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CANADA

MEDICAL & SURGICAL JOURNAL

JANUARY, 1882.

Original Communications.

ON ERYSIPELAS.

By R. W. POWELL, M.D., OTTAWA.

(Read before the Ottawa Medico-Chirurgical Society.)

We are fortunate, I think, in having chosen erysipelas as a subject for discussion, because it is a disease with which we all ought to be intimately acquainted. It crosses us at times, no matter what branch of the profession we are engaged in—as physicians, surgeons, or obstetricians,—and though, under these altered circumstances, it may wear different aspects, yet we have to deal with one and the same poison.

To the physician, it constantly assumes a severe character, either by its being prolonged from day to day, perhaps with a discharge and an elevated temperature, thus tending to exhaust the patient; or frequent relapses may bring about a similar result; or, again, its frequent repetition in the same patient leaves both himself and his physician in a state of uncertainty as to its cause, its prevention, and its consequences.

To the surgeon, it is a continual source of anxiety, often marring the effects of an otherwise successful operation, always an interference with nature's efforts at repair, and occasionally placing a patient in jeopardy who has sought the surgeon's aid to rid him of perhaps some slight disfigurement or deformity. Following an operation, it lends a totally different complexion to the case at once, and though it may not actually cause death, yet it seriously impairs the result, as well as retards recovery.

The danger of this, however, is now reduced almost to a minimum by a strict observance, on the part of the surgeon, of proper antiseptic precautions, cleanliness, and well-directed drainage.

To the obstetrician, it is, perhaps, a still graver complication when it occurs; but, I believe, in this country it is a rare sequel to parturition, mainly, I daresay, owing to the few maternity hospitals and few centres of dense population, and thus overcrowding is avoided and the chances of contagion much reduced, but partly, let us hope, our immunity to be due to the precautions and cleanliness observed by Canadian surgeons.

Though some periods of life are less obnoxious to this disease than others, and though it may be more frequent at certain seasons of the year, yet it will occur at all times of life and in every month in the year. It will, at times, attack the new-born as well as the octogenarian, the rich and well-to-do as well as the pauper. The gouty system due to the effects of high living and sedentary occupation will be as prone to it as the system broken down by intemperance and bad hygienic surroundings; and, lastly, the sexes serve to divide the palm about equally.

These considerations, then, should teach us to watch closely for its premonitions, to observe carefully its clinical varieties and peculiarities, to take reasonable precautions against its occurrence when we are aware of its close presence, and, more than all, to be careful, in our own dealings with the disease, not to convey it by any means from patient to patient. Though erysipelas has been recognized since the earliest times as a specific disease, and has received the attention of the most able in our profession, there seems yet to be some difficulty in accurately defining it so that we may place it in its proper class. The earlier writers believed it to be due to a poison generated in the body itself, and finding a local expression in the skin whereby it was thus excreted from the body. Later on, it was supposed to occur in consequence of a stoppage to the escape of acrid materials from the blood through the pores of the skin. The theory that it was, in fact, a lymphangitis first emanated from Germany, and this was followed by another, which classed it as a simple dermatitis.

The later theory, and the one acceptable to the greater number, places it among the acute exanthems. It has, however, some marked differences from these diseases, among which are the following: The short invasion, the indefinite course, the liability to relapse, the definite starting point (usually from that part which happens to present a broken surface), its occasional protracted course, and, further, the first attack, instead of being a protection against subsequent invasions, often renders the patient peculiarly sensitive to the action of the poison for ever after. To these may be added, its occasional apparent tendency to attack certain families, *i.e.*, to be hereditary, though this is not established. On these grounds Trousseau opposed the view of its being an exanthem, and he therefore makes no distinction between idiopathic and traumatic erysipelas, and, in fact, regards every erysipelas as traumatic, believing that, if looked for, a wound in the surface will always be found as a starting point. There can be very little doubt, at any rate, that erysipelas is due to a specific poison, but that it comes fairly under the category of the exanthemata is open to grave question. It would appear, also, that, according to some observers, the varieties of the disease depend in great part upon the mode in which the poison enters the system, all not holding with Trousseau that it invariably enters by a wound; and, in fact, many close observers acknowledge that it may arise spontaneously (that is, not due to a previously existing case.)

More recent investigations into the nature of this poison have discovered a bacterium or a microphore, and it would seem that this growth constitutes the true *materies morbi* of erysipelas.

However produced, when once it attacks the skin it seems to be endowed with great powers of reproduction, and thus the disease is extended by actual contact, and the resulting dermatitis is the effect of the irritation produced by this minute foreign body in countless myriads. They would appear to be endowed with only a brief existence, but, as I said before, having great powers of reproduction, so that by their rapid multiplication the disease is extended from part to part. The experiments of Lukomsky go to shew that the micrococcus is only present

during the dermatitis and disappears as it subsides. This observation explains itself better I think, and is more consistent with the theory, if we say that the dermatitis subsides when the term of life of the micrococcus ends.

This theory to my mind fills the gap in the pathology of erysipelas and fully accounts for the symptoms and clinical history of the affection. The varieties met with will depend first upon the virulence of the poison when it attacks the system—*i.e.*, with its state of dilution as it were—and the degrees of severity in different cases will depend in a great measure upon the fertility of the soil upon which the poison is sown. This accords with what we actually observe. Subjects in fair health and with their secretions all in a normal state, do not seem to take on the morbid action even when exposed to the contagion, and if they do it will occur as a rule, mildly. As we descend the grade of health we observe the disease attacks in a more severe form, and especially is this observed in those living in bad hygienic surroundings. This disease, then, usually confines itself to the skin, but it is agreed that the mucous membranes will sometimes take on the morbid action as well, and, indeed, it very frequently begins near one of the orifices of the body where skin and mucous membrane seem to merge the one into the other. Trousseau says it is this fact that sometimes leads one to believe that it arises spontaneously and without a break of surface because the swelling and inflammatory action that at once ensue on its introduction mark the probably small and insignificant wound in the soft mucous membrane.

As to its affecting internal organs it never does so primarily, but if lungs, stomach, intestines or other viscera become affected it is due to the spreading of the poison by actual continuity of surface. I have contented myself, then, with these few observations on the pathology of the disease in the hope that others here may offer remarks upon other branches of the subject. To go into the symptomatology, clinical history, terminations and varieties of the disease would occupy too much of our time for one evening. With regard to the treatment of this affection I think our knowledge is yet very imperfect. If the

pathology hinted at above is correct, then we may hope for some specific treatment to arise in the near future. Now that animal and vegetable chemistry is assuming such an important place in our therapeutics we must hope for an antidote to this erysipelatous germ, if I may use the word. In the meantime, we must content ourselves with rational orthodox treatment. I would like now to ask those present to state shortly their method of treating this affection, taking a moderately severe case and standard. Whether they have found Tr. Ferri Chlor. sufficient to meet the symptoms. If so in what doses is it prescribed in the case of children and of adults? Lastly, whether any benefit can be expected from local applications? If used, what variety seem to be the most beneficial? Do they ever check the onward march of the disease?

SOME CASES OF GUN-SHOT WOUNDS.

By W. H. BURLAND, M.D., MONTREAL.

(Read before the Medico-Chirurgical Society of Montreal.)

Mr. President and Gentlemen,—The paper I am about to read to you this evening is not a dissertation upon gunshot wounds, but simply a synopsis of several severe injuries of this class, whose course I had an opportunity of watching, as they were treated in the practice of the Montreal General Hospital during my residence in that Institution.

Our attention has been but lately called to the sad results of a wound of this nature in depriving the neighbouring Republic of its chief magistrate; and