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SUTURE OF THE EXTERNAL  
POPLITEAL NERVE.\*

BY A. B. ATHERTON, M.D., L.R.C.P. AND S. EDIN.,  
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Surgeon to St. John's Hospital, Toronto.

N.M., æt. 11, consulted me for the first time on July 22nd, 1891. A year before he had fallen from a bicycle and severely injured the left knee. The medical man called in at first took the case to be one of dislocation of the joint. Three weeks subsequently a consultation was held, and it was then decided that there had been a fracture of the lower end of the femur. An attempt was made under chloroform to rectify displacement, and the limb put up in a semi-flexed position. Two weeks after this the skin ulcerated over the outer condyle posteriorly, and the bone was laid bare. Later on an operation was done for the removal of dead bone. During the following winter the patient suffered from an attack of what was supposed to be inflammation of the bowels, which kept him in bed two or three months.

On examination of the limb, I found the following conditions present: Much wasting of the leg, with dropping of the toes and inability to extend them. Tendo-Achillis contracted, and tarsus and ankle stiff, and held in such a position as to bring the foot nearly in a straight line with the leg. Knee bent at an angle of

about 150°, and moves through an angle 15°. A deep hollow in lower thigh just above patella, and a corresponding protuberance behind. He can hobble about a little with a stick, the toes of left foot merely touching the floor, with but little or none of the weight of body borne upon them. Sensation fairly good in leg and foot, except on the dorsum of the latter and of ankle. A feeling like an electric shock experienced when pressure is made on cicatrix over outer condyle. No pulsation felt in posterior tibial artery, and doubtful whether there is any in dorsalis pedis. Left femur one and a quarter inches shorter than the right.

July 2. *Operation.*—Assisted by Dr. B. E. McKenzie. An incision was made three inches in length over course of peroneal nerve behind knee. The upper end of the divided nerve was readily found to the inner side of biceps' tendon, its bulbous extremity being involved in cicatricial tissue at the site of former ulceration and operation for removal of dead bone. After much search we found a contracted cord, which seemed to answer for the lower end of the nerve, lying close to the head of tibia. The two ends of nerve were now cleared a little and a small bit cut off of each. Then they were united with two catgut sutures, the prominent portion of the outer condyle beneath nerve being previously chiselled off so as to produce less tension on united ends.

During the operation the internal popliteal nerve was exposed in the popliteal space, and seemed quite healthy. A continuous silk suture

\* Read before the Ontario Medical Association.

was employed for the closure of the wound without drainage, and powdered iodoform, with salicylated cotton dressing, applied. Finally the left tendo-Achillis was divided, and the foot forcibly flexed upon leg. Adhesions were felt giving way in tarsus and ankle. The foot and leg were bandaged and placed on a pillow, the knee being well flexed.

July 24. Wound at the knee was redressed.

July 26. Doing well. P. 88; t. 98.6°; says his foot feels warmer than it has done for months. It is also moist, while, formerly, he states that the skin was always dry. Not much manifest improvement in sensation.

July 30. The dressings were removed from knee for the second time since operation, and the suture taken out. Patient can feel the prick of a pin slightly on dorsum of ankle and foot. A poro-plastic posterior splint was put on limb, with knee well flexed, so as to relax nerve, and a starched bandage applied over it.

Aug. 7. Allowed out of bed to-day. There is not much further improvement in sensation, but there seems to be a slight return of power in the extensor muscles of the toes. He can also evert the foot a little, which he was unable to do before the operation.

Aug. 13. With both feet resting side by side on the floor, while he is in a sitting posture, the anterior part of the left foot can be lifted about half as high as the right. Sensation over dorsum of foot is also improved.

Aug. 20. The splint was removed and reapplied, with the knee in a little straighter position.

Aug. 22. He left for home, with instructions to keep splint on for three or four weeks.

April 6th, 1892. Patient presented himself for inspection. Since the removal of splint six or seven months ago, he has been going about freely on the limb with the aid of a cane. The toes of the left foot now rest well down on the ground when he walks. Sensation seems to be about normal everywhere. Considerable hyperæsthesia exists over cicatrix behind outer condyle. The muscular power has considerably improved in parts supplied by the peroneal nerve. Some contraction of tendo-Achillis still present. The left leg has developed a little more, in comparison with the right, but is much smaller yet. The knee now moves through an angle of about sixty degrees, instead of fifteen,

as at first. He cannot straighten limb much more, however, than formerly.

June 1. He says he continues to get about with more and more ease and facility. He can run with other boys, and has begun to ride a bicycle again a little. Can walk fairly well without his stick, but soon tires unless he uses it.

*Remarks.*—As cases of secondary suture of nerves are somewhat rare, I thought the report of the above case and the presentation of the the patient might be interesting to the Association.

During the last few years, as you well know, a considerable amount of more or less satisfactory work has been done in this field of surgery. Various methods of securing union of the divided nerves have been employed. Doubtless, when the ends are near together, as in my case, the simplest and best mode of procedure is to freshen the extremities and suture them directly with catgut, or perhaps silk. It is generally advised that one should pass the sutures only through the sheath of the nerve when it is of sufficient thickness to hold it. But as cases in which the nerve itself has also been included have apparently done equally well, it is doubtful if it matters much whether one adheres to this rule very strictly or not. I did not do so in the present instance, and indeed it would have been impossible to do so in dealing with the attenuated lower end. Other methods of bringing about union must be employed when the divided ends are not near each other. When the distance between them is not more than an inch, they can often be approximated by dissecting them up for some distance and freeing them from surrounding parts, the nerve at the same time being stretched a little, if necessary, before the sutures are introduced. In cases where even this plan fails to allow the ends to be brought into apposition, some have connected them by means of the strands of catgut used in their suture, and have trusted to these strands serving as a basis for nerve tissue being formed subsequently. A better method than this probably is that of inserting a bit of nerve taken from one of the lower animals, or from a freshly amputated limb. A fair measure of success seems to have attended this plan of operating, and it has now been made use of in several instances.

Dr. Gardner, of Australia, has recently re

ported a case of gunshot wound of the elbow in which he was able to bring together the widely separated ends of the ulnar nerve by dissecting the upper end from behind the inner condyle of humerus and carrying it across in front of that bone, so as to reach the lower end of the nerve by a short cut. This method is obviously only applicable to a very limited number of cases, but it is worth remembering, as it gave a satisfactory result in the patient operated upon by him. Still another way of filling in the gap between the ends of a divided nerve is that of splitting up the proximal portion, beginning just above its extremity and proceeding upwards a sufficient distance, then cutting across one of the halves and turning it down to attach it to the distal end of the nerve. When success follows any of these methods, sensation generally begins to return in a few days after the operation. The motor fibres, however, owing to their degeneration, take a much longer time to recover their lost function; often several months elapse before there is any return of voluntary power in the affected muscles. In the case reported some signs of their recovery seem to have occurred in the short space of two or three weeks.

In a large proportion of cases, complete restoration of muscular force *never* takes place, although improvement may not cease for two years or more.

With regard to the further management of the present case, I feel disposed to allow things to go on very much as during the last few months, or until all improvement ceases, both in the movement of the knee-joint and in the use of the limb. His leg will be massaged every day, and some attempt made to straighten the knee without the exercise of much force. I hesitate to forcibly extend the leg on the thigh as yet, for fear of disturbing the union of the divided nerve. This, I think, would be all the more likely to occur because of the lower end having been so much bound down by inflammatory adhesions at the time of the operation. The condition of the leg as a means of locomotion is so far superior to what it was before operation that I should be very sorry to run any risk of a return to its former helpless state. Although there is much manifest deformity of the knee-joint, and the patient is still in a crippled con-

dition, he gets about with comparative ease, while when first seen the leg was simply useless as an instrument of progression; and if nerve connection had not been restored, the next best thing would have undoubtedly been an amputation at the knee-joint.

### ANGINA LUDOVICI.\*

BY G. L. MACKELCAN, M.D., HAMILTON.

Having read one or two articles in the London *Lancet* descriptive of this disease, and having met with three cases in practice, I venture to bring the subject before the Association in a very brief manner.

The etiology of the disease seems to be very obscure. It is said sometimes to arise from decayed teeth, and at other times seems to be epidemic. The text books scarcely mention the disease, only eight lines being devoted to it in Dr. Osler's work on "Practice of Medicine," which is, of course, up to date. Mr. Barker, in the *Lancet*, reports two cases in University College Hospital, and his definition of the disease is submaxillary cellulitis. It is essentially an acute inflammation of the areolar tissues beneath the deep cervical fascia. Dr. Lediard reports a case originating from a decayed wisdom tooth, which proved fatal from the administration of chloroform for the purpose of making the necessary incision for the evacuation of the purulent collection below the deep fascia.

The affection seems to prove most frequently fatal by way of pyæmia. Pus has been known to find its way down behind the deep fascia, where it is attached to the margin of the first rib, into the pleural cavity, constituting empyema with all its consequences. Therefore the necessity for an early opening of the pus cavity.

*Case 1.*—Was called to see Mrs. F. on Dec. 20th. Found her sitting up in bed, complaining of having caught cold and of a sore throat. She had been ill for three or four days. The throat did not show anything more than a little redness. On the left side of the neck there is a good deal of swelling, not like that of an inflamed gland, prominent and circumscribed, but underneath the jaw it is evenly hard and unyielding, and has a dusky, brownish-red color.

\*Paper read at the Ontario Medical Association.

The swelling and discoloration extend down nearly to the clavicle. The temperature was never very much elevated, 102° being the highest point reached. The induration continued to spread slowly, but there was no fluctuation to indicate suppuration until January 1st, when there seemed to be a small point at and to the left of the median line, where there was slight softening of the hard mass. I therefore made an opening at that spot, only a small one, and found pus, which escaped freely under continued poulticing, and recovery was slow but sure, for the induration was a long time in disappearing.

