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Founded in 1824, and organized as a Faculty of McGill University in 1829, this School has enjoyed, in an unusual degree, the confidence of the profession throughout Canada and the neighbouring States.

One of the distinctive features in the teaching of this School, and the one to which its prosperity is largely due, is the prominence given to Clinical Instruction. Based on the Edinburgh model, it is chiefly Bed-side, and the student personally investigates the cases under the supervision of special Professors of Clinical Medicine and Surgery.

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Besides these, there is a Pathological Laboratory, well adapted for its special work. It is a separate building of three stories, the upper one being one large laboratory for students 48 by 40 feet. The first flat contains the research laboratory, lecture room, and the Professor's private laboratory, the ground floor being used for the Curator and for keeping animals.

Recently extensive additions were made to the building and the old one remodelled, so that besides the Laboratories, there are two large lecture-rooms capable of seating 300 students each, also a demonstrating room for a smaller number. There is also a Library of over 15,000 volumes, a museum, as well as reading-rooms for the students.

In the recent improvements that were made, the comfort of the students was also kept in view.

MATRICULATION.—Students from Ontario and Quebec are advised to pass the Matriculation Examination of the Medical Councils of their respective Provinces before entering upon their studies. Students from the United States and Maritime Provinces, unless they can produce a certificate of having passed a recognized Matriculation Examination, must present themselves for the Examination of the University on the first Friday of October or the last Friday of March.

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The Maritime Medical News,

A MONTHLY JOURNAL OF MEDICINE AND SURGERY.

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CONTENTS.

Original Communications.

"ERYSIPELAS."

Read before the Maritime Medical Association at Charlottetown, July 12th, 1893.

BY P. CONROY, M. D., Charlottetown.

* * * * *

The term "Erysipelas" is employed by modern medical writers to designate a certain form of inflammatory action attended by special characters, and due to a specific cause.

The name does not denote any particular or distinct disease involving any special tissue, but is a general term applied to a morbid inflammatory process that may affect any tissue of the body. Erysipelas is not a disease of the skin any more than it is of the peritoneum.

The determining cause of the disease is a specific virus or micrococcus, which finds entrance into the circulation from without, and when once admitted into the blood it sets up a peculiar septic inflammatory disturbance known as "Erysipelas." The spontaneous origin of erysipelas or its idiopathic development as a distinct disease, is denied by many modern authorities. That the determining cause is a germ cannot be doubted, and that the cause is always extrinsic is confirmed by scientific observation. The fact that the disease has altogether disappeared from the field of antiseptic surgery as well as from that of intelligent obstetric practice proves conclusively its external origin.

The disease may affect the integument, the vessels—the lymphatics—the cellular tissue—the mucous or serous membranes, but the determining cause is always the absorption of a septic germ through an abraded surface. Certain disturbed conditions of the blood may permit the operation of the determining cause by defect of resistance to its influence, but the disease is never directly produced by impaired nutrition, by disordered health, by cold, or by over-indulgence as was generally supposed by the older writers. All these conditions may be pre-disposing causes, but without the presence of the specific germ no erysipelas can develop. The point of entrance of the micrococcus is not always the seat of the inflammatory process. The

effects of the virus indeed, usually manifest themselves at an appreciable distance from the site of the innoculation. The nose and face are the most frequent seats of what appears to be the spontaneous development of the disease. In these cases septic matter is absorbed through an abrasion on the mucous membrane of the nasal passages. This abrasion is often caused by the finger-nail which infects the wound at the same time that it produces it. The prick of a dirty pin on the tip of the finger may set up erysipelatous lymphangitis at the elbow or in the axilla, or a diffuse cellulitis over the whole arm. The absorption of septic discharge from a wound produces the same result, and at a point sometimes very distant from the site of the entrance of the virus. Symptoms of blood poisoning are always present in such cases. After the micrococcus of erysipelas has been admitted to the circulation it may continue to live and to multiply in the blood, and to give rise from time to time to successive and distinct symptoms of the inflammatory process, and these may be at intervals more or less remote from each other, sometimes several months.

We note the fact, that many persons are subject to regular and periodic attacks of erysipelas during a great part of their life-time. The germ in these cases, after its admission to the circulation seems to multiply until it has acquired sufficient strength to cause an outbreak of the disease, which itself in time subsides, to be followed by another attack at a later date.

The development of erysipelas at the site of an external wound is utterly impossible when strict antiseptic rules are observed, and the occurrence of the disease after surgical operations is always due to faulty management on the part of the surgeon. For neglect or ignorance in such cases the surgeon is sometimes held accountable for damages in courts of law.

The most efficacious local application in the treatment of erysipelas affecting wounds, or as a preventative against its occurrence when there exist a liability, is, without doubt, the bichloride of mercury, and the internal administration of the same drug has also a destructive influence on the germ, in cases where the disease seems to recur at periodical intervals, on account of the continued presence of the specific virus in the system. A case which brought forcibly to my mind the fact, that the germ of erysipelas may live in the blood for an indefinite time, occasionally manifesting itself by the development of the disease at regular periods during many years came under my observation some few years ago. The patient, a woman, aged 40, of otherwise apparently robust health, came to my office while suffering from an attack of erysipelas of the face. Her cheeks, eyelids, nose and ears were swollen, shiney and painful, with the usual attending febrile disturbance. She gave the following history:—About seven years previously she was first seized with an attack of erysipelas affecting the same parts as were then involved. There was also at the time a painful excoriation of the mucous membrane of the nostril, accompanied by a purulent discharge. After running a course of about a week's duration the trouble subsided, and the patient seemed to have regained her usual good health. About a month afterwards she was seized with a fresh outbreak of the disease, affecting the same parts and pursuing the same course as did the first attack.

For the seven years that followed patient had suffered a regular monthly recurrence of erysipelas, always affecting the face and attended with the same symptoms. During that long period of time she had taken many remedies, but without experiencing any change in the regular monthly appearance of her unwelcome visitor. The knowledge of the fact that every remedy, usually

given in such cases, had been presented for the patient, made me satisfied that nothing more could be done for her by pursuing the old established plan of treatment. I therefore determined that as an experiment based upon the theory of the bacillary origin of erysipelas, I would try the effect of the bichloride of mercury on the germ, which I took for granted was causing the disease, and was living and being multiplied in the blood of the patient. On that supposition the case presented itself to me for treatment as if it were one of primary siphilis. As the patient belonged to the country she was persuaded to remain in town so that I might watch more closely the effect of the treatment. I gave her the bichloride of mercury, which was pushed gradually to salivation and slight soreness of the teeth. When the usual time at which she should expect a recurrence of a visit from her old enemy had come and gone without any such visitation, I discontinued the mercury and allowed the woman to go to her home. It is now more than seven years since that time, and the patient has not since had the slightest sign of a return of the disease. Having casually seen the patient a short time ago in conjunction with another physician, a fresh recital of the history of this case was obtained as a supplement to the notes I had previously taken, and to establish the patient's subsequent and present complete freedom from her old malady.

