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THE CANADA LANCET.

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Original Communications.

SCROFULOUS OR TUBERCULOUS GLANDS OF THE NECK *

BY GEO. E. FENWICK, M.D.,

Surgeon to the Montreal General Hospital; Professor of
Surgery, McGill University.

The lymphatics of the neck are frequently affected by simple inflammation from cold. They sometimes become sympathetically enlarged from some local irritation; but what are known as scrofulous glands are so intimately connected with tubercle, if, indeed, they are not actually tuberculous, that they demand a separate consideration.

The term scrofulous has never appeared to hold any very definite signification. It certainly cannot, *per se*, be regarded as a positive state of diseased action known or indicated by a certain set of signs and symptoms, but is rather a state of the system generally, a peculiar constitutional condition or diathesis, acquired or inherited, which subjects the individual to the invasion of certain well-marked affections. The term scrofulous, as applied to enlarged lymphatic glands, does not indicate the actual condition of change in the gland structure. It is true that enlarged and caseating glands are constantly met with in persons suffering from what is termed scrofula or struma, but this state of enlargement and alteration in texture has long been recognized as due to or depending on the presence of tubercle. To discuss the history of tubercle would be foreign to my purpose, and would occupy more time than I have at my disposal. First definitely described by Bayle in the early part of this century, various theories and opinions have from time to time appeared. The discovery by Koch in 1882 or '83 of what he

*Read before the Can. Med. Asso. at Quebec, Aug., 1886.

named the "tubercle bacillus," and which he has demonstrated as existing in all tubercle, has completely revolutioned the views tacitly admitted by pathologists as to the actual nature of this change in the tissues. Koch believes the bacillus to be *materies morbi* of tubercle, so that the views held by Virchow that it requires evidence of the presence of military tubercle in connection with cheesy products to constitute true tuberculosis must be greatly modified, and it is now held that all inflammatory changes, whether in a state of cheesy degeneration or not, if the bacillus of tubercle can be therein demonstrated, must be regarded as tuberculous. While I have confined my observations to tuberculous glands, I must state that there are many other structures which are liable to the invasion of the tubercle bacillus, and which are recognized as properly coming under the heading, not of scrofulous degeneration, but of tubercular infection.

In discussing the subject of the liability of the various tissues and organs of the body to the invasion of tubercle, Volkmann holds that the evidence of tuberculosis depends (1) on its well-known structural appearance, (2) on the presence of the tubercle bacillus, and (3) on the positive results given by experimental inoculation. There is scarcely any texture of the body which is exempt from the invasion of tubercle, and it would seem that the lymphatics are specially open to attack, since their very function, as it were, exposes them to infection. Clinical experience points to the liability of the tissues to this invasion of the bacillus. While this great fact is borne out by every-day observation, it is equally true that a peculiar aptitude or condition of the system must exist to favor the occurrence of the disease known as tuberculosis. We may believe that many, if not all, are occasionally exposed to the influence of the *materies morbi* of Koch, but it would appear that a suitable soil is essentially necessary in which the germ can develop and give rise to the various changes that have been noticed in its wake. To this state of special liability to the invasion of tubercle—to this peculiar diathetic condition the term scrofulous may be applied with some definite signification.

Of all the superficial glands, those of the neck exhibit a special aptitude to the invasion or development of tubercle. The glands of the axillary

and inguinal regions are rarely affected. In the neck, the most favored localities are the submaxillary, the glands at the angle of the jaw, and those situated in the posterior triangle. Usually, when first seen, they are somewhat small, unless, indeed, they have for a time escaped notice, and have been left undisturbed, when they will occasionally attain a considerable size. They are described as having been met with, several inches in diameter, although I must say that very large glands have not, so far, come under my own observation. They are rarely single, more frequently the entire chain of glands is enlarged, some being exceedingly small, but very distinct, and sometimes the glands on both sides of the neck are implicated. They present firm, painless, non-adherent growths, quite movable, and feel as if they were connected the one with the other, which in verity they are, by enlarged and thickened lymphatic vessels. Occasionally large masses are met with, made up of several small glands held together by dense areolar tissue, not, however, completely fused, as the capsule of each, although markedly thickened, is perfectly distinct. The centre of each gland, if examined, will be found to contain soft, cheesy matter, somewhat resembling the curd of milk. This I have seen in very slightly enlarged glands, so that it would appear to be an early condition of change, and is not evidenced by any inflammatory state, such as redness or excessive sensibility. If the enlargement is left to itself, or if irritated by some local application, suppuration will advance. The skin over the growth inflames, becomes red and tender, the abscess, for such it is, soon bursts, and a thin, curdy pus is discharged. The areolar tissue around the gland is involved, and the skin becomes adherent. The abscess cavity, after the discharge of its contents, may fill up and close. More often, however, an indolent sinus is left, with thin, purplish undermined edges, or the integument may ulcerate, giving rise to a troublesome and unhealthy sore, which heals with difficulty. This constitutes the well-known strumous ulcer. If the sinus or ulcer heals, it leaves a depressed cicatrix, which becomes adherent to the deeper tissues. Occasionally prominent papillæ remain bound down by cicatricial ridges or bands. Resolution, after a fashion, does, in exceptional cases, occur without suppuration and discharge of pus.

The caseous matter becomes dry, the enveloping capsule becomes firm and dense, and an indolent, but somewhat unsightly, nodule remains, but which does not wholly disappear.

Another clinical feature of these so-called scrofulous glands is the tendency to extension to other unaffected glands in their immediate neighborhood. The disease will show itself, it may be, in a single gland, and will in due course extend, so that the entire chain of glands become implicated, thus showing a marked contrast with enlarged glands from other causes, these latter are generally single, and do not tend to implicate others. Constitutional remedies do not appear to possess any controlling power, but, like a smouldering fire, the action will go on regardless of all attempts to arrest it by either local applications or constitutional remedies. The disease, if left to itself, or if treated by internal and local means, will be found to follow the same course as above described. Abscesses will form and open, sinuses or ulcers be left, which in due course, if they do heal, will leave the part seamed, scarred and disfigured. While this local injury is in progress, we cannot prevent the infection of other vital organs, as this bacillus is in length about one-third the diameter of a blood-corpuscle, and in thickness it is stated to be one-fifth of its own length. A micro-organism of such a size is capable of entering the blood-stream, or of getting into lymphatic vessels, and of being carried to any organ or gland of the body. It naturally follows that if tubercle is in verity a mere inflammatory change due to the presence of this microbe, the sooner the microbe is removed the better, and the safer for the patient's life.

Very little is known concerning the actual mode of entrance of the microbe. Various theories have been proposed on this point, and perhaps all are correct, as they possess the semblance of truth. There is, however, one other fact in this connection to which experience points, which is, that individuals are not subject in the same degree to the chances of infection. It has been supposed that the bacillus may enter by the stomach or lungs, or some abraded surface, cuticular or mucous, and yet do no harm. The power of protection appears to reside in healthy-living tissue. But if there is some defect in constitution, some special vulnerability, the microbe meets with suitable soil, and

will there develop. It has been suggested that the peculiar soil in which the bacillus grows may with propriety be called scrofulous, and that the seed itself, the consequences of its growth and the manifestations which follow, would more properly come under the heading of tuberculous. Another point of great importance is that concerning the development and multiplication of the bacillus. Koch has pointed out that the larger the number of microbes introduced by inoculation the more rapid will be the diffusion of tubercle, until it becomes general. He has also described the mode of multiplication of the microbe by fission and the formation of spores. Such, then, being assumed as true, it naturally follows that to delay the removal of an infected gland is to expose the individual to the risk of general tubercular infection. But we have positive evidence on this point: it is within the experience of most of us that phthisis in many instances can be traced to or connected with scrofulous glands of the neck, or some other tuberculous affection either of the bones or joints or of other tissues in which the local malady preceded the general diffusion. And I think we can record other facts in this connection in which the removal of diseased or enlarged glands or of tuberculous joints has been followed by general improvement in health. Such general improvement will follow after the healing of sinuses or ulceration, which is the sequence to the discharge of pus from a tubercular abscess.

But what a contrast is the part which is left to nature with that which has been early dealt with by the surgeon's knife. In the one instance, the individual, after being subjected to the risk of general tuberculosis, will recover with the part seamed and scarred in every direction with adherent and puckered cicatrices, and this probably after years of suffering; in the other, the disease is at once removed, the patient is to a certain degree protected from infection by the entire removal of the diseased tissue, and this at the expense of a simple and not hazardous operation, a week or ten days surgical treatment, and ultimately a scar, which is not more than a narrow, thin white line, and which in some instances is scarcely perceptible. This radical method of treatment is, to my mind, preferable to that adopted by some surgeons, as laying open the part and scraping all diseased tissue away. In cases

where sinuses and ulcers remain, I should think the use of the spoon would be attended with good results, but even in these cases where there remains a ragged opening with thin undermined edges, it appears to me that removal of the entire diseased mass, freeing the skin from deep attachments, and bringing the edges carefully together, is a better method of treatment than that by the spoon.

Mr. Treves recommends the use of the fine point of a thermo-cautery, which he thrusts into the gland and passes it in several directions in the gland tissue. This method I never have employed, and I must say that it appears to me an unsurgical proceeding. I should trust alone to complete removal by the knife, and I may say that so far, I have not met with any case in which the entire removal has not been applicable. After removal, the subsequent healing is rapid; very frequently two or, at most, three weeks has sufficed to produce perfect union, and the subsequent scar has been slight and in time scarcely perceptible.

CASE I.—On the 17th April, 1873, I was consulted by a gentleman, aged 27, with a large glandular tumor situated on the right side of the neck, extending as high up as the ear. It was nodular, firm, and appeared to consist of several glands held together by dense fascia; it was to the inner side of the sterno-mastoid muscle, and was quite moveable. The tumor had been there for some two years, and had proceeded apparently from cold and exposure. For over twelve months he had been under treatment, various applications had been made, and the directions of his surgeon had been implicitly followed. He had taken iodide of potash, cod-liver oil, etc., without the slightest effect on the growth. When seen, the growth was the size of a goose egg. I recommended its removal, and the operation was performed on the 21st April, 1873. This man, although he had recently returned from England, was pale and looked out of health; he was weak, an unable to stand much fatigue. The wound united by first intention. It was before the days of strict antiseptic precautions. Silk sutures were employed, a drain was inserted, and the wound dressed with wet lint and oil silk. Four distinct glands were removed, and were all in a state of softening and contained pus. This I con-

sidered remarkable at the time, because there was no external evidence of such an event as suppuration having occurred. The following autumn he returned with an enlarged glandular growth lower down, and apparently beneath the sterno-mastoid muscle. This was removed on October 13th; three small-sized glands were removed with ease without disruption of their capsule, and in each instance the gland was found in a condition of caseation. Recovery in this instance was rapid; the wound closed in the course of ten days. I met this gentleman during the early part of the present month, August, 1886. He is robust and healthy in appearance, and the two scars in his neck are so indistinct that they would be readily passed over by a casual observer.

CASE II.—March, 1874.—This was a young woman, aged 27. She had a glandular growth situated near the angle of the jaw on the right side. Had been under treatment for several months. The iodide of lead ointment had been used, and other internal remedies. She was pale, thin, and with a phthisical family history, her mother, a sister and a brother having died of phthisis. She consulted me in regard to the tumor, which was most unsightly. I advised its removal, and the operation was done on the 23rd March following. A single straight incision was made and three distinct glandular masses, softened and breaking down, were removed. A portion of the skin over the growth, which had thickened and was adherent, had to be taken away. Recovery was rapid. Six months after the removal this patient had greatly improved in personal appearance, and a very slight whitish scar was visible, but it was soft and non-adherent to the deeper parts.

CASE III.—M. R., aged 20, admitted into the Montreal General Hospital in April, 1883. This patient had been operated on before, and several glands removed from the upper part of the neck. There was a chain of glands, enlarged, extending down almost to the clavicle; two at the upper part, a little below the angle of the jaw, had suppurated, and several sinuses led into a lot of gland tissue, which was disintegrating and discharging. This gave her great annoyance, and had a marked effect on her general health. She was pale, anæmic in appearance, had a very anxious, troubled look, and was very much depressed in spirits. I

recommended their removal, and she willingly consented. The operation was performed on the 25th April. An incision to the outer side of the sterno-mastoid and reaching to the clavicle had to be made; from this quite a number of glands were removed—in fact, all that in any way were enlarged. Several were open and were discharging pus, these being situated at the upper part of the wound; lower down they were small, but all had softened, and contained cheesy matter. With some considerable difficulty they were all removed, the edges of the skin pared and brought well together, and the wound dressed in the usual way after Lister's method. The spray was used throughout the operation and subsequent dressings. On reference to my note-book, I find that the wound had quite closed on the 15th May, but she did not leave the hospital for several days thereafter. I may state that this young woman is at present in robust health, and from being a weak anæmic girl, she is now making rich blood, and has greatly improved in appearance. The scar is white but perfectly free, soft and pliable, and unattached to the deeper parts.

I have the notes of some eight cases in private besides ten or twelve performed at the Montreal General Hospital, making over twenty cases that have come under my own observation. In all the results have been quite satisfactory. The general health of all these patients has been greatly benefited by the removal of the glands. Several, from presenting an appearance of decided ill-health, exsanguine, anæmic, and in a state in which you would suppose a general break-up was threatened, have markedly changed for the better, and assimilation has greatly improved. Several of these patients have become quite healthy and robust, have increased in weight, and have in no way suffered from the removal of these important organs, which were in verity, before their removal, so damaged as to possess little, if any, functional activity. I cannot do better, in this connection, than endorse the conclusions of Mr. Pridgen Teale, in some very excellent clinical remarks made by that surgeon in reference to tuberculous glands: "That surgery can secure the healing, in a very few weeks, of sinuses and cavities leading to diseased or tuberculous glands, even though they have existed for years, and that in cases of caseous and suppurating glands, the action of the surgeon should be vigorous and thorough."

CASE OF DILATATION OF THE STOMACH
ARISING FROM CANCER OF
THE PYLORUS.*

BY R. W. BRUCE SMITH, M.D., C.M., SEAFORTH, ONT.

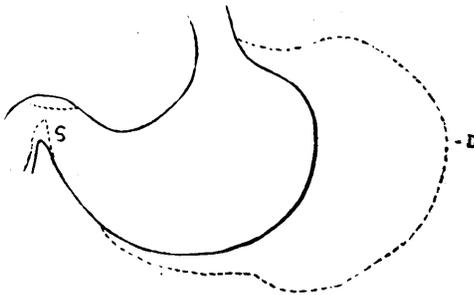
The case which I have been requested to report to this meeting, has in it some peculiar features to which I shall call your attention in the few hurriedly written notes I have before me. The case is that of H. R., a prominent citizen of this town, who died last week at the age of fifty-four years. His family history was good, both of his parents having lived to old age. He worked hard for many years as a carpenter and builder until about eleven years ago, when he noticed what he considered were symptoms of dyspepsia coming on. These symptoms gradually grew worse, and by those who saw him at the time his sufferings have been described to me as most severe. He suffered great pain, with nausea and vomiting. He became rapidly debilitated, and his appearance in every way indicated that his condition was most serious. After a few weeks, hemorrhage became almost a constantly recurring symptom, so that during the next fortnight he would several times a day, when vomiting, eject quantities of blood. Suddenly, however, there occurred a remission of the anorexia, pain, hemorrhage and vomiting so that the patient believed he was recovering and was able to take plain nourishment in small quantities. The natural condition of the stomach seemed to have returned and he was soon able to do light work. The medical men who had seen the case were as much surprised as they were pleased to notice this remarkable change. Their diagnosis had been cancer of the stomach, and although their patient seemed to be recovering, they did not waver in their opinion. I may depart from this subject to note the fact that one of the medical men, Dr. H. L. Vercoe, a man highly esteemed in the profession; has himself died of cancer of the intestine since the apparent recovery of the patient, whose case I am to-day reporting to you. I well remember Dr. Vercoe relating to me the peculiarity of this case and assuring me that he still believed there was malignant disease of the stomach in the case of Mr. R. His consultant in the case had been Dr. Gouinlock, now of Warsaw, N. Y.

