this form of cancer, of practising cauterizations in the depth of the morbid tissue. For my own part, I avow that I have only had recourse to this proceeding under conditions in which it was impossible to employ other forms of treatment. The proceeding consists in this: by means of a Pravaz syringe, intended for this purpose, I inject the tissues with perchloride of iron or acetic acid. These injections provoke mortification of the tissues and prevent hæmorrhage.

Lastly, if destructive processes fail, a purely palliative treatment must be instituted,—the sole object being to diminish the sufferings and to prolong as far as possible the life of the patient. The first point in the treatment will be hygiene in all its forms, with reference to air, food, rest, and cleanliness. To build up the patient's forces, recourse will be had to quinine and iron, and especially arsenic, which, it appears, possesses certain anti-cancerous properties. For insomnia, conium will be prescribed; poultices of fresh hemlock, or injections of a decoction of hemlock, or hemlock pills may be employed. In the later stages, large doses of morphia, or morphia and chloral, may be required. The discharges should be combatted by detersive and antiseptic injections. The formula which I employ is this: carbohc acid, ʒijss; alcohol, ʒxxx; one or two tablespoonsful of this solution in a quart of water. Locally, charpie may be employed, saturated in this solution pure, or in tannin. In the last place, metroirrhagia is a very grave accident likely to occur. It may be treated by rest, cold water, and position. The tampon, too, may be employed, but only with great prudence and in extreme cases. It is also necessary to change it frequently, and to pack but lightly its component parts.—*Le Practicien.*

CHRONIC CERVICAL METRITIS TREATED BY INTERSTITIAL INJECTION COUPLED WITH DILATATION.*

BY J. M. BENNETT, M.D.

* * * * *

Having tried most of the constitutional and local formularies recommended by our most celebrated authorities, I was induced to try the interstitial injection of iodine, from the fact that I had, in the first place, obtained more benefit from its local application in the form recommended by Dr. Greenhalgh than from any other treatment; and secondly, from the consideration that, if such benefit could be gained by its application to the indurated covering of the os uteri, much speedier absorption and more lasting results might be attained by the absorbent agent being brought into direct contact with the new hypertrophic matter distributed in the midst of the uterine tissue, in a position where absorption might be favourably sought. Acting upon these bases, I first prepare my patient both generally and locally; the latter by relieving any super-engorgement by means of local depletion, carried out by means of cupping, the frequent use of warm water, and the application of glycerine, so as to induce osmotic action, care being taken to avoid the period of menstrual excitement. I then use a simple modification of the hypodermic syringe, which is sufficiently long to be used with Ferguson's speculum; its points are made of eighteen-carat gold; and the other portion, which might come in contact with the iodine, bromine, or other agent inimical to any metal less resistant than gold or platinum, is mercurially gilt. The instrument should be charged with a solution composed of ten grains each of the iodide and bromide of potassium, to which half a drachm of tincture of iodine and sufficient distilled water should be added to bring it up to two drachms. I then either puncture through the speculum, leaving the uterus free if the os and cervix be very large and low down, or fix it with Sims's tenaculum, using a duckbill speculum. I generally make from three to five punctures, according to the amount of hyper-

* The substance of a paper read before the Lancashire and Cheshire Branch of the British Medical Association, 1878.

plastic matter to be absorbed. A cotton pledget well soaked in glycerine is placed against the part, and rest enforced for at least twelve hours. I seldom find more than three operations are required; and I have never found any disturbance of moment set up, either generally or locally, by the procedure; on the contrary, I have had a number of cases turn out successfully when other methods had proved unavailing.

I have now a patient under observation, thirty-eight years of age, who had been the mother of three children before she was thirty, who had suffered from subinvolution, followed by chronic cervical metritis, and remained barren until after December last, when I treated her by the foregoing method. She is now in the fifth month of pregnancy, and enjoying good health.

In most cases I conjoin the treatment with dilatation by means of the sponge tent, which I put in practice after the first effect of the interstitial injection has passed off. By means of these combined methods of procedure my most sanguine expectations have been fulfilled; the hypertrophied os materially lessened, and resolved to its healthy condition, and that with an absence of those after-consequences, such as loss of tissue, painful cicatrices and stricture, which must have presented themselves to the practitioner who has steadily adhered to the mode of treatment by caustics, cauteries, &c.

I may add that I have ventured to try this mode of treatment in some cases of chronic subinvolution, with this difference that I first began with the interstitial injection of a solution of ergotin, and followed it after an interval with the iodine. My success has been such as to warrant a more prolonged trial.

The only drug administered has been the bromide of potassium in large doses, with the object, first, of quieting the excitement of patients, and secondly, of obtaining some of the benefits described by Professor Binz, of Bonn, who speaks of the potash salts as being positively specific in subinvolution; and, strange as it may appear, I have many times seen advantages derived from a continuous use of this salt quite equal to those described by Dr. R. Williams, who attributed such wonderful powers to its action in splenic hypertrophy.—*Lancet*.

MANAGEMENT OF BREECH PRESENTATION.

* * * * *

Do not hurry the early stages of a breech case, and never put your finger (and still less a blunt hook) around the child's groin. At this period the breech is aiding you very materially, all the time, by its action in dilating the parts. But the instant that you find it distending the perineum you should change your tactics entirely. Having placed the patient on her back across the bed, with her feet resting on two chairs, give one limb into the care of the nurse, and the other into that of a competent physician, whom you have previously summoned, and who should always keep one of his hands free, so that he may assist you as required. The chief principle in the delivery is this: that the force that is to expel the child must come from above, and not from below. Therefore, now give a large dose of ergot hypodermically, in order that it may produce a powerful effect instantaneously upon the uterus. As soon as the cord comes within reach, get hold of it; and then ask the physician who is assisting you to press down upon the head with all his force. The patient, if she is a woman of any force of will at all, ought not to be under the influence of anæsthetics, and you should call upon her to bear down as strongly as she possibly can; telling her that the life of her child depends upon her exertions. When all these forces are called into play, the result is usually a very speedy delivery. In a second or two you can get two fingers into the child's mouth, and thus make traction by means of the inferior maxilla.—Dr. T. GAILLARD THOMAS, in *Medical and Surgical Reporter*.

PHYMOSIS.—M. Huet, of Rouen, operates as follows: The prepuce on its dorsal aspect and opposite the base of the glans is pierced by a needle carrying a caoutchouc thread; the portion of the prepuce in front of the puncture is then ligatured, and the operation is finished. At the end of three or four days the section is completed. The patients do not suffer, and may, if necessary, continue their ordinary occupation. M. Huet has seen the operation succeed in eighty cases, including both old men and children.

Original Communications.

THE EXTERNAL TREATMENT OF SOME OF THE MORE COMMON FORMS OF SKIN DISEASE.

(Read before the Toronto Medical Society.)

BY J. E. GRAHAM, M.D.

In taking up the external treatment of some of the more common forms of skin disease, I wish to direct your attention principally to eczema, psoriasis, and sycosis. I shall say little of the internal treatment, not that I consider it of small importance, but because, in my opinion, the external treatment is often made little of by practitioners. There is no doubt but that skin diseases are most successfully treated by a proper combination of internal and external remedies.