Another case, with a somewhat similar history, is as follows :—A. L., aged 50, of good health, came to the "Charlottetown Hospital" to have a wart removed from the side of his nose. The little wound after the removal of the wart was washed with antiseptic, dusted over with iodoform, and dressed with a few thin layers of flesh colored absorbent cotton soaked in elastic collodion and applied with a brush—a dressing I had often used successfully on small wounds on the face where a cosmetic effect was desired. This dressing being impermeable and adherent, no escape of discharge was possible. Thinking that I had an aseptic wound, and that healing would go on readily as I had witnessed it on other occasions, I paid no particular attention to my patient, whom I might see every day in the ward of the hospital. On the 3rd or 4th day after the operation, I was told by the nurse that my patient was complaining of feeling sick. I at once saw him and noticed that his nose was red and shiney, indicating the onset of an erysipelatous inflammation. I immediately removed the dressing and found beneath it a small collection of pus. Under an open antiseptic dressing the erysipelas soon passed away, and the little wound healed in a few days. About a week afterwards when my patient had considered himself well he was taken suddenly with a chill, and an erysipelatous eruption broke out on his cheek which spread to the ear on the same side. When this process had run its course and recovery seemed to be complete, a third attack supervened on the other side of the face, much to the discouragement of my patient and to my great annoyance. This last attack began four weeks after the original wound had entirely healed. All the topical applications usually employed in such cases were used together with general tonic treatment. When the third attack broke out, I considered from experience I had with the other patient, that this was another case of systemic infection by the specific virus, and I began at once the administration of the bichloride of mercury. Recovery soon took place—no other attacks followed and the patient left the hospital well—minus only the loss of his hair.

The conclusions to be drawn from what I have said are :

1st—That erysipelas is always due to the absorption from without of specific virus.

2nd—That this virus may live and multiply in the blood and develop erysipelas at remote periods.

3rd—That the bichloride of mercury, taken internally, is a certain destroyer of the virus in the blood, and a reliable cure in cases of erysipelas of a recurrent character.

RHEUMATOID ARTHRITIS.

Paper read at Annual Meeting, New Brunswick Medical Society, July, 1893.

By A. C. Crocket, M. D., Fredericton, N. B.

The object of this paper is not to throw any new light upon the pathology, causation or treatment of this interesting malady, but to take a general survey of the disease, and to impress upon us those prominent features of the affection whose want of recognition has led to such terrible results. There are few symptoms we fail more often to recognize, notwithstanding that we observe them, than those of rheumatoid arthritis, and few affections whose want of early recognition is attended in its later stages with such helplessness and misery. Even in its advanced stages rheumatoid arthritis is often not recognized, the unfortunate victim of the disease being treated for gout, spinal curvature, rickets, or for tuberculosis of the joints. It is then the importance of the subject which has suggested this short paper upon the disease.

The affection is for the most part brought on by conditions which produce lowering of the vital powers such as overwork of body and mind, in adults prolonged grief and anxiety, circumstances provocative of catarrh, such as residence in low lying districts, in badly drained and ill-ventilated houses, and occupations involving exposure to cold and damp. Exposure to cold and dampness following fatigue is a powerful factor in producing the disease. In woman hyperlactation and menorrhagia are potent causes. Traumatism is responsible for some of the cases, more especially of the monoarthitic form. It is not unfrequently a sequel of acute articular rheumatism, and in some of the cases under my observation I was able to trace a strong history of rheumatism in the family. Persons of all ages may suffer, but those between 20 and 40 years of age are most prone to the disease. It is not, however, an uncommon affection in children. One of the severest cases I have met with occurred in a female child 10 years of age, a relative of my own, a case which presented every feature of the disease in its most typical form.

The pathology of the disease is obscure. There would appear to be a condition of chronic inflammatory changes affecting all the structures of the joints, bone, cartilage, synovial membrane and ligaments. The cartilages are more or less completely absorbed, the denuded bones are worn away presenting a condition of eburnation, bony growths form at the free margins of the cartilages and may extend to the capsules and tendons. Wasting and fatty degeneration of the muscles surrounding the joint also occur. Hydroarthrosis sometimes appears in the early stages due to effusion into the synovial sac. Small nodules form at the edges of the cartilaginous covering, producing the well-known nodosities of Haygarth and Heberden.

The exact nosological position of rheumatoid arthritis is far from being definitely settled. The opinions held with respect to it are:

(1) That it is a form of true rheumatism.

(2) That many of its manifestations appear to be dependent upon lesion of the spinal cord.

It is unfortunate that in a few cases the early stages of rheumatoid arthritis may be unattended with any subjective symptoms. In the large majority, however, the disease sets in with well-marked symptoms. The acute form

resembles in some respects the onset of acute rheumatism, except that the duration of the attack is longer, there is absence of profuse perspiration, and there is little or no liability of the disease to attack the heart. In the chronic form pain in the joints is often a prominent symptom, being often worst at night or on awaking in the morning after lying long in one position. Swelling soon occurs, followed after some time by grating and crackling in the joints, symptoms of the very greatest importance in the diagnosis of the disease. Deformities after a variable time ensue, giving rise in the hands to that knobby condition of the fingers so frequently seen in this affection, and in the lower extremities to large and irregular joints. In this condition of the large joints the grating and crackling I have above alluded to may be readily detected. Often in the case of children all the joints of the hands become affected, wasting of the muscles ensues, giving rise to that claw-like condition of the hand which is almost diagnostic of the disease. As we can often recognize a colles' fracture from the appearance of the wrist, so from the appearance of the wrist and hand alone can we often recognize a case of rheumatoid arthritis. The changes just spoken of progress till the movements of the joints become so limited from the ankylosis which is set up, that great crippling results. In rare cases a single joint may be affected, as for instance the hip, a condition which is not infrequently mistaken for sciatica.

Spondylitis, or inflammation of the vertebrae, is a frequent and often a most distressing symptom. In two cases which came under my observation, it was one of the most distressing conditions, and in one of them was the symptom which led to the condition being several times mistaken for lateral curvature of the spine, and for the employment for many months of a plaster jacket. The cervical and lumbar vertebrae are most commonly affected, while the atlo-axial joints are those which suffer most of all. The temporo-maxillary joints are prone to the disease, and in advanced cases give to the condition a terrible gravity on account of the difficulty that is met with in giving nourishment to the patient. There is scarcely any other disease in which this combination of symptoms (inflammation of the vertebrae and of the temporo maxillary articulation) occurs, so that their presence assists us greatly in coming to a diagnosis. A symptom which I observed in the case of a young girl, and which I always regarded as a manifestation of the disease, was an enlargement of the tongue, attended with a flabbiness and smoothness which were quite unique. The tongue appeared too large for the mouth, while there was a stammering and stuttering in the speech which was at times quite painful to listen to. In looking up the literature of the subject I could find no reference to it, until a short time ago I found in Fagge's classic work the following allusion to it :—"I lately saw an old lady 71 years of age, who for about three months had complained of a curious affection of the tongue and cheeks which, perhaps, belonged to the disease, inasmuch as she had hydroarthrosis of each shoulder joint and a less marked affection of the knees. The tongue was uniformly enlarged and had a peculiar firm fleshy consistency without being at all indurated ; its surface was rather smoother than natural." If this condition belongs to the disease it is quite possible to account for it on the neurotic theory of the malady.