*Read before the Huron Medical Association, Jan., 1887.

Since the time when Mr. R. began to recover from his severe illness, his condition, as I have said, continued to gradually improve, and two years afterwards he visited Scotland and seemed to return with renewed vigor of body and mind. In company with his sons he continued for several years to manage a grocery and a large meat packing establishment having at times a great deal of responsibility resting upon him. He however enjoyed fairly good health although he had at all times to exercise great care over his diet, any irregularity in which would bring on the distressing vomiting, similar to that of his former and much dreaded illness. He received little or no medicinal treatment. He had a powder composed of bismuth subnit. and sodii bicarb. and a pill of nux vomica, with which he told me he regulated any slight attack of indigestion that might arise. His appearance, although not rugged, bore no evidence of any serious ailment. On November 30th and December 1st he had long drives amounting in all to about 60 miles, and was exposed to cold and went home on the evening of December 1st, thoroughly chilled. I saw him on the following morning and found him with both temperature and pulse normal, but suffering greatly from nausea and unable to retain anything on his stomach. I prescribed lime water and milk with 10 grs. of lactopeptine combined with sodii bicarb., and this relieved him for a few days, after which all the symptoms of the illness from which he suffered eleven years previously, with the exception of the pain, returned. Liquor bismuthii was tried with success for a few days, but like the other remedies seemed to only afford temporary relief. It is not necessary, gentlemen, to occupy your time by reading to you all the notes I have on this case. The patient gradually became weaker and the stomach refused to bear all nourishment, and latterly everything was vomited shortly after being taken. The bowels were constipated throughout. A splash or succussion sound was plainly heard on shaking or moving the patient, and when a large mouthful of fluid was swallowed it could be distinctly heard dropping into the enlarged cavity. These latter diagnostic signs were more marked than I had ever seen them before, and convinced me that the amount of dilatation must be very great. The irritable condition of the stomach continued, and nothing but small quantities of peptonized milk

would be retained longer than an hour. Owing to the very weak condition of the patient, and the apparently hopeless nature of the case, rectal alimentation was not resorted to. He died of exhaustion after being confined to the house for 36 days, and he assured me the day before death that he had scarcely felt a pang of pain during his illness. In his sickness eleven years ago his pain was very severe. At that time he had frequently vomited blood, this time no appearance of hematemesis was manifest until shortly before death.

Post Mortem.—Having secured the consent of the family, a post mortem examination was made twenty-eight hours after death, at which I was favored with the presence and assistance of Drs. Campbell and Scott. After exposing the viscera, we found the stomach greatly enlarged and extending down into the lower portion of the abdomen. The liver was crowded out of its normal position, until the left lobe had taken the position of the right, and the latter was occupying a more central position. Between the stomach and the liver the result of local peritonitis was seen in numerous



adhesions, most of which bore evidence of not being of very recent origin. The gall bladder was found higher up than usual, and between it and the muscular coat of the stomach near the pylorus strong adhesions were found. The coats of the gall bladder were broken down and the contents escaped. The liver was about normal in size and color, although there were slight patches of discoloration, these were probably due to the escaped contents of the gall bladder. I have made a rough diagram representing as well as I can the size of the stomach, and indicating the site of the malignant disease.

Measuring the greater curvature as shown in outside dotted line, we found it to be 30 inches, and that a straight line from the cardiac orifice to the pylorus was 19½ inches. In the stomach was

found about a quart of fluid, of black yeasty appearance, and intensely sour in smell. The mucous lining of the stomach was found slightly congested, but free from any appearance of ulcerations. You will note in the diagram the site of the malignant growth, which under the microscope was found to be scirrhus. It extended slightly into the duodenum on one side. Under the microscope the fibrous stroma appears far in excess of the cell element, but the latter is sufficiently distinct to fully demonstrate the nature of the growth. The stenosis was most marked, the pyloric orifice being reduced to the size of an ordinary lead pencil.

One of the peculiar features of this interesting case was, as you will notice, the great length of time that elapsed between the first appearance of those symptoms, which lead to the diagnosis being made of cancer of the stomach, and the second attack—eleven years. I believe that this case establishes the fact that during the course of cancer of the stomach we may be often much puzzled by a remission of the anorexia, pain, hemorrhage, and vomiting, and have such improvement seeming to take place that the patient believes he has recovered. In this case two careful practitioners after diligently studying all the symptoms of the case, announce the fact that the patient is dying of cancer of the stomach. The patient's condition suddenly improves, and shortly afterwards he resumes every day work. For eleven years, although not very strong, he enjoys comparatively good health, and has suddenly a return of all the old symptoms with one notable exception—the pain is absent. Then after a week's illness the patient dies, and a post mortem examination reveals the fact that the diagnosis made eleven years previously is verified.

COMPOUND FRACTURE OF THE LEG, TREATED BY PLASTER-OF-PARIS BANDAGE.*

BY DR. CAMPBELL, SEAFORTH.

W. H., æt 37, a native of Canada, laborer in the Seaforth Salt Works, when working at his occupation of raking salt, the following accident took place. He allowed a book to fall down between plates of iron which were leaning against

*Read before the Huron Medical Association.

the wall. These plates each weighed 450 lbs. The book having fallen between the second and third plates, he undertook to separate them, by pulling two of the plates towards him. He found, however, that they were too heavy and he was forced back with his load, when he tripped on a plank which was behind him, and fell with 900 lbs of metal on the top of his legs. The edge of the plates pressed in his right knee breaking both bones of the leg four and a half inches above the ankle. He was taken home and his boot pulled off, when it was found that the ends of both bones had not only come through the skin, but through a woollen sock as well. The hemorrhage was pretty severe, but yielded at last to pressure and plugging with surgical cotton wool. The wound was dressed in the blood with the surgical wool well sprinkled with iodoform placed over the orifice, the whole being covered with lint and oil silk. It was then placed in a fracture box in which it was kept for four weeks, and carefully watched but the wound never exposed during all that time. Pain was relieved with Wyeth's pellets of morphia. There was no bad odor from the wound, no pus discharged and no elevation of temperature during the whole period.

At the expiration of the four weeks the wound was found almost completely healed, there being only a small granulation about the size of the point of the little finger remaining to shew where the wound had been. This we touched with argent. nit., after which, with the aid of Dr. Smith, we put on a well-fitting plaster of Paris bandage which was left on for seven weeks, after which time it was taken off and the patient furnished with crutches which he used for a time.

Sixteen weeks from the time of the accident he walked by the aid of a staff, and twenty-one weeks from date of fracture began his old business, and has worked at heavy work ever since, and suffers no inconvenience whatever. The present condition of the patient is good; there is no pain in the limb, the union is perfect and there is not the slightest deformity.

The patient was examined by the members of the Association, and the result proved to be an excellent one. Dr. C. strongly recommended the treatment of this formidable accident, which used to be so unsatisfactory, and in many cases fatal, by the plaster bandage aided by iodoform and sealing

the wound in the blood. The treatment of simple fractures of the leg and arm by this method was eminently successful and gave the surgeon very little trouble.

Correspondence.

POST MORTEMS AND POST MORTEMES.

To the Editor of the CANADA LANCET.

SIR,—As it may be somewhat instructive as well as amusing to your many readers, I thought I would give you a description of a Post Mortem examination recently held in the State of Michigan. This morning I was called upon by a brother knight of the scalpel, and asked to assist him at a P. M., on the body of a child, found dead in bed on the morning of the 31st ult. I accordingly went with him more to see the "performance" than for any other purpose. I might here state that there was to be an *inquest*, by one of the J. P.'s of the Township. After the jury (of six) was assembled and sworn, my colleague and myself proceeded to our part of the work. The body was brought into the room where the inquest was to be held, and "viewed," not only by the jury but by the company at large. My brother of the scalpel produced a jack-knife and what seemed to be a jeweller's tongs (which I found out afterwards to be so.) He then proceeded to make the P. M. He made an incision, from the superior end of the sternum to the tip of the ensiform cartilage. Then dissecting back, he soon had the sternum and cartilages turned over the face of the corpse. He then turned out the right lung and gave the jury a lecture on it, showing the difference between hypo-static congestion and congestion from suffocation. He then proceeded the same way with the left lung. He next raised the heart into view, stating at the same time what he expected to find there, and with his "knife" made two "slashes" into it, and looking very wise, shewed to the admiring jurors and spectators present that *he* was correct. This finished the P. M. He was then duly sworn and gave his evidence accordingly, I was then sworn and had of course to corroborate my senior's evidence. One thing which struck me as being very odd was that the father of the child was absent and was not called as a witness. The J. P. seemed very proud of his position, but ad-

mitted that this was his first case of the kind. This is how they do things in certain parts of Michigan, and the medical ethics and etiquette are treated in about the same way. There is a code, but no one pays any attention to it, not even the leading light of the profession.

Yours, etc.,

MEDICO.

Michigan, Feb. 1, 1887.

Reports of Societies.

CHATHAM MEDICAL AND SURGICAL SOCIETY.

Chatham, Feb'y 4th.

The President, Dr. Rutherford in the chair.

Dr. Bray reported a case of double synchronous amputation of the upper extremities in a boy, seven years old, with a good result. The injury necessitating this operation was the crushing of both arms by a shunting railway car. One limb was taken off about two inches from the shoulder, the bone not being shattered into the joint; the other, about the middle of the forearm. Dr. Bray wished to know if his treatment was correct or should he have disarticulated at the shoulder joint. Most of the members present thought he pursued the proper course.

Dr. Rutherford related the case of a boy, shot in the palm of the hand, the bullet lodging about two inches above the wrist. The bullet was removed and both wounds were closed with lint soaked in compound tincture of benzoin, with compresses of wadding over this. Both wounds were perfectly healed and the boy able to return to his work in four days.

Dr. Holmes narrated a case of suppression of urine, which will be published in full at some future date.

Dr. Bray read a paper on the treatment of pneumonia, dividing his cases into children, adults and those over 45 years old. Children; first clean out the bowels with oil or rhubarb and soda, with a little grey powder, then give a mixture of spts. mindererus, æther nit. and in some cases tincture of aconite, with small doses of quinine. At the same time envelop the chest and back with hot linseed poultices, applying a lint or two over the chest if there be great dyspnœa. After the

acute symptoms have subsided, substitute a cloth soaked in chloroform liniment, B. P., and covered with oil silk, for the poultices. If cough be troublesome, a stimulating expectorant of carbonate and muriate of ammonia with squills, and senega is given. Diet on milk, adding lime water and pepsine when necessary. He rarely gives anodynes to children, except when acute pleurisy is present. If the latter be subacute with much effusion he applies iodine or cantharidal collodion. Adults; much the same treatment will suffice, but pain must be controlled with anodynes. If the heart be weak, leave out the aconite and add digitalis to the mixture given in the acute stage in children, also give stimulants in the form of brandy or whiskey. The great danger in these cases is from heart failure and this must be guarded against by every possible means, medicinal and dietary.

In the last class of cases stimulants must be given from the first. In these cases especially, avoid blisters and all depressing measures. The reader of the paper has seen nothing to convince him that pneumonia is contagious; but believes that climatic and atmospheric influences produce epidemics and epidemics of it. When pneumonia is epidemic, give stimulants early and a guarded prognosis.

MONTREAL MEDICO-CHIRURGICAL SOCIETY.

Montreal, Dec. 15th, 1886.

J. C. Cameron, M.D. President in the chair.

Dr. W. G. Johnston exhibited a specimen of aneurism of the innominate artery, which had eroded the sternum and first and second ribs on right side. The arch of the aorta was unaffected. The right carotid and right subclavian were given off from the sac. The left carotid and left subclavian pressed upon and pushed over towards the left. The superior vena cava was obliterated through pressure at a point two inches above its origin. Azygos vein enlarged to the size of the ring finger, and communicated by a large branch with the superior intercostal vein. Superficial anastomoses of epigastric and hypogastric veins were prominent. Hemorrhoidal veins normal.

Dr. Ross said that the patient had been under his observation for eighteen months, and was never recognized as a case of aneurism of the innominate

artery, but the symptoms pointed more to the arch of the aorta. The earliest symptoms were pain at the back of the neck and shoulder of a neuralgic nature, accompanied with cough. These were relieved by potassium iodide. The patient got better of his first attack, but was frequently laid up in hospital. Enlargement of the superficial veins of the abdomen and thorax was early evident, but lately the superficial veins were tortuous and as large as a man's finger. The patient also exhibited signs of intra-thoracic pressure—such as paralysis of the right vocal cord, rattle in the larynx, and signs of pressure on the trachea.

Dr. R. L. MacDonnell who had had the case under observation for the last fourteen months said: There were two points of clinical interest in the case. In the first place, the results of the use of the sphygmograph were deceptive. The tracings obtained showed very marked interference with the blood current through the left radial, hence he had assumed that the aneurism was situated on the arch at a point beyond the giving off of the innominate artery, the fact being that the great dilatation of the innominate artery caused not only an impediment through that channel, but by its bulk had pressed upon the subclavian and disturbed the flow of blood to the left upper extremity. In the second place, the relief afforded by the iodide of potassium had been most effectual. Whenever the drug had been discontinued, or whenever the patient had been unable to obtain it, the pain and dyspnoea had increased.

Dr. Wilkins referred to a case in his practice where there was obliteration of the superior vena cava from clot, which produced no varicosity.

Dr. Ross said one of the early symptoms of the case was a suffused appearance of the face, but the varicosity did not progressively increase; it was sudden and at the last.

Dr. Johnston exhibited for Dr. Neelson specimens from a case of typhoid fever complicated with diphtheria. There was a well defined membrane covering the fauces and extending through the larynx to the smaller divisions of the bronchial tubes. The spleen was enlarged, and there were typhoid lesions in the intestines.

Dr. R. L. MacDonnell exhibited the skull of an idiot which had been dissected at McGill College. There was on both sides deficient development of the petrous portion of the temporal bone. The

base of the skull, as seen from within, was flat, the petrous bone not forming the normal ridge between the middle and posterior fossæ. The organs of hearing had never reached development, there being in reality but a rudimentary tympanic cavity. The foramina through which the various nerves passed were small. No previous history of the case had been obtained. The subject presented several other abnormalities. 1. The right common carotid divided into its external and internal division opposite the lower border of the thyroid cartilage. 2. The left common carotid did not divide at all, but was continued upwards as the internal carotid, the superior thyroid and lingual arteries were given off this common trunk, and the facial from the lingual. 3. The hypoglossal nerve was given off from the pneumogastric. 4. There was deficient development of the teeth. The bicuspid were represented by small round pegs. The molars were ill formed, small, and rounded like milk teeth.

Dr. Wilkins, 1st Vice-President, then took the chair, and Dr. Cameron read a paper on "*Aseptic Midwifery.*"

Dr. Kennedy agreed with Dr. Cameron in his conclusions. He rarely allowed a patient to have a douche; always believed in using it in person, as he found nurses, as a rule, unreliable. He could tell by the temperature chart in the hospital which nurse had charge of a ward. He did not believe in the use of a douche unless there had been operative procedure.