I subsequently had two other cases, the notes of which I have lost, which ran a very similar course and were treated in the same way. My principal reason for reading this short paper is that the disease seems to be so little known and so often fatal.

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## Selections.

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### SCORBUTIC HÆMATURIA IN AN INFANT.

BY JOHN THOMSON, M.D., F.R.C.P. EDIN.,  
Extra-Physician to the Royal Hospital for Sick Children, Edin.

The following case seems worthy to be put on record as being an example of an extremely rare type of infantile scurvy. The clinical facts are as follows :

J.E., aged seven months, brought from Leith on February 11th, 1892. The infant has been losing flesh and energy for two months, and for the last month his urine has been red. The parents are healthy and tolerably well-to-do. They are very careful of the infant, and his home surroundings seem, on inquiry, to be quite satisfactory from a hygienic point of view. At birth he seemed quite strong and healthy. From birth to the present time he has been given condensed milk. During the first week of life he had nothing else. Then for a month or two months he had barley water added to it. After that for about ten days he was given a little raw meat juice along with the condensed milk; but he did not like it, and it was therefore stopped. When the raw meat juice was abandoned (four months ago) he was given a pancreatised "infant's food," and on that, along with condensed

milk and water, he has been fed exclusively since. He has been in the habit of vomiting about half of the food given to him. His bowels have always been regular and normal in their action. Of late he has been very restless at night; he has always sweated very freely on his head. He has never before had any illness, except that he was "feverish" and had a slight cough when his teeth appeared. About two months ago the infant was noticed to be very languid and to be getting thinner and paler. This has gone on steadily increasing. At the beginning of January the father, who was eating an orange, held it out to the infant. He made a wry face at first when he put his lips to it, but immediately afterwards he clutched hold of the orange with both his hands, and would not give it up until he had sucked a considerable amount of the juice. After doing this he was very sick. The parents were amused at his eagerness to suck the orange, but they thought they had made him ill by letting him have it, and therefore they have never allowed him to have anything of the kind since. About a month ago the urine was noticed to be bright red, and it has remained so ever since. The infant has suffered no pain of any kind, except occasionally "from wind." No special tenderness or bruise of any part has ever been noticed.

The infant is very languid and listless, with a pale, yellowish, earthy complexion; the gums are pale, and not at all swollen, and there are no ecchymoses on them. The lower central incisors are the only teeth through the gum. The fontanelle is large and the ribs beaded, but there are no further signs of rickets. The abdomen is normal; no tumor is to be felt, and the liver and spleen are not enlarged. The heart and lungs are normal; temperature also normal. There is no distinct tenderness anywhere on palpation or passive movement, but the child evidently dislikes being pulled about. There is no ecchymosis, and no swelling of any bone, or joint, or other part. The urine is of a bright red color. On standing, a copious reddish deposit takes place, but the clear urine which is left remains bright red; reaction acid. Much albumen found on testing with nitric acid and boiling. On microscopical examination the deposit is found to consist almost entirely of red blood corpuscles. There are also a few leuco-

cytes and blood-plates, but no tube casts, and nothing else of importance. The case was diagnosed as scorbutic hæmaturia due to improper feeding. The infant was ordered to have nothing but the following diet: (1) As much fresh cow's milk and barley water (equal parts) as he will take, every three or four hours; (2) a deserts spoonful of raw meat juice (prepared as advised by Dr. Cheadle) thrice daily; (3) a deserts spoonful of orange juice twice daily. No medicine.—Feb. 18th: For some reason the diet recommended was not given until the evening of the 13th. On the 14th the urine was quite free from any red color, for the first time for a month. On the 15th it was somewhat pink, but since then it has been quite free from any tinge of red. It is now found on examination to be perfectly normal in appearance; there is not a trace of albumen, and no deposit is seen with the naked eye or under the microscope. The mother reports that the child is "very much better." He sleeps better, is more satisfied with his food, and has stopped vomiting altogether. He is also "much cheerier." His complexion has improved greatly, and he kicks about his legs while being examined in a healthy way which contrasts strongly with his former lassitude.—21st: Improving in every way. "Just very well." Urine remains quite clear.—29th: Still improving in every respect, except that he is somewhat restless at night and sweats a little on the head. Ordered cream, to be added to the milk, and cod-liver oil emulsion.—March 14th: Sleeps well; sweating stopped. Oat flour once daily.—24th: Very well in every respect; has cut two upper incisors.—May 5th: Has continued to gain steadily in strength since last note, and now has a rosy complexion, firm limbs, and the general appearance of a thoroughly healthy child.

*Remarks:* The specially interesting and, so far as I know, unique feature of this case is the fact that, with the exception of the general lassitude, the hæmaturia was the only apparent manifestation of scorbutus present. And yet there cannot surely be any doubt whatever about the diagnosis, in spite of the entire absence of sponginess of the gums, periosteal hemorrhages, and the other well-known signs. Hæmaturia is a recognized symptom of infantile scurvy, although one which is met with only in a small

proportion of cases. Dr. Cheadle reports\* a case of "obstinate and unexplained hæmaturia," very like this one, which, however, was found to be associated with ecchymoses, œdema of the limbs, and sponginess of the gums, and which was clearly scorbutic. The absence of spongy gums in this case does not militate against the diagnosis, for not only is this condition not met with where there are no teeth, but Dr. Barlow has published† an undoubted case of scurvy in which two incisors had appeared (as in this case), yet the gums were quite unaffected. The diet in my case was one well fitted to produce scurvy. The child's craving for the juice of an orange is an interesting incident, and tends to confirm the diagnosis. A similar craving in an infant with scurvy, who clutched hold of an orange which was offered to it, and "then proceeded to souse its lips and nose in the juice," has recently been recorded by Dr. Northrup, of New York.‡ Finally, we have here, in a marked and satisfactory degree, the "most important diagnostic of all, definite and rapid amelioration by anti-scorbutic regimen" (Barlow).—*Lancet*.

#### CLINICAL NOTES OF PARALYSIS OF THE DIAPHRAGM.

BY C. W. SUCKLING, M.D., M.R.C.P.,  
Professor of Medicine to Queen's College, Birmingham.

Paralysis of the diaphragm is a rare affection, but in my opinion it is frequently overlooked, though it may be easily detected if searched for. During the past year I have met with six cases. The first case, which I saw with Mr. Stanley, of Small Heath, was that of a young gentleman who had strained his neck over a horizontal bar in an athletic display. Within an hour he complained of numbness and weakness of his legs, and when I saw him these symptoms had increased. He had difficulty in swallowing, and scarcely any power of phonation. I found paralysis of the right half of the diaphragm, the left half acting but feebly. By keeping the patient absolutely at rest, and by careful feeding, with frequent application of a faradic current to the right phrenic nerve, the patient was kept alive. The diaphragm gradually recovered

\* Artificial Feeding and Food Disorders of Infants, p. 193.

† Article "Scurvy" in Keating's Cyclopædia of Diseases of Children, vol. ii., p. 269.

‡ Archives of Pediatrics, Jan., 1892, p. 5.

power, and in six or seven weeks he was quite well. The lesion in this case was probably hemorrhage around the cord above the origin of the phrenic nerve, the pressure being greater on the right side.

The second case, which I saw with Mr. Hall-Edwards, was that of a young lady who was suffering from influenza, and I was called in on account of severe neuralgic pain in the right lower extremity. The pain was paroxysmal, and of such severity that morphine injections had to be given constantly. On my second visit I found the right half of the diaphragm paralysed. There was no dyspnoea and no alteration of the voice. We decided to apply a faradic current to the phrenic nerves, one pole being placed at the lower end of the anterior triangle in the neck, the other over the hypochondrium. The patient improved with this treatment for a day or two, then died quite suddenly. This was in my opinion a case of acute multiple neuritis, and the paralysis of the right half of the diaphragm was due to neuritis of the right phrenic nerve, the implication of the left nerve being the probable cause of sudden death.

The next three cases were all due to diphtheria, and were all fatal. I believe that paralysis of the diaphragm is the cause of the great majority of sudden deaths after diphtheria, and that only a few can be attributed to syncope. I believe also that in many cases the diaphragmatic paralysis is not recognized. Of the three cases, one was a man and the other two children. In all the cases paralysis of the legs was present, and there was no difficulty in recognizing the diphtheritic origin of the mischief, though in one case the sore throat had been very slight. While at rest in bed there was no dyspnoea, but phonation was very feeble and defaecation and micturition impeded. On examination of the abdomen the diagnosis was readily made. The hypochondrium on the affected side became depressed on inspiration instead of being propelled forwards, and by placing the hand under the ribs the non-descent of the diaphragm could be easily ascertained. There was compensatory overaction of the lower intercostal muscles and great enfeeblement of the breath sounds at the base of the lung on the affected side. In each case the right half of the diaphragm was chiefly affected, but I be-

lieve this is due to the presence of the liver on this side and to the inability of the weakened muscle to push the organ down, while on the left side the muscle can descend until quite paralysed.

In all three cases the paralysis was recognized a day or two before death, and special precautions taken, but in each case death occurred quite suddenly. One little boy was brought to my consulting room; observing the feeble cough and phonation, I had him stripped and examined the diaphragm; I found it paralysed. This enabled me to caution the parents of his grave danger, and I heard afterwards that he died suddenly the day after seeing me. If both halves of the diaphragm become paralysed, death ensues from asphyxia, and the fatality of diaphragmatic paralysis after diphtheria can easily be understood when we remember the severity of the neuritis which frequently follows diphtheria, some patients being paralysed for a year or more.

As to treatment I would recommend that every case of diphtheritic paralysis be kept in bed from the first, and that plenty of nutritious food be given. Iron and strychnine should be administered in large doses. If weakness of the diaphragm is observed the patient should be raised in bed with pillows, so that the diaphragm may act more easily. A gentle faradic current should be used three or four times a day and blistering fluid painted over the course of the phrenic nerve in the neck. Stimulants should be given freely.