I. *Eczema*. I consider eczema to be a catarrhal inflammation of the skin, which may present very different appearances at different stages of the disease and in different constitutions. For purposes of treatment, it may be taken up under three heads,—eczema simplex, eczema rubrum, and eczema impetiginosum. We will take up first

ECZEMA SIMPLEX,

as it appears, for instance, in children. Here we have redness of the skin, followed by the appearance of vesicles; the vesicles break, and a transparent sticky fluid exudes, which may harden into crusts and scabs. In acute eczema, it is well to avoid the use of ointments, as the lard itself is irritating to the skin when the latter is in an inflamed condition. Water, even, may have an irritant action, especially well water. I remember seeing a case made infinitely worse by the application of a wash in which well water was used. It is better, then, to apply either dry powders or astringent lotions, which ought to be made with rum or distilled water.

A wash which T. Fox recommends is,—

- R Pulv. calamin ʒi
- Zinci oxidi ʒss
- Glycerini ʒij
- Aq. ʒvi

Ft. Lotion.

To be applied with a small brush.

Instead of this, the lotio plumbi et opii may be used.

The following powder is recommended by Prof. Hebra :

- R Zinci oxidi
- Pulv. aluminis
- " rad. iridis ʒi
- " amyli ʒij

To be dusted on the part affected.

When the inflammation has subsided and the eczema has taken on a more subacute character, astringent ointments may be applied. Of these, the most common is the ung. zinci oxidi. I have used, to a very considerable extent, the following :

- R Ung. zinci oxidi
- " plumbi āā ʒss
- " hydrarg. oxid. rub . . ʒij

M.—To be applied externally.

In an acute attack of eczema simplex, these are usually all the remedies required. The disease runs a certain course, and has a tendency to heal, providing that all irritants are removed.

ECZEMA RUBRUM.

This is a form which frequently attacks persons debilitated by overwork or bad surroundings, and who, of course, require appropriate hygienic and internal treatment. It may be divided into acute and chronic: the former very often terminates in the latter. In the acute form, it presents a very red appearance, and is of a very sensitive character; hence, it is never wise to use stimulating ointments in the earlier stages. When the part is very irritable, it is better to use bran infusion, or decoctions of marshmallows, or poppy heads. If there is much weeping or exudation, dry powders may be applied, oxide of zinc, starch, &c. After the discharge has ceased, and if the parts become stiff and irritable, it is better to use some mild form of ointment. The ointment used by Hebra, and one which I have found to be of the greatest benefit, is ung. diachyli. A piece of fine old linen cloth is smeared over with a layer of this ointment and bound over the part. I might say here that this is the best way of applying all kinds of ointments when there is much irritability. Ung. zinci oxidi may be used, or that of which I spoke in the treatment of eczema simplex. Sometimes the

part becomes covered with a crust, which ought to be removed by soaking in *ol. olivæ*, or by poulticing with linseed meal. As I have before stated, the acute very frequently passes into the chronic form. In the latter, of course, a different mode of treatment must be adopted. T. Fox divides the chronic form into three varieties:—

I. In which the disease is light.

II. Marked by abundance of scabs, weeping, and the formation of crusts.

III. In which there is considerable thickening and infiltration of the skin.

In the first form—that is, when the disease is light,—any of the following astringents may be used:—

1. Borax, ʒss; glycerine, ʒi; rose water, ʒviij.

2. Zinci oxidi, ʒij; glycerine, ʒi; lead water, ʒiss; aq. calcis, ʒvi; or ordinary ung. zinci benzoat.

In the second form, that marked by the formation of scabs, infiltrations, exudation, crusts, &c., the tarry compounds are used with benefit; for instance, the ung. picis liq. of the pharmacopœia, or even the pure tar, where the skin is not too sensitive. It is best applied with a small brush. In almost all cases, the tar should be used carefully at first, as it does not suit every patient. Even in cases where, to all ordinary appearance, it would be good treatment, it is found not to answer. Instead of tar, pyroligneous oil of juniper, or the liq. carbonis detergens, may be used. Tar may also be used in combination with the soap treatment and continuous bathing. I have now a case of this form of eczema which I am treating as follows:—At night the tar ointment is applied, and allowed to remain through the whole night; in the morning, the spirits saporis viridiis applied, and in half an hour the patient goes into a bath, where he remains for half an hour. The skin is then gently anointed with *ol. olivæ*, and he is allowed to follow his usual amusements throughout the day. At night, the same process is gone through. This is a tedious process, but I have seen cases in whom every vestige almost had disappeared in three or four weeks' time. Instead of remaining half an hour, patients may

remain several hours. I have seen them remain the whole day in a bath.

In the third form of this disease, the soap treatment is the best. According to Hebra, it is applied as follows: the part is rubbed with a small piece of the *sapo. viridis*, a little water being used to produce a lather. It is then allowed to dry, and some mild ointment is applied, as ung. diachyli or ung. zinci oxidi. The ung. hydrarg. iodid. virid. is also used. Iodide of potassium may be given internally. If the infiltration and thickening of the skin is very great, liq. potassæ may be applied with a brush. It must be done carefully.

Before concluding this part of my subject, I might mention a treatment brought into use by Balmanno Squire, viz., the glycerole of the sub-acetate of lead. The formula is as follows:—

Plumbi acetat 5 pts.

Litharg 3½ "

Glycerine 20 " by weight.

Mix and expose for some time to a temperature of 350°F. Filter through a hot water funnel.

A number of cases treated with this application are given by Duhring and Van Harlingen, of Philadelphia. Many of them were cured in a remarkably short time, and all except one benefitted. They say:—‘The results in the cases noted, and also in others coming under our observation during the last six months, lead to the following conclusion. In the glycerole of the sub-acetate of lead, we have a valuable addition to the therapeutics of certain forms of chronic eczema, particularly eczema rubrum of the lower extremities. It is most useful in those cases where the affection is extensive, of a dusky hue, accompanied by much weeping, oozing, and infiltration of the skin, together with swelling and œdema of the subcutaneous tissues, and a full and varicose condition of the venous circulation. In such cases glycerole of the sub-acetate of lead, used with diligence and accompanied by bandaging, constitutes a remedy of the highest value.’ As these kind of cases are very common, especially among the poorer classes, this remedy will in future be of great value.

ECZEMA IMPETIGINOSUM.

This is a form of disease in which there are scabs and a considerable amount of suppuration. Formerly, cases of this kind were put under the head of impetigo. The internal treatment will be tonics, cod-liver oil, fresh air, good diet, &c. Where there is a strong tendency to suppuration there will be a low state of the constitution, which must be attended to if the disease is to be successfully treated.