Dr. Roddick said he had long believed antiseptics to be as important in midwifery as in surgery; but from his experience, as well as from the facts in the paper, he now regarded it of even more importance in the former. In 1877 he had been asked to give some rules for the guidance of a friend, then superintendent of the Hamilton Hospital, and had laid stress on the use of antiseptic injections previous to delivery, as before operations in surgery. The results were good in Hamilton, though only tried for a very short time. He thought the excellent results obtained in the Queen Charlotte Hospital were largely due to the previous washing out of the vagina, as the discharge before labor was often septic.

Dr. Alloway said that owing to the acceptance of aseptic midwifery the mortality had notably decreased during the past five years. It is rare now

to hear of septic cases, much less of death. For the last five years he had been an antisepticist, and had not witnessed a single death during that period, though, through nurse or midwife examining patients, he has seen many cases of septi-cæmia. He cited, as an example, where one midwife had lighted up several septic cases. Dr. Roddick's importation of Listerism had induced him long ago to apply it to midwifery cases. Dr. Cooper of New York reports 40,000 cases in Vienna with results similar to those stated by Dr. Cameron. He (Dr. Cooper) insists on using corrosive sublimate whenever there is any abrasion of the vagina.

Dr. Trenholme said he had never had a case of septi-cæmia in his practice, though he never uses a tube, and believes this result due to the great care in removing the membranes and placenta entire.

Dr. Shepherd called attention to the results, as stated by Dr. Cameron, of removing by the curette any adhering portions of the placenta as soon as septic symptoms appear.

Dr. Cameron, in replying, stated that the use of the jute pad and iodoform to the vulva after delivery was analogous to the mode of stopping a test tube in germ culture. There is always danger of carrying in the air with the douche, and for that reason he prefers the dry dressings.

Selected Articles.

EXAMINATION OF THE URINE.

BY J. MILNER FOTHERGILL, M.D., EDIN.

When I was a medical student—a good many years ago—I was taught with scrupulous care how to examine the urine for albumen and sugar; but long years of practice have taught me that it is much easier to detect the presence of either of these substances, than to make out their significance when found. The simplicity of test-tube examination possesses a certain fascination for some persons. Albumen is found, and of course Bright's disease is afoot. Sugar is found and behold the dreaded *Diabetes Mellitus* has laid its mortal grip upon the patient. This is all very well if it only happened to be true! There is where the hitch lies. For that class of mind which can only see the gravest aspect of any subject, this is all very well. Some people can never restrain themselves from exhibiting their cleverness in the shape of letting one see they know and realize the full significance of what they discover. How many medical men took to their beds to die when they found albumen in

their urine, soon after Bright drew attention to albuminuria; but finding that the King of Terrors did not call for them threw off their apprehensions, left their beds, and went back to their work? A great many more than care to say much about it. What Dr. Bright did teach was that "when dropsy was found with albumen in the urine then disease of the kidney was present." But very soon the dropsy factor got left out, and albuminuria alone involved Bright's disease. This shows as Franklin Blake said in "The Moonstone;" viz., "We English are the most slovenly thinkers in the world except when making machinery." But in this case the English do not stand alone in slovenly thinking. The medical world at large simply took leave of its senses. I do not for one moment wish to convey the impression that the reaction of the urine in a test tube is not to be noted; only it does not work well in practice to attach undue and disproportionate importance to one symptom, to the exclusive and comparative neglect of others. Yesterday a patient at the hospital with syphilitic cachexia brought some urine as she had been directed to do by my clinical assistant. I told him it would probably be albuminous. He examined it, and found one-fourth albumen. Now what light does this clinical fact throw upon that particular case? I am bound to admit that I, at least, do not know. The darkness is unilluminated by it; but my *belief* is that her cachectic state is largely due to the loss of albumen by the kidneys rather than that there is any kidney disease present.

This is an aspect of albuminuria in my opinion, too little considered. If there exist a constant drain, no matter whether of serum-albumen or peptones, the system will be imperfectly nourished. A case came under my notice two years ago in the form of a Cambridge undergraduate who was pale and weak, and feeling unfit for his work. Albumen was present in the urine in unmistakable quantities. In that case two views could have been taken up, and maintained perfectly honestly. My opinion inclined to the case being one of malnutrition in which the loss of albumen played a part. At any rate the lad got well, and the albumen disappeared from the urine. But because such cases do crop up, the systematic examination of the urine need not be flung aside like an obsolete weapon. Then again persons who have had malarial fever are very apt to pass some albumen. One well-known surgeon left India and came home believing that his health was broken and gravely impaired; but after ten years he is still hale and vigorous. We often talk the matter over, and regret that so much misapprehension exists on the subject. In any interference to the portal circulation, albumen is liable to show itself in the urine. When the interference is removed the albumen disappears.

Bearing in mind these facts, the obvious conclusion is this: It is not proper to assume that albuminuria indicates Bright's disease. A medical man has no moral right to alarm a person by announcing Bright's disease merely on the discovery of albumen in his urine. It is as unjustifiable as to inform a man his house is on fire merely because his chimney is ablaze. Before saying anything to the patient the urine should be carefully searched for tube-casts, and if they are discovered then the announcement is justifiable, but not until. Of course, no man but a fool or a crank would undervalue the significance of the evidence furnished by the test tube. Say it is a case of cardiac dropsy. The appearance of albumen in the urine while the case is under treatment is almost the herald of despair. But here the circumstances of its appearance are known; but if a patient comes under notice with cardiac dropsy, and the urine is found to be albuminous, its significance is by no means so ominous. Any cause of venous fulness in the kidney may give rise to albuminuria; but it is very important what the cause is, as that will determine the significance to be attached to the albuminuria. An albuminous condition of the urine derives its import from its associations, and the men who disturb the peace of a family merely because the urine in the test tube gives evidence of albumen, are scarcely fit for their vocation, and certainly take a very oblique view of the moral obligations of a family physician. Again as to the presence of sugar in the urine. Many medical men have lost their heads in a manner nowise creditable to them on finding some sugar in the urine, whether their own or that of some one else. The discovery of sugar should at once put the medical man on the alert, just as does the discovery of albumen. In either case the medical man should at once be upon his guard; but this is a very different matter from abruptly delivering an adverse opinion. The latter is very much like condemning a suspected man without going through the preliminary of a trial to ascertain if he is guilty. The evidence against him at first sight may seem damning, but the process of trial may demonstrate his innocence and not his guilt. When albumen or sugar is detected in the urine of a patient, then a searching examination into the facts of the case is incumbent upon the part of the physician.

As to sugar, corpulent persons often pass saccharine urine, and especially corpulent, gouty persons. What significance glycosuria possesses under the circumstances is unknown to me. One such case has been under observation for over eighteen months. There were other symptoms present telling that the case was something more than mere glycosuria. While allaying the lady's apprehensions as to any immediate danger, both she and I firmly believe she will die of diabetes.

And why do we both believe this? Because from family circumstances she is subjected to worry and annoyance from which she can not emancipate herself. But as to other cases they seem to go on for years without any deepening of the condition. There are other circumstances, however, under which glycosuria is found which give it much significance. All physicians of any experience have met with cases where an acute condition of diabetes is started by a sudden shock or fright. Such associations are matter of notoriety. But the association of chronic *diabetes mellitus* with mental conditions is far less generally realized. Yet those who are giving special attention to the subject are beginning to be strongly of the opinion that diabetes is casually dependent very often upon "carking care," disturbing the liver as regards its glycogenic function. If this view can be substantiated, and I for one think it can, then the appearance of sugar in the urine, even in small quantity and titful as to presence, is terribly suggestive. If such a case be watched it will be found to deepen in gravity; for a while a strict diabetic dietary may afford relief, but it turns out to be a case of "the further in the deeper." Of course this is the more likely to occur if the patient continue to carry his load of care. If, however, the load be lightened the result may be otherwise. The glycosuric condition may remain static for years. With one such case I am intimately familiar.

Diabetes—not merely glycosuria, but something more—is a malady which does not necessarily progress with steady, relentless tread to the tomb. We must learn to regard it as a disease which may take its origin in small beginnings and deepen to death; or be arrested, as the case may be, and according to what measures are taken. If this view be well founded the appearance of sugar in the urine is fraught with high significance. Nor is the difficulty to be met by gluten bread and almond biscuits. That is the narrow not the wide view of the subject. When a hard-working business man is a patient, in my opinion, a regular periodic inspection of the urine should be made, and when traces of sugar even are detected, to keep a keen watch over the patient. If small quantities are pretty constantly present, then he should be told frankly and honestly his true position, and the facts looked in the face. Such a man will be liable to temporary aggravations of his condition on any passing extra mental perturbation. Such a case is well-known to me, where a glycosuric man is a diabetic when anything gravely puts him about. In such cases the urine varies hand in hand with the general condition; and the urinometer will register the case pretty accurately. Then there are cases of glycosuria where the amount of sugar is considerable in the urine passed three hours after a meal; while the urine passed in the morning contains but little

sugar. Speaking broadly such a condition carries with it a better prognosis than where the morning urine differs little from that passed at other times.

Sugar, like albumen, in the urine is a stiff hint to a medical man to put on his studying cap? As to the presence of phosphates in the urine, they may merely be made visible because the urine is not acid enough to keep their solution. It gives a patient a greater interest in himself and his maladies to tell him he has phosphates in his urine; especially if at the same time the impression is conveyed to his mind that phosphates do not belong to healthy urine. Even if they be present in considerable amount it is not easy to appraise their import, since Sir William Roberts, F.R.S., in his well-known treatise on "Urinary and Renal Diseases," says:—"There is not the least reason to believe that there is any constitutional state specially characterized by and excessive excretion of phosphates."

If in what has been written here the reader detects a latent contempt for test-tube examination of the urine, he will kindly please to understand that the contempt is not felt for test-tube examination of the urine—certainly not—but for the way it is too often done! No medical man ought to give an opinion on one examination of the urine. Of course in consulting practice one has too often to remain contented (or may be discontented) with one examination; and as a consequence of this, the examination of the urine of one twenty-four hours falls into a subordinate place in the diagnosis. One has to teach oneself to observe the other features of each case. And there is one matter about the urine of the very highest importance and significance in my opinion, and that is—the patient's account of it! How much he passes; if he gets up at night to pass it; what it is like when it is passed; and what it is like when it has stood over night in a cool place.

When the urine of an animal possessed of a four-chambered heart and a fluid urine, deposits, on cooling, a quantity of urates—the form of urinary excretion belonging to animals with a three-chambered heart and a solid urine—depend upon it, the kidneys will suffer sooner or later for this reversion on the part of the liver. Human kidneys are not constructed to excrete the comparatively insoluble urates; and if they have to do so for a continuous time they become injured. If the urates are formed in large or considerable quantity, one of two things must occur, (1), the kidneys are injured by the out-put; or (2), the urates are retained in the system as gout. The first gives Bright's disease; the second gout in some form. Often the condition is a blend of the two. If the bulk of urine be habitually small, some obstruction to the blood flow in the pulmonic circulation (heart or lung) suggests itself. When the flow is copious

and the color pale, and the specific gravity low, Bright's disease with the large left ventricle, and the hard artery—with the resultant high arterial tension—is fairly certain. This is rendered more probable if at the same time the patient gets up at night to empty the bladder. Why he does so is too long a story to be told here. Examination of the urine as regards the patient's account of it, is grossly neglected; just as the reaction of one sample of urine in a test-tube is too highly estimated at the present time. And if the points put in this paper be conned over by the reader, and applied to his cases under care, I venture to think some mistakes—potential or actual—may be avoided. A negative lesson it certainly conveys. Let not the reader abandon test-tube examination of urine; but let him make it more perfect and more extended as to time and duration of observation. What I do denounce—and I do not denounce it more heartily than I detest it—is the too common practice of giving grave opinions from a casual observation. And to point out the sources of fallacy, as has been done, is the only way to secure more careful examination. Certainly no patient should be told he is the victim of Bright's disease until a patient microscopic examination has been made. In the same fashion must the significance of sugar be determined—only here the microscope can lend no service; viz.: by common sense and special knowledge. Rash medical opinions rapped out on insufficient evidence may appear to establish the cleverness of the utterers; but it is positively certain they have added a distinct amount to the sum total of avoidable human misery; and therefore constitute a practice to be heartily denounced and reprobated by every one who loves his fellow-men.—*New England Medical Monthly.*

SOME POINTS IN MINOR SURGERY AT THE PENNSYLVANIA HOSPITAL.

Dr. Thos S. K. Morton (*Medical News*.) Shock is combated usually by warmth and stimulants. The former is applied by means of hot baths or water bags, generally the latter. The patient is surrounded by rubber bags filled with hot water. These we have had made for the purpose. They are round, from one and a half to two and a half feet long, from four to six inches in diameter, and have a filling-hole with a screw cap at one end, and a handle at the other. Atropia is freely used. Whiskey, ether, digitalis, aromatic spirits of ammonia, or, in desperate cases, aqua ammonia itself, was given. The injection of pure ammonia is, of course, always followed by local sloughing. Mustard, hot fomentations, large enemas, and drinks of warm fluids do good service. Previously warmed blankets are a great comfort as well as of benefit.

In the amputation of fingers and toes below the metacarpal or tarso-phalangeal joints, rubber umbrella rings are used as tourniquets. The flaps are closely stitched, and, if there be any bleeding when the ring is taken off, a deep lateral stitch back of the line of incision on one or both sides will always effectually control it. We never put a ligature upon these arteries, finding the above method amply secure, and, as far as our last few hundred such amputations show, unattended with disadvantage.

In exarticulation at the metacarpal or tarso-phalangeal joints ligatures are applied if possible, but if the bleeding is obstinate, a deep stitch into the palm or sole can be made to control the appropriate vessel. These operations receive the usual house dressing and a palmar splint. They are, as a rule, not dressed for from ten days to two weeks, when solid and complete union is expected and usually found. Catgut sutures are passed through finger- and toe-nails without fear, if by so doing crushed or cut parts can better be brought into shape, and also in operations for ingrowing nails. We have saved many fingers, ears, and noses, which came in hanging by mere shreds of tissue, by promptly sewing them in place, and treating antiseptically. No opportunity has occurred by which to test the saving of those parts when entirely severed from the body. Abrasions and brush burns are carefully cleansed and treated with either boracic acid ointment, or the standard house dressing. The latter consists of: Protective; Lister gauze, wrung out of 1: 1000 Hg-Cl₂ solution, and its skin surface thickly dusted with iodoform; a pad of dry 1: 1000 cotton, and moist 1: 1000 gauze bandages over all. We have found that Lister's boracic acid ointment makes up better if wax be substituted for the paraffine of his formula. Our receipt is: boracic acid and yellow wax, each 1 part, cosmoline 4 parts.

Ligatures are never applied except in the largest operative and accidental wounds. Sutures run under or through the bleeding points effectually control them. No trouble is experienced in tying catgut sutures or ligatures, when the first tie of the knot is made as for a surgeon's knot. Catgut is invariably used for these purposes. In treating some hundreds of scalp wounds, no matter how extensive, I have never applied a ligature, always finding that carefully placed sutures will stop all hemorrhage. Stitches are placed very close together in all wounds; this presupposes proper drainage if it is necessary. If so, it is secured by a few strands of finest catgut, placed along the bottom, and brought out at one end of the wound. Small or superficial wounds as rarely require drainage as ligature. Scalp wounds are not drained unless extensive. If the edges are much contused or torn, they are excised. Quite small wounds of the scalp or elsewhere, and sometimes larger

ones, are, after antiseptic closure, covered, in with a minute pad of bichloride cotton, and plastered down with either pure collodion or combinations of it with such drugs as evaporated tincture of benzoin (evap. fl. ʒ ij. tr. benz. comp. to fl. ʒij. and make to fl. ʒ ij., with collodion), iodoform (10 per cent.) salicylic acid, etc. Wounds too small for stitches are similarly treated. Large wounds, of course, receive the house dressing and possibly drainage.