The disease for which rheumatoid arthritis is most frequently mistaken is gout, and it is seldom that in articles on the subject any other condition is mentioned. I have, however, seen the disease mistaken for rickets, angular and lateral curvature and for tuberculosis of the joints. To mistake

rheumatoid arthritis in its early stages for gout is a terrible error. Bearing in mind the prominent symptoms of gout we should seldom overlook the disease:—The suddenness of the onset, most frequently during the night, the severity of the pain, the joint most frequently attacked, the shortness of the attack, frequently not exceeding ten or twelve days, a history often of gout in the parents, or a history of indulgence in beverages.

With respect to rickets the age of the patient, often under a year, the disproportion between the size of the face and head, the squareness of the latter with prominence of the frontal sinuses, the thickened sutures, the tendency to profuse sweating about the head, the prominence of the abdomen, the flatness of the chest at its lower and lateral parts, the beading of the ribs and the bowing of the long bones should serve to distinguish the disease from the one we are considering.

A careful examination of the spine should serve to distinguish angular and lateral curvature from rheumatoid arthritis more especially if the joints of the extremities be at the same time examined, and it be borne in mind that the temporomaxillary joint is as often affected in rheumatoid arthritis.

Early, persistent and judicious treatment is of the greatest service in this affection If the diagnosis be made before ulceration of the cartilages has taken place we may reasonably hope for marked and often rapid improvement. The cause should if possible be removed. Residence should be sought in dry and if possible elevated localities. Rest in the early stages is important and when deformities begin to appear the use of well-padded splints will in the great majority of cases prevent further deformity and correct what has already taken place.

All lowering measures should be avoided. Baths should be used with great caution. Turkish baths have often caused crippling long before in the ordinary course of affairs this would have occurred. I have however seen good result from the occasional employment of luke warm salt water baths.

As to diet, a good amount of meat together with bread and vegetables and a moderate amount of porter will sometimes alone bring about a change for the better.

Locally, belladonna, soap liniment, or linimentum opii are probably the best applications in the acute stage and are sometimes of much service in the chronic affection also. Where there is much effusion the application of iodine or cantaridine liniment should be used. I have seen decided benefit from the application of hot sand to the joints where other local remedies fail to give relief to the pain. It improves the stiffness also.

Internally I believe the best results will be obtained from theadministration of arsenic. Even in the later stages it often brings about decided improvement and I feel that we would be remiss in our duty to our patient if we did not give the drug a patient trial. Iodide of potassium in increasing doses is often of signal benefit but more often fails.

Cod liver oil should be administered and administered persistently. Sir Alfred Garrod has strongly recommended the syrup of the iodide of iron and has obtained good results from its use. Sulphur, preferably in the form of sulphur lozenges should be combined with the treatment. A couple of these thould be given every day and continued uninterruptedly for months. Actea racemosa as recommended by Ringer has given satisfactory results. It appears to be most useful where the pain is worse at night and especially when the disease is traceable to uterine derangement. Shampooing, massage and electricity are useful adjuncts in the treatment. Gentle movement of

Arsenite of Copper for Choleraic Ailments.

WYETH'S COMPRESSED TABLET TRITURATES. ARSENITE OF COPPER, 1-100 GRAIN. 1-150 GRAIN. 1-200 GRAIN. 1-3200 GRAIN. PRICE 50 CENTS PER BOTTLE OF 500.

We have received a large number of letters from physicians in all parts of the country confirming the experience of those mentioned on the attached circular, in cases of Cholera Morbus, Cholera Infantum, Dysentery, Diarrhoea, and other complaints of a similar nature.

It is claimed that Copper Salts have proven valuable in all the Cholera Epidemics within the last fifty years, and medical literature affords abundant confirmation of its great value in complaints of a choleraic nature, many physicians also claiming that the Arsenite will prevent the development of those symptoms which so often lapse into Asiatic Cholera.

JOHN WYETH & BROTHER.

I was called to attend a lady, a resident of Savannah, Ga., who is on a visit here, on Friday morning, the twenty-third instant. I found her suffering intensely from paroxysmal pains of intestinal colic attended with diarrhoea. My patient declared that she could not live another hour unless relieved. I felt sure that I could relieve her pain by giving an injection of morphia and atropia, hypodermically, but would be apt to have a nauseated patient to look after the balance of the day, so I dissolved a tablet of the Arsenite Copper (one one-hundredth grain) in four ounces of water. Gave her the first teaspoon myself and begged her daughter to give another teaspoonful every ten minutes for the first hour, the none dose every hour after, until I called again. I went back in two hours time and found the patient sleeping. She was relieved after taking the third dose of the Arsenite. I requested her daughter to give a dose once each hour, and left with a promise to call again that evening. I found my patient up and feeling well at eight o'clock, and so much pleased with the treatment that she wanted to put the remaining portion of the solution in a phial to carry back home with her. She says that she is subject to these attacks of colic, and was never so easily and pleasantly relieved by any other form of treatment.

C. E. DuPONT, M. D.

Grahamville, S. C.

A. P. Brown, M. D., Fort Worth, Texas, writes us in reference to the above as follows.

Messrs. John Wyeth & Bro.

"Bloody Flux is very prevalent here, and these Tablets, 1.100 grain to four ounces of water surpass any other medicine we have used in arresting this painful and dangerous disease; its effects are simply wonderful, and it is no trouble to get a patient (even a babe) to take it. Thanks, many thanks, for your prompt reply to my requests for tablets, etc."

Recent medical literature confirms the practical experience of Dr. A. P. Brown in the use of this remedy, in serious dysenteric cases, with an additional therapeutic value in indigestion, diarrhœa, etc.; also, as an antisudoral in the night-sweats of phthisical patients.

DAVIS, LAWRENCE & CO.,

General Agents

MONTREAL.

P. S.—We direct your attention particularly to the Triturate 1-3200 Grain which has been specially prepared so as to give an exact dose without the trouble of dissolving.

the joints should be practised but only such an amount as will not cause pain on the following day.

As in rheumatic conditions, flannel clothing should be worn and all sudden changes of temperature avoided.

I have a firm conviction that rheumatoid arthritis in its early stages, more especially in the young, is a curable disease, and that patience and good judgment applied to each individual case that comes before us, will prove it to be so.

An hour in the Operating Room of the Hospital for Ruptured and Cripples, N. Y. By W. Ross Martin, Senior House Surgeon.