Now, as to the local treatment. The first process is allaying irritation and removing scabs. This may be done by linseed poultices and poppy-heads. After the scabs have been removed mild astringent ointments may be used. If the disease occurs on the scalp, the hair must be cut short before the above treatment is adopted. In this condition of the scalp pediculi are often present. These may be destroyed by ung. staphisagriae or chloroform vapour. Coal oil has been used for this purpose by Hebra. Sometimes after the crusts are removed it is requisite to first use sedative lotions, on account of the irritability of the part. In these cases, cod-liver oil has been used with good effect. Generally speaking, in eczema impetiginosum, the internal treatment is of equal, if not of greater importance than the external means.

I shall now briefly give the outline of treatment for eczema attacking particular parts of the body.

Eczema rubrum of the hands may be successfully treated by ung. diachyli, being careful that the ointment is well applied between the fingers. Hebra recommends the wearing of india rubber gloves. These may be worn at night only, or during day and night. The perspiration retained softens, and has a curative action on the skin. I have tried this plan of treatment, but with little success. I have always found that eczema of the hands is most successfully treated by the ordinary methods.

Eczema of the scalp.—Under the head of eczema impetiginosum, I spoke somewhat of the treatment of this condition. In order to remove the crusts, the head should be well soaked in olive oil. It may be applied by rags being

thoroughly saturated and bound on. Some have recommended the persistent use of arsenic internally; but in cases of children teething, the disease so frequently recovers of itself, when the process of dentition is over, that I do not think it advisable to employ such an heroic remedy.

In summing up, then, the local treatment of eczema, the following points may be noticed:

1. In the stage of irritation, when there is much exudation present, astringent lotions and drying powders should be used. The use of ointments must be avoided.
2. When the exudation has ceased and the part has become dry, ointments may be tried.
3. In eczema rubrum, when there is a good deal of scabbing and crusting, use tar, which must be done with care, as some will not bear it.
4. When there is great infiltration and thickening of the skin, the green soap treatment will give the best results.

In all cases of skin disease, successful treatment depends to a large extent on correct diagnosis and a proper appreciation of the pathological conditions present. It is always well to examine for a syphilitic history, as this is, of course, of the greatest importance in the treatment and also in the prognosis.

(To be continued.)

THE DEVELOPMENT OF THE GRAAFIAN FOLLICLES DURING PREGNANCY.—Contrary to the opinion then prevailing, and contrary to that now generally taught (for example, Barnes' "Diseases of Women," p. 28), the late venerable Professor of Midwifery at the Jefferson Medical College, Dr. Charles D. Meigs, used to teach that the development of the Graafian follicles continued uninterruptedly during pregnancy. This opinion has been confirmed by some researches and post-mortems made by Dr. Slaviansky, which we find in the *Med. Centralzeitung*, October 30th. A woman of twenty-four years, who died suddenly in the third month of pregnancy, displayed follicles on the point of bursting, and recent corpora lutea. This may be said to decide a question of considerable physiological interest.

A CASE OF CARDIAC THROMBOSIS, OR POLYPUS OF THE HEART, OCCURRING IN CONNECTION WITH PNEUMONIA.

(Read before the Toronto Medical Society.)

BY C. K. CLARKE, M.B.

The patient in whom this heart complication existed was a male, who had been an inmate of the Toronto Asylum for about eleven years, and at the time of his death was fifty-six years of age. Physically, he was a strong man, and was always considered one of the healthiest patients in the building. He was very industrious, and manufactured all the soap required for the use of the institution—an occupation which is far from being a healthy one.

One morning in April he complained of being indisposed, and was found to be suffering from an attack of acute lobar pneumonitis, the lower lobe of the left lung being involved. Opium was given; and as the patient was now troubled with diarrhoea, this medicine proved doubly useful. The diarrhoea was exceedingly troublesome, and as the poor fellow was losing strength rapidly, stimulants were administered freely, apparently with benefit. The case seemed to be progressing favourably enough until the fourth day, when the patient complained of a smothering sensation, was restless in his bed, the pulse was feeble and fluttering, and the general appearance anxious. This state of things lasted for a few hours, when death took place. As the case seemed to be a peculiar one, and the cause of death not plain, it was decided to make a post-mortem examination. The autopsy was made twenty hours after death, *rigor mortis* marked, and body well nourished. The pleura was adherent on each side, the adhesions being firm and evidently of long standing. The right lung was crepitant and quite healthy in every respect. The lower lobe of the left lung was found completely hepatized and of the consistence of liver. Upon section, some dark grumous fluid exuded, but the vesicular appearance of healthy lung tissue had completely disappeared. The heart was next examined, and was of normal size and healthy appearance. The right ventricle was almost filled with a

firm fibrinous clot of a yellowish-white colour, entangled with the columnæ corneæ and chordæ tendineæ. This clot extended into the pulmonary artery, and was continued for some distance into its right and left divisions. I have preserved the portion of the clot which was found in the ventricle; but, of course, this does not convey to you any idea of the original size. What you can see here will hardly fail to convince that the clot was formed at a considerable time before death.

This case was an interesting one, occurring as it did in connection with pneumonia, and shows the importance of watching for such a complication in this disease. Flint, in his "Practice of Medicine," calls attention to the danger that arises in pneumonia from this cause, and seems to think that a considerable proportion of the deaths in this disease are caused by the formation of heart clots, and explains that we may always expect to find the clot in the right side of the heart, because of the obstruction caused to the pulmonary circulation. Owing to this obstruction, the blood on the right side of the heart is impeded in its flow, the fibrin deposited, and a clot formed. In the case of the patient we have under consideration at present, there were two conditions which favoured the formation of a polypus. In the first place, he was suffering from pneumonia, a disease in which there is an increase of fibrin. In addition to this favourable condition, there was severe diarrhoea.

Dr. Martin L. James, of Richmond, Virginia, in an exhaustive paper on "Cardiac Thrombosis," states that the symptoms of heart-clot in the right side of the heart are well marked, and describes them as follows: "The temperature is reduced, sometimes to a degree approaching that which obtains in cholera; the pulse is irregular, usually frequent, and I think will be always found feeble and small in volume. Frequently it is described as fluttering, and sometimes obliterated, except in the larger arteries. The surface is marked by pallor or venous congestion. The dyspnoea, from a clot on the right side of the heart, is peculiar. The patient has no difficulty in performing the voluntary part of respiration, and auscultation shows the entrance of air into the vesicles, and

yet he feels that he is suffocating—the fact being that the respiratory effort has been an abortion in the circumstance—that aeration, its grand end, has failed, because the blood has not reached the lungs on account of the physical obstacle in its path.” . . . “The sensations of the patient, too, vary with the location of the clot. If the clot be located on the right side of the heart, he will describe a terrible sense of oppression at the heart itself.”

Hope, in his work on “Diseases of the Heart,” describes the symptoms of cardiac thrombosis as follows: “A sudden and excessive aggravation of the dyspnœa, without any other obvious adequate cause; the pulse is small, weak, irregular, intermittent, and unequal; the patient is in an agony from an intolerable sense of suffocation; he cannot lie for a moment, and he continues tossing about in the most restless and distressed condition until his sufferings are ended by death.”