The prognosis of paralysis of the diaphragm after diphtheria is very grave, and its onset may possibly be prevented by keeping patients in bed and at rest whenever any signs of paralysis are present. The early recognition of paralysis of the diaphragm is very important from a prognostic point of view.

The sixth case was that of a woman, aged 37, who was admitted for a second attack of alcoholic paralysis. The hands and feet were dropped, and the usual symptoms were present in a typical manner. The diaphragm was observed to be paralysed, and the patient died suddenly a day or two after this observation. I am not aware that paralysis of the diaphragm has been previously observed in alcoholic paralysis, or that it has been noted as a cause of

sudden death, most of such deaths being attributed to cardiac paralysis. This case emphasizes the great similarity that exists between alcoholic and diphtherial paralysis, and as alcoholic paralysis is recognized as being due to multiple neuritis, the paralysis of the diaphragm being also due to neuritis of the phrenic nerves, we may reasonably infer that paralysis of the diaphragm after diphtheria is also due to neuritis of the phrenic nerves. In none of the above cases could a *post mortem* examination be obtained.—*Brit. Med. Journ.*

### ON THE ENUCLEATION OF ENLARGED TONSILS, AND ON HEMORRHAGE FOLLOWING TONSILLOTOMY.

BY BILTON POLLARD, B.S., F.R.C.S.,

Assistant Surgeon to University College Hospital, and Surgeon to the North-Eastern Hospital for Children.

Ligature of either the common or the external carotid artery for hemorrhage after tonsillotomy is surely a very severe method of treatment, and one which would hardly be resorted to until (other plans having failed) the patient's condition was really critical. In the discussion which took place on Mr. Arbuthnot Lane's paper at a recent meeting of the Clinical Society, and in the two memoranda which have appeared in the *British Medical Journal*, the only alternative methods of treatment referred to were local pressure and styptics. There is, however, another plan which is surer and safer than either of them, and more in keeping with the surgical methods employed for the arrest of hemorrhage in other regions, namely, ligature of the bleeding vessel itself in the throat.

Two cases of alarming arterial hemorrhage after tonsillotomy have recently occurred in my practice, and in both of them the bleeding vessels were tied in the wound with complete success. As both the patients were young and very timid children, chloroform had been given, and it was most fortunate that it had been. The first case occurred at the North-Eastern Hospital for Children. The right tonsil had been enucleated with the finger, and very little bleeding had occurred. The left was excised with Mackenzie's guillotine. The throat at once filled with blood, and continued to do so as quickly as the blood could be sponged away. A sponge fixed on a holder was plugged into

the wound between the pillars of the fauces, whence the tonsil had been removed. It was held there for some minutes, but, on quickly removing it, a momentary glimpse was caught of two jets of blood issuing from beneath the anterior and posterior pillars of the fauces respectively, and making a cross fire towards the centre of the throat. The wound was again tightly plugged with a sponge, and preparations were made for securing the bleeding vessels. After the throat had been mopped dry the sponge plug was removed quickly by an assistant, and one of the bleeding points was instantly seized with a pair of Spencer Well's forceps. The second vessel was picked up in a similar manner. In all probability the vessels might have been twisted with safety, but it was judged wiser to tie them, because, had torsion failed to check the bleeding, it would have been necessary to pick up the vessels a second time. There was no recurrence of the hemorrhage, and the patient recovered as rapidly as if no unusual bleeding had occurred.

The second case was encountered in the outpatient department of University College Hospital. There was only one spurting vessel in that case. It was picked up and tied in the manner just described.

In connection with this subject I should like to refer to a method of removing tonsils which appears to me to be but little known and less practised at the present time. I mean the enucleation method. The operation may be done in the following way: The surgeon places the tip of his forefinger between the upper and back part of the tonsil and the posterior pillar of the fauces, tears through the mucous membrane at that spot, and then peels off the tonsil from the wall of the pharynx until it hangs loose in the throat by a short pedicle attached to its lower and anterior part. The pedicle may be either torn through by twisting it or snipped across with a pair of scissors. The operation is often an almost bloodless one.

Although advocating enucleation as a most useful method of removing tonsils in suitable cases, I freely admit that Mackenzie's guillotine and a pair of vulsellum forceps are ideal instruments for performing the operation in the majority of cases. I usually employ them for the purpose, but sometimes they are unsuitable.



In some cases the tonsils, though very large and the cause of much obstruction to respiration, are so buried between the pillars of the fauces and so soft and friable that they cannot be drawn through the ring of the guillotine. The crypts are often at the same time very large and plugged with very septic concretions. Such tonsils may be partially destroyed and scarred by burning them with the galvano-cautery, but several sittings are required in order to do this satisfactorily. They may, however, be removed completely at one sitting under chloroform by the enucleation method which I have just described. I have practised this operation on many occasions, and have been very well pleased with it.

Lest I should be told that I am describing an old operation as a new one, I may add that I am aware that the operation of enucleation of tonsils is a very old one, and that it was reintroduced to the notice of the profession by the Italian surgeon Borelli in 1861.—*British Medical Journal*.

**SLEEPLESSNESS.**—Whether, as appears likely, sleeplessness is more characteristic of our own days than those of our predecessors, or that, in accordance with a scientific fashion, it is now more noticed, we certainly hear of its prevalence with somewhat startling frequency. The nostrums proposed for the cure of this disorder are numerous. Many, if not most of them—we do not for the moment speak of narcotic drugs—are empirical, and are cast upon the public intelligence without any conscious reference to causes actually at work upon the brain and other nervous tissues. It does not necessarily follow that they are valueless, and we should no more think of repudiating their ordinarily legitimate exercise than of refusing the occasional aid of such medicinal agents as may be trusted safely to discharge the same needful function. It is to be understood, however, that we would, wherever possible, avoid, and replace by simpler non-medicinal methods, even such occasionally useful aid. This attitude is but rational, if we consider that the true object of treatment is never by choice merely palliative, but curative, and for cure there is needed the detection and removal of an active cause. The revelation of the causes of insomnia is, indeed, no simple matter.

Thus much, however, we may say—namely, that just as the state of the brain in normal sleep implies a quiescent cerebral circulation somewhat reduced in volume, so in those whose nights are habitually restless we shall commonly find a condition of cerebral vascular tension. This, let it be noted, is not incompatible with general anæmia or with defective brain nutrition. There is, indeed, nothing so conducive to local vascular congestion as the constant exercise of a weakened organ. Mental worry thus acts upon the jaded brain, and we need not wonder, therefore, that it “murders” sleep. The true means of relief is as clear as it is often impossible. In such cases, however, and still more in others where adequate, or even more than adequate, nutrition is maintained, we find a simple and ready antidote in physical exercise. Muscular activity, in fact, may be employed to balance nervous irritation. In it we provide a means of counter exhaustion. There is a transference of vascular excitement, and of tension, with corresponding relief at the site first affected. Further, the same process implies a stimulation of the general metamorphic energy and the removal from the tissues of irritant excretable products. This brings us to another cause of insomnia, particularly of that which we sometimes observe in the gouty and rheumatic. It is probably on the ground of removal of such superfluous substances that we must explain the salutary action of the traditional “night-cap” of hot water, or the boiled onion, a stimulant of the kidney, at supper. Where mental over-activity or irritation has to do with insomnia, the influence of change—that is, of change in thought—should have a trial. It is no doubt a blind groping after this remedy that induces some to read themselves asleep. Better in several ways is the practice introduced by the German Kant, who spent some time before he retired for the night in cutting off by an effort of thought each mental occupation of the previous working hours. We might, however, multiply the stock of remedies without meeting all possible needs. The desirable course for any sleepless unfortunate to adopt is obviously not to resort to sedative drugs to allay his distress, but to seek the advice of his trusted medical attendant and its remedy in the discovery and the removal of its cause.—*Lancet*.

DEATHS FROM THE SWALLOWING OF ARTIFICIAL TEETH.—The case reported in the daily newspapers last week of a police constable who met his death from the impaction of a set of artificial teeth in the neighborhood of the larynx should draw general attention to a danger to which many are daily exposed. It will be remembered that in this particular case the constable, summoned by the whistle of a comrade conveying a prisoner, whom there was an attempt to rescue, to the police station, came running up and took hold of the arm of the prisoner, but almost immediately fell to the ground. He was at once conveyed to King's College Hospital, but died on the way there. The *post mortem* examination revealed a set of false teeth impacted just above the larynx, and this had caused death from suffocation. The report adds that the teeth were of inferior make, and no doubt became loosened through the deceased running. Year after year there are recorded cases of death from swallowing artificial teeth, and probably many occur which are not reported or even suspected. As a rule, these artificial teeth are what is known as "partial cases," where a few teeth are mounted on a small plate, with clasps attaching them to two or three of the remaining natural teeth. These plates may be so ill-fitted as to be loose from the first, and thus easily displaced; but more often the supports—the natural teeth—decaying little by little, the hold of the plate becomes very precarious, yet so gradual is the loss of anchorage that the patient in some instances hardly notices it, and by means of the tongue and the opposing teeth of the other jaw keeps them in position, while the muscular movements are unconsciously performed. The danger in this latter class of cases is the greater because of the insidious growth of its cause. It has been urged that these small dentures ought never to be inserted, but this contention is hardly practicable; the dentist, however, should always impress upon his patient the necessity of seeking advice should they become loose, especially where they are worn during sleep. The extraordinary foolhardiness which is sometimes displayed in such a case is shown by the following history. A man wearing a gold plate carrying three or four front teeth attached by means of clasps to the bicuspid returned home one

night after a carouse, and, in attempting its removal, allowed it to slip down his throat. After waiting patiently for three days he found, to his joy, that it has passed per rectum and he proceeded straightway to place it in its proper position. He saw his dentist a few days later, and told him that he had taken aperients, and passed a great part of his time looking for the lost teeth. The plate was green and slimy, but nothing could induce him to have it removed from his mouth or to have a frame made which would be impossible for him to swallow. However it is not always the small artificial sets which have been the cause of death by suffocation, for the pharynx is sometimes large enough to accommodate a whole upper suction case, and in the museum of the Middlesex Hospital there is a preparation showing a loin mutton chop, including the bone, impacted in the pharynx, which is surely as large as anything made in the way of artificial teeth.—*Lancet*.