Very tense hematoma are freely incised, the clot or fluid blood curetted out, any bleeding vessel stitched or tied if it can easily be found, and the whole sewn up with or without a drain, according to size, and dressed with some compression. Slowly resolving hematoma or those in which suppuration is present or incipient, are manipulated in exactly the same way.

Punctured wounds are laid open, curetted, washed with 1: 1000 corrosive sublimate solution, and closed as above. If the bottom cannot be reached, a small drain should be carried as deep as possible, and the best hoped for.

Gunshot wounds are treated in much the same manner. If it can readily be done, the ball is extracted through the wound or by counter-opening. The entrance and exit (if there be one) wounds are excised, the track of the ball curetted thoroughly, a small gut drain carried all the way through, and the external wound treated as simple incised ones.

Compound fractures, if the skin wound is small, are freely cut into, washed with 1: 1000, curetted, accurately stitched, and, if extensive, drained with catgut. Some of them are dressed more frequently than the actual wounds require in order that good position of the bones may be secured. Wounds of joints are treated in precisely the same manner, save that, unless they are dirty, we are satisfied with thorough washing with 1: 1000, and omit the curette. Cure in one dressing is here attempted and good function expected.

Poisoned wounds are also treated somewhat similarly, but the utmost care is taken to get to the bottom of the wound itself and into all ramifications and sinuses with the curette and strong antiseptic solution (1: 500). If the wound is very bad and cellulitis present or threatening, continuous antiseptic irrigation (1: 2000) is started as soon as the cleaning out is effected. Large glass percolating jars, with glass stop-cocks, or other regulating device, suspended over the part give best satisfaction. Whilst thus employing irrigation any wounds should be well covered with protective, the whole part covered with lint, and the solution allowed to drip upon it. Suppurating wounds might be classed as poison wounds, for the treatment is almost the same, namely: curette and antiseptic solution (1: 1000 or 1: 500), excision of wound edges and, as usually, accurate approxima-

tion, with or without a drain as circumstances indicate. Punctured, gunshot, suppurating, poison, and compound bone and joint wounds when thus dealt with, as a rule heal by primary intention and under but one dressing.

Felons, buboes, simple and suppurating cysts, inflamed bursæ, and large, small, and diffused eradicable abscesses are treated by exactly the same method and usually with like results. In-eradicable abscesses, such as the psoas, are treated by this method as far as it can be made to go, and are then drained into an antiseptic dressing by means of a rubber drainage tube; through which they are from time to time washed out with antiseptic solution. Care must be taken in so doing, however, whether it be these or other cavities, not to let any of the solution remain in. It should be displaced by a weaker solution or distilled water. It cutting into abscesses, old hematomata, etc., a better result is secured by opening them from one side through sound tissue. Simple cellulitis is treated like the complicated form as described above.

Burns, if small in area, or confined to an extremity, are treated by the regular antiseptic dressing. All easily removed, dead skin, etc., is taken away; the parts washed with 1:1000 bichloride solution, or iodoform sprinkled on (in part for its analgesic effect), then protective in narrow strips, and the dressing and cotton. Anæsthesia may be required to do this properly. Extensive burns are covered in with boracic acid or oxide of zinc ointment, the surface of which is sprinkled with iodoform and, if there is much pain, smeared thinly with oleate of morphia. This dressing is covered in with cotton batting and a bandage or binder.

Just here it may be well to speak of sloughs, granulations, and skin-grafting, but what is said applies to all wounds as well as burns. Under the antiseptic dressing sloughs are very slowly thrown off. It is our custom to excise them as soon as they become demarked. If properly done this causes scarcely any pain or bleeding and places the wound days and perhaps weeks nearer closure. By picking up the edge of the slough with a pair of forceps, and cutting with knife or scissors through its readily apparent junction with healthy tissue, it is easily accomplished. By this same process I have successfully, and without pain or hemorrhage, amputated even fingers and toes which we had attempted to save. All forms of exuberant granulations are usually shaved of with a sharp knife. The moist bichloride dressing, applied without the intervention of protective, is found to produce ample stimulation, if such is indicated. If skin grafting becomes necessary, a patch of thin skin is selected and made aseptic, as is also the granulating surface, if it is not so already. Almost microscopic pieces of the cleansed skin are

then cut out by means of a purified needle and a pair of scissors, and planted among the granulations. Narrow strips of protective are applied, and upon this is passed either the "house dressing," or simply a pad of dry 1:1000 cotton. Any bichloride solution remaining about the parts should be washed of with distilled water before the grafts are cut and set, and strong solutions should not be used while the islets of epithelium are forming.

Leg ulcers, when small, are stimulated, if necessary, by scoring with a sharp knife, nitrate of silver stick, etc.; dusted with iodoform; accurately fitted with a piece of protective, and gauze dressing put on with a firm roller. If they are large, and have callous edges, these latter are trimmed off, the sore curetted, perhaps straps applied after the iodoform and protective, and then the same dressing. By this method they can always be kept perfectly sweet and clean; the discharge is but slight, and the pain still less. If the ulcers are very irritable, and will not bear the gauze dressing boracic acid ointment is substituted for it. Those painful, non-ulcerative conditions of the legs so often met with behave excellently under one or the other of the above dressings.

In such regions where it is impossible to apply or retain a regular dressing, great pains are taken in the cleansing before and after an operation, and iodoform in conjunction with frequent corrosive sublimate irrigations is freely used afterward. Especially are these applications valuable about the genito-urinary organs and rectum. In females after most operations thereabouts, the vagina is washed with 1:1000, and then filled with iodoform. Beyond an occasional irrigation of the external parts, nothing more need be done until the stitches—if they have not been of catgut—are ready for removal.

Chancroids heal wonderfully if kept buried in iodoform; sometimes they are previously brushed over with acid nitrate of mercury, etc. No treatment is directed to hard chancres unless complicated.

Body parasites are destroyed with 1:500 corrosive sublimate solution. No unpleasant effects have been known to follow even the freest use of the solution in this way. If the ear has been invaded, it is syringed with that solution, and then filled with oleate of morphia, and a little wad of cotton put on top.—*American Medical Digest.*

ELECTRICITY IN OBSTETRICS.

Dr. W. T. Baird, in the *Am. Jour. of Obstetrics*, concludes an article on the above subject by way of recapitulation, as follows:—

Apparatus.—Any good, reliable induction apparatus will answer, but it *must* be reliable and in perfect order, otherwise it will most likely fail at the very moment its services are most required. 1

use one which was manufactured by Dr. Jerome Kidder for Dr. Heed and myself sixteen years ago, and it is still reliable, although having been in constant use during all that time. This is the one he calls "The Physician's Visiting Machine": but when it is not convenient to carry one so bulky, I use a "Pocket Induction Apparatus," also manufactured by J. Kidder. This is very convenient, and gives all the current which could be required in any case. The only objection to it is that, if its use is required for longer than one hour, it will be necessary to re-charge it.

Electrodes.—I use one small copper plate, one and one-fourth inches wide and five inches long, one large surface sponge-electrode, and also one wrist electrode.

Application.—As soon as I deem it necessary to make the application, I do so in the following manner: The patient is placed in a dorsal position. I then attach one cord to the copper plate, and covering it well with a napkin wet with warm water, apply it to the sacro lumbar region. The other cord I attach to the wrist electrode. I now set the machine in action and attach both the cords to it,* the one connected with the plate to the positive pole. Then slide it under the bed or couch, where it and the cords will remain out of the way of the necessary attendants. The wrist electrode I now attach to one of my wrists (first covering the wrist with a napkin wet with warm water), then close the circuit by applying the hand (well moistened with warm water) of that wrist to the abdominal parietes.† By this means I am able to determine the exact condition of the uterus, and to note correctly all the changes which may occur in its contour, and I can also estimate the amount of increase which occurs in its contractions, and I am also enabled to perform uterine manual pressure, and if it is necessary to use both hands for this purpose, it can readily be done, and each hand then conveys the current to and from the uterine walls. When the application is made in this way, it enables the operator to estimate correctly the strength of the current which he is applying, and the hands being much more sensitive to the current than the abdominal walls, as long as he continues the operation through his hand, there will not be the slightest danger of his producing any unpleasant effects upon his patient, but on the contrary, a current as strong as can be borne ordinarily by the operator's hand will have a pleasant and soothing effect upon her. If an operator were timid, or could not bear a current of sufficient strength through his hand to be effective, he could then use a large surface sponge electrode in place

of his hand, but if he does this, he should first test the strength of the current with his hand before applying it, in order to be very certain that it was not too strong at the commencement, as otherwise he might induce painful spasmodic contractions of the abdominal muscles, which would be most likely to cause a hasty suspension of the experiment. It is always best to begin with very mild currents, and gradually to increase them to the desired strength. I always make the application with the hand *continuous* until a sufficient amount of sedation is produced (from five to thirty minute), then I open the circuit by removing my hand, during the interval between the pains, and close it again when the pain recurs. In short, after all reflex pain has been subdued, and the patient rests well in the intervals, I then *only keep the circuit closed during the time occupied by the rhythmical contractions of the uterus.* By this intermittent application, we are effectually guarded against the danger of destroying the electro-muscular contractility of the muscles which we wish to stimulate and strengthen, and in my opinion it was owing to a neglect of this precaution which led to the results spoken of by Dr. Kilner when he said: "The current sometimes failed to produce contractions when most needed. After its use for an hour or one and a half hours, its sedative effects were manifest, but it no longer increased the uterine contractions." Now, it is evident to me that, if he had used it for an hour or an hour and a half continuously, he had produced a condition of paralysis or destroyed the electro-muscular contractility of the muscular fibres of the uterus, and therefore the current was powerless to longer increase the uterine contractions.

Beard and Rockwell say: "Experience shows that the effect of electrization, *if not too long continued*, is to give tone to the muscles." (Italics mine).

I have used it in this manner, in tedious labor, for twenty-four hours; and during all this time it furnished to the nerves and muscles all the elements of increased *strength and rest*, as was fully evinced by the ability of the patient to withstand her pains, and by her earnest desire, often reiterated, "not to allow her to have a pain without closing the circuit." Whenever it becomes necessary for me to support the perineum (and often sooner, if I need rest), I instruct a nurse or friend how to make the applications, to open and close the circuit, being careful to direct her that with each recurring pain to change the location of the electrode, so that *all* the muscles engaged may be brought *directly* under the influence of the current. As soon as I wish to facilitate the labor (at the beginning of the second stage), I use a current of as much force as the patient can bear with comfort, and in practice it will be found that the stronger the current used in this stage (short of

* The wrist electrode may be dispensed with by taking any common electrode in one hand, and applying the other hand to the abdomen of the patient, allowing the current to pass through both arms of the operator.

† Using 1st and 2d coil (B D current) of the apparatus.

producing spasmodic contractions of the abdominal muscles) the better it will suit the feelings of the patient. After the perineum is well dilated, I moderate the force of the current, and in cases where I have any reason to apprehend danger to the integrity of this structure, I withhold it entirely for a few minutes prior to the escape of the foetal head from the vulva, so as not to hasten unduly the labor at this stage, and to give ample time for its full, free and safe dilatation. As soon however as the head escapes, I direct the circuit to be closed *most* of the time until after the completion of the third stage of the labor, which in nearly all cases occurs with but little or no assistance in a very few minutes. In all of my cases in which I have used it, the placenta has been expelled in from one to ten minutes from the birth of the child, with very slight or no traction upon the cord. This I regard as more simple, far less painful, and fully as speedy and efficient as Prof. Credé's method.

INJECTION OF ETHER AND IODOFORM INTO COLD ABSCESSSES.

The use of iodoform has been of such marked advantage in the treatment of wounds that it is not surprising to find its employment extended to the treatment of lesions beneath the surface, such as cold abscesses. Of the vehicles which have been used, glycerine has certain disadvantages, on account of its density and the difficulty of bringing it into intimate contact with the whole of the abscess wall. Ether has the great advantage of being an admirable solvent, and so fluid that it can penetrate where glycerine cannot. Besides this, it is believed that its vaporization by the heat of the body causes a further penetration and serves to convey the iodoform into the deepest recesses and most intricate sinues.

The injection of iodoform dissolved in ether into cold abscesses was first brought prominently to the notice of surgeons by Verneuil, at the Congress of French Surgeons in 1885, and since then it has been used to a considerable extent, in France especially. Recently Verchère, in the *Révue de Chirurgie*, has called attention again to its advantages, and given an account of its use in twenty-three cases, including abscesses connected with disease of the bones of the thorax, pelvis, and spinal column, of the humerus, of the femur, of the elbow, and of the carpal bones, and abscesses in the neck, and in the temporal fossa. In all of these cases, except one, the treatment was followed by prompt improvement, and by more or less complete recovery. In one case death followed from causes unconnected with the treatment, and this furnished an opportunity to demonstrate how thoroughly the iodoform had been deposited upon the entire wall of the abscess.

It appears from the reports of Verchère that this method is of special value in the treatment of tubercular abscesses. The iodoform seems to have a specific action upon tubercular deposits, and may act constitutionally as well as locally, since there is abundant evidence that it is absorbed when injected into an abscess, and its internal administration appears to be beneficial in general tuberculosis.

The method of Verneuil consists in evacuating the whole or a part of the contents of an abscess by means of an aspirator—or of a hypodermatic syringe, if the abscess be very small—and in injecting through the same tube a suitable quantity of iodoform-ether. Two dangers accompany these injections: 1. That of too great distention from the expansion of the vaporized ether. 2. That of iodoform poisoning. Verchère saw a case in which the distention of an abscess in the front of the neck was so great that symptoms of suffocation, from compression of the trachea, appeared, and another in which the whole of the scalp was raised from the bone. In both of these cases prompt relief was afforded by introducing needles of hypodermatic syringes, which permitted the escape of the ether vapor. The danger of iodoform poisoning is to be avoided by using only moderate quantities of iodoform. Verchère considers a drachm to be the maximum quantity which can be used with safety. In large abscesses about one and a half fluid-ounces of a five per cent. solution may be injected; in small abscesses a ten per cent. solution, or even a saturated solution may be used. In the case of very small abscesses with thick contents, Verchère employs the following ingenious method. He introduces the needle of a hypodermatic syringe into one part the abscess and leaves it in place, while at another point he evacuates the abscess through an aspirator and closes the aperture with collodion and gauze; when this is done, he injects the ether through the hypodermatic needle.

It is important, where it is possible, to prevent the escape of the ether vapor after the injection, and this is accomplished by closing the opening with collodion and gauze, as stated above. As the iodoform remains a long time in an abscess cavity before it is wholly absorbed, the injections should be repeated, if necessary, only after a considerable interval; Verchère advises once a month in cases of large abscesses in which the skin does not give way, until a cure is effected. This may require six or more months. When the skin does give way after the injection, the sac is eliminated as a sort of slough, and the cure is more rapid. The observation of this fact leads Verchère to suggest opening the sac as part of the treatment.—*Med. News.*

In England two doctors die for every clergyman.

THE TREATMENT OF RHEUMATIC FEVER.

The Medical News has presented its readers with brief reports on the methods employed in the treatment of rheumatism in the chief hospitals of Philadelphia, New York, and Boston.

For a knowledge of the natural history of rheumatic fever uninfluenced by drugs we are indebted to the late Dr. Flint, who treated thirteen patients in Bellevue Hospital with infusion of quassia, and to Dr. Sutton, of London, who treated a large number of cases with mint water. The observations of the latter physician, in conjunction with Sir William Gull, deserve a more thoughtful consideration than has been afforded them by many clinicians, as they are of primary importance in enabling us to judge of the effect of medicine on the disease.