It will be seen that in the case of the patient referred to to-night the symptoms closely correspond to those described by the authors quoted; and it is doubtful had the nature of his disease been accurately diagnosed could anything have been done to relieve him. Brandy and opium are highly recommended by some in the treatment of these cases, and all seem to be in favour of carbonate of ammonia, on account of its supposed action in preventing the deposition of fibrin from the blood in the shape of clots. The patient had whiskey and opium given freely, but no carbonate of ammonia.

Shortly after the occurrence of this case we had another death caused by the formation of a heart-clot. The patient was only a day under our observation, and had not received much attention. He seemed to be weak and anæmic, but no particular notice was taken of his case beyond this fact. On the morning of his death he went to breakfast, appeared to be very weak, and had to be assisted to his bed almost immediately. In bed he was restless, and would not, or rather could not, keep quiet, and in a few hours died. The symptoms were so similar to those which occurred in the other case that heart-clot was suspected, and the post-mortem examination verified the diagnosis.

The lungs were found tuberculous, but there were no traces of pneumonia. The clot was on the right side of the heart, and occupied the ventricle, extending for some distance into the pulmonary artery. The clot was quite adherent to the side of the heart, and required some little force to detach it. In size and shape, as well as organization, it was very similar to that removed from the first case mentioned. There is little doubt but that the formation of the clot was dependent upon the anæmic condition of the patient, in conjunction with tuberculosis. Writers upon the subject consider either of these conditions quite sufficient to account for cardiac thrombosis.

THE PATHOGENESIS OF CEREBRAL HÆMORRHAGE.

Eichler (*St. Petersburg Med. Wochenschr.*) gives the following conclusions:—

1. Primary idiopathic cerebral hæmorrhage owes its production to the rupture of miliary aneurisms of the smallest cerebral arteries.
2. The miliary aneurisms are *aneurismata spontanea vera totalia*.
3. They are due to a chronic endarteritis identical with arterio-sclerosis.
4. Miliary aneurisms, like arterial sclerosis, are pre-eminently senile diseased conditions.
5. The dissecting aneurisms are sharply separated from the miliary aneurisms. They are simple hæmatomata, and not a cause, but a consequence of hæmorrhage.
6. The capillary dilatations are likewise distinct from miliary aneurisms. They are to be compared with tetangiectases of other organs, and like them, are congenital.
7. The coats of the vessels are in three layers: the intima, the media, and an externa, separated from the muscularis by a simple space.—*Journal of Nervous and Mental Diseases*.

PALUDAL TORTICOLLIS.—M. Jules Simon records a case occurring in a child four years old, who suffered every day about the same time from spasmodic contractions of the sternomastoid, lasting four or five hours. It had previously suffered from several attacks of intermittent fever. It recovered under quinine treatment.

Translations.

A REMARKABLE CASE.

At the *Académie de Médecine* on 28th January, 1879, M. Broca presented a pathological specimen which had been sent to him by the Pastor Muston, which was obtained from a young peasant of the Drôme Mountains. The child, otherwise healthy, presented from its birth this abnormal peculiarity, that after falling asleep at night he could not be awakened by any means whatever. In the morning, on the contrary, he was readily awakened quite naturally. One evening he was left alone near the fire seated upon a chair. When the folks returned, they found that he had fallen forwards almost into the fire; a large felt hat he was wearing was completely consumed around his head, which was itself deeply burned; but he had remained in his usual deep sleep. He was put to bed in the belief that the burn was not very deep. The next day he awoke as usual and set out to take care of his flocks, without complaining of any pain, and so on during the following days. At the end of some weeks, however, an immense eschar becoming detached, laid bare the bones of the head, which appeared black and mortified, then all around about the borders of the wound a rosy line revealed the process of separation of the dead from the living. One day at length a sequestrum was detached which comprised the whole of the external table and a part of the diploe of both parietals, of the upper extremity of the frontal and a portion of the occipital. The temporals, covered over by the muscles of that name, had not suffered. Pastor Muston visited the boy at various times, the first time about a year after the accident. The osseous wound had commenced to be covered by fleshy granulations. At a single point, corresponding to the middle region of the right parietal, pulsations were observed isochronous with the cardiac beat. This was explained upon examination of the sequestrum, for at this point it comprised the whole thickness of the parietal, inner table and all. Later, during the following year, these pulsations had disappeared, demonstrating that osseous separation had

been effected, as often happens in losses of substance of slight extent, going down as far as the dura mater, but leaving that membrane intact. The wound itself, however, is, at present, almost as large as it was a year ago; the cicatrization is proceeding with extreme slowness. But the young shepherd, who has thus lost a great part of his cranium, has none the less every day attended to his flock. The wound is dressed from time to time by covering it with a rag dipped in oil, over which is placed a felt hat. He frequently carries upon his head heavy loads and thorny branches, and it appears he congratulates himself upon no longer feeling the thorns which previously often pricked the hairy scalp.—*La France Médicale*.

ECZEMA MARGINATUM.

At the *Société de Biologie*, M. Vidal communicated some researches upon the disease described by Hebra under the name of eczema marginatum. Under this appellation several parasitic affections which are not eczemas have been confounded together. One form, characterized by its frequent location in the axillæ and on the inner side of the thighs, presents clearly defined borders, which distinguish it from true eczema; its colour is yellowish or brownish, and the parasite which is found is the *microsporon furfur*. It is in reality pityriasis versicolor. Other cases described under the name of eczema marginatum, in which prominences on the skin occur, and the tricophyton is found, and in which the affection may last several years and invade a great part of the body, belong to *herpes circinatus*. But there is a third variety which clinically and microscopically differs from the two preceding forms and resembles the *pityriasis rosea* of Joubert and Bazin. Clinically, this form is characterized by a rapid dissemination of the redness (in a few days). Slight desquamation and small vesicles formed by the agglomerated parasites. The affection, instead of progressing regularly, extending from the median line of the trunk like a pseudo-exanthem of slow course, lasting at least six or seven weeks, presents irregular features in its generalization; and the borders are not limited by an intense redness as in *herpes circinatus*. Lastly, an important fact, a cure is rapidly and easily obtained by a few sulphur baths, or frictions with Helmerich's pomade.—*Le Practicien*.

SYPHILITIC FEVER.

We extract the following account from a clinical lecture delivered by M. Potain at the *Hôpital Necker à propos* of a case of associated tuberculosis and syphilis, in which the problem was to determine whether the febrile symptoms were due to the tuberculosis or the syphilis. The lecture is published in the *Gazette des Hôpitaux*, 17th October, 1878.—

“Syphilis is, in fact, frequently accompanied by a febrile process; but it is generally only manifested by malaise, perceptible to the patient in a greater or less degree. If, moreover, the latter consult the physician for this indisposition, it often happens that he has not remarked the stains upon the skin, which sometimes are very inappreciable; the physician, for his part, does not think of a syphilitic affection, of which the patient presents or complains of no symptom, and he attributes the fever to some totally different cause. Often-times syphilitic fever is confounded with an eruptive fever, or with the beginning of a typhoid fever; the error is the more easy to make because frequently the prostration is extreme, and recalls completely that of synochal fever.