INCREASE OF CHOLERA.—Disquieting intelligence reaches us from the East regarding the increase of cholera. The disease for some time past has been smouldering in Persia, but now accounts are forthcoming of its active appearance in that country and in Cashmere. The chief places affected appear to be Meshed, where the mortality is said to have reached 60 per cent., and Srinagar, where the deaths have ranged between fifty and sixty per hundred of the cases. These reports may be, and we hope are, unfounded and exaggerated. Nevertheless, grave cause for apprehension exists, the more especially as cholera is reported to have shown itself at Turbeti Sheikh Djami, a town on the Perso-Afghan frontier. This looks as if there were going to be an extension into Afghanistan, and thence into India. Thus, Western civilization is at present exposed to invasion by cholera at two points, viz., overland from Persia through Russia, *via* the Central Asian railway communications, and by sea from India, through the Suez Canal. With regard to the former, the Russian government is taking precautionary measures, chiefly of an administrative character, at Tiflis. It is satisfactory to learn that "sanitary precautions" are being taken at Djami. If these are carefully carried out in Afghanistan, the disease may not acquire an epidemic foot-

hold in our Indian empire. Without in any way anticipating the conclusions or agreements of the parties to the Venice Sanitary Conference, it is to be hoped that the combined system of inspection and disinfection that will be promulgated in the Red Sea will arrest any Indian cholera infection at its entrance into Europe. For us Europeans, therefore, there is yet ample time given to put our houses in order, and to afford no opportunity to the dread enemy to settle in our midst. Should cholera burst the barriers raised against it in Russia and at the Canal, its success in establishing itself in any country will be in inverse proportion to the hygienic condition of that country. All filth conditions, of whatever sort, and every kind of pollution of air, water, or soil, are the nidus in which cholera flourishes. All our efforts, therefore, should be centred in perfecting our sanitary defence against the disease, which appears at the present moment to be afflicting our brethren in the East. The death of Sir Henry Harrison and his daughter at Chittagong from cholera has been the subject of much regret, as he was one of the ablest members of the Bengal administration, and was instrumental in carrying out many of the municipal reforms in Calcutta of late years. It is stated that many Europeans died of cholera at Chittagong in March last, but the disease was supposed to have disappeared.—*Lancet*.

EFFECTS OF MEDICATED INHALATIONS.—Dr. A. Irsai, of Buda-Pesth, has made some instructive laboratory observations on the effects of the inhalation of various substances on the lungs and air passages. Almost immediately after a few inhalations of air impregnated with oleum terebinthinæ the lungs became pale, but regained their ordinary appearance on the readmission of pure air; a second administration of turpentine vapor was followed by the same appearances as the first. The cause of the pallor was doubtless a spasmodic contraction of the pulmonary vessels—probably due mainly to peripheral action. When oleum juniperi or oleum pini sylvestris was employed, results of a similar kind, but less in degree, were obtained. Oleum pini sylvestris, however, is a more powerful vaso-motor constrictor than oleum terebinthinæ. With eucalyptus, oleum anisi, oleum menthæ, and menthol

scarcely any change was produced in the color of the lungs. With oleum thymi and thymol three or four inspirations were followed by a distinct reddening, which increased as they were continued. Creasote and, in a still greater degree, guaiacol produced redness, there being rapid relaxation of the vessels and great hyperæmia of the lungs. From these observations Dr. Irsai concludes that in acute catarrhal affections with swelling, hyperæmia, and profuse secretion, substances should be selected for inhalation which produce anæmia, and that in chronic torpid conditions, or in phthisis where the supply of blood and the nutrition of portions of the lung are defective, substances which induce hyperæmia should be used. Of course, it is needful to exercise due vigilance in employing creasote or guaiacol in cases where there is any tendency to hemorrhage.—*Lancet*.

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THE  
Canadian Practitioner

A SEMI-MONTHLY REVIEW OF THE PROGRESS  
OF THE MEDICAL SCIENCES.

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TORONTO, JULY 1, 1892.

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CORONERS' AUTOPSIES.

The present system of choosing physicians to make the *post mortem* examinations for coroners is anything but satisfactory. It frequently happens that the autopsies are conducted in a very perfunctory style by men who are incompetent for such work. We do not wish to cast any slurs on the capacities of many able general practitioners who have made such examinations in Ontario during the last few years; but we believe it will generally be acknowledged that the time has now arrived when such work should be placed in the hands of skilled pathologists, when such can be found. In Toronto the coroners appear to think that all physicians are perfectly competent for such purposes, and that men who pay special attention to pathology, in some cases

making it the chief work of their lives, have indulged in superfluities as far as medico-legal cases are concerned.

Our friends in the Province of Quebec are setting us a good example in this respect. On Wednesday, June 8th, a deputation representing the Medico-Chirurgical Society of Montreal, waited upon the Attorney-General of the Province of Quebec and presented the following memorial on behalf of the members of the society:

At the regular meeting of the Medico-Chirurgical Society of Montreal, held Friday, May 27th, 1892, the president, Dr. Buller, in the chair, and forty members present, the question of appointing an expert for performing autopsies ordered by the coroner was discussed. The very inefficient and unsatisfactory manner in which, with a few memorable exceptions, such coroners' autopsies have been performed has been a subject of regret to all who desire to see this important work carried out in a satisfactory manner. It has been felt by members of the medical profession of Montreal that the ends of justice have been more than once defeated by the unsatisfactory way in which the work has been done. In most of the cities of the size of Montreal a thoroughly competent person with special training performs this work, and it is felt that the time has come when the city and district of Montreal should have the advantage of such special skill.

The following resolution embodying these views was moved by Dr. T. G. Roddick, and seconded by Dr. W. H. Hingston, and carried:

Whereas the city of Montreal is without a properly qualified expert to perform autopsies for medico-legal purposes; and

Whereas the present system of allotting coroners' autopsies to the physician most readily accessible at the time is such that it is impossible for any one physician to acquire the experience necessary to become an expert; and

Whereas the system adopted in European and most American cities, allotting all medico-legal autopsies to a specially qualified coroner's physician, has proved highly satisfactory;

Resolved, that the Government of the Province of Quebec be, and hereby is, petitioned to appoint some capable physician, thoroughly skilled in *post mortem* work, to act as coroner's physician for this city, and to perform all autopsies for medico-legal purposes within the city and district of Montreal.

F. BULLER, *President*,  
KENNETH CAMERON, *Secretary*.

#### ONTARIO MEDICAL COUNCIL.

The recent meeting of the Ontario Medical Council, held June 14 to 18, was not prolific of any startling legislation of any kind. It was hoped that some strenuous efforts would be made to allay the hostile feeling that exists throughout the province with reference to the past acts of the Council. We regret to say that the members did not appear to be equal to the

occasion, as practically nothing was done in this direction, excepting the adoption of the following resolution:

"Moved by Dr. Bray, seconded by Dr. Ruttan, that a committee be appointed by the Council to meet a committee and such other members of the profession as may choose to attend from among the promoters and supporters of the bill introduced into the Ontario Legislature by Dr. Meacham for the purpose of discussing any differences of opinion due to the recent amendment to the Medical Act, with a view to the better understanding of the said amendment and the restoration of the feeling of harmony that had existed prior to the said legislation, and should continue to do so between the profession and their representatives in the Medical Council."

This is well enough so far as it goes, but it comes far short of what was expected. The desires and objects of the supporters of Dr. Meacham's proposed amendment to the Medical Act, which was introduced into the Ontario Legislature at its last session, are well known to the members of the Council; and yet they do not consider it worth their while to express an opinion on any one point raised.

We are entirely opposed to many features of Dr. Meacham's bill, but we cannot shut our eyes to the fact that it contained certain clauses which are strongly supported by a large and powerful section of the profession in Ontario. We may go further, and say that the present constitution of the Council is not just and fair in the interests of the general profession. The numbers of "school men" are far in excess of what they should be when compared with the numbers of territorial representatives. This fact is simply incontrovertible, and well known to the Council; and yet its members had not backbone enough to take the question up, discuss it intelligently, and express an opinion on it. The Council may as well recognize the fact that the "Medical Defence Association," which includes a number of strong men, such as Drs. McLaughlin, Coburn, Sangster, Armour, Eastwood, and many others, are enthusiastic, united, and thoroughly in earnest. The do-nothing policy may stem the tide for a short time; but a more manly and dignified attitude is necessary to avoid defeat, if not disgrace, in the near future.

## THE CURRICULUM OF THE MEDICAL COUNCIL.

There were but few changes made in the curriculum at the last meeting of the Council. The time for the acceptance of the matriculation examinations under the old rules, which required a four years' course, has been extended from July 1st, 1892, to Nov. 1, 1892. The object of this is to allow intending students to present themselves at the departmental examination during this ninth (July), and also the supplemental in September, and still come under the old régime. The effect of this change will be to postpone the working of the five-year regulation until 1893.

The students will be pleased at the decision to hold two examinations in the year as heretofore—one in April, and the other in September. Some slight changes have been made in the methods of conducting the examinations and paying the examiners. In the future it will only be necessary to have one presiding examiner present at each examination instead of two. There are few changes in the examining board. Dr. Albert Macdonald, of Toronto, will examine in Midwifery in the place of Dr. Wilson, and Dr. Small, of Ottawa, will take *Materia Medica* in the place of Dr. MacKinnon.