Case I. Oscar G. Age 11 years. Personal and Family history good. Date of inception of present disease six (6) years ago, when he had rubeola and immediately following it complained of pain in knee, walked lame and had night-cries. About one year after inception he commenced to wear a high brace and progressed favorably for 18 months when brace was left off. About this time the other hip became affected and he was put to bed with weight and pulley, which treatment was kept up for one year, when an abscess developed and ruptured spontaneously, the discharge continuing for three (3) months. A double hip brace was then applied and worn up to 6 months ago, when he was admitted to the hospital, in fair general condition, walking with crutches. No other apparatus. Without support could stand with greater part of weight on right limb; the left limb flexed at hip and knee; marked lumbar lordosis spine being 4 inches from table when in horizontal position, with the limbs parallel. About one (1) inch apparent shortening. The right limb presented an A. G. E. 130 degrees, with 5 degrees of antero-posterior motion. Attempt at further motion eliciting marked spasm but no pain. No sinus or abscess about hip. Trochanter ½ inch above Nelaton's line. Knee and ankle normal.

Left limb. Hip fixed at A. G. E. 130 degrees on outer side of middle third of thigh an old cicatrix (site of former abscess). Nelaton's line relations normal. Common measurements showing 8 degrees adduction.

C.M.	A	N	A.S.P.	T	K	C
R	23	26	7	11	9¼	8½
L	23	25		10¾	9½	7¾

Patient put to bed on frame with weight and pulley and extension made in line of deformity. He is now in excellent condition, having grown fat during his stay of 6 months in the hospital; shows a deformity of A. G. E. 130 degrees, the same as when treatment was begun. He is consequently etherized and Gants femoral osteotomy done, the limbs placed in best possible position about 175 degrees which is practically straight and a double plaster of paris spica applied. Patient seen 5 hours after operation doing well. Comparing this with the case I reported some time ago as illustrative of the weight and pulley treatment in properly selected cases, it will serve to impress how important it is that a guarded opinion must be given as to the outcome of any one method of treatment, because many times an operation will be unexpectedly indicated.

Case II. Mary N. Diagnosis: right hip disease. Date of inception, 3 years ago. Aug. 26th, 1892; hips manually corrected from A. G. E. 165 to 175 degrees. Following this operation the patient had temperature 103° F.

Sept. 4.—Abscess having formed is aspirated and f ℥ii of pus withdrawn.

Feb. 28, 1893.— Again aspirated f℥ii pus withdrawn; basket strapping and hip brace was applied and patient put to bed.

March 21.— Aspiration attempted but proved a failure.

April 21.—Aspirated and f℥ii pus removed.

May 5.—f℥i of pus removed by aspiration.

Oct. 23.—Abscess sac found partially collapsed, but still contains a cheesy mass too thick for aspiration. As this mass has proved the source of slight irritation, the patient is etherized this morning and abscess sac exposed by a linear incision about three inches in length over its most prominent part, and the sac dissected from the surrounding tissues; the remaining cavity thoroughly irrigated with sterilized water, counter-drainage by opening in the most dependent part, and firm pressure applied by means of the dressing after the incision wound was closed with strong silk. Patient seen ten hours after operation doing well. The operation was in every particular successful, there being very little hemorage and union by first intention is expected, and as a result obliteration of the abscess cavity thus obviating the intense danger of the cheesy mass acting as an irritant, and the source of an acute process, culminating in prolonged suppuration.

Case III.—John O. Admitted to hospital Sept. 6, 1893, history as follows: Age 10 years. Family and Personal history good. Date of inception of disease 6 years ago. Caused by fall. Has had no treatment. Comes in without apparatus. Stands with weight on left limb, right flexed at hip knee and ankle, ball of great toe touching the floor. A large, open, freely discharging sinus in Scarpa's triangle on right side. A. G. E. 110° fixed. Sept. 19. Counter opening made and gauze passed through it and into the sinus, which was found to pass around the outer side of great trochanter (posterior aspect). Considerable cheesy pus was found. This morning head, neck and part of great trochanter are excised, they all being involved in the necrotic process. In the centre of great trochanter a small abscess was found containing ½ ℥ of pus, the abductor tendons and fascia lata are divided subcutaneously and the limb placed in the position of A. G. E. 108° and held firm by plaster of paris spica, the wound to be dressed through an opening in the plaster.

Society Proceedings.

ST. JOHN MEDICAL SOCIETY.

Regular Meeting Oct. 18th, 1893,—The President, Dr. A. F. Emery, in the chair.

The president, exhibited two cases from the General Hospital.

Tubercular Caries of the Vertebrae. A child of three years presented an angular posterior curvature of the lower dorsal region, following an injury two or three months previously.

Sarcoma of Scapula. The man, 76 years of age, presented a large, solid tumor of the left scapula, first noticed in December 1892. The growth involved the posterior surface below the spine, and ran all around the anterior bodies.

Dr. F. H. Wetmore showed the following specimen and gave the clinical history.

Cancer of the Stomach.— The growth, probably scirrhus, involved a small portion of the pyloric end, and had adhesions to the pancreas, but not to other organs. The man, aged 56, had a history of coffee-ground vomiting for about seven months. He had been confined to the house for three months, complaining of persistent vomiting and epigastric pain. There was extreme emaciation, and death apparently from pure inanition.

Dr. Wetmore also reported two heart cases.

Case I. *Idiopathic Paroxysmal Tachycardia, heart beats 230 and 236 per minute.* The patient was an unmarried female domestic, 37 years of age, anaemic, but without further sign

of disease of heart or ohter organs, who gave the following history. For years she had been subject to recurring attacks of rapid heart beat, accompanied by praecordial distress, and blueness, and coldness of the surface, the attacks have been known to last twenty-four hours, and always necessitated her lying up as soon as they commenced. When first seen her pulse was 72; tongue furred, bowels constipated; dysmenorrhoea every three weeks. The patient was seen in two attacks, each occuring after a few days extra hard work, especially heavy lifting. The patient was compelled to be up during the attacks, and was unable to work for two or three days subsequently. They began and ended suddenly; all at once her heart, as she expressed it, "took a leap up, and then a fall down," continuing at a rapid rate. She was found lying perfectly still in bed, complaining somewhat of praecordial and epigastric distress, but with nothing unusual about her appearance. Her face was pale, cold, and clammy to the touch. Temperature normal; respirations during first attack 20, during second from 40 to 50 per minute. The pulse at the wrist was full, soft, compressible, and irregular in rhythm and volume; it could scarcely be counted. The heart was beating somewhere between 208 and 240 times in the minute during the first attack; in the second 230 and 236 were the respective rates during two counts for the full minute. The first attack lasted 10 hours, and the second 6 hours in spite of treatment. The left side of thorax and abdomen was sore after the attacks. Antispasmodics, and afterwards opiates were used during the attacks, and a preparation of iron continued in the intervals.*

*At a subsequent society meeting Dr. Wetmore reported that he had found both kidneys to be moveable. He remarked that a number of cases had been reported in the *Medical Journals* in which a functional disturbance of the heart was associated with some abnormality of the abdominal viscera. In his case he looked upon the conditions in the relation of cause and effect.