“From this fact a very useful practical lesson follows: whenever the physician finds himself in the presence of a patient affected with a remitting fever of indefinite character, for which he can find no very clear or satisfactory explanation, he ought to look for syphilis.

“In our patient the eruption of roseola immediately decided the diagnosis; but, if this eruption had not existed, we would nevertheless have found that the fever possessed a special character, and was not the fever which ordinarily accompanies the tubercular process. The attacks, in fact, are diurnal, and they commence with an intense chill, followed by heat and transpiration. This character alone should make us think of syphilis; it is altogether different from that of tubercular fever. In tubercular fever the febrile attacks recur at night; they commence, not by a chill, but with fever, sharp and severe, which is afterwards followed by sweating. Lastly, the chill only occurs when the body is covered with sweat, and from the fact of a loss of heat. The dif-

ference is therefore considerable between these two processes, as far as the fever is concerned. And if I insist upon this difference, it is not simply for the purpose of making a precise diagnosis; you will readily conceive the therapeutic indications will be different in the two cases.

SATURGINE ANEMIA, WITH DOUBLE CRURAL SOUFFLE.

Patient, a man, twenty-nine years of age. Avocation, a decorative painter. He has never had colics, or arthralgias, and he presents no indication of paralysis. But he bears a slight saturnine border of the gums, which denotes, if not an intoxication, at least saturnine contact. He presents all the signs of profound anemia: excessive feebleness of pulse, vertigo, jugular souffle, weak heart sounds, etc. Lastly, we find in him a special symptom, a double crural souffle.

It is known that when the stethoscope is applied over the crural artery in the normal state, the compression determines a dry diastolic *bruit*, of greater or less intensity, but always single. This *bruit de souffle* is normal. But in individuals affected with aortic insufficiency, Durozier has observed a double *bruit de souffle*; that is to say, that after the first normal diastolic *bruit*, there is heard another *bruit* somewhat less intense. This double crural *bruit* exists sufficiently constantly in patients with aortic insufficiency to be regarded almost as a pathognomonic sign of that affection, if there be at the same time observed a souffle with the second sound at the base of the heart. This peculiar *bruit* may also be heard in other arteries, in the brachial, carotid, etc. But it would be more difficult to determine its presence when it might be complicated with venous *bruits*, so that it is always looked for in the crural artery, where its discovery renders the question less complex. The double crural souffle has not been found in any other cardiac affection; but, by a still unexplained phenomenon, it has been found in patients suffering from saturnine intoxication; the cause of this singular peculiarity has not been determined.

The treatment will therefore consist, apart from the prophylactic counsels which follow from these considerations, in combatting the saturnine intoxication, which is the cause of the anemia, by the usual medication: purgative, and iodide of potassium. Lastly, we shall promote recuperation by tonics, iron, and sulphur baths.—*Gazette des Hôpitaux*.

Formularies.

A VALUABLE EXPECTORANT.—Dr. Kessler has used all the expectorant formulæ, besides a great many of his own mixtures, but has obtained best results from the following :

R. Pix liquida.....	gttxx	1	
Spts. nitr. dulc.....	ʒi	4	
Syr. simpl.....	ʒii	70	

M.—S. Teaspoonful night and morning. Very few doses will suffice in most cases.—*N. Y. Brief.*

FOR LARYNGEAL PHTHISIS.—

R. Acid carb. concent....	f ʒj	4	
Tr. iod. comp.....	f ʒij	8	
Aquæ.....	f ʒiiss	75	

M.—S. Teaspoonful three or four times daily by spray or inhalation.

IVY POISONING.—Dr. Tydings, in the *Maryland Med. Jour.*, highly recommends :

R. Ext. belladonnæ alc....	ʒi	4	
Aquæ.....	ʒiij	90	

M.—S. Apply to parts affected with a feather

FORMULAS FOR GIVING MEDICINES TO CHILDREN.

R. Quinæ sulph.....	gr. xvi	1	
Acidi tannic.....	gr. ij	13	
Ol. menthæ pip.....	gtt. ij	20	
Syrupi sarsaparillæ co.	ʒij	70	

M.—S. Dose, one teaspoonful. Shake the bottle before using.

Syrup of chocolate, such as is used at soda fountains, completely conceals the taste of quinine.

An agreeable formula for giving iron to children :

R. Ferri et potassii tart... ʒij	60		
Aquæ cinnamoni.....			
Syrupi simpl.....	āā ʒiiss	45	

M. et ft. solutio.

S. Dese, one half to one teaspoonful between meals and at bedtime.

EUCALYPTUS IN A COLD OF THE HEAD.—Professor Strambio, in the *Gaz. Med. Ital. Lombard.*, has found that prolonged mastication and swallowing of a dried leaf or two of the eucalyptus globulus almost immediately liberated him from all the effects of a severe cold.


THE CANADIAN Journal of Medical Science,

A Monthly Journal of British and Foreign Medical Science, Criticism, and News.

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

TORONTO, MARCH, 1879.

SUBSCRIBERS.

 Bills have been mailed to every subscriber in arrears. Though some have kindly and substantially acknowledged their receipt, there are many who are still in our debt: we must again urge these latter to pay up. The journal cannot be conducted successfully without funds, and funds we *must* have. Surely, every one who has not paid his subscription will help us to still further improve our monthly issues by remitting promptly the amount he owes. A reference to the date attached to the address-label will show when the subscription in advance became due.

DEATH OF DR. DUNCAN CAMPBELL

We regret to have to announce the death of Dr. Duncan Campbell, President of the Council of the College of Physicians and Surgeons of Ontario. Dr. Campbell had been long subject to very severe attacks of *angina pectoris*, but has only been confined to the house during the past three months. He was born at Ardchattem, in Argyllshire, Scotland, and at the age of ten was sent to Caen, France, to be educated. At the age of fifteen he returned to Edinburgh, and was apprenticed to Bell & Simpson, Physicians and Surgeons, for five years, graduating at the University of Edinburgh in 1833. He came to Canada in 1834. He was appointed Surgeon to the first battalion of incorporated militia, and served during the rebellion of 1837. At the close of the rebellion he settled in Hamilton, but shortly afterwards moved to Niagara, where he remained until 1858, re-

moving thence to this city. As shown by the Provincial Register, he received the Licence of the Royal College of Surgeons of Edinburgh in 1831; M.D., University of Edinburgh, 1833; Prov. License, 1834; was elected a member of the General Council of the University of Edinburgh, 1859; received the M.D. of the Western Homœopathic College of Ohio in 1859; became a member and was elected President of the Homœopathic medical board, 1859-69; member of the Council of the College of Physicians and Surgeons of Ontario, 1869-1879; Vice-President of the same, 1872-73, 1876-77, 1877-78.