## UNIVERSITY OF TORONTO SENATE ELECTION.

The next election for the Senate of the University of Toronto will be held in September. There will be four elected by the graduates in medicine. We understand that the graduates of Victoria College will have the right to vote. The present members are Drs. I. H. Cameron, A. H. Wright, L. McFarlane, and W. H. B. Aikins, and all are candidates for re-election. Drs. R. A. Reeve, A. B. Macallum, and Jno. S. Mullin (Hamilton) are also in the field. \*

At a meeting of the trustees of the Johns Hopkins University, Baltimore, the following graduates of the University of Toronto were appointed fellows for the year 1892-3: Lewellys F. Barker (M.B. Tor., '90), Fellow in Pathology; Arthur P. Saunders (B.A. Tor., '90), Fellow in Chemistry.

## Meeting of Medical Societies.

### ONTARIO MEDICAL ASSOCIATION.

(Continued from page 286.)

Thursday, June 2nd.

#### THE MEDICAL SECTION.

Dr. Groves, of Fergus, in the chair. A symposium upon

#### THE PNEUMONIAS OF CHILDREN

was introduced by a paper by Dr. W. H. Henderson, of Kingston, on the "Diagnosis of Pneumonic Consolidation from Pleural Effusion," which was read by Dr. Wishart in the absence of the writer. This was followed by a paper upon

#### DIAGNOSIS OF LOBAR FROM LOBULAR PNEUMONIA AND OF PNEUMONIA FROM BRONCHITIS,

by Dr. H. T. Machell, Toronto. A paper on

#### PROGNOSIS IN PNEUMONIAS GENERALLY

was read by Dr. Wishart in behalf of Dr. A. Baines, Toronto. The discussion was opened by Dr. Powell, of Ottawa, who said: "I have long been of opinion that in the routine practice of chest disorders of children insufficient care is taken in the physical examination of the chest for the purposes of diagnosis, and too much is taken for granted. I speak now of ordinary, everyday work, and not of cases seen in consultation, or ones of special interest or importance. Speaking broadly, we may regard the sudden onset of a chest inflammation in a healthy, strong child to be lobar pneumonia, whereas the gradual onset of lung complication during the course of, or following, one of the exanthemas ought always to put us on the lookout for a lobular pneumonia. If, besides the sudden illness, we have short, sharp cough, rapid breathing, flushed cheeks, brilliant eyes, and, what to my mind is of great value, the facial expression of distress, and all accompanied by a sudden rise of temperature, we very fairly diagnose a pneumonia, though physical examination of the chest ought to be resorted to to establish the fact and should never be omitted. I consider the cardinal signs of pneumonia often wanting and rarely all present in children; indeed, the rule is, some of them are always absent, and those that are present are usually irregular.

The rigor cannot be depended on; it is rarely present, but in very young children its place is often taken by a convulsion which, in their case, may be taken as the analogue of the rigor in the adult. The pain in the side is often irregular; in a recent case under my care the pain throughout the illness was referred to the umbilicus. Finally, I consider it not always possible, and often impossible, to diagnose absolutely between lobular pneumonia and capillary bronchitis."

Dr. Saunders, of Kingston, said: "I would add to Dr. Powell's remarks as to the substitution of convulsions in children for the partial rigor in pneumonia that sudden and otherwise unaccountable vomiting is more frequent than even convulsions; either may replace the rigor, but vomiting probably does so the most frequently.

"With reference to the diagnosis between pneumonic consolidation and pleuritic effusion, I would lay stress, in the former, on the presence of bronchial breathing, which is absent in effusion without consolidation; also on the transmission of the cardiac impulse felt by the fingers placed on the intercostal space of the affected side; this is not felt when the thorax is filled with a consolidated lung, but is readily perceived if the thoracic space is occupied by fluid

"I would also notice the importance of delirium as a diagnostic symptom in inflammation of the apex of lung, in which it is almost invariably present, but not so frequent in inflammation of other parts."

Dr. Shaw, of Hamilton, was here called on to read his paper on

THE DIAGNOSIS OF LOBULAR PNEUMONIA, ACUTE AND CHRONIC, FROM TUBERCULOSIS,

and was followed by Dr. J. J. Brown, of Owen Sound, in a paper on the

TREATMENT OF PNEUMONIA,

and by Dr. H. S. Clarké, of Lucan, with a paper on

ACUTE SUPPURATIVE PLEURISY.

The discussion upon all these papers was then resumed. Dr. Oldright, of Toronto, said:

"Regarding pneumonia I will say nothing further than that I have found great benefit in several cases, at a critical period, from antipyretic doses of quinine.

"I have been much interested in the remarks of Dr. Shaw regarding the spread of phthisis. Whilst the most skeptical regarding the culpability of germs must now admit theoretically the contagiousness of pulmonary tuberculosis, we do not practically act upon the knowledge as we do regarding diphtheria or smallpox. We see patients spitting on floors and in handkerchiefs, the dried sputa being allowed to disseminate in the air. In Philadelphia, owing to the efforts of Dr. Dixon, notices were posted in the street cars forbidding persons spitting on the floors. Greater care should be taken to see that consumptives use a spit-cup, and that the sputa be sterilized. Boards of health should look after houses which have been inhabited by tuberculous patients, and see that they are thoroughly disinfected. If any person is skeptical on this point, I would refer him to the diagram of Whittaker in Sajous' "Annual of Medical Science," two or three years ago, showing at a glance the localization of phthisis, and the repeated occurrence of cases in houses occupied by successive families.

"In connection with Dr. Clarke's paper on empyema, I would again refer to the mode of treatment by the daily washing out of the pleural cavity, commencing as soon as pus is diagnosed, on the syphon principle, by means of a rubber tube placed in the wall of the chest. The advantage of this method is that the pleural cavity remains a closed cavity, the bellows action of the thoracic walls is not destroyed, and the expansion of the lungs during the period of recovery is encouraged.

"I can cite cases in which patients treated by this method have been examined years afterward by other practitioners, and no difference could be detected in the action of the lungs on either side. There is no danger of the tube slipping into the cavity, as in Dr. Clarke's cases, and the slipping out could be easily remedied by replacing the tube by one of a larger size if it should get too loose in the opening. Flocculent obstruction blocking the tube would be removed by moving the carbolyzed fluid to and fro in the syphon tube. Any flakes of lymph remaining in the cavity, becoming too large to pass through the tube, would do no harm."

Dr. H. A. Macallum, of London, said: "Œdema of the surface calls at once for surgical interference. It does not matter whether this is a pathognomonic sign of pus in the pleura or not. If it is, it calls for immediate surgical interference. If not, the pressure enough to produce stasis of the lymph vessels in the skin points to stasis of these in lung tissue, and there is an absolute demand for surgical interference. I do not believe in a possibility of pus in a pleural cavity without germs. These may be either pneumococcus, streptococcus, staphylococcus, bacillus coli commune, or bacillus tuberculosis."

Dr. Mitchell, of Enniskillen, said: "I am now treating two cases of suppurative pleurisy. One has been ill for nine weeks. The case began with pneumonia. The patient was aspirated and two pints of pus withdrawn. A tube was inserted and the cavity was washed out by siphon method."

"The second, which was a case of pleurisy from the first, was ill four weeks. He was aspirated in fourteen days from the time he took the chill and seven and a half pints of pus withdrawn. As large flocculi were afterwards found in the cavity, a free incision was made and the case treated by the open method."

"The cases are both improving at present, but the outlook is not good on account of family history. "I believe in any case, no matter how treated, air will be admitted into the side; therefore I prefer treating by the open method with antiseptic dressings."

Drs. Powell, of Ottawa, and Arnott, of London, also made some remarks, and the discussion was closed by Dr. Machell, of Toronto, who, in reply, instanced the three hundred cases recorded by Holt, in which it was shown that delirium *per se* was not typical of pneumonia confined to the apex. Respecting the incision in suppurative pleurisy, Dr. Machell said that this should be free. In regard to the drainage tube, he said that he usually took a piece one inch long out of one side of an ordinary drainage tube, doubled it on itself, and so obtained a double drainage tube, which was secured from slipping in by an ordinary safety pin in the end of either tube. He seldom or never, unless indicated, washed out the chest cavity, but usually applied a good large pad of absorb-

ent gauze; over this, tarred jute or carbolized tow; over these, a layer of rubber dam; and over all absorbent cotton and a binder. The rubber acted as a valve, allowing the secretions to pass out under it, but not allowing the air to pass in.

Dr. H. J. Saunders, of Kingston, then read a paper on

#### HERPES,

in the discussion of which Dr. Powell, of Ottawa, said:

"It is quite new to me to hear any attempt made to draw a similarity between zoster and the exanthemata, excepting in so far as the vesicles may resemble the vesicular stage of the eruption of variola. As to the pathology, it is generally admitted to be the result of an interference with the roots of the trophic nerves that pass into the roots of the spinal nerves from the spinal ganglia of the sympathetic. As to treatment, while many cases are notoriously rebellious, I have found the greatest benefit accrue from good doses of quinine—say, three or four grains thrice daily. Locally, I have found nothing better than olive oil, and I regard its value as due to its protective influence in guarding the eruption from air, and probably water too; which are both known to be obnoxious to eczematous eruptions."

#### SURGICAL SECTION.

The discussion on Dr. Macallum's paper on chloroform inhalation was resumed.

Dr. Charles Trow, speaking on chloroform inhalation, said:

"The hint thrown out as to cocaine being used to do away with nasal stenosis due to swelling of the mucous membrane is a good one. Throat specialists find the difficulty with cases who cannot breathe through the nose, especially those having adenoids; as soon as the mouth is closed the breathing stops. In some of these cases we have to hold the mouth open and pull the tongue forward. If, in spasm, a clot enter the larynx, we should be ready for a tracheotomy or an intubation. Strychnine hypodermically might act well as a heart stimulant. It is very necessary to feel the pulse frequently. In many of the German hospitals they make one of the students hold the pulse during the whole operation. Prof. Billroth's

anæsthetic is largely composed of alcohol, and the patients as much drunk as anæsthetized."