Case II. *Bradycardia: dilatation of right heart; general cardiac dropsy; heart-beats 36 to 40 per minute.*

A farmer, aged 59, married, was seen first on May 28th, 1893, complaining of general dropsy worse in legs and scrotum, supervening an attack of *la grippe* three months previously. He was rather short of breath, and had required to walk slowly for some years. He had never indulged in alcoholic stimulants. Two brothers had died suddenly from fatty heart. His general appearance was very suggestive of serious cardiac disease. The lower extremities and scrotum were much swollen and oedematous, pitting on pressure; some oedema of abdominal walls, less marked in the rest of the body. Temperature 67° F; respirations 20; pulse 36. Cardiac percussion dullness commenced above at the third space, and extended horizontally from the middle line of the sternum on the right, to within an inch of the left nipple. A well marked murmur, loudest during inspiration, accompanying the first sound of the heart, not replacing it, could be heard in a circumscribed area two inches in diameter, to the left of the ensiform cartilage, and not conducted into the left axilla. The cardiac sounds were not more frequent then the pulse beats. The pulmonary percussion resonance encroached somewhat on the hepatic area; expiration was prolonged. The urine was diminished in amount, dark red in color, acid, of specific gravity 1024, and without albumen or sugar. He had been taking digitalis, but had been allowed to be up and around. With rest in bed and active catharsis the dropsy gradually left, but a systolic murmur appeared at the left apex, and was transmitted into the left axilla; the second pulmonary sound was now accentuated.

On June 13th, pulse was still 37 or 38, and heart still showed signs of dilatation. Iron was not well borne; digitalis, dilute hydrochloric acid, and

strychnine were ordered, under which he improved sufficiently to enable him to go to work again. In July and October the pulse was 39 or 40, and irregular. The man was by no means well; his legs were still swollen, sore, and stiff, and all his movements were slow.

Remarks on Paroxysmal Tachycardia. Case I. was considered a typical example of paroxysmal heart hurry, a distinct affection according to Bouveret, who had made a special study of the condition. Overexertion, physical or mental, he held was the chief exciting cause of the attacks. In some cases he investigated, the attacks lasted days, weeks, or months, when there was great danger from failure of the pulmonary and systemic circulation. The attacks were likely to recur. The condition was seldom cured; matters generally went from bad to worse.

The patients should avoid tea, coffee, and tobacco, and any indication for treatment in the general condition should be fulfilled. For the attacks Whittier of Boston had said compression of the pneumogastric in the neck was the only efficacious treatment. Drinking strong coffee, or ice water was of benefit, in one case. Osler recommended an ice bag over the heart.

Remarks on Case II. The dropsy was due to regurgitation through the tricuspid orifice, the dilatation there being possibly due to the slight emphysematous condition present, or more probably secondary to disease of the mitral valve. Degeneration of the myocardium was no doubt an important factor. An involvement of the scrotum in cardiac dropsy was unusual. Loomis in the article in Pepper's "System of Medicine" said it occurred but slightly, if at all. The slow pulse was probably that sometimes seen in connection with fatty degeneration of the heart muscle.

Should digitalis have been given in such a case? With the physical signs of dilatation and its results present, that drug was thought to be indicated, whichever the valve affected, or whatever the condition of the myocardium, and the result had justified such an opinion.

During the discussion which followed the reading of the paper, Dr. T. D. Walker cited a case of rapid heart, with pulse beats over 150 to the minute, lasting two or three days at a time; the patient was a neurotic young female with hysterical symptoms; valerian was of service.

Notes and Comments.

We extend congratulations to Dr. James Clark, of Tatamagouche, on his marriage to Miss Sedgewick, daughter of the Rev. Dr. Sedgewick, of Tatamagouche.

Dr. Dickson, of West River, Pictou Co., was in town and attended a meeting of the Halifax Branch of the Brit. Med. Assoc., Nov. 9th.

Dr. M. A. B. Smith, of Dartmouth, has returned from his visit to the Post-Graduate schools of New York.

The Halifax Medical College has the largest attendance this winter of any in its history.

Dr. W. H. Hattie read an excellent paper on the "Cholera Bacillus" before the Branch of the Brit. Med. Assoc. on November 9th. On the 22nd of November, Dr. W. S. Muir, of Truro, gave a most interesting history of 184 cases of typhoid fever in his own practice since 1889. We hope to present both of these papers to our readers in future issues.

Maritime Medical News.

DECEMBER, 1893.

THE diagnosis and treatment of diphtheria is still one of the most perplexing problems to the practitioner. Thanks to Bacteriology the diagnosis may now be definitely made—the presence of the Klebs-Loeffler bacillus being the all distinguishing feature of true diphtheria. Dr. F. H. Williams of Boston, in a paper read before the Massachusetts Medical Society (Am. Jour. Med. Sciences, Nov. 1893), discusses diphtheria and other membranous affections of the throat. In 96 cases of membranous throats, where the diagnosis was made by cultures and coverslip preparations 42 were not cases of true diphtheria. There was no membrane in sight in four cases of true diphtheria. These facts demonstrate clearly the value of bacteriological examinations. Moreover the mortality in true diphtheria, uncomplicated, was 50 per cent while in pseudo-diphtheria the rate was small. These facts are also borne out in the excellent work which the New York city board of health is doing in New York, viz., that nearly half of the cases diagnosed as diphtheria are not cases of true diphtheria, that the mortality in true diphtheria is very high, while in pseudo-diphtheria it is very low.

Dr. Williams has made an extensive study of the therapeutics of diphtheria. In general treatment, the food deserves special attention. Alcohol is of service in some cases. In 16 out of 19 cases that appeared anaemic, Fleischl's haemometer showed 100 per cent haemaglobin or over. The inference from this is that iron is not indicated nearly as often as it is prescribed. Mercury in small doses did not seem to be of any special service. Behring's cases treated with blood serum of immune animals encourage us to hope that a feasable internal remedy may yet be found.

Local remedies take the first place in treatment. They are best adapted to cases seen early and where the membrane is accessible. Membranes should not be torn off as they rapidly return and over a greater area. Chlorate of potash did not seem to be of any service and

may do harm in large doses. Nitrate of silver does not penetrate deeply enough. Iodine and chlorine are irritating when inhaled. Solutions of carbolic acid are poisonous and inefficient as germicides. No success with digestives.

The effective agent in solutions of iron is the acid. Corrosive sublimate is inhibitory rather than germicidal in its action. The membrane persists under its use. The number of agents that have been used in diphtheria are very great.

An agent is required that will kill the bacilli quickly and which is not poisonous to the patient. A solution of hydrogen peroxide of between 12 and 25 volumes containing $\frac{1}{4}$ to $\frac{1}{2}$ per cent of acid respectively killed the bacilli in 10 seconds. A saturated solution of carbolic acid did not do this. A 50-volume nearly neutral solution of hydrogen peroxide was required for the same work.