Since the introduction of salicylic acid in 1875, this remedy and its compounds have been universally employed in rheumatism, and about sufficient time has now elapsed to permit us to arrive at a safe judgment of its uses. On looking over the reports, we find that in some form or other it is still employed in every one of the hospitals represented, and we ask for no better guarantee of its merit than this one fact. As a rule, a decade plays sad havoc with a drug announced with the *éclat* which attended the introduction of salicylic acid, but the experience of many physicians the world over seems to have accorded it a safe place in the therapeutics of rheumatism. The early anticipations, however, that we had in it a specific have not been realized, and too rapid cures have been expected. The elaborate analysis by Palmer Howard in Pepper's *System of Medicine*, vol. ii., seems to indicate very surely that cases treated by this method do not get better any quicker than on the old alkaline plan; indeed, if statistics are worth anything, they show that the cases do not get well so soon. Cardiac complications are probably more frequent, though in the reports we have published Dr. Loomis alone suggests that the effects of the acid favor their occurrence. It is a very general opinion, also, that under the salicylate treatment relapses are more frequent. Unquestionably the most striking action of the drug is in the relief of the pain and the reduction of the temperature, so that the extreme suffering and the general misery of the patient are promptly relieved. Upon these manifestations of the disease it often acts "like a charm," and possibly relapses are in many cases brought on by careless exposure or errors in diet in patients whose acute symptoms have been removed while the *materies morbi*—whatever that may be—still remains in the system. A combination of the salicylates and alkalis has probably a more decided effect upon the disease than either

remedy alone. Dr. Kinnicutt, as shown by the report from St. Luke's Hospital, New York, continues to have good results from the use of oil of wintergreen, which seems to act almost as promptly as salicylic acid, of which it is a methyl ether.

That rheumatic fever is essentially a self-limited disease, and is not materially influenced in its *duration* by drugs, is an opinion fully justified by a comparison of the reports of Sutton with those of the various writers who have published the results of the alkaline and salicylate plans of treatment. We have been too ready to mistake the relief of symptoms for the cure of the disease.

The reports do not refer very fully to the use of antipyrin in this disease, which is spoken of by recent German writers as a specific. It would seem, like the salicylates, to reduce the fever and to relieve the pain, and so far it may be specific, but we require further evidence to show that it really limits the course of the malady. Frankel, in *Deutsche medicinische Wochenschrift*, Nos. 43 and 44, speaks very highly of its value in thirty-four cases, but acknowledges that in certain cases it cannot replace the salicylates.

HOW TO TREAT HÆMORRHOIDS BY INJECTIONS OF CARBOLIC ACID.

Dr. Charles B. Kelsey, of New York, thus sums up his method of treating hæmorrhoids:

1. Use only the purest crystalized carbolic acid, the purest glycerine, and distilled water in the preparation of solutions. The glycerine is added to the solution of carbolic acid in water in just sufficient quantity to make a clear fluid, and the amount is not important. As soon as a solution begins to assume a yellowish tint it should be replaced by a fresh one.
2. Use only the finest and most perfect hypodermic needles and a perfectly-working, clean syringe with side handles. After each injection when the syringe is put away, clean it thoroughly to be ready for the next time.
3. The treatment may be applied to every variety of internal hæmorrhoids, no matter what their size. It is not applicable to external hæmorrhoids, either of the cutaneous or vascular variety, both of which may be treated by better means.
4. Before making an application give enema of hot water, and let the patient strain the tumors as much into view as possible. Then select the largest and deposit five drops of the solution as near the centre of the tumor as possible, taking care not go too deep so as to perforate the wall of the rectum and inject the surrounding cellular tissue. The needle should be entered at the most prominent point of the tumor. If the hæmorrhoid does not protrude from the anus, a tenaculum may be used to draw it into view. After the injection has been made the parts should be replaced, and the patient kept under

observation for a few minutes to see that there is no unusual pain. The injection will cause some immediate smarting if it is made near the verge of of the anus; if made above the external sphincter, the patient may not feel the puncture or the injection for several minutes, when a sense of pressure and smarting will be appreciated. In some cases, no pain will be felt for half an hour, but then there will be considerable soreness, subsiding after a few hours. If it increases, instead of disappearing, and on the following day there is considerable suffering, which may not perhaps be sufficient to keep the patient on his back but is still enough to make him decidedly uncomfortable, it is a pretty good indication that a slough is about to form. For the reason that it is impossible to tell absolutely what the effect of an injection is to be until at least twenty-four hours have passed, it is better to make but one at a visit and to wait till the full effect of each one is seen before making another. If on the second day there is no pain or soreness, another tumor may be attacked, and this will often be the case. 5. The strength of the solution must be regulated by the nature of the case, and in my own practice varies from five per cent. to pure crystalized acid. In a large, vascular, prolapsing tumor, which is well defined and somewhat pedunculated, five drops of pure acid may be used with the expectation of producing a circumscribed slough which will result in a radical cure. A thirty-three per cent. solution under the same conditions will probably produce consolidation and shrinkage without a slough, but the injections will have to be repeated several times. A small tumor which protrudes but slightly, is not pedunculated, and can be seen and felt as a mere prominence on the mucus membrane, may be cured by a single injection of a five per cent. solution, which will cause it to become hard and decidedly reduce its size, while an injection of a fifty per cent. solution might make considerable trouble, the remedy being too powerful for the disease. Guided by this principle, some experience will soon determine the choice of the solution. There is no arbitrary rule which can be applied to every case. As in any other surgical operation, some will be more satisfactory than others, and an occasional accident must be expected; but, on the whole, it seems to be the best method of treatment yet devised.—*N. Y. Medical Times.*

DISCUSSION ON TRANSIENT ELEVATIONS OF TEMPERATURE AFTER DELIVERY.

Dr. Hanks opened the discussion. He considered it very difficult to tell, within the first twelve hours after delivery, whether a rise of temperature was due to septic or malarial influence

If, on careful examination of the genital tract, he found a laceration of the cervix or perineum, or an œdematous state of the vagina around the cervix, he was inclined to attribute the rise of temperature to the absorption of septic matter. In case the uterus was large, and the lochia fetid, he resorted to the douche.

Dr. Rodenstein stated that a chill coming on suddenly and followed by sweating was apt to mean malaria. A strong point in differential diagnosis he considered to be the state of the external os. In sepsis, he had noticed that the os was always patent; in malaria, usually closed.

Dr. Patridge stated that the pelvic organs should be carefully and thoroughly examined, not alone once, but repeatedly, for frequently the second or third examination would reveal a cause not appreciable on the first. If, finally, he could find no cause for sepsis, he then concluded he was dealing with malaria. When we remembered how much constitutional disturbance might result from a simple abrasion on the surgeon's finger, it was amply evident how a slight lesion of the cervix, for instance, might be overlooked, and yet be at the bottom of septic infection.

Dr. Murray had never seen a case in which careful examination would not reveal some cause for the elevation of temperature, aside from malaria. He pleaded for careful examination of the genitals, both external and internal, and recalled the fact that a patient might have a large plastic exudation without much febrile disturbance, and yet this be entirely overlooked if a vaginal examination was not made. He had noticed the fact that in every case of sepsis the external os was patent, but he believed that the prime differential point between malaria and sepsis lay in the fact that in the latter there was never complete remission in the temperature, and that generally there were two exacerbations daily. The constitutional depression also was greater in sepsis than in malaria.

Dr. Mundé stated that it was his habit to assume rise of temperature after delivery as probably due to septic absorption. Patency of the external os to him signified something within the uterus—remnant of placenta, or decomposed clot. He had recently seen a case in a pronounced malarial neighborhood, where the patient's temperature was 104°, the pulse 130, the facies bad, the lochia very offensive, the uterus large, the os admitting three fingers. With his long curette he had removed a mass of offensive blood clot at the placental site, washed out the uterus, and given antipyrene and applied the ice-coil. The temperature was lowered, but for three days there had since occurred chills and rise in temperature which he was now inclined to believe were due to malaria. Malaria, he was well aware, was a hobby with some gentlemen, as was evident in a

case he had recorded a few years ago, where one of his consultants clung to the diagnosis of malaria in the face of a metastatic abscess on the wrist. This case he had considered pure septic pyæmia. He was convinced that peri-uterine exudations were often overlooked, for the simple reason that careful vaginal examinations were not resorted to. These were, of course, the very cases where intra-uterine irrigations would be productive of harm instead of good.—*Am. Jour. of Obstetrics.*

THE MANAGEMENT OF PLACENTA PRÆVIA.—1. In any case, avoid the application of all chemical styptics, which only clog the vagina with inert coagula, and do not prevent hemorrhage. At the very first, the patient should be put in a state of absolute rest, body and mind, and a mild opiate is often desirable at this stage, to quiet irritation.

2. Inasmuch as the dangers from hemorrhage are greater than all else, to both mother and child, at the earliest moment preparations should be made to induce premature labor, and labor being once started, the case should be closely watched to its termination by the accoucheur.

3. In primiparæ and mothers with rigid tissues, the vagina should be well distended, by either the colpeurynter or tampon, as an adjuvant to the cervical dilatation.

3. In the majority of cases, and in all cases, especially where there is reason to believe that rapid delivery may be required, it is more safe to rely on the thorough, continuous, hydraulic pressure of a Barnes' dilator than on pressure on the fetal parts.

5. Where the implantation is only lateral or partial, and where there is no object in hurrying the labor, bipolar version, drawing down a foot and leaving one thigh to occlude and dilate the os, may be practiced, according to the method of Braxton Hicks, except in cases where the head presents well at the os, when,

6. The membranes should be ruptured, the waters evacuated, and the head encouraged to engage in the cervico-vaginal canal.

7. In the majority of cases, podalic version is to be preferred to the application of the forceps within the os.

8. In some cases, in the absence of assistance or the necessary instruments, the complete vaginal tampon, in part or wholly of cotton, may be applied and left *in situ* until (within a reasonable time) it is dislodged by the uterine contractions and the voluntary efforts of the mother. In cases of favorable presentation—occiput or breech—the tampon will not materially obstruct the descent of the child, and in some cases the tampon, placenta and child will be expelled rapidly and safely without artificial assistance.

9. The dangers of septic infection by means of

the tampon or india-rubber dilators are so slight, if properly used, as not to be considered as seriously impairing their great value.

10. Whenever it is possible, dilatation and delivery ought to be deliberately accomplished, in order to avoid maternal lacerations.

Finally. As cases of placenta prævia offer special dangers from post-partum hemorrhages, septicæmia, etc., the greatest care must be exercised in every detail of operation and nursing to avoid conveying septic material to the system of the mother. M. McLean in *Am. Jour. Obstetrics.*

BICHLORIDE OF MERCURY IN UTERINE CATARRH.—I have been using a solution of bichloride of mercury as an application to the cervical canal and uterine cavity in cases of chronic mucopurulent discharge. Originally it was suggested to my mind by some considerable success with the same agent in gonorrhœa, as recently recommended. The suspected relation between many chronic inflammatory conditions of the female genital organs and gonorrhœa still further suggested the use of the bichloride, though in much stronger solution. One-half to one grain to the ounce of water was the strength I employed, and, on trying it, my success was so much better than ever before that I have continued to use it in all possible cases of the kind. It has several manifest advantages. Applied with the cotton-wrapped applicator, it excites no immediate uterine contraction, as iodine, carbolic acid, and other agents generally do. This enables one to make two, three or more applications in rapid succession, and affords a much better chance for reaching the entire endometrium. It leaves behind it no coagulated mucus, or film of chemically-altered epithelium, as carbolic acid and nitrate of silver do, to be detached and expelled subsequently by a process almost necessarily involving fresh supuration. A similar solution may, as a final measure, be applied to the whole vaginal membrane as the speculum is withdrawn, and irrigation with hot water or a very weak solution of bichloride continued for some days. In obstinate catarrh of the cervix, with almost endless ropy secretion, I have also had good success, while I do not remember, after many trials, any success worth mentioning with any agent employed previously. In nearly all the cases two or three applications entirely checked discharges of long standing. Sometimes they recurred at the monthlies, but were again checked for good apparently by another application. In two cases single applications did the work, and out of the twenty-three cases treated solely in this way, two only resisted treatment, and were complete failures.—*Dr. Watson, Therapeutic Gazette.*

AVIAN TUBERCULOSIS.—The study of comparative pathology will, it may be hoped, ere long at-

tain to the proportions that its importance as an aid to the understanding of disease demands; and although we have not hitherto derived such assistance in medicine as its thorough prosecution would render possible, there is, notwithstanding, some trustworthy evidence forthcoming to show that this reproach in the past will cease to have weight in the future. For one thing, it may be urged in defense of our present ignorance on the subject, that the conditions necessary to successful study of disease in animals have, in effect, to be made, and that whoever would enter on it with any satisfactory prospect of advantage therefrom, must first, of necessity, take steps for acquainting himself with details, zoological and morphological, which can only be acquired by a special and prolonged education. Fortunately, however, there are not wanting in this age spirits able and willing to undertake the huge task that such a devotion implies; and among the band of workers in this field of investigation, Mr. John Bland Sutton, F. R. C. S., has already made considerable advances in this country. We have already been able to publish in these columns some of the results of Mr. Sutton's observations; and we have now to draw attention to a very valuable essay contributed by him to our American contemporary the *Journal of Comparative Medicine and Surgery*, on the subject of tuberculosis in birds. The observations embodied in this paper extended over a series of years, and were principally carried out in the gardens of the Zoological Society of London, where the author has long enjoyed the privilege of making *post mortem* examination of the animals dying in confinement there. Mr. Sutton points out that one of the earliest conclusions to which he was driven, is that disease in animals observes a zoological distribution, and that as regards tuberculosis, the class almost peculiarly affected is that of which the food consists of grains, fruits and vegetables. It occasionally, however, is met with in birds of prey; but in this connection it is interesting and important to learn that it is conveyed to them from infected graminivorous or frugivorous birds forming part of their food. Other examples also are given of animals contracting the disease from their ingesta, and the suggestiveness of the conclusion thus arrived at will not fail to commend itself to medical men; nor can we fail to reflect on the significance of the fact, demonstrated now for the first time by Mr. Sutton, that grain-eating birds are in an enormous majority among those in which tuberculosis is developed; and from this to the danger of infection from such infected material the mind very readily passes. The paper to which we have alluded describes in careful detail the morbid anatomy and etiology of the tuberculous process in birds, and contains a vast amount of material of the highest interest to professional readers; and we heartily welcome it as a noteworthy addition

to the labors already so efficiently carried out in a neglected field of study by an exact and painstaking investigator.—*Medical Press*.

MEDICAL NOTES.

To disguise the odor of *iodoform*, the best agent is thymol.

It has been recently asserted that massive doses of iodide of potassium will cure *gonorrhœa*.

Dr. Longstreth affords patients suffering with *stomatitis* much relief by the local application of cocaine.

Nine or ten inches below the tubercle of the tibia is the place to amputate in order to get the *best stump* for the application of an artificial leg. (Prof. Brinton).

It may not be widely known that an extemporaneous liquor ammonii acetatis may be produced by simply dissolving the carbonate of ammonia in pure vinegar.

For the cough of *phthisis* :—

R—Terebene,
Creasoti, āā f ʒij.—M.

Sig.—Inhale fifteen or twenty drops from a hot sponge several times daily.

Do not let patient with *phlegmasia alba dolens* be moved before four weeks after the beginning of the disease. Use a bandage when patient begins to sit up. (Prof. Parvin).

In incipient *fatty degeneration of the heart*, and myocarditis, a combination of exceeding value is iron with nitro-glycerine. (Prof. Bartholow).

In *angina pectoris* the centesimal solution of nitro-glycerine seems to be mostly used with good results at the Jefferson College Hospital.