A man of great intellectual power, high scholarly attainments and indomitable will, Dr. Campbell did much to further the cause of higher medical education in Ontario while a member of the Council. He was always a hard worker in this good cause and ever evinced a laudable desire to make the diplomas of the College of which he was so active a member, and at the time of his death President, second to none as evidences of thorough practical knowledge. Though he has not lived to see the fruition of his labours, still his good work remains, and we hope that in time many of the reforms in medical education he was so anxious to see carried out will be adopted.

OBITUARIES.

It is with very great regret we notice the announcement of the death of France's greatest hygienist and juris-consult, Dr. Tardieu, at the age of sixty. He was for many years Professor of Medical Jurisprudence at the Faculty of Medicine, a member of the Academy of Medicine from 1859, and once its president. He also was president of the Council of Hygiene of Paris and of the Medical Association of France.

Old Guys' men will regret to learn of the death, on Christmas Day, of James Stocker, M.R.C.S., the old apothecary of Guys. He was connected with the hospital from 1829 up to within twelve months of his death, which occurred at the age of 74.

Dr. John B. Biddle, Professor of Materia Medica in Jefferson Medical College, and Dean of the College Faculty, died on January 19th.

Book Notices.

Beiträge zur Pathologischen Anatomie des Auges. Von Dr. Adolph Alt, Toronto.

Université Laval à Montréal Bureau de la Revue de Montreal, 1878.

Address of W. O'Daniel, M.D., President of the Medical Association of Georgia, delivered at the 29th annual meeting.

The Relations of the Conducting Mechanism of the Ear to Abnormal Hearing. By SAMUEL SEXTON, M.D., New York.

Twenty-sixth Annual Announcement Medical Department, University of Vermont, for the year 1879.

Fifty-third Annual Report of the Massachusetts Charitable Eye and Ear Infirmary for the year 1878. Boston: Alfred Mudge & Son, 34 School Street.

Transactions of the American Ophthalmological Society—12th, 13th, and 14th Annual Meetings. New York: Published by the Society, 1878.

The Use of Calcium Sulphide in the Treatment of Inflammations of the External Auditory Meatus. By SAMUEL SEXTON, M.D., New York.

Excerpta from the Annual Report of the Board of Health for 1878. By JOSEPH HOLT, M.D., Sanitary Inspector of the Fourth District of New Orleans.

Transactions of the American Otolological Society. Eleventh Annual Meeting, Newport R.I., July 24, 1878. Vol. II., part 2. Boston: Houghton, Osgoode & Co.; The Riverside Press, Cambridge.

Vick's Floral Guide, published at Rochester, N.Y., No. 1, 1879, is a capitally illustrated catalogue of seeds, bulbs, and plants, with information as to the selection of seeds, sowing, lawn-making, bedding, balcony gardening, &c., &c. We can recommend the "Guide" to those fond of gardening.

On Fracture of the Femur. By EDWARD BORCK, M.D., St. Louis.

This is a reprint of articles that appeared in the *St. Louis Medical and Surgical Reporter*. The author describes the various methods of treatment advocated by the most eminent surgeons, and compares them with the plan he adopts, which is the double inclined plane, with extension by means of a cord and weight attached to adhesive straps applied to each side of the thigh. The traction is made in a line with the femur as it lies on the double inclined plane. The best results are claimed for this method of treatment.

Habitual Drunkenness and Insane Drunkards.

By Dr. BUCKNILL, F.R.S. London and New York: McMillan & Co.; Toronto: Willing & Williamson, 1878.

This is a readable little book made up of articles that have appeared previously in the *Journal of Mental Science*, *The Contemporary Review*, and *The London Times*. It also contains a report of the author's inquiries &c., respecting the operation of Inebriate Asylums in America, and an address to a meeting of the Medico-Psychological Association, &c., &c. Dr. Bucknill's report on Inebriate Asylums in America, gave rise to many vigorous replies from indignant Americans, but in the preface of this little work he shows, that his report was based upon careful personal inquiry into the working of American Institutions, and upon information obtained from able and experienced American physicians.

Dr. Bucknill takes and defends the view that there are two kinds of drunkards, the habitual and the insane, and discusses the causes and treatment of each kind, and the duty of the State in the matter.

An Atlas of Human Anatomy, illustrating most of the Ordinary Dissections and many not usually practised by the Student, accompanied by an Explanatory Text. By RICKMAN JOHN GODLEE, M.S., F.R.C.S. Philadelphia: Lindsay & Blakiston, 1878.

We have received Part I. of this work, which is to be completed in twelve or thirteen

bi-monthly parts, folio size, each part containing four large plates—two figures in each plate, coloured—each plate faced by a page of references, and each part accompanied by an octavo part containing the explanatory text, forming, when complete, a large folio volume of plates and references and an octavo volume of from 300 to 400 pages of explanatory text. The price of each part, including plates and text, is \$2.50.

Of this work, by one who, in addition to occupying a very high reputation as an anatomist and a teacher, is a most skilful artist, we can speak in terms of the highest praise. The study of regional anatomy should form an important part of a student's course; and, outside of the dissecting-room, we know of no better guide to recommend students than these plates, which are excellent in every way. We trust the enterprise will meet with a success that will amply satisfy the author and publishers. Part I. shows dissections of the head and neck, each plate being faced by a page of references.

CANADIAN MEDICAL LITERATURE.—We are informed that a work on "Physiological Therapeutics," based on a new interpretation of physiological facts, will appear about the last of March. Dr. T. W. Poole, of Lindsay, is the author.

JOURNALISTIC.—We have received the first number of the *St. Louis Courier of Medicine and Collateral Sciences*, published monthly by the Medical Journal Association of Missouri, Dr. A. J. Steele, Editor; Dr. W. A. Hardaway, Associate Editor; and can heartily congratulate the editors on the appearance of their first issue.

UNIVERSITY OF TORONTO.—Examiners in the Faculty of Medicine for the year 1879—Physiology and Comparative Anatomy, Dr. Osler, Montreal; Surgery and Anatomy, Dr. Malloch, Hamilton; Medicine and Therapeutics, Dr. Joseph Workman; Midwifery and Medical Jurisprudence, Dr. D. Clarke. Medicine and Arts—Chemistry, Dr. W. H. Ellis; Natural History, Dr. George Sedgwick Minot, Boston.

Miscellaneous.

CHAPPED HANDS.—R. Carbolic acid, gr. xv; yolk of egg, one; glycerine, ʒij—mix. A small portion to be gently smeared over the affected surface several times daily.

PERFUMED SOLUTION OF IODOFORM.—Shake tincture of iodine with a fragment of fused potash until the colour is removed, then add cologne or lavender water to cover the odour of iodoform.

GONORRHOEA.—Dr. Bauer, of St. Louis, advocates local treatment. He prescribes the following injection: R Inf. sem. lini. (ex. ʒij parati) ʒvj; ext. opii aquosi fl. gtts xvij—M. To be used warm every three hours.

ELASTIC BANDS ON BATTLE-FIELDS.—It has been recommended that all regiments of soldiers should be provided with simple elastic bands for use on the battle-field, in order to stay a flow of blood until the arrival of the surgeon.