The ordinary hydrogen peroxide solutions offered for sale have a strength of 7.5 to 10 volumes or less of which some are neutral and some acid. By evaporation in a shallow open dish over a water bath a solution of 25 volumes or stronger may be obtained. The initial solution should not be too acid, the dish should not be of metal and should be free from organic matter.

The advantage of the strong hydrogen peroxide solutions are that they are good germicides and are not poisonous nor harmful to the mucous membrane; they cleanse a foul throat and break up and disintegrate certain portions of the diphtheritic membrane thus rendering the bacilli more accessible.

A weak solution of peroxide whitens even traces of membrane by the formation of a fine foam. Thus traces of membrane can be seen which otherwise would remain undetected.

No rule can be given for applying these solutions which will cover all cases. Generally the strong solutions containing about $\frac{1}{2}$ per cent acid should be gently but thoroughly applied every four hours during the night and more frequently during the day for the first few days. The 25-volume solution may be used in spray; the 50-volume solution may be applied a drop or two at a time, on a swab until the membrane is removed or much diminished, in certain cases it may be applied with a syringe in or behind the membrane. Stronger solutions may be used for resistant membranes. It is well to use cocaine before applying the peroxide. With bromide at night, the patient loses very little sleep in being aroused for treatment. Every precaution should be taken to spare the patient's strength, and it is not necessary the head should be raised from the pillow while the applications are being made. The bacilli are not limited to the membrane so that antiseptic sprays or gargles should be used over the rest of the throat.

Dr. Williams does not convey the impression that every case of true diphtheria can always be cured by hydrogen peroxide solutions. They are more efficient and less harmless than any other known treatment. All the cases seen early by Dr. Williams, recovered under their use.

Correspondence.

POST-GRADUATE MEDICAL INSTRUCTION IN NEW YORK.

By M. A. B. SMITH, M. D.

There was no organized post-graduate medical school in the world till eleven years ago. There are now nearly a dozen such schools in the United States. There are schools in Boston, Philadelphia, Chicago, (2), New Orleans, San Francisco, St. Louis, and the last city to fall in line, London, England. Of all these the Post-Graduate Medical School, New York was the first. It was organized by Dr. J. J. Little, W. A. Hammond, St. John Roosa and others. It was established in the spring of 1882. Failure was predicted by most medical men and the movement was derided by some. Success and permanency soon became apparent, and the next post-graduate to be opened was the Polyclinic in New York.

It was suggested to me that some account of the methods and scope of instruction in these schools might be of interest to practitioners who have not visited them, and as I have just returned from a post-graduate course in New York I venture an attempt to carry out the suggestion.

Post-graduate medical schools are becoming more and more popular. The medical men who are attending them, as far as my observation goes, are always glad they have come. Often one meets men who have taken former courses. Some make it a practice to attend every two or three years. Most of the physicians who visit the schools are young, between thirty and forty years of age. The older men do not appear to avail themselves of these institutions. The majority are from small towns. These physicians come from all parts of the continent from the Pacific to the Atlantic.

The shortest course given occupies six weeks and this is the time usually chosen, though there are those who remain as long as six months. It is long enough to get a general idea of new methods, and a longer course is apt to become tiresome to a man who has a home. The cost of the general ticket is $90 at the Post-Graduate School and $100 at the Polyclinic. In addition to this there is a charge of $15 for each of three laboratory courses, Clinical Microscopy, Pathology and Bacteriology. To follow up any one properly it is necessary to miss one or two lectures a day of the general schedule.

It is of course impossible to follow up all the classes included in the general ticket. Still if a man wishes to review what is required in a general practice the advice of the college announcement is good, that it is better to take out a general ticket. Each branch costs about $30. The general course is much better worth $90 than any one branch $30.

There is one thing that must be said on the other side about these schools. I was talking to one of the most eminent physicians of New York on the subject. He said: "The trouble is the teaching is not thorough enough. That is practically my own experience. There are too many indifferent cases in some classes with too little didactic teaching. A physician, who had attended the physical diagnosis classes, on examination gave bronchial breathing as one of the physical signs of bronchitis. Another stated that a splashing sound would be heard in simple pleurisy with effusion. A third said that simple tubular obstruction would cause increased vocal fremitus. These were not incapable men, they only needed thorough instruction. They had examined many chests but had not been thoroughly taught. A man intending to take a course in a special branch and be thorough in it had not better put all his faith in a

special course at a post-graduate school. He had better combine it with special private instruction. It can be got to as good advantage in New York as any where in the world perhaps if one knows where to go for it.

It appears to me that the courses should be to some extent systematized so as to give a resumé of a special branch in a given time. Instead of this there are branches in which leading recently discovered facts are only taught by chance at irregular intervals.

But to a man living away from the great medical centres the course is most refreshing. And the contrast between them and under-graduate schools is noticeable at once. Here there are particular and personal opportunities of seeing and hearing what is being demonstrated. A man may ask questions and have answered all the difficulties that have been occurring to him. At the post-graduate school this is especially true. The classes are not large enough to make the clinical lectures very formal and each doctor has full opportunities to see and hear. There is also a sort of speaking acquaintance between faculty and students.

The general classes at the post-graduate contain at the present time about thirty. The number is nearly the same or a little less at the Polyclinic. In the summer there are not more than half as many at either school. Those in attendance are always coming and going; and, as I have intimated, the courses are practically without beginning or end.

The post-graduate schools being young institutions the professors and instructors are generally young men and in this respect differ somewhat from the teachers in under-graduate schools who have grown old with their institutions. These young men are well abreast of the times and think for themselves.

But whether young or not the professors both of the Post-Graduate and Polyclinic are, a number of them, eminent in their profession. At the Post-Graduate there are: Dana, on diseases of the mind and nervous system; St. John Roosa, on the eye and ear; Robert Abbe, on clinical surgery; Hanks, on diseases of women; Graeme Hammond, on the mind and nervous system; Phelps, on orthopaedic surgery; Bangs, on venereal diseases; Stephen Smith Burt, on physical diagnosis; Seneca D. Powell, on clinical surgery; Bache Emmet, on diseases of woman; Ferguson, on pathology, pathologist to the New York hospital; Boldt, on diseases of woman; Willey Meyer, on clinical surgery and R. T. Morris, on the same subject; Kelsey, on diseases of the rectum, one of the best men on the subject in America; Porter, on pathology and clinical medicine, and others. At the Polyclinic there are such men as Sims, Munde, Wylie, Gerster, Wyeth, Gray, Gibney, R. C. M. Page, Robinson, Bronson, Holt, etc.

At the risk of being tedious I will state some of the topics of the first two or three days clinics that I attended, copied from my note book, as representing the ordinary day's work. Prof. Powell described and illustrated methods which he uses of curing old varicose ulcers without operation; also of curing ingrowing toenail without operation, and of preventing lateral displacement in colles' fracture by an adhesive strap. We afterwards saw the progress of these cases to a cure. Also at another hour in the operating room he removed the carpus, leaving the metacarpus to form a ligamentous union with the radius and ulna. He has a large out-door clinic. His clear reasoning, originality and pleasant off handed style make him the most popular man on the faculty. Prof. Willey Meyer described five different operations of gastrostomy for cicatricial contraction of the oesophagus, and

presented a case that had been operated upon by Witzel's method; he also diagnosed tubercular lymphoma of the neck by careful exclusion. In this case he spoke highly of arsenic, but if that should fail he recommended early removal of all the glands involved. He is the best teacher on the staff His clearness and thoroughness have a lasting impression. Prof. Ferguson demonstrated a number of pathological specimens, showing how post-mortem examinations revealed errors in diagnosis. He is a Nova Scotian who has become wealthy and distinguished in New York His demonstrations are thorough and scientific, and he is very popular. Prof. Burt devoted ten minutes to the didactic teaching of heart murmurs, and then presented a number of cases to the class for their examination. The number of patients and examiners on the floor together made matters confused. Prof. Porter described rheumatism, its identity with gout and both as being produced by over-eating. The oxidizing process was a limited one. Short thick men especially could not take enough oxygen by the lungs to oxidize their food, if in excess. He showed what food could best be oxidized by economizing the 750 grammes of oxygen an ordinary man could take in a day, and so he went on to diet and rational treatment. Dr. Morris operated on two cases of appendicitis, one through an incision of an inch saying an inch and a half was too long. He is becoming eminent in this line and is an exceedingly neat operator. Then followed a laparotomy for uterine sarcoma performed in the Trendelenburg position. The prevention of adhesions to surrounding tissues by the application of aristol to the stump after operation or to an inflamed area of the bowel to destroy ptomaines, and his "wick" drainage tube consisting of a small roll of iodoform gauze covered with perforated oil silk, are expedients of his own which he has found successful. He intimated his working theory that the biggest little thing in the world is neatness. Prof. Phelps demonstrated his method of applying the plaster corset in Potts disease and in lateral curvature of the spine and expressed something near contempt for steel appliances in these diseases. He showed an admirable wood corset for the latter disease. He is at variance with the Shaffer school in the matter of instrumental treatment of most orthopaedic diseases, but his methods are becoming more and more popular. He is now president of the American Orthopaedic association. Professor Dudley presented half a dozen gynecological cases, calling upon different sections of four physicians each to examine different cases and make diagnoses. Also in the operating room he performed his own operation for laceration of the perineum, removing the mucous membrane by the shoestring method and using his own method of suturing which is popular.

These illustrations will perhaps serve to show the kind of instruction at the Post-Graduate. Of course there are classes in childrens diseases and many other subjects.

Then there are several small sectional classes of five each in anterooms, which furnish direct instruction and would be more successful if better followed up by the students. Prof. Kelly gives an excellent course on the cadaver in practitioners anatomy. Opportunities are occasionally afforded of witnessing post-mortems on cases which have been treated.

There was only one professor at the Polyclinic whose lectures I was able to attend, R. C. M. Page. He has the deserved reputation of being the best teacher of physical diagnosis in New York. The sectional quiz classes which he holds three times a week for this subject at the North-Western Dispensary should not be overlooked by any student interested in this branch.

There is one disadvantage that the Polyclinic has as compared with the Post-Graduate. It has no hospital of its own to speak of. There are, however, sixty beds under the roof of the Post-Graduate in a well disciplined hospital with a staff of trained nurses. These beds are nearly all surgical. In this one institution half a dozen operations are performed every day and few patients remain longer than three weeks. Students can pass from the clinics to the operating room without the serious loss of time spent in traveling around to outside hospitals. This time-saving system is a great feature of the Post-Graduate. The Polyclinic has even a larger number of out door patients than the Post-Graduate.

The new Post-Graduate school, within a stone's throw of the old, is nearly completed. It will be one of the finest post-graduate buildings in the world. It covers a square of a hundred feet, and is six stories high. Its cost will be $400,000. It is built of Indiana gray stone and granite. Its hospital will be isolated from the school and will contain 200 beds. The dispensary portion will include nine sets of rooms of three rooms each.

Editor of the Maritime Medical News:

SIR,—

Recently one of the largest insurance companies in New York forwarded me a note from its medical director, asking my opinion of the "capability, integrity and sobriety" of a physician in this province who had been proposed as medical examiner for said company. "Your reply will be held strictly confidential." To this I replied that I would be happy to give the desired information on the payment of a fee of five dollars. I received a courteous reply to this from one of the assistant medical directors saying: "We are very sorry that we cannot agree with you in your view of this matter, as Dr. —— requested us to refer to you."

Now let us examine this matter. The aforesaid company wishes to do business in the vicinity of this physician. The canvasser in all probability goes to the physician and urges him to insure in the company, and as an inducement tells him that he will get him appointed examiner, using the prospect of the fees to be earned as a bribe to get him to insure. He furnishes him with a blank application, to fill out, and in this he is required by the company to give the names of two physicians, who will vouch for his fitness for the position. What is this for, but to enable the company to insure Dr. —— and to do a safe business in that district. The company professes to do this for the benefit of the physician. How disinterested! For every five dollars he gets the company issues policies varying in amount from $1,000 to many times that sum, out of which and others who insure with them they pay princely salaries, and also give a handsome income to their medical directors and assistant medical directors.

Some of the best companies have a medical referee, to whom all such applications are referred, and he receives a fee for such services. That is a manly and straightforward way of doing business, and completely knocks in the head the specious plea that the reference is in the interests of the one proposed for medical examiner. Again, observe the statement that "the reply will be held strictly confidential." Now does any company suppose that I am so simple as to inform them that any physician is unfit for the position of medical examiner, and that I can believe that this information is *for his benefit.* They are simply asking me to malign him for *their* benefit, and are too mean to pay me for the information. And where do the medical directors stand in this matter, in their relation to their professional brothers. Is there any "golden rule" here? I hope every physician in the province will

refuse to have anything to do with such references unless paid for his services. I have in times past thoughtlessly signed them, but for some time have refused. I would readily do anything reasonable for the physician in question, as he has been a friend of many years standing, in order to oblige *him*; but the company has no claim on me, nor no right to any knowledge gained through my profession without paying for it. Let us take a leaf from the lawyers' book and "never do something for nothing."

STEPHEN DODGE, M. D.

Halifax, Oct. 18th, 1893.

We are glad to note a meeting of delegates from the Medical Boards of Nova Scotia and New Brunswick at Truro, Friday, Nov. 24th, to consider the question of reciprocal registration for the Maritime Provinces. Delegates from P. E. Island were expected to be present but through some mishap did not attend.

BOOKS AND PAMPHLETS RECEIVED.

Health Readers, Nos. 1 and 2. Published by T. C. Allen & Company, Halifax, Nova Scotia.

These, readers have been prescribed by the Council of Public Instruction for use in the schools of Nova Scotia They have special reference to the effects of alcohol, tobacco, etc. upon the human system. They are written in clear, simple, and concise style and admirably arranged for the purposes of the teacher. The effects of alcohol upon the human economy are clearly pointed out and no child in Nova Scotia should grow up without a distinct knowledge of the dangers involved in slight indulgences in beverages containing even small amounts of alcohol. Teaching of this kind is sure to work to the gain of our common country. These books are well bound with clear type on good paper.