Next to ergot as a remedial agent to restrain *hemorrhage*, Prof. Parvin places *hydrastis canadensis*, gtt. xv-xx ter die. He has never seen any good derived from gossypium.

In the treatment of *gout* and those with a gouty constitution, Prof. Bartholow states that sulphate of manganese is a remedy of great utility, its virtue being chiefly due to its effect on the hepatic functions.

Prof. Parvin recently gave the following formula for *amenorrhœa* with anæmia, which he has used for many years, and in certain cases derived very satisfactory results :—

R—Terebinthinæ albæ,
Pulv. aloes,
Ferri sulph. exsic., āā gr. j.
Ft. pil.

Sig.—Ter die.

In *alcoholic nervousness* or hallucinations, Prof. Da Costa prescribed gtt. xv of the fluid extract of erythroxyton, ter die, and to increase to tolerance. Also—

R—Sodii bromidi, gr. xv
 Chloral, gr. x
 Syrup,
 Aquæ, āā q.s. ad f ʒj.—M.

Sig.—As required.

For *exophthalmic goitre* in a robust and plethoric subject, Prof. Da Costa prescribed:—

R—Tinct. aconit. rad., f ʒj.
 Tinct. zingiberis, f ʒj.
 Syr. simplicis, f ʒj.—M.

Sig.—Ten drops three times daily, for months, to be gradually increased as the patient will bear it.

Terebene has been much prescribed of late, in various lung troubles, at the Hospital. The following is a prescription given by Prof. Da Costa for *acute bronchitis*:—

R—Terebene, f ʒj.
 Mucilag. acaciæ, f ʒij.
 Morphina sulph., gr. ½
 Syrup tolu, f ʒj.—M.

Sig.—A teaspoonful every third hour.

THE DURATION OF INFECTIOUSNESS IN SCARLATINA, SMALL-POX, MEASLES, MUMPS, AND DIPHtheria.—There is one point I wish to raise in this discussion. We must distinguish infection from the person and that from clothes. We must know for how long infection is exhaled from the patient as well as the potency and duration of infection attaching to the cast-off *débris* of pathological processes induced by the disease. A case may be said to be first infectious and later contagious.

Infection is exhaled for a much shorter time probably than we have generally imagined. The question to determine is, for how long the pathological processes induced by the different diseases—for example, the desquamation of scarlet fever and the catarrh of measles—continue the carriers of the contagion. How long will the discharge from skin and mucous membrane bear infective properties?

I have reason to believe that personal infection, or exhaled infection, in contradistinction to infection by contact or inoculation of the disease products, has a definite duration, and that a special period of duration of this exhaled infection characterises each disease. On the other hand, many things are explained to hasten or hinder the elimination of infection with the characteristic discharges of the disease. The rules given, that scarlet fever is infectious as long as desquamation lasts, small-pox as long as every scab or scale re-

mains on the skin, diphtheria while sore-throat, or albuminuria, or discharges from mucous surface continues, are all open to question. Upon this hypothesis, we could never say when a person ceases to be infectious.

I would suggest that infection only attaches to those cast-off products of the disease when they were formed during its strictly infectious period: that, for example, the early desquamation of scarlet fever, and not the second or third peeling, is infectious; the primary albuminuria of diphtheria as well as scarlet fever, but not that which may remain for weeks or months or years afterwards. I hold that these pathological conditions and their products, induced in a characteristic way for each disease, are not any guides as to the continued infectiousness of a patient, and on this basis I would urge that a mild case is as long infectious as a severe one.

My observations make the duration of infection in the several diseases as follows: Measles, from the second day, for exactly three weeks. Small-pox, from the first day, under one month, probably three weeks. Scarlet fever, at about the fourth day, for six or seven weeks. Mumps, under three weeks. Diphtheria, under three weeks.—*Dr. Pearse in Br. Med. Jour.*

ADVICE TO YOUNG DOCTORS.—Dr. Robert Batty, in a recent address before the Atlanta Society of Medicine, thus spoke of the younger members of the profession: If you want to succeed in professional life, don't be too careful when a call comes to you to inquire into the circumstances of your patient, whether he is able to pay a good fee or not. Don't be too careful to prune closely at the outset and trim your practice into influential patients only, and all that sort of thing. Try to infuse within your own heart and soul a true spirit of benevolence, love of your kind, zeal in your profession, anxiety to relieve human suffering, and if you pursue your mission with your whole heart, with true earnestness of purpose, *somebody* will find it out, and it will not be a great while before a great many people will find it out, and they are not going to let you starve. That sort of men is too scarce to let starve. They don't starve in America. They can't be spared. If you want to be sure of your bread and meat and provender for your horse and something for the blacksmith and carriage man, take that recipe and try it awhile. I think I can say confidently, gentlemen, from the very first day that I practised medicine it has been a rule with me to give no thought for the morrow, what I should eat, wherewith I should be clothed. Consult the interests of your patients. Try and get them well in the shortest possible time and somebody will clothe and feed you and you will have an established practice and an established reputation. You will have the support and con-

fidence of the community in which you live.—*Practice.*

HYSTERIA IN A NEW LIGHT.—According to *The Lancet*, September 4, 1886, the views of Mr. de Berdt Hovell on the subject of hysteria are to be carefully received as those of a shrewd practitioner of long practice and large experience. He strongly protests against the whole hypothesis of hysteria. He thinks the theory that localizes the disease in the uterus is the mere survival of medical demonology, which located ill humor in the spleen, blue-devils in the liver, and the soul in the pineal gland. He claims for hysterical patients more fairness of treatment and more discrimination. He attributes many of the cases to shocks, physical or moral, leading to deficient or depressed nerve-power, with all that this implies in the way of pain, irritability, inability for locomotion, etc. Mr. Hovell admits that the cases are difficult to cure; but he maintains that if we are to deal with them effectually we must "set aside all consideration of the organs of reproduction, which most probably are not concerned, and transfer our attention to the moral nature." Mr. Hovell gives several cases in which there was a distinct history of shock or exhaustive work, to explain the breakdown in the nervous system. We live in days when the nervous system is getting its full share of attention from pathologists and physicians, and when even gynecologists are finding out that the uterus, and even its appendages, which are now blamed by some for everything, are not such culprits as has been supposed. Mr. Hovell will admit that the cases of so-called hysteria do occur chiefly, though by no means exclusively, in women. In their organization there is *something* specially favoring the occurrence of this state or disease. It may not be in the special organs of the female so much as in the special organization of the nervous system. Mr. Hovell deserves credit for insisting on this point, and he may well be satisfied to know that the drift of opinion among physicians is towards the acceptance of his views. Women are more finely strung than men. They are more liable to pain or pains of all sorts from mere functional causes. Such a constitution is perplexing to the physician, but it has to be considered, and not treated as a sort of crime, as has too often been the case.—*Medical Record.*

THE TRANSMISSION OF MEASLES FROM PLACE TO PLACE BY HEALTHY PERSONS.—The possibilities of carrying the contagious principle of measles from place to place by the medium of the bodies of healthy persons was recently discussed by the Medical Society of Berlin, and one gentleman, Mr. Joel, of Lausanne, presented certain facts which lead to the belief that such a possibility does exist, and that the medium is often furnished by physi-

cians themselves. One case which was cited was that of a boy who was brought from Geneva to Lausanne while he was passing through the incubation state of measles. The butcher and the postman who served the institution to which the boy was brought conveyed the disease to their children, who were attacked with it in a short space of time, and, what is quite remarkable, the children in almost every house to which the postman delivered letters were attacked. A little girl was brought to a hospital, and in a few days had undoubted symptoms of measles. Her father had paid her several visits before the measles appeared, and it was ascertained that two of his children were suffering at home with the disease. Eight other children in the hospital were quickly seized with it. It is thought the physicians cannot always avoid carrying the contagium with them, even when extraordinary care is taken. Prophylactic means on the part of the physician should be as thorough as possible, however, by disinfection, change of garments, and all other available procedures.—*The Archives of Pediatrics.*

INTUBATION OF THE LARYNX.—Dr. Northrup, Pathologist to the New York Foundling Asylum, thus concludes a paper in the *Medical Record* on Laryngeal Diphtheria and Intubation: Briefly, the advantages and disadvantages are estimated as follows, in order of importance: Intubation relieves dyspnoea due to laryngeal stenosis. There is no objection on the part of the parents and friends. The operation is comparatively simple, and free from danger and free from shock. No anæsthetic is needed, and no trained assistants. No fresh wound is added. The subsequent care of the case requires no trained attendant. The inspired air enters the lungs moist and warm. It does not preclude tracheotomy, and may be found useful as a guide upon which to cut.

Intubation has one conspicuous fault, attested by all. It embarrasses, and sometimes interferes with, the swallowing of fluids. The nourishment of the child is never more important. As a rule, however, the child learns to swallow fairly well, and many times has but slight embarrassment. There is likewise *one danger*, illustrated by one published case. It is the danger of pushing tenacious tracheal pseudo-membrane before the entering tube and blocking the trachea. I know of no death from this cause, but I believe it threatens every reinsertion of the tube after the pseudo-membrane has begun to soften, and is easily detached. The medical profession are called upon to relieve the urgent symptom of laryngeal diphtheria—dyspnoea. For such relief tracheotomy has been offered. The question now before us is, what part of the field intubation is capable of covering, and what advantages, if any, it has over the cutting operation. First, let us question close-

ly whether it meets the requirements. Does it relieve laryngeal obstruction? Waxham, with 96 collected cases, says it does. O'Dwyer, with 48 cases, says yes. Hance, with 5 cases, says yes. Jennings, with 4 cases, admits that it does. Northrup, with 12 cases, says yes. One hundred and sixty-five cases, carefully reported and well attested, say it relieves laryngeal dyspnoea promptly and effectually. Now, does it leave the patient without any of the advantages offered by tracheotomy? For the answer to this question we must look to results. Twenty-eight and one-half per cent. have thus far recovered, and in estimating the usefulness of the operation it must be remembered it is new, and while its advocates have been making these records they have at the same time been accumulating experience which will tell in future reports. Some of the accidents here mentioned are grotesque, and can never occur again. I do not mention tracheotomy records, because they are so variously estimated. Do you believe that if every case were collected the percentage of recoveries after tracheotomy would reach twenty-eight and one-half? If the number of cases is insufficient, we have not long to wait, for enterprising Chicago sends us the report of 96 cases. Intubation is in use in Kentucky, Indiana and Virginia.—*Gaillard's Med. Journal.*

CHLOROFORM VAPOR IN PAINFUL EAR CASES.—I would like to draw the attention of practitioners to the use of this vapor in ear cases, so that it may become better known and more frequently adopted, as at least a preliminary part of the treatment in cases in which intolerable pain is the chief complaint. I have very often used it with almost magical effects and very pleasing results in cases in which the pain in the ear was so great that the patient could not bear the parts to be touched even in the gentlest possible manner. In cases of furunculosis, and in diffuse inflammation of the external meatus, as well as in acute inflammation of the tympanic membrane, I have found it to relieve the pain so much that the patients considered themselves cured. In some cases the pain was kept in abeyance so long that the necessary manipulations and treatment were carried out without the least inconvenience to the patient, and in many cases there was no return of the distressing symptoms.

Its application I have also found exceedingly useful (in fact a complete cure) in cases of otalgia, in which, on examination of the ear by means of the speculum and mirror, no apparent cause for the pain could be ascertained. Again, in cases of neuralgia, where the pain is shooting all round the ear, and seemed to originate from it, the relief was permanent. Also, in cases of earache arising from carious teeth, as well as in cases of toothache of the molars, without any pain in the ear, it has proved very beneficial.

It is a very simple matter to introduce the vapor into the ear, and the only thing to guard against is the introduction of the chloroform itself, which might irritate the part and perhaps cause unnecessary discomfort.—*Robb, Brit. Med. Jour.*

ABDOMINAL SUPPORT DURING PREGNANCY.—I always advise patients in a pregnant condition to leave off their corsets (from about the fourth month onward, should I see them at that time), and having supplied the want of a corset by a suitable bodice, to wear a supporting belt with elastic sides, so arranged as to exercise a comfortable pressure, from below, on the muscles, and fitted with tapes or straps to relax the pressure as the uterus enlarges. In every case in which I have recommended this to be done, and where my directions were followed, the patient not only expressed herself as feeling far more comfortable, but I have remarked that the subsequent labor was of much shorter duration than usual, owing, I believe, to the support afforded in time to the abdominal muscles, and which by husbanding their tone and strength, enabled them to assist the uterus, in its efforts of expulsion, in a marked degree.

When engaged to attend primiparæ, I also direct the bandage to be left off at night, and the abdomen well rubbed with lard at bedtime. When this treatment is followed in primiparæ, I find there is little or no trace of the "linea albicantia" to be discovered after the patient recovers from the lying-in, and the abdomen also resumes its natural appearance, which the patient as a rule is the first to remark.—*Dr. Duke in Provincial Med. Jour.*

A NEW "CURE FOR CANCER."—*Dr. Velloso* lays claim to having cured several cases of epithelioma of the face and lips with the juice of *alvelos*, a plant which belongs to the family of *Euphorbiacæ*. It acted as an irritant, and destroyed the diseased tissue, which was quickly replaced by healthy granulations. Of the three different kinds of *alvelos* (male, female, and wild), the second is considered the most efficacious. It is found at Pernambuco, and although the natives have employed the juice for some time, it has not come into extensive use on account of the severe pain which it causes. The best results were obtained with the juice in a concentrated solid form, and with the addition of vaseline or lanoline. This preparation should be applied with a brush to the affected part (previously washed with a solution of carbolic acid), which should then be left exposed to the air for at least an hour. It should afterward be covered with lint. This treatment should, as a rule, be repeated every two or three days, and never more than once in twenty-four hours, as the pain of the application is severe. The treatment was more speedily successful when begun before ulceration had occurred.—*Brit. Med. Jour.*

VENEREAL INFECTION PRONOUNCED A CRIME.—

Some consternation may be caused among a certain class by a recent judgment of Justice Wills of the Central Criminal Court, England. The charge against the prisoner was on two counts, one with having carnal knowledge of an imbecile woman, aged eighteen, and another, under 24 and 25 Vict., c. 100, s. 47, for a "fraudulent assault" upon the same woman, occasioning her actual bodily harm. The harm done was the wilful infection with syphilis. The prisoner was found guilty on both heads, and sentenced to two years' imprisonment for the first, and five years for the second. The most remarkable piece of information is that a man who has immoral sexual connection with a woman, knowing himself to be suffering at the time from gonorrhœa or syphilis, is liable to prosecution and penal servitude.—*Med. & Surg. Reporter.*

WANTS TO STUDY MEDICINE.—Dr. J. B. Kell, of Delphos, O., writes: "Dr. S——, of our city, received the following letter, from a Reverend of Putnam Co., O., who desires to 'sudy medson.' I give it in full.

"H——, Putnam Co. O.

"Dr. S——.

"DEAR SIR: aS I think of StuDing medson, and am Aqanted With you by rep and aS you bore the name of A Criston I thout you Would be a good man to Sudy under and ASK you if there Would Be Eney Chance to Have you fore councele I will fernish my oan books and Bord Ples ancer By return male and I will come up Yours in crist.

"REV. R—— P——."