Dr. Arnott, of London, said: "The position taken by Dr. Macallum, that alcohol has an action analogous to chloroform, and that therefore alcohol should not be administered after chloroform, as it would be continuing the action of an anæsthetic, is a most serious statement. If this be true, then we have been acting on wrong lines and must have done immense harm by this course, not only after chloroform, but in medicine as well. A year ago I read a paper advocating the view that alcohol is not a stimulant in any dose, unless indirectly by its action in allaying nervous irritation and relieving pain. Last July Prof. Wilkes, of Guy's Hospital, opened a discussion on the subject before the British Medical Association. During the course of his remarks he incidentally said: 'Some antiquated physicians still retain the idea that alcohol is a stimulant.' In the discussion which followed the statement was not challenged. Prof. Whitla also, in his book recently published on materia medica and therapeutics, says that we will never understand the action of alcohol as long as we look upon it as a stimulant.

"With regard to which occurs first, asphyxia or heart failure, we must understand that asphyxia may occur while the patient is apparently breathing, but is really doing so insufficiently. All indications, therefore, of imperfect breathing should receive our careful and intelligent attention. This condition may go on for a length of time until we suddenly have blanching from heart failure. The *post mortem* reveals a dilated heart, clot in right heart, and blood very dark. Clinically we meet with two conditions, either lividity or blanching. Either one or both of them may occur early or late. When they occur early, the probability is that the cardiac and respiratory centres lying so close together have been paralyzed simultaneously. When they occur late, I am inclined to the opinion that asphyxia occurs first, assisting or causing the drowning of the enfeebled heart. Practically, we should in all cases secure the confidence of our patients, as cases often die from fright. This occurs when no anæsthetic has been administered at the first cut of the knife.

"We should carefully examine the blood pressure of every case, as this will often induce us to examine the urine microscopically, when we will often either discern disease of the kidneys or indications warning us of degenerations of the heart and other organs. Further, I believe that a slow or incomplete anæsthesia is always dangerous. A prolonged administration saturates the system with a large quantity of the drug, which, in case of accident, takes a long time to eliminate. Incomplete anæsthesia increases all the dangers from reflex irritation."

Dr. John Odlum, of Woodstock, asked if Dr. Macallum would invert the patient in all cases of suspended respiration. Do all patients who appear to cease breathing do so by the influence of the anæsthetic, or do some do so by force of will?

Dr. Macallum, of London, in his reply, said: "I do not object to pulling the tongue forward except when vomiting. The exciting effect of forcibly pulling the tongue forward can be as readily obtained by pinching the skin in exciting respiration. Spasms are not always voluntary. There seems to be in the medulla a 'spasm centre' which becomes excited and may lead to general convulsions. Push your chloroform here as in eclampsia in a midwifery case. I would, as a law, advise everting patients in the accidents of chloroform. One cannot tell always whether your asphyxia is primary or secondary—being due to a failure of circulation. Clinically they may look alike, and as a precaution all cases of asphyxia should be everted along with artificial respiration, as well as injections of strychnia. I agree with Dr. Arnott in thinking the beneficial action of alcohol is usually obtained by reason of its narcotic effect only in a narcotic dose, but disagree with him in thinking alcohol never a stimulant. Chloroform stimulates in the early stage the nerve centres, so may alcohol, but I will not suggest that either one is ever a heart stimulant. It is safer to administer chloroform in labor than elsewhere, because (1) there is a physiological hypertrophy of the heart, and (2) the full uterus presses on the abdominal vessels and partially prevents syncope. Watching the pulse constantly is useless; taking it occasionally does no harm, though the face is a better guide. If the abdomen contains a tumor be careful about everting your patient, for fear of this tumor



pressing on the diaphragm and partly inducing asphyxia."

The symposium on

#### HIP-JOINT DISEASE

was opened by Dr. Gibson, Belleville, with a paper on its early diagnosis. He was followed by Dr. G. A. Bingham, of Toronto, on Expectant Treatment; Dr. A. Primrose, of Toronto, on the Operative Treatment; and Dr. McKay, Ingersoll, on Mechanical Treatment before and after.

Dr. B. E. McKenzie, Toronto, followed with a paper on the

#### PREVENTION OF UNNECESSARY DEFORMITY IN HIP-JOINT DISEASE.

The discussion of the whole question was opened by Dr. Bingham, of Toronto, who said: "Traction is a prime factor in fixation of a joint. There is no objection to a patient going about with a fixation splint as soon as possible after operation."

Dr. Primrose, of Toronto, said: "Dr. McKenzie in his remarks referred to a case which had been submitted to the operation of excision and was now probably dying of pyæmia. I operated on the patient referred to, and wish to state that the case was one of advanced hip disease with the development of a large abscess when first brought under treatment. The condition urgently demanded surgical interference by operation, and an attempt was made by excising the joint to remove the disease and to secure free drainage. The disease was acetabular. The child's chances were undoubtedly improved by the operation, and the surgical interference is in no way responsible for his present condition. I hold that it is unfair to cite such cases as throwing discredit on operative procedure in hip-joint disease. The question really at issue is concerning the advisability of treating *early* hip disease by operation or by fixation apparatus. The case referred to by Dr. McKenzie proves nothing as far as the question under discussion goes. The child did badly, very badly, and one is not surprised that it did so. It is surely legitimate surgery to open an abscess when the patient is suffering acutely, and having let out the pus it is surely imperative for us to remove the cause of the suppuration if possible; if the cause lie in a diseased bone of an articulation, by all means remove it."

Dr. Dupuis said: "I have been practising all methods of cure for thirty years, the last eighteen years in the Kingston Hospital, and I see and hear nothing new to-day. I prefer a Thomas' splint for fixation of parts; traction on the limb by adhesive straps above the knee; elevation of the foot of the bed rather than perineal bands; constitutional treatment and operation for the removal of dead bone when this is present. This includes the whole treatment both past and present."

Dr. B. E. McKenzie, of Toronto, replied as follows: "I would call attention to the figures given by Dr. Bingham showing that about thirty-five per cent. operated on and recently reported by Dr. Poore have proved fatal, whereas Howard Marsh claims that by the expectant plan of treatment there is a mortality of less than ten per cent. One of the cases shown here to-day is a girl, the case having gone on to suppuration, and having discharged pus for some months. Treatment was carried out by means of the American traction splint for a little more than one year. Nearly two years have now passed since the removal of the splint and now there is no lameness or shortening, and the limb is but very little smaller than the other. Such a result cannot be obtained after operation. The most successful case is yet a maimed case after operation, and in nearly all of them there is much shortening and lameness. Dr. Primrose admitted that half the cases required the use of a stick to aid in walking after operation and recovery. The statement made that Dr. Bingham's case was allowed to be up too soon was based upon his remark that the boy was 'trotting around the ward' in three weeks after excision. Since Dr. Bingham explains that he was protected by the use of a Thomas' hip splint, the objection to his being up in that short time has been withdrawn. It was admitted by some of Parker's followers that up to the present time operative treatment has not given as good results as conservative treatment. I hold that when a joint is known to contain pus this should be removed and the wound treated antiseptically; extreme devotion to non-operative methods is as far from correct measures of treatment as are the methods of those who operate early in every case. Had this plan been adopted in the case above referred to, the girl could not have made the perfect recovery

which she has done. When due attention is given to the number of relapses that occur after operation, it will be seen that the gain in point of time saved is not so great as would appear. I would cite two cases operated on within the last fifteen months. One had the wound heal up without the appearance of any pus and was discharged from the hospital in good condition, but returned a short time ago having an abscess. The other, though having no sinus at the time of admission, was doing badly since the operation."

At 3 o'clock p.m. the Association resumed in

#### GENERAL SESSION.

The report of the Committee on Nominations was read by Dr. G. A. Peters, of Toronto. It was as follows: The Committee on Nominations beg to report as follows: President, Dr. Hillary, Aurora; 1st Vice-President, Dr. L. Brock, Guelph; 2nd Vice-President, Dr. Preston, Newboro; 3rd Vice-President, Dr. McKay, M.P.P., Ingersoll; 4th Vice-President, Dr. A. R. Harvey, Orillia; General Secretary, Dr. D. J. Gibb Wishart, Toronto; Assistant Secretary, Dr. I. Olmsted, Hamilton; Treasurer, Dr. Barrick, Toronto.

The Association then divided into Sections.

#### MEDICAL SECTION.

Dr. J. E. Graham, of Toronto, was called to the chair.

Dr. W. J. Wilson, Richmond Hill, read a paper on

#### DIPHTHERIA,

in the discussion of which Dr. Harrison, of Selkirk, said: "We owe a debt of gratitude to Dr. Wilson for bringing forward the facts he has given us. It shows that the poison of diphtheria may be carried by a person who has been exposed to the disease without having had it himself. With regard to disinfection, I think it is not yet settled what will surely kill the germ of diphtheria. Prudden says he subjected linen or cotton cloth in a bell-glass for twenty-four hours and found some of the bacteria still living, and could culture in suitable media colonies of them from the tissue. With regard to the cause of diphtheria, an interesting question is whether a case of diphtheria must be caused by a bacterium developed in a previous case. Spo-

radic cases where there has been no known communication with a previous case goes against this view; and though in the older sections of the country there might have been, as is said, cases of the disease perhaps years before in the same house, the germs of which have lain latent, in the newer parts of the country where the history of every house is known, as in my own neighborhood, this cannot have been the case. Yet I have known many cases where the house was new, the place recently cleaned, the occupants entirely isolated, and yet there have been marked attacks of diphtheria. If the idea of Prudden, that a single bacterium may cause in one case abscess, in another erysipelas, and in a third diphtheria, is correct, it might throw a light upon on this question."