Physiology, Part 1. By M. Foster, M. D. Sixth edition. Published by MacMillan & Co., New York and London.

Saunders' Question-Compends, No. 12. Essentials of Minor Surgery, Bandaging and Venereal Diseases. By Edward Martin, M. D. Published by W. B. Saunders, Phila.

These question-compends are not intended to take the place of text books which every student must have. Used with care they serve an admirable purpose.

Operation Blank. Second editton, by W. W. Keen, M. D. W. B. Saunders, publisher, Philadelphia

This consists of two parts, one of which contains instructions for the nurse, the other a list of dressings and medicines that may be required from the drug store. This is a convenient blank, and will save time for the busy operator.

Annual Announcement and Catalogue. College of Physicians and Surgeons, Baltimore, Md.

Circular No. 1. 1893. Germs and Disease. Rules for checking the spread of contagious and infectious diseases. Special instructions in regard to cholera and provincial statutes relating to health. Issued by the Provincial Board of Health of Nova Scotia.

Suturing the Tendo Achillis in the correction of deformities of the feet. By H. Augustus Wilson, M. D., Phila.

Selections.

MIGRAINE.—Migraine may be relieved, Lucking says, with a pill, twice daily for some time, consisting of Indian hemp one-sixth grain, phosphate of zinc one-tenth grain, and arsenic one-thirtieth grain. The severity of the attack may be effectually diminished with liquor trinitrine, in minim doses, two or three times daily.—*N. Y. Med. Record.*

SALOL IN CYSTITIS.—Arnold (*Therap. Monatsch.*, May, 1892,) relates cases of acute and chronic catarrh of the

bladder which have been much benefited by the use of salol in gramme doses in addition to the local treatment. Even tuberculous cystitis has been relieved by it. Arnold observes that salol makes the urine acid, and renders it ultimately almost clear and free from smell; that the drug is well borne, even when administered for some length of time, and that it is a useful adjunct to the treatment, especially when only weak antiseptic solutions can be tolerated by the bladder.—*Brit. Med. Jour.*

GOUT AND RHEUMATISM.—A Frenchman being afflicted with the gout, was asked what difference there was between that and the rheumatism.

"One very great difference," replied *monsieur*. "Suppose you take one vise, you put your finger in, you turn de screw till you bear him no longer—dat is rheumatis': den s'pose you give him one turn more—dat is de gout."—*Ex.*

PROLAPSUS OF THE UMBILICAL CORD.—Take a soft sponge, the size of a large orange, wash it well in hot water, then push up the cord in an interval of pain, passing up immediately after it the moist warm sponge between the uterus and the head of the child. This simple operation prevents the return of the cord, and the sponge comes away with the placenta. After an experience of more than thirty-six years, I have found this method the most satisfactory way of dealing with cases of prolapsed funis.—*Brit. Med. Jour.*

VISITOR (picking up the baby): So this is the baby, is it? Bless his little tootsie-wootsies! Kchee-e-e! Watch me poke um's ribs!

The Boston baby: Mother, will you kindly inform me whether the deplorable condition of this person is due to permanent dementia or spasmodic and intermittent insanity?—*Nat. Med. Review.*

HOW SHOULD THE GENERAL PRACTITIONER DEAL WITH STRANGULATED HERNIA?—Gerster *(Boston Medical and Surgical Journal*, July 20, 1893), holds that the conduct of the general practitioner in dealing with a case which may possibly be, or is, strangulated hernia, should be regulated with the following rules:

1. In cases of uncertainty give the benefit of the doubt to the assumption that an obscure tumor of the groin is a hernia.

2. Be gentle in attempting taxis, and do not spend too much time over it.

3. Be thoroughly aseptic in herniotomy, and divide the constricting bands freely, not with the probe-pointed knife cutting from within outward, but with the scalpel under the guidance of the eye, from without inward.

L. B. GRANDY, M. D., Demonstrator of Anatomy and Microscopy, Southern Medical College, Atlanta, Ga., says:—"Antikamnia has given me the most happy results in the headaches and other disagreeable head symptoms that have accompanied the late catarrhal troubles prevailing in this section. In my practice it is now *the remedy* for headache and neuralgia, some cases yielding to it which had heretofore resisted everything else except morphine. I usually begin with ten-grain dose, and then give five grains every fifteen minutes until relief is obtained. A refreshing sleep is often produced. There seem to be no disagreeable after-effects."

REMEDY AGAINST CHILBLAIN, BY PROF. NEUMANN, VIENNA:

℞ Plumb acet.
Alum crud.....aa 5.0
Cetac.
Ceræ alb. .....aa 30.0
M. Olivarum q. s. ut. f. unguentum molle.

To apply every evening.—*Ex.*

M. P. P.

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In no single instance has it been rejected by the most delicate stomach.

Where the stomach has been so irritable that no food could be retained, *Malto Peptonized Porter* has acted like a charm, and there has been *no difficulty* thereafter in the stomach *retaining food.*

In the many cases in which *Malto Peptonized Porter* may be indicated are the following

(a) Convalescence from acute diseases—such as typhoid fever.

(b) Atonic Dyspepsia.

(c) In persons of consumptive tendencies. Here it has been found to be a most perfect substitute for Cod Liver Oil—the malt giving the fats producing elements necessary to the supply of the wasted tissues, with the other ingredients furnishing the tonic and stimulating effect required.

(d) In the treatment of cases of Alcoholism. In all cases in which it has been used it has answered admirably in allaying the irritation, vomiting, and consequent desire of stimulants of an unhealthy nature.

(e) In wasting diseases of children.

(f) For administration to nursing mothers.

(g) Where there is sleeplessness from flatulence, over-taxed brain and nervous system.

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Our Malt Preparations are Medicinal Products to be dispensed by the Pharmacist as the Physician shall prescribe.

A malt extract, properly speaking, is both a nutritive and a digestive—nutritive because of the presence in it of a large percentage of digested starch; and digestive by virtue of the diastase it contains. It should be remembered that in the administration of pre-digested foods the stomach is entirely relieved of the labor ordinarily incident to digestion, and the assimilation of the full quantity of nourishment introduced into the alimentary canal is thus assured. Malt extracts, as regards their digestive power, are valuable or not, according to the care exercised in their manufacture and the amount of diastase which they contain. This, fortunately, is a matter capable of easy determination by estimating the action of a given quantity of any sample upon starch, under conditions similar to those which prevail during natural digestion.

We have devoted much time and study to the subject of digestives and their manufacture, and in introducing to your attention our Malt Extract we do so with the positive knowledge that it is at once a more active digestive and concentrated nutrient than any similar preparation on the market.

Aside from the digestive and nutritive value of malt extract, its sweetness and palatability make it a valuable vehicle for the administration of remedies possessed of a disagreeable or nauseating taste.

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