—*Med. Record.*

A NEW BACTERIOLOGICAL JOURNAL.—A new *Centralblatt*, devoted to the subject of bacteriology and animal parasites, will shortly appear in Germany under the editorship of Dr. Oscar Uhlworm, in Cassel. The extensive and rapidly increasing literature on these subjects, and the absence of any weekly journal devoted to this particular science, will render this venture acceptable to all who interest themselves in these matters. The contents of the journal will embrace references to recent work, historical essays and original papers. Dr. Uhlworm will be assisted by a numerous class of collaborators in the various European countries.—*Brit. Med. Jour.*

A coincidence showing a probable septic origin for pneumonia, is reported in the *Lancet*. On the 18th of October, a man and his wife were admitted into St. Thomas's Hospital, suffering from acute pneumonia of respectively three and four days' duration. Each was aged thirty-two years. The disease ran an acute course, being little influenced

by treatment, and they died at the end of four days within a few hours of each other. At the post-mortem examinations which were made on the same day, acute inflammation of the right lung were found in each; this had attacked chiefly the base in the case of the man, and the apex in the woman. It would appear that they had left their house, and moved into lodgings only two or three days before the commencement of the disease on account of the bad smells, making it probable that the disease was of septic origin.—*Boston Med. & Surg. Jour.*

AN English gentleman found a large turnip in his field of the shape of a man's head, and with the resemblance of the features of a man. Struck with curiosity, he had a cast made of it, and sent the cast to a phrenologist, stating that it was taken from the head of a celebrated professor, and requested an opinion thereon. After sitting in judgment it was reported that it denoted a man of acute mind and deep research, that he had the organ of quick perception, and also of perseverance, with another that indicated credulity. The opinion was transmitted to the owner of the cast, with a letter requesting, as a particular favor, that he would send them the head. To this he politely replied that he would willingly do so, but he was prevented, as he and his family had eaten it the day before with their mutton at dinner.

"LINES TO A TIMID LEECH."

Nay, start not from the banquet where the red wine foams for thee,
Though somewhat thick to perforate this *epidermis* be;
'Tis madness, when the bowl invites, to linger at the brink,
So haste thee, haste thee, timid one. Drink, pretty creature, drink!

I tell thee, if these azure veins could boast the regal wine
Of Tudors or Plantagenets, the draught should still be thine!

Though round the goblet's beaded brim plebeian bubbles wink,
'Twill cheer, and not inebriate. Drink, pretty creature, drink!

Perchance, reluctant being, I have placed thee wrong side up,
And the lips that I am chiding have been farthest from the cup.

I have waited long and vainly, and I cannot, cannot think
Thou wouldst spurn the oft-repeated call: Drink, pretty creature, drink!

While I watch'd thy patient struggles, and imagined thou wert coy,
'Twas thy tail and not thy features that refused the proffer'd joy.

I will but turn thee tenderly—nay, never, never shrink—
Now, once again the banquet calls: Drink, pretty creature, drink!

—*Chemist and Druggist.*

THE CANADA LANCET.

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STRICTURE OF THE URETHRA.

There is no subject in the domain of surgery of the urinary organs of greater importance than stricture of the urethra. The disease is a very common one, the treatment is much more complicated, and the prognosis is more grave than is ordinarily supposed. The victims of the disease are numerous and confined to no particular climate or locality. The poor sufferer is usually subjected to temporary treatment by local physicians. Year by year he grows worse until he is worn out by catheterization, bladder irritation, or other complications of kidney troubles, and at last falls a victim to a disease that on the onset seemed of little moment. A small urethral calibre would seem in itself of no consequence, and very little if any inconvenience, yet it is too often the warning note of a fatal termination. Every case of stricture, no matter how trivial in character, may be possibly grave in its results. Most physicians of ordinary experience can recall cases in which the stricture had been dilated and the patient discharged; in course of time it closed, the patient returned for treatment, with an almost impassable stricture, catarrh of the bladder and disease of the kidneys, and death ended the suffering. The profession is probably indebted to Sir Henry Thompson for more valuable suggestions regarding the careful and conservative treatment of stricture than any other surgeon who ever wrote upon the subject. He was among the first to point out the gravity of

strictures of the urethra, and understanding this so well, he was also able to treat strictures more successfully than surgeons who were in the habit of looking upon mild cases lightly.

In the treatment of all strictures, the first important thing is to give the patient to understand all about the consequences of an old narrow stricture, enjoining him strictly to keep himself under the observation of a competent surgeon. Sir Henry Thompson suggests that simple stricture, the history of which is recent, requires nothing save gradually restoring the calibre of the canal to its normal size by means of flexible bougies; for this purpose he used the style of bougie called "Olivaire," which were followed in severe cases by polished steel dilators to be used for an indefinite time. By carefully looking after a urethra treated gently in this way, no further trouble may be anticipated. The patient can be trained to the proper use of the bougie, and should be instructed to follow its regular use for years. When there is a narrowing or stricture of the external meatus, congenital, organic, or acquired, dilatation will not relieve it. Such strictures should be freely cut. Sir Henry Thompson further says that strictures three and a half or four inches from the meatus are not often benefited by dilatation, and in old age the same is usually true, the tissues having become rigid. Dilatation may however be first attempted in such cases. In all cases, in which there is a decided tendency to contract, despite the dilatation, internal urethrotomy should be at once resorted to. Prompt action, says the above named author, will save much suffering, avert perineal abscesses, fistulæ, and organic changes in the bladder, ureters, and kidneys. To delay until symptoms of such troubles appear, involves complicity in a course which irretrievably damages the patient's life.

There is another condition incident to strictures of long standing requiring probably a different course of treatment; we refer to septicæmia. We have had patients under our care, who, when first seen by us, had almost complete obstruction to the passage of urine by reason of an old rigid stricture, through which the smallest guide could not be made to pass. These patients usually show well-marked symptoms of septicæmia; the strictures are usually extensive, and the bladder complications a prominent symptom. In cases of this char-

acter, any attempt at gradual dilataion or internal urethrotomy only tends to increase the constitutional disturbance, and renders the prognosis more unfavourable. The urgency for a speedy relief is so imperative that the only hope for the sufferer is in external perineal urethrotomy. By this operation we can at once get into the bladder, and thoroughly wash it out; thus the patient is placed in a condition of temporary comfort, compared with his former condition. After restoring his health in a measure, and all the alarming symptoms have disappeared, the surgeon may proceed with the necessary operation to enlarge the urethra.

It is not possible, in any operation for stricture, to promise immunity from its return, although the more completely the contracted tissues are divided the more likely we are to have a certain cure. As a rule, the stricture will return, when the same treatment should be resorted to. Surgeons can not be too particular in reminding the patient as an injunction to not delay long in having the returning stricture treated after it manifests itself. By so doing, the implication of vital organs is avoided, and the patient is permitted to live out an average life in comparative comfort.

TREATMENT OF ERYSIPELAS.

Erysipelas is a well known specific inflammatory disease of the skin. It has long been known to be more or less contagious, but latterly Koch and Fehleisen have succeeded in obtaining pure cultivations of the erysipelas cocci, in inoculating them upon nutrient gelatine, and from the latter setting up erysipelas upon the living individual by inoculation. Hence the fungus or microbe of this disease is clearly established. Consequently it is essentially necessary that there be a previous wound or abrasion of the cutis or mucosa, in order that the morbid germ may obtain a starting point. The door must be opened or it cannot obtain an entrance. The wound may be and often is so minute that it escapes notice, and therefore a previous lesion cannot always be demonstrated. The local and constitutional symptoms are so well known that any reference to them would be superfluous. We shall therefore confine ourselves to the treatment.

At one time bad fluids in the stomach and intestines were said to be the cause, and emetics and purgatives were freely administered with the object of removing them. The peccant humors of the blood were long charged with being the cause not only of erysipelas but of most other pathological conditions, and consequently phlebotomy was added to the purgatives and emetics, and a great variety of alleged blood-purifiers was administered. This mode of treatment failing to accomplish the object, or to be followed by success, the theory of poverty of the vital fluid, the lack of fibrin, was promulgated and accepted as the chief cause of this, and many other kindred diseases. It was held that this was a simple inflammatory process, which spread, because there was not sufficient fibrin in the blood to form the necessary protective barrier. With this view, iron and quinine, with various other tonics, reconstructive remedies, abundant nourishment, and even stimulants were administered ad lib.; while argent nit., tr. iodine, lead lotions, incisions, and even the cautery were locally applied, with the idea of assisting to establish the necessary barrier to its extension.

This treatment was doubtless much better than the former and produced incomparably better results. An innumerable number of other remedies have all along been advocated as specifics, based on no particular theory, but used empirically. Among the many, we will mention but two which prolonged their existence upon the principle of the survival of the fittest, viz., aconite and belladonna. Many prominent physicians have claimed good results from the latter remedies, and confidently advocated their use. Among these we may mention Liston, Fleming, Thompson, Trosseau, Phillips, Bartholow, and Köhler. Even at the present, opinion appears to be divided with regard to the merits of the two methods of treatment, although we believe the large majority have more confidence in the former or iron treatment.

But within the last ten years, more attention has been given to the removal of all foci from which infection might originate, pure air and disinfectants, in brief, to securing the most perfect hygienic environment possible. And now that it has been established through the persistent work of Hueter, that wherever there is erysipelas, cocci are found, and where there are no cocci, there is no erysipelas, antiseptic treatment must supersede

every other. But, unfortunately, it was found that applying antiseptics externally was insufficient to prevent its advance. Hueter found that only when a 2% solution of carbolic acid in water was injected, so that the whole erysipelatous area was undermined, was the disease conquered, and the multiplication of cocci stopped. But this method was too severe, although unfailing in its results, and many experiments have been tried with a view of accomplishing as good results with less suffering and cruelty. Kraske recently advocated scarifying the erysipelatous area, and applying carbolised compresses, but this would be no less painful than the former. Very recently, Professor Von Nussbaum, of Munich, claims to have absolutely arrested the erysipelas without pain and in an easy manner. When erysipelas attacks a wound, or sets up at any point, after proper disinfection and covering it with a gauze compress, Professor Von Nussbaum paints the whole erysipelatous surface with ichthyol ointment, composed of equal parts of ichthyol and vaseline. He then covers the painted part over with 10% salicylic lint, and fixes it on with a hydrophilous gauze bandage. This has absolutely arrested the disease in every case. "In a word," he says, "all symptoms of active irritation were, as it were, charmed away and returned no more." He recommends ichthyol collodion in erysipelas of the face, and ichthyol soap when on the hairy scalp.

He does not claim any antiseptic power for ichthyol, but thinks it probable that its reducing action so starves the nutrient soil of the cocci, that it is no longer suitable for their multiplication.

If this treatment be found so wonderfully successful in other hands, a great boon has been conferred upon us, and the professor is entitled to the gratitude not only of the sufferers, but also of the profession.

DEGREES IN MEDICINE.

The Toronto School of Medicine has applied to the Legislature for University powers, so far as to enable that "Corporation by or through such member or members as they may from time to time elect or appoint for such purpose, to confer the degrees of Master of Surgery and Doctor of Medicine upon candidates.

It seems a very strange departure for a medical

school to take, and one undoubtedly calculated, were the powers sought for bestowed upon the school, to lower medical degrees very much in Canada. For were such powers given to one school, they could not with the least show of justice be withheld from any of the others, and it needs no prophet to predict the result of the erection of as many medical graduating bodies as there are medical schools.

Trinity School is also seeking a few slight amendments to her Act of Incorporation, of no importance, outside of the Corporation itself. In view of the bare possibility of the degree conferring power being given by the Legislature, to any school of medicine, the Corporation of Trinity School has petitioned that it is desirable that they should be placed on an equal footing with other medical schools and colleges in respect to the power to grant degrees in Medicine, Surgery, and Midwifery. A section has been added to the Trinity Amendment Bill making due provision in this direction. Let us hope that this section may not be rendered necessary. On looking at the *Ontario Gazette* it appears that the notice of the application of the Toronto School was published more than a fortnight before that of Trinity. We believe we are correct in saying that unless degree conferring powers are given to other medical schools, Trinity has no wish whatever to obtain them. But were they so given, not only Trinity but all other medical schools in Ontario, would of necessity have to obtain equal privileges. Now it is scarcely to be conceived that the Legislature will grant such powers to all the medical schools in the Province. The whole history of University education goes to show that where many institutions in a country are given university powers, the degrees become cheap and comparatively worthless, and the reason for such deterioration is on the surface. Such action on the part of the Legislature would be to throw us hopelessly backwards for years as regards medical education, for we know by experience how tenacious of life even the smallest and most insignificant of degree granting institutions are. The medical profession in Ontario occupy, under present circumstances, at least a respectable position. Let us hope that we shall never fall upon the evil days of the cheap and worthless degrees, which have so long disgraced some of the states in the neighbouring republic; but that our young men

from all medical schools, shall as heretofore, go for degrees in Medicine and Surgery, as well as in Arts, to our universities only.

ONTARIO MEDICAL COUNCIL.—The *Br. Med. Jour.* Feb. 5th, 1887, has the following comments on the proposed action of the Ontario Medical Council, in regard to British qualifications: "It is reported that the Medical Council of Ontario proposes to refuse to register diplomas obtained in Great Britain or Ireland, and to compel all persons holding such diplomas to submit to an examination before the Council. All persons registered in the United Kingdom have been entitled to registration in Ontario without undergoing further examination. The reason for this retrograde step is stated to be, that many students of medicine from the Province, after graduating in one of the universities, travel to England, where they spend one year in further study, and obtain an English qualification, on the strength of which they claim registration on their return to Ontario. As the Ontario Medical Council does not, we are informed, refuse to permit men to practise after a three-years' curriculum, it is not clear that the new regulation is framed in the interest of the public. The new Medical Act (1886) permits the registration of colonial diplomas in this country on and after next June, yet this is the epoch chosen by the Ontario Medical Council to impose a vexatious regulation. What name must be applied to such a course? It is not reciprocity, for the Province withdraws a privilege at the moment that the Old Country grants a privilege; perhaps it is to be styled retaliation. Has not La Rochefoucauld a maxim to the effect that the surest way to turn a friend into an enemy is to do him a service?"

TYPHOID FROM A SINGLE DRAUGHT OF WATER.—M. Dujardin-Beaumetz, reports (*Br. Med. Jour.*), the case of a family which was stricken with typhoid by drinking once of water from a contaminated well. They had rented a house at a fashionable resort, and *then* were warned that the water was dangerous. As a result of such warning, no member of the family used the water until the last day of their stay, when the artificial water they had been using being exhausted, the wife said: "For once, surely, there can be no harm in drinking the well-water." Out of nine persons who

partook of it, six have since died from typhoid. On examination, the water was found to contain the bacilli said to be causative of typhoid fever.

PATHOGNOMONIC SIGN OF CANCER OF THE STOMACH.—German writers have held that in cancer of the stomach, hydrochloric acid is always absent. This has been corroborated (*Lancet*) by M. Debove, who finds such a condition to be constant in cases of cancer, and he proposes such it shall be a pathognomonic sign of malignant disease of the stomach. He says hydrochloric acid is constantly present in every other form of indigestion. In the case of a patient shown by him to the Société Médical des Hopitaux, the diagnosis of cancer was made by this means when no other symptom was present, though there is now no doubt as to the nature of the disease. M. Debove proposes that the liquid shall be obtained from the stomach by means of the œsophageal tube, and tested for HCl. Among other tests mentioned is the German one of a solution of gentian violet, 1 to 5000, which gives a blue color with HCl.

CHRYSOPHANIC ACID IN ACNE.—Dr. Metcalfe (*Boston Med. and Surg. Jour.*) highly recommends this agent in acne. He says he has not failed to cure perfectly any case in which the treatment has been adopted. The face is to be washed with soap and well dried, at night. Before retiring, the parts in which the acne is, are to be well rubbed with an ointment of 3 grains of the acid to the ounce of vaseline, and this is repeated nightly until a sharp inflammation of the skin ensues. The inunction is then omitted till the dermatitis is gone, when it is repeated. In most cases a 3-grain ointment is of sufficient strength, but occasionally the strength is to be increased up to 5 grains to the ounce, or even more. The patients are to be cautioned about the staining of their fingers and clothes and to guard their eyes.