Dr. C. A. Hodgetts, Toronto, spoke of a case occurring in the Nipissing District, where, some two years after diphtheria had been in the family of a settler, an old rug had been used to staunch the flowing blood in a cut foot. A diphtheria membrane developed, and one or two deaths occurred in the family from laryngeal diphtheria. Dr. Wilson replied briefly.

Dr. N. A. Powell, of Toronto, exhibited a case of

#### LANDRY'S PARALYSIS,

and read a paper thereon. The discussion was opened by Dr. Meyers, of Toronto, who said: "This case is very interesting from its similarity to multiple neuritis, in which a purely motor form is quite possible, as is seen in those cases formerly described as anterior poliomyelitis of the adult, but which are now generally acknowledged to be an affection of the peripheral nerves, and it is only by the exhibition of cases such as this, and the study of its pathology, that a distinction will finally be made between peripheral and spinal affections, since the careful examination of peripheral nerves has recently shown that several diseases of the spinal cord in which no definite lesions are found *post mortem* are really cases of peripheral neuritis.

Dr. McPhedran said that this case was a very typical one, the only symptom absent being disturbance of respiration; this was peculiar in view of the fact that both speech and deglutition were involved. There was much difference of opinion as to what cases should be included in Landry's paralysis. In most of the late re-

ported cases the nerves, as well as the spinal cord, were the seat of the lesion, and it would seem wiser to include all such so long as they showed decidedly the symptoms of acute ascending paralysis. In a case reported by Klebs last year there was found thrombosis of the anterior central artery of the cord and of its branches to the anterior gray horns, the nerves being all healthy; in some others there was disease of the anterior roots of the nerves or of the nerves themselves; in many micro-organisms being found in connection therewith. In the present case, in view of the absence of wasting and disturbance of sensation, and the normal reflexes with unchanged electrical reaction, there is little doubt that the spinal cord is the seat of lesion. For the same reason the multipolar cells of the anterior cornua must have escaped; the only part of the affection of which would account for the symptoms would apparently be the terminal plexus, in which the fibres from the brain terminate in the gray matter of the cord.

Dr. J. E. Graham related the history of two cases which had occurred in his practice during the last few months, both cases of myelitis, which closely resembled that given by Dr. Powell.

In the first case the course of the disease was almost identical, with two exceptions. (1) The electrical reaction to the galvanic current was abnormal in quality, and electro-irritability to the faradic current was lost in the most of the muscles affected. The temperature was raised for the first two or three weeks of the attack. The patient is now recovering. In the second case death occurred after four days' illness though involvement of the medulla. *Post mortem* examination revealed intense engorgement of the vessels of the anterior horn of the gray matter throughout the whole length of the cord, but much greater in the cervical and lumbar regions. Extravasation and inflammatory softening existed in the same situation. These changes produced a decidedly pink color, which could be at once appreciated by the naked eye. From a study of these cases compared with those of Landry's paralysis, I am of opinion that in the latter disease the lesion was in the same region, but of a somewhat different character.

The discussion was closed by Dr. Powell.

Dr. G. H. Burnham, Toronto, read a paper entitled

A CASE OF RHEUMATIC AFFECTION OF THE EYES  
TREATED BY PILOCARPINE.

This will appear in a future number of THE CANADIAN PRACTITIONER.

Dr. A. C. Meyers, Toronto, followed with a paper on

SYRINGOMYELIA.

Dr. J. E. Graham, in discussion of this paper, said: "I have noticed in the cases I have seen that the hands present an abnormally large appearance. This is principally owing to the atrophy of the muscles of the arm and forearm. I would ask Dr. Meyers if he has observed this in his cases? In a case of central myelitis recently under my observation, there was an absence of the power to distinguish between heat and cold over parts where the tactile sensation was fairly good. The posterior portion of the cord was found to have been more affected than the anterior.

Dr. James Thorburn, of Toronto, read a paper on

SOME POINTS IN LIFE INSURANCE.

The discussion was opened by Dr. Mullin, of Hamilton, who thanked the writer for the paper and spoke of the importance of some of his conclusions.

Dr. J. E. Graham, of Toronto, was of opinion that in many of the cases of so-called functional albuminuria the precipitate was not really albumin. Reagents were often used which precipitated other compounds—peptone, for instance. The only reliable test which always at hand was heat and nitric acid.

The Section then adjourned.

SURGICAL SECTION.

Dr. Temple, of Toronto, took the chair in the absence of Dr. Holmes. Dr. Meek, of London, opened with a paper on

VENTRAL HERNIA,

and Dr. Dupuis, of Kingston, followed with one on  
OPERATION FOR THE RADICAL CURE  
OF HERNIA.

The discussion on these papers was opened by Dr. H. O. Marcy, of Boston, who said: "I owe my thanks to Dr. Dupuis for his valuable contribution upon one of the most interesting subjects that surgery ever presents for discussion. I am especially interested in his remarks upon the

use of the caribou-tendon suture, and, with the permission of the Section, I will confine myself to the subject of the animal suture, which is so very important in its application to the cure of hernia.

"As a student of Mr. Lister, I became deeply interested in the use of catgut as a ligature, and unsuspectingly used it for years as a trustworthy material for sutures. Sepsis which may have resulted I attributed to other causes. Engaged in a long series of bacteriological investigations, I took occasion to test specimens of catgut, the thicker varieties of which, although for a long time immersed in carbolic oil, were shown to be septic, and bacterial cultures were made from them. A careful study of the material in its preparation for musical purposes showed that such general conditions were exceedingly probable, and at the same time explained the reason why catgut was oftentimes so troublesome in its application because of its pulpy swelling, and, when knotted, was so untrustworthy on account of the ease with which it loosened.

"About fifteen years ago I sought for material better as a substitute for the catgut ligature and suture. Knowing that from time immemorial the Indians had sewed their skins with "animal thread," I applied to this source for information. In the teepees of the Sioux of the far northwest, the squaws instructed me as to the sources and preparation of their suture material, which was generally taken from the broad fascia of the shoulders of the buffalo, but sometimes from the long tendons of the leg of the moose and caribou. This was carefully sun-dried immediately upon removal from the animal, and kept dry until required for use.

"In 1882 Dr. Simmons, of Charleston, S.C., sent me beautiful specimens of tendons with long, fine parallel fibres, taken from the tail of the fox squirrel, but these were too short and fine for general use. I at once instituted a careful investigation of the caudal appendages of various animals, in a considerable measure with ludicrous and disappointing results. Reasoning from analogy that the kangaroo should furnish a distribution of tendons not unlike those found in the squirrel, I interested an Australian friend to investigate the subject and send me specimens. These proved far more

satisfactory than the tendons of any other animal, and, indeed, furnish the ideal material for ligatures and sutures. The different varieties of animals called by the general name kangaroo, the opossum of the Southern States, the squirrel, and the common rat, so far as known, are the only animals which have this remarkable distribution of parallel tendons running to the extremity of the tail. They are each attached to a separate fasciculus of muscle, and in anatomical construction are independent. Twenty-five or thirty parallel tendons are found in each animal, and they vary in size and length proportionate to the animal's development. Many are sufficiently fine for the most delicate surgical use, while others are quite too large for any purpose, but are generally capable of subdivision, although rarely as satisfactory as the undivided tendon, which is uniformly even and round. They vary in length from eighteen to thirty inches.

"For years I had very great difficulty in obtaining a supply of tendons sufficient for my own use; but through a few publications in the press of Australia and through the mercantile houses engaged in the collection of kangaroo skins, I have established the collecting of tendons in a regular way. At first they were very expensive, I having paid sixty dollars a hundred in Australia for the tendons as collected by the hunters. They are now, however, furnished in a quantity ample for general use, and can be supplied, properly prepared, at a cost of about the sum of ten dollars per hundred, not much in excess of the cost of catgut. The histological structure of the connective-tissue sheath of the intestine from which catgut is made is interesting. The fibres are generally obliquely disposed, interlacing with each other so as to admit of easy extension and contraction in order to accommodate the bowel in its ever-varying degree of contents. That this connective sheath may be separated from the other coats of the intestine, it must be macerated for days until it becomes a seething mass of putrefaction. This, in our own country, is saved by the butchers, and furnishes the sausage skin of trade. In Italy, where the best catgut for musical purposes is prepared, it is made from the intestine of the sheep. A cork armed with short knives is drawn through the sheath, sub-

dividing it to produce the requisite size for musical purposes. The cement substance which binds together the connective-tissue cells is by this method necessarily softened, and it becomes everywhere invaded with bacterial infection, which may escape destruction in the subsequent methods of preparation for surgical purposes. It is only with the greatest care in keeping catgut perfectly dry that it serves its purpose for musical uses. However, for surgical purposes it must ever be considered as a wet, softened material. When in this condition it is yielding, soft, and comparatively weak, and the comparison is not far-fetched between the spinning of silk into a fine thread, weaving it into a delicate fabric, cutting it into diagonal strips, and twisting it in order to manufacture a cord, instead of keeping its fibres parallel. In the tendon, the strongest tissue in the animal economy, the fibres are constantly maintained parallel, and when properly preserved and prepared are aseptic and trustworthy. The knot is firm and unyielding as in silk; aseptically applied it is unirritating, and is slowly absorbed to be replaced by new connective-tissue cells. Silkworm gut is unchanged in the tissues, and, as wire, remains as a foreign body, or must be removed. Silk is encapsuled and not absorbed, and, even when aseptically applied, frequently becomes an irritant, and when buried in the tissue is often eliminated months after as a foreign body. As the profession come to understand the advantages of the use, in the daily widening field, of buried sutures, the value of tendon for this purpose will be appreciated, and I hazard little in predicting that the day is not far distant when the surgeon will feel the necessity of providing himself with a supply of trustworthy suture material."