MALTINE.—From a report by Professor Attfield, which has been forwarded to us, it appears that this is an aqueous extract of malted wheat, oats and barley. It is semi-solid in consistence, and agreeable in flavour. That it is genuine is proved by the fact, which we have tested by experiment, that it is capable of converting starch into sugar.—*London Lancet.*

TO RESTORE SYRUP OF IODIDE OF IRON.—L. Myers Connor, of Dallas, Texas, writes to the *Louisville Medical News* that syrup iodide iron which has become oxidized by exposure or age (known by its change from a green to a yellowish red), due to the liberation of free iodine, can readily be made to assume its proper colour by heating the syrup gently with fine iron wire free from oxide (rust).

FAVUS OF THE EPIDERMIS.—Dr. Bulkley reports in the *N. Y. Medical Journal* for Feb. six cases of favus occurring on various parts of the body. In three cases it was found on the face, in one on the knee, and in one on the buttock, one on the loin. These cases all came under his

observation at Denult Dispensary last year. They yielded readily to treatment, the eruption being slight, in some cases solitary.

LINIMENT FOR CHILBLAINS.—(Gillebert Dhercourt)—Venice Turpentine, ʒij; castor oil, ʒjss; collodion, ʒvijs; mix.—Apply the liniment with a camel's-hair brush to the fingers or toes which are the seat of the chilblains, whether ulcerated or not. Repeat as often as necessary to preserve the part from contact with the air, and continue until cured.—*L'Union Médicale.*

POISONING FROM AN OVERDOSE OF SWEET SPIRITS OF NITRE.—Mr. H. Cripps Laurence in the *London Lancet* records a case. The patient had been taking an ounce of sweet spirits of nitre in water at intervals during almost every day for three weeks. He was drowsy, incoherent, delirious, when roused answered questions, complained of headache, and said he had found it difficult to walk straight of late. He could see clearly, irides dilated, acting feebly; constipation, no vomiting, urine scanty, bladder empty. He recovered under diaphoretics and purgatives internally, poultices and dry cupping over kidneys.

M. Ernest Besnier and the majority of dermatologists now a days employ Volkmann's method in the treatment of lupus. This consists in scraping off the diseased parts with small spoons having cutting edges. The operation is desisted from as soon as it is perceived that the instrument is no longer attacking indurated tissues. As this scraping is very painful, the skin is anaesthetised by the ether spray, or the patient is subjected to chloroform. The resulting wound rapidly cicatrises. If the lupus be very extensive, the scraping is spread over two sittings; and, in fact, this is almost always necessary to ensure the complete removal of the indurated parts. Another method of treating lupus consists in making very close punctures in the indurated tissue, which give rise to an abundant flow of blood, and which are renewed every four or five days if necessary. The indurations are not slow to disappear and become effaced, and the skin gradually resumes its normal aspect.—*L'Union Médicale.*

The *British Medical Journal*, with the beginning of the year, has cut its leaves—an immense convenience to all its readers. Another new feature is the establishment of a "Confessional," in which mistakes, errors, or ignorances, can be anonymously reported *pro bono publico*. This feature is to be specially commended. Few men have the nerve to report anything that may possibly tell against them in any way. Journals are filled with glowing accounts of success, to such an extent as to give a very wrong impression of what the status of medical and surgical progress really is. The "Confessional," it is to be hoped, will prove a counter-check. Other journals, perhaps all, could establish it with advantage.—*Ohio Recorder*.

In the *Revista de Medicina y Cirujia Practicas*, published in Madrid on the 22nd Sept., 1878, a remarkable case is recorded as occurring in the surgical clinic of Prof. Kreus. It was a case of normal pregnancy with death of the foetus at the seventh month, due to a violent fall on the part of the mother. Putrefaction within the womb occurred, and fistulous tracts were formed through the cervix uteri and through the abdominal wall; when these latter formed, those through the cervix healed up. Gastrotomy was performed by Prof. Kreus twenty-seven months after conception. Some fever and signs of slight peritonitis were present for a few days; but the patient subsequently did uninterruptedly well, and a complete recovery ensued.

DIAGNOSIS OF THE PERSISTENCE OF THE DUCTUS ARTERIOSUS.—M. Fr. Franck makes an interesting communication to the French Association for the Advancement of Science, in regard to the diagnosis of the persistence of the ductus arteriosus. The diagnosis is founded on the following signs:—The existence of a systolic murmur behind the chest, on the left side of the vertebral column between the spines of the vertebræ and the vertebral border of the scapula, about the level of the third and fourth dorsal vertebræ. The strengthening of this murmur during inspiration. The marked increase of the effects of inspiration upon the arterial pulse. The absence of cyanosis if there are no other congenital lesions.—*Arch. Gen. de Med.—Practitioner*.

CHARITY FOR ERRORS IN DIAGNOSIS.—Prof. D. Hays Agnew, in his address before the Pennsylvania Medical Society, closes with the following words: "There are some persons who never commit errors, or, committing them, never have the magnanimity to acknowledge that they were deceived. I confess that I am humbled every year in making errors in diagnosis. Like Lucretius, I sink the lead over and over again and find no bottom. Indeed, I know I shall never attain to such an imperial reach of wisdom that disease will surrender all its secrets at my bidding. I shall make mistakes as long as I am in the flesh. There never was but one physician who knew all the truth, and He was divine. With what tenderness does nature conceal her unsightly deformities by the interlacing tendrils of ivy or rhus, which she so ingeniously spreads over the smitten tree or the rugged cliff. Emulating her example, let us over each other's imperfections draw with loving hand the veil of charity." There are few medical men, we imagine, who were taught in Philadelphia during the last two decades that do not remember with pleasure the lectures of Professor Agnew at the Pennsylvania Hospital. There was so much earnestness, common sense, and honesty in his discourse that Prof. Agnew was a favorite with all the schools.—*Louis. Med. News*.

TRAINING SCHOOL FOR NURSES, TORONTO GENERAL HOSPITAL.—The Trustees of the Toronto General Hospital have made arrangements for giving, at the Hospital, two years' training to women desirous of becoming professional nurses. Persons wishing to receive this course must apply either to the medical superintendent of the hospital, or to the lady superintendent, upon whose approval they will be accepted as pupils in the hospital. Candidates must be over twenty and under thirty-five years of age. They must be of sound health, and must present, on application, a certificate from some responsible person as to their good character. Applicants will be received one month on probation. During this month they are boarded and lodged at the expense of the hospital, but will receive no compensation should they leave or be discharged before the expiration of the