CONTAGIOUSNESS OF TETANUS.—The idea that tetanus is contagious is gaining ground. The *Lancet* mentions an interesting paper, read by M. Langer, in which he seems to show clearly that the disease is contagious. He mentions the case of four patients who died of tetanus, after different wounds which should not have produced serious trouble, but who were placed in contiguous beds. Another case is cited in which a veterinary sur-

geon had an epidemic of tetanus in horses, five of which died after castration by an écraseur used on a horse that died of tetanus. The écraseur was then disinfected by heat, and no tetanus was produced in animals on which it was afterwards used.

THE SIR ERASMUS WILSON BEQUEST.—A round-robin has been signed by a large number of the leading medical men in London, and sent to the council of the Royal College of Surgeons, asking that a part of the Sir Erasmus Wilson bequest be appropriated to the establishment of an institution under the direction of the College, which shall have for its object "Physiological and Pathological research." They note the fact that such an institution has long been needed, and that Englishmen have now to look to Berlin, Paris and the other continental cities for the newest developments of physiology and pathology.

REDUCTION OF DISLOCATION OF THE HUMERUS BY RIGHT-ANGLE TRACTION.—We notice several reports in the various journals, relative to the ease with which shoulder dislocation may be reduced by Mr. McLeod's process. It consists in making traction at right-angle to the patient's body, steadying the body by the foot, or by any other means the operator chooses. All who have attempted it, seem to regard it as highly successful, the reduction being obtained with the minimum amount of pain and force. The characteristic "snap" is sometimes wanting.

SALICYLIC ACID IN CHANCROID.—The above drug has been recommended by numerous authors in the treatment of chancroid. The sore should be first washed with some antiseptic fluid, and then dusted with finely pulverized salicylic acid. This should be repeated twice a day for four or five days, when the sore will usually have been converted into a simple ulcer. Then nothing more is required than the employment of say a boracic acid lotion, under which it rapidly heals. This plan causes little pain or inconvenience of any kind, and can be carried out by the patient himself.

EXPERT TESTIMONY.—Dr. Darby, of Morrow, O., has submitted (*Boston Med. and Surg. Jour.*) to two days' imprisonment, rather than recede from his position that he should not be called upon to give expert testimony without receiving an ex-

pert's fee. He answered as to questions of fact in the case, one of wife murder, but refused to reply to the question "whether in wounds like this there would be immediate gaping, or would the lips of the wound for a time remain in contact, or nearly so?"

OPHTHALMIA NEONATORUM.—The following is given (*Progress*) as an excellent collyrium in simple cases :

R Sodii boratis, gr. xv.
Sodii chloridi, gr. ii.
Acidi carbolici, mij.
Aq. destil.
Aq. camph. āā ʒj.

Sig.—Drop into the eyes *p. r. n.*

THE BINIODIDE OF MERCURY AS AN EMMENAGOGUE.—Dr. Illingworth, writing to the *Lancet*, says he has found the red iodide of mercury a certain and safe emmenagogue. He uses the following :

R Sol. hydrarg. bichlor, ʒj.
Potass. iodid. ʒss.
Ferri. amm. cit. ʒj
Ether chlorici, ʒij.
Aquam ad. ʒviij.

Sig.—ʒss. after each meal.

RESORCIN IN ECZEMA.—Dr. Chace (*Therap. Gaz.*) reports prompt and complete cures of eight cases of chronic eczema from the use of the following :

R Resorcine, ʒij.
Glycerin, q. s. ad. ʒij.

Sig.—Apply with camel's hair pencil morning and evening.

VOMITING OF PREGNANCY.—Dujardin-Beaumetz gives (*Jour. de Phar.*) the following for the uncontrollable vomiting of pregnancy :

R Cocaine hydrochlor. gr. viii.
Aq. destil. ʒ x, M.

Sig.—ʒj every hour.

ANTIPYRINE IN ULCERS.—Dr. Bosse reports (*Berliner Klin. Wochens*), the cure of several chronic ulcers by the application of Antipyrine for ten days, followed by an ointment containing 2 per cent of inhate of silver.

PULSATILLA IN ACUTE ORCHITIS.—Mr. Gerard Smith writes to the *Lancet* concerning the action of pulsatilla in inflammatory states of the testicle, epididymus and spermatic cord. He says it subdues the pain so rapidly that morphia is not needed, and that swelling and heat subside "more rapidly than under any other drug."

DEATH FROM PASTEURISM.—The death of a boy at Odessa is reported, from inoculation according to Pasteur's system. He died of rabies, about four months after the operation, though the dog which bit him is still alive, and up to the present time has shown no symptoms of hydrophobia.

INCISION IN TONSILLITIS.—Dr. Maclean recommends (*Br. Med. Jour.*) the early incision of the tonsils in quinsy. He has found that the free use of the knife results in a speedy abatement of all the troublesome symptoms.

VIBURNUM PRUNIFOLIUM IN ABORTION.—This remedy says the *Medizinal Zeitung*, has been lately again brought under notice by Wilson of Liverpool. He has used it with the most gratifying results, especially in cases where abortion was habitual. The author uses it in doses of 2 grs. four times daily, in pills or powders. Opium was only added when the contractions of the uterus were very painful.

HONEY AS A PREVENTIVE OF DIPHTHERIA. Dr. W. L. Smith, of Glanford, Ont., writes to say, that he has observed that where honey has been used freely as an article of diet, cases of diphtheria have not been met with. He would like to hear from his professional brethren on the subject.

BRITISH DIPLOMAS.—Dr. Charles Trow (Trin.), has obtained the L.R.C.P., London, and Drs. Edward Foxten, of Brockville, and Hewitt, of Toronto, have obtained the M.R.C.S. Eng.

APPOINTMENTS.—Dr. H. S. Clarke, of Lucan, has been appointed Coroner for the Co. of Middlesex.

Dr. C. E. Casgrain, of Winsor, Ont., has been appointed a member of the Senate, Ottawa.

Dr. R. P. Howard, of Montreal, has been elected Associate Fellow of the College of Physicians, Philadelphia.

PARTNERSHIP.—The friends of Dr. W. F. Chap-

pell will be pleased to learn that he has formed a partnership with Dr. A. H. Smith of New York.

For full particulars regarding the Medical Council Examinations, 1887, see advertisement.

SOZODONT.—This preparation consists (*American Analyst*): Soap, 5 parts; glycerine, 6 parts; spirits, 30 parts; water, 20 parts. Flavored with several cheap oils, and colored.

GONOCOCCI IN JOINTS AFFECTED WITH GONORRHOEAL RHEUMATISM.—Bergman has recently confirmed (*Centralb. F. Chirurg.*), the views of Neisser and Bockhart on this question. He found the organisms in abundance in the turbid fibrinous fluid taken from the inflamed joints.

J. B. JOHNSTON, M. D.

It is our painful duty to announce the death of Dr. J. B. Johnston, of Sherbrooke, on the 2nd of January, at the ripe age of 74 years. The deceased was educated in Edinburgh and took his degree of M. D. from Edinburgh University in 1833, after which he spent some time in the Hospitals of London and Paris. He came to this country in 1845 and settled in Sherbrooke. He had in a great measure retired from practice during the past few years. He was a man of superior education and good judgment, and was well known as one of the oldest and most respected practitioners in Canada. He leaves one son only, a worthy successor of a worthy man, Dr. W. G. Johnston, of Montreal.

A. M. DINGWALL, M.D.

We regret also to announce the death of Dr. Dingwall, of Glanford Ont., at an early age, after a protracted illness of two years. Deceased was a graduate and Gold-Medalist of Trinity University, Toronto. He graduated in 1873. He was also a graduate of Long Island College Hospital. He was a successful practitioner, greatly beloved and respected by those who knew him, and bore his long illness with Christian fortitude. His end was peace. He leaves a loving wife and two sons as well as many other near and dear friends to mourn his loss.

Books and Pamphlets.

DISEASES OF THE BLOOD AND NUTRITION, AND INFECTIOUS DISEASES; being Vol. IV. of "A Handbook of Practical Medicine." By Dr. Herman Eichhorst, Wood's Library for 1886; Illustrated: New York, Wood & Co.

This volume does not fall short of its antecedents in evincement of the wide erudition of this indefatigable author, who seems to have been inspired with the conviction that it behoved him to expatiate on the whole range of human morbidity, with that love of minute details which is the well known virtue of all German writers. It is questionable whether some of the fastidious class of readers might not be disposed to condone the oversight (had it occurred) of a few of his chapters, in which he has treated of diseases, the presence of which in Switzerland must be of very rare occurrence, if indeed it has ever been known. Take, as example, "Yellow Fever." How many cases of this dread malady could ever have come under the observance of the Zurich professor? Was not the medical world already as abundantly supplied with cyclopedic publications, as to have ungrudgingly dispensed with the author's two pages on a disease which has commanded the earnest study of a host of close observers and powerful thinkers, in countries in which it is an endemic resident, or to which it is an enepidemic visitant? It has been said that "brevity is the soul of wit." The reader who, probably thankfully, lights upon Professor Eichhorst's five terminal yellow fever lines, in which he despatches the momentous subject of "*Treatment*," may feel tempted to accuse him of possessing this unnatural German endowment; and as it holds good in our Hibernian fellow-countrymen, that keen wit and the faculty of uttering bulls are twin sisters, so when he finds the leading item of yellow fever *treatment* to consist in the following prescription, he may suspect that the author, or his fore-bearers, have once trodden the soil of the "Island of Saints." Here it is: "Ships, passengers and merchandize from yellow fever ports must be strictly quarantined and disinfected." This, of course was written for the instruction of foreign physicians—not for those of Switzerland, who do not see many ships enter their ports, and need not any quarantine laws to protect them from entrance of the scourge.

Three lines more, for the benefit, of course, of outsiders, dispose of the Swiss treatment of yellow fever. What a benefactor to oblivious Grecians would the author, or his obedient translator, have been, had he felt able to use simpler and shorter words throughout his learned treatise. Aged readers who have long ago forgotten the elements of the Greek language, as well as younger ones who never loaded themselves heavily with etymological spoils, find it trying on their patience, to have continually to search Dunglison for their mother tongue equivalents of polysyllabic jaw-breakers, which if boiled down would have sounded quite as euphonicly, and have averted much disquietude. If space permitted, we could furnish a pretty long list of these learned monstrosities; but as the book is one of high general merit, we may safely commend it, as a whole, to the kind verdict of the readers of our LANCET.

DISEASES OF THE LUNGS AND PLEURÆ INCLUDING CONSUMPTION. By R. Douglas Powell, M.D., Lon., F.R.C.P.; Physician to the Middlesex Hospital and to the Hospital for Consumption, at Brompton. Third edition, with illustrations; Wood's Library for 1886. New York: Wood & Co.

This is a book of great value. The author has had ample opportunity for the study of the diseases of which it treats, and no one who reads the work carefully will say that he has not availed himself of the advantages presented in the important professional positions held by him. The style is simple and clear, and the diction is equally free from prolixity and obscurity. Perhaps it may be thought by some readers that the space devoted to the various forms of phthisis—two-fifths of the whole volume—is comparatively long; but it is very natural, and indeed very laudable, that a "Physician to the Middlesex Hospital and the Brompton Hospital" should dwell at greater length on this terrible malady, not indeed, we fear, because of any great advance made of late years in its treatment, but with the view of rendering the etiology and pathology of the disease better understood by the general profession. That Dr. Powell has well succeeded in this relation no experienced or well-trained practitioner of medicine will question. Amid the deluge of new books now teeming from the medical press it is really comforting to light upon one that is worth both the cash outlay and the time devoted to the perusal. This book is worthy of both, and will give a good margin of profit.

THE SCIENCE AND ART OF OBSTETRICS. By Theophilus Parvin, M.D., LL.D., Prof. of Obstetrics, etc., Jefferson Medical College, Philadelphia; Octavo 697 pages, with 214 engravings. Philadelphia: Lea Bros. & Co. \$4.25.

The author in his preface says: "This work was begun five years ago, and a task which then seemed comparatively easy grew in difficulty as the author proceeded in his effort to present a clear, and, as far as the limits of such a volume permit, a complete exposition of the Science and Art of Obstetrics." Nearly his entire time, for the last eight months, has been devoted to the rearrangement of material that had been collected, adding to it, and to its supervision as the book was passing through the press. He has endeavored to present the most recent information relating to Obstetrics, at the same time not overlooking important truths established by past experience. Having been actively engaged in practice for upwards of thirty-four years—and nearly two-thirds of that time a medical teacher—he has endeavored to write a book which will be useful alike to students and practitioners. This new treatise on the Science and Art of Obstetrics will undoubtedly prove acceptable and useful to the profession. We recommend it to the attention of our readers.

MANUAL OF LIFE INSURANCE EXAMINATIONS. By James Thorburn, M.D., Edin., Prof. of Materia Medica, Toronto School of Medicine, Surgeon Toronto General Hospital, etc. Toronto: Ellis & Moore.

This little brochure will, we are sure, be gladly welcomed by the medical profession in Canada. The examination of applicants for life insurance is a most important duty, and one requiring a knowledge of many facts not taught in our schools, and not alluded to in the text-books; hence the value of a work of this kind. It deals with classification of risks; influence of heredity and other circumstances affecting the risk; examination of the urine; expectation of life, etc. The work will be found most practical and useful, and should be in the hands of those who are in the habit of examining applicants for life insurance.

HOW WE TREAT WOUNDS TO-DAY. A treatise on the subject of Antiseptic Surgery by Robt. T. Morris, M.D., late surgeon to Bellevue Hospital.

Second Edition. New York: G. P. Putnam's Sons, \$1.00.

This quaint and unique little work has been most favorably received by the profession. The author says in the "FIRST WORD": "This book is modest only in size. It possesses dignity only in its facts. There is little of originality in what it teaches." The author's idea is "to present in digestible form a dish of truth from which all the bones have been removed." The style, matter and construction of the work bear out the author's statements in his "First Word."

VICARIOUS MENSTRUATION.—Puech has collected the statistics of 200 cases of vicarious menstruation, with a view to determine the parts of the body most liable to be the seat of vicarious hemorrhage. Bleeding occurred from the roots of the hair in 6 cases; from the auditory canal in 6; from the lachrymal gland in 10; nose, 18; gums, 10; cheeks, 3; mouth, 4; bronchi, 24; stomach, 32; mammary glands, 25; axilla, 10; umbilicus, 5; bladder, 8; intestines, 10; hands, 7; inferior extremities, 13; various other regions, 8. In girls who are the subjects of vicarious menstruation, the genitals are always moist at the menstrual periods, and give rise to a muco-sanguinolent secretion.—*Giornale Italiano delle Scienze Mediche.*

MUSCULAR RHEUMATISM DUE TO THE USE OF TOBACCO.—I have met a great many cases of muscular rheumatism (says Dr. Edward Lawson in the *Maryland Medical Journal*) due to the use of tobacco in some form, mostly in the shape of snuff placed under the tongue. All remedies were unavailing whilst the use of the weed was indulged in. Every practitioner, I think, on meeting with a case of the above disorder, should inquire as to the tobacco habit, and correct it, if possible.

Births, Marriages and Deaths.

On the 7th ult., Dr. Jas. Beckwith, of Tusket N.S., aged 76 years.

On the 5th ult., H. M. Peters, M.D., of Carleton, N.B., aged 67 years.

In Toronto, on the 20th Feb., Dr. J. W. Patterson, formerly of Harrowsmith, Ont., aged 33 years.

* * * The charge for Notices of Births, Deaths and Marriages is Fifty Cents, which should be forwarded in postage stamps with the communications.