Dr. Marcy exhibited to the Section specimens in considerable variety of the tendons of the kangaroo.

Dr. Meek replied briefly. Dr. Dupuis also pressed the use of the kangaroo tendon.

Dr. J. F. W. Ross, of Toronto, read a paper entitled

HYSTERECTOMY WITH AND WITHOUT A PEDICLE,  
A CRITICAL REVIEW FROM CLINICAL HISTORIES.

Dr. Laphorn Smith, Montreal, opened the discussion by referring to the mistake frequently

made in ascribing the formation of adhesions to electricity. Dr. Smith cited a case which, he considered, proved that electricity was not the cause of adhesions. One drawback in the operation without a pedicle was that adhesions were likely to form, and adhesion of the bowels was a very serious matter.

Dr. Atherton, of Toronto, said: "I think we ought to vary our treatment to a certain extent. When the tumor is not overly large and has not, probably on that account, formed a good pedicle, in such cases total extirpation may be necessary. In a large tumor with well-formed pedicle, the old method of operation by extra-peritoneal method is still the best. I think electricity is of value, but I am not a complete convert to the method. We must not discard any form of treatment too summarily."

Dr. Temple, of Toronto, considered the subject of hysterectomy of great importance. "There is a danger," said he, "of hysterectomy becoming fashionable, though probably it will not be so popular in the future. A considerable number of cases of fibroid of the uterus can be treated successfully short of hysterectomy. I have seen four cases of mania after hysterectomy. We should consider each case carefully, and the removal of the appendages should first be tried. Cases very hemorrhagic might call for hysterectomy. The intraperitoneal pedicle is preferable to the extra-peritoneal."

Dr. Ross, in reply, said: "I do not think that one or two cases will prove the statement made concerning the non-injurious effects of electricity. I believe that certain cases of fibroids are best left absolutely alone, though perhaps a little ergot may be administered."

The Section then adjourned.

THE EVENING SESSION.

The session opened at 8.15.

Dr. Oldright, Toronto, exhibited a patient who had suffered from

FRACTURE OF THE BODY OF THE SCAPULA,  
and made some remarks thereon.

Dr. Harrison, of Selkirk, had seen a similar case many years ago, where the injury had resulted from the striking of the back upon the dashboard of a carriage when being thrown out.

Dr. Mitchell, of Enniskillen, opened the discussion in therapeutics, taking up

#### THE THERAPEUTICS OF CONSTIPATION.

He was followed by Dr. McKinnon, of Guelph.

Dr. Acheson, of Toronto, read a paper dealing with new remedies.

The remainder of the session was chiefly occupied with routine work, the presentation of reports of committees, etc. The President then having vacated the chair, it was taken by Dr. Mullin, of Hamilton, and the following resolution was moved by Dr. Williams, of Ingersoll:

"That the thanks of this Association are due and are hereby tendered to the retiring President, Dr. R. A. Reeve, for the able manner in which he has conducted and expedited the business of the Association for the past year."

This was seconded by Dr. Mitchell, of Enniskillen. Carried.

Dr. Reeve expressed his thanks to the Association.

Dr. Reeve resumed the chair, and regretted that, owing to the absence of Dr. Hillary, he could not introduce him to the Association, and declared the Association adjourned.

ceedings of the Council, and agreed with him in nearly all his points. I listened to a discussion by the Medical Association also on the iniquity of advertising, some of the speakers almost holding it an offence to put one's card in the newspapers, and yet *cui bono*? Members of the Association may voluntarily refrain from making their professional business prominent; but incorrigible men, who have neither the fear of the Council, nor of the Association, nor of the prosecutor before their eyes, will do as the following advertisements prove, and denude what medical knowledge they may possess to the one object of making money in a way that other professional men would scorn to practise.

It seems to me that if the profession would express their views decidedly on this flagrant breach of medical ethics, the Council would bestir itself to find a remedy. And the following are not the only advertisements that fill the newspapers or are circulated about amongst the community; their name is "legion."

THOS. P. DUPUIS.

Kingston, June 9, 1892.

[We publish with pleasure the above communication from Dr. Dupuis, but have not space for the insertion of the advertisements. We may say, however, that one of the delinquents was struck off the register at the last meeting of the Council, and we hope the others will soon receive due attention.—ED.]

## Correspondence.

Editor of THE CANADIAN PRACTITIONER:

SIR,—If you have space in THE PRACTITIONER for the following advertisements I would think it a good procedure to print them *seriatim*, for the purpose of calling the attention of the profession to what is going on in our fair Ontario, with the best medical legislation in the world. The laity see these advertisements constantly, and are induced by them to pour money into the pockets of the advertisers. The Council must be aware of their existence, and wink at this monstrous imposition both on the public and profession; for, as yet, it cannot be prevented.

I have always been a stickler for our Medical Council, and have paid my yearly assessments without grumbling at anything but the arrant quackery which all the while prevails. I listened with the utmost attention and interest to Dr. Williams' eloquent address at the Medical Association in Toronto in justification of the pro-

## Personal.

It is said that the staff in the new Medical Faculty of Queen's University, which has absorbed the Royal College of Physicians and Surgeons of Kingston, will be as follows: Medicine, Drs. Fowler (dean), Henderson, and Herald; surgery, Drs. Sullivan and T. Dupuis; anatomy, Drs. Garrett, Mundell, and Ryan; obstetrics, Dr. K. N. Fenwick; pathology, Dr. Anglin; otology, laryngology, etc., Dr. Connell; biology and physiology, Dr. Knight and Dr. Cunningham; chemistry, Prof. Goodwin and Nicol.

DR. J. E. GRAHAM, of Toronto, sailed for Europe, June 19th.

DR. MARTIN, of Toronto, has returned from England.

### Therapeutic Notes.

TREATMENT OF ABORTIONS.—It is not exactly decided by authority how these cases should be conducted. One authority will advise patience, while the next dogmatically preaches immediate interference. Grigoriantz' analysis of 60 of his abortions treated showed 3.7 morbidit, and nothing of mortalit. His treatment is: douche 2 or 3 times daily, secale or ergotine, iodoform tampons if hemorrhage is severe. If ovum and membranes do not yield at once he dilates, or if open to admit fingers he removes, after which the curette is applied, and the internal wall of the uterus cleared off. Out of the 60 cases treated, 39 were separated by the instrument. The manner of using the curette in the uterus must be carefully performed. After finding it slip in, pass it methodically from side to side, examining every part of the internal surface. In no case has he had any untoward results. In ordinary cases he uses a 3 per cent. carbolic lotion. If temperature high:

Rx.—Sublimate . . . . .	o.1
Acid, Carbolic . . . . .	20.1
“ Borici . . . . .	40.1
“ Salicylici . . . . .	5.0
Zinci Chlorati . . . . .	10.0
Aq. Distilati . . . . .	2000.0
	—Medical Press.

HYPNOTIC EFFECT OF WARM BANDAGES.—Warm baths, as is well known, produce a calming effect, and tend to bring on sleep, and Allendorfer has attempted to apply such a method in patients where a sedative effect is desired and yet where a bath is inapplicable. His method consists in wrapping the lumbar region and belly with linen cloths soaked in warm water, and then covering them with oiled silk or rubber cloth, so as to prevent evaporation, while the whole is kept in place and loss of heat prevented by a flannel cloth. This procedure is of ready performance, and the author says that by this simple means he has obtained the most astonishing results in the treatment of insomnia. By dilating the large vessels of the intestinal tract, by the warmth applied, a condition of anæmia of the brain is produced, favoring sleep. These large intestinal vessels have very properly been termed the waste-gates of the circulatory system.—*Jour. de Med. de Paris.—Med. and Surg. Reporter.*

ICHTHYOL.—Among cutaneous diseases, Dr. Charles (*The Lancet*,) found ichthyol, in an ointment of two to ten per cent., especially valuable in burns of the first and second degrees and in scalds. Externally and internally, it was very efficacious in erythemata of unspecified nature. Several rapid cures of chilblains were obtained by washing with hot water and ichthyol soap, and subsequent application of ichthyol and turpentine, equal parts; of ichthyol and glycerine, equal parts; or of ichthyol, three parts, glycerin, water, and dextrin, all ten parts. In intertrigo it was also useful, as well as in zoster and in eczema, in acne and acne rosacea, in sycosis and in psoriasis. He also found the ichthyol treatment very efficacious in boils, carbuncles, and erysipelas.—*Medical and Surgical Reporter.*

It is generally assumed that the decomposition of salol, a compound of carbolic and salicylic acid, in the alimentary canal is effected by the pancreatic secretion. More recent observations by Dr. Gley, published in the *Semaine Médicale*, show that the compound is broken up even in animals experimentally deprived of the pancreas. We must, therefore, look elsewhere for an explanation of this phenomenon upon which the therapeutical value of salol depends.—*Medical Press and Circular.*

GLYCERINE administered by the mouth is quickly absorbed by the lymphatics, and notably by those going to the hilus of the liver and to the gall bladder; it is a powerful cholagogue. Given in large doses (1 oz.), glycerine arrests the pain of hepatic colic, and when given teaspoonful doses daily in a little alkaline water it prevents a recurrence of the attack.—*Medical Press and Circular.*

NERVOUS ASTHMA.—Prof. Da Costa recently treated with marked success a case of pure nervous asthma with one-fourth grain of cocaine per diem. After obtaining the desired result the remedy was only given twice afterward, and but once a day.—*St. Louis Clinique.*

THE CANADIAN PRACTITIONER is printed for the Publishers by Messrs. BROUGH & CASWELL, 14 to 18 Bay St., Toronto. Messrs. Brough & Caswell make a speciality of fine office stationery for Physicians' use, and of announcements, calendars, etc., for medical institutions. Correspondence solicited.