month, or be found incompetent by the lady superintendent. The medical superintendent of the hospital and lady superintendent (with concurrence of medical superintendent) will have full power to decide as to the fitness of the nurses for the work, and the propriety of retaining or dismissing them at the end of the month of trial. The same authority can discharge them in case of misconduct or inefficiency at any time. A vacation of two weeks is allowed each year. Pupils are required to wear the dress prescribed by the institution, and will be provided with two dresses each year and with caps and aprons. As the Toronto General Hospital is unsectarian, no regular religious services are connected with it, but all nurses are expected to attend morning prayers daily in the hospital, and to attend the place of worship they prefer once every Sunday. They will reside at the hospital and serve as nurses in the wards. In sickness, all pupils will be cared for gratuitously. The medical superintendent may send any pupil to act as nurse in any place in the Province, but no pupil shall be required to be absent from the hospital more than three months in any year. The hospital to pay the travelling expenses of the pupil, and all remuneration charged and received for her attendance shall belong to the hospital, the pupil not being entitled to extra payment for any such attendance, nor to receive any perquisite or gratuity without the sanction of the lady superintendent. *Training:* Those persons complying with the foregoing conditions will be accepted as pupils, by signing a written agreement to remain at the school for two years, and to conform to the rules of the hospital. The instruction includes:—1. The dressing of blisters, burns, sores, and wounds; the preparation and application of fomentations, poultices, and minor dressings. 2. Application of leeches, and subsequent treatment. 3. Administration of enemata. 4. Use of female catheter. 5. The best method of friction to the body and extremities. 6. Management of helpless patients; moving, changing, giving baths in bed, preventing bed sores, and managing position. 7. Bandaging, making bandages and rollers, and lining splints. 8. Making beds, and changing sheets while the patient is in bed.

9. That no part of the hospital is clean if it can be made cleaner. The pupils are taught to prepare food, together with drinks and stimulants for the sick; to understand the art of ventilation without chilling the patient, both in private houses and hospital wards, and all that pertains to night, in distinction from day nursing. To report to the physicians accurate observations of the state of the secretions, expectoration, pulse, skin, appetite, temperature of the body, intelligence (as delirium or stupor), breathing, sleeping, condition of wounds, eruptions, formation of matter, effect of diet, stimulants, or medicines, and to learn the management of convalescents. Instruction will be given by attending and resident physicians and surgeons at the bedside of the patients, and in various other ways, also, by the lady superintendent and head nurse. Lectures and demonstration will be given from time to time, and examinations held at stated periods. The pupils will pass through the different wards, serving and being taught, for one year. They will be supplied with board and lodging, and will be paid \$6 per month. This sum, with their education, is considered a full equivalent for their services. At the expiration of one year, they will be promoted to such positions as they may be found capable of holding, and will be paid \$9 per month. Arrangements will be made for pupils who may desire a special course of instruction in midwifery, to attend the Burnside Lying-in Hospital, after their first year of pupilage. When the full term of two years is completed, the nurses thus trained, after passing a final examination, will receive diplomas, certifying to their knowledge of nursing, their ability, and good character, and will then be in a position to choose their own field of labour either in hospitals, private families, or public institutions.

THE DRY SUTURE.—Dr. John H. Packard recommends this in closing long wounds. He uses strips of Seabury and Johnson's porous plaster two and a half inches wide and the length of the wound. These are applied on each side of the incision, and then the sides laced together, using the holes in the porous plaster.—*Phil. Med. Times.*

SIMPLE REMEDY FOR SCIATICA.—Dr. Ebrard, physician to the Hospital of Nimes, publishes in the *Courrier Medical* this new method of treatment. For many years I have treated the pains of sciatica and other neuralgias without having recourse to any other electric battery than a smoothing-iron, which, along with vinegar, is to be found in every house. This is how they are employed: The iron is heated hot enough to vapourise the vinegar, and is wrapped up in some material, preferably woolen; it is then dipped in the vinegar and applied upon the painful part. The operation is repeated two or three times in the day. It rarely happens that the pain has not disappeared at the end of twenty-four hours. This action is easily understood, on account of its contact with the fire, the iron becomes magnetic, and if an acid be added while it is hot, electricity is produced, and the same effects are obtained as with an electric battery.

CLINICAL VALUE OF THE THERMOMETER IN ABDOMINAL AFFECTIONS.—By Prof. Peter.—The physician may be called to a case of disease of the stomach; he finds no material proof of the existence of cancer, but he may feel intuitively that there is one. In such a case, the application of the thermometer is of real importance. Being called in consultation by my distinguished confrere, M. Leudet (de Rouen) to the case of a man 52 years of age, percussion of the epigastrium, practised *en doulant*, showed certain points of dulness. Under these circumstances, I had recourse to the thermometer to clear up the obscurities of the diagnosis. In the epigastric depression the thermometer registered $37^{\circ} \cdot 5$ ($99^{\circ} \cdot 4$ Fabr.); but it is known that the normal temperature of the epigastrium in the healthy individual is about $35^{\circ} \cdot 5$ (about 96° Fabr.). In painless atonic dyspepsias, the temperature remains unchanged. The result of my researches goes to show that the temperature in the vicinity of a cancerous lesion is elevated from 1° to $1^{\circ} \cdot 5$ (centigrade) above the normal. This is not due to phlegmasia but to irritation. The fact is, in my opinion, significant. In simple gastralgia, there may be elevation of temperature, but it is ephemeral, and only lasts as long as the pain continues. This is a fact

which appears to me to be worthy of remark and which is interesting because it enables us to comprehend how, even in cancer, a cauterization of the epigastrium, resorted to opportunely, may dissipate the hyperæmia; to say nothing of the important diagnostic deduction derivable from this means.—*La France Méd.*

COLD BATH IN DELIRIUM TREMENS.—D. Féréol, of the *Hôpital Lariboisière*, late records (*L'Union Médicale*) the successful treatment of a case of "acute febrile alcoholic delirium" by cold baths. The patient, a young man twenty-six years of age, entered the hospital on the 14th August "in a state of delirium excitation, which at night required the straight jacket to be applied. The night was passed amidst cries, vociferations, furious agitation and hallucinations of sight and hearing. Temperature very elevated, but impossible to place the thermometer; pulse very frequent. On the morning of the 15th, I prescribed the cold baths, to be given during the day, and a mixture containing 10 grammes of bromide of potassium. The first bath was followed by amelioration, the agitation seemed even to abate. But, at the second, given two hours after the first, the patient grew calmer, and was scarcely replaced in bed when he fell into a sleep, lasting two hours; on awakening he was given a draught, and a short time afterwards he again fell into a sleep, which lasted throughout the night up to 5 o'clock in the morning."

Births, Marriages, and Deaths

BIRTHS.

In Bowmanville, on Jan. 26th, the wife of Beith, of a son.

On January 31st, at Guelph, the wife of Dr. H. of a daughter.

MARRIAGES.

On Jan. 21st, at Toronto, W. J. Wilson, M.D. Stouffville, to Mary Ann O'Neil, of Toronto.

At St. Mary's, on Feb. 1st, J. J. Hall, M.D. Mrs. Morphy.

At Napance, on February 18th, Milton Ira Beer, M.B., to Miss Lilian Hanault.

On January 22nd, Francis M. Howe, M.D. Fordwich, Ont., to Mary A. McDowell, eldest daughter of the late A. C. McDowell, of Manitoba.

DEATHS.

At Cobourg, on Feb. 8th, William Wade, M.D. On Wednesday, Feb. 5th, at 112 Bay St., Dr. Campbell, M.D., in the 67th year of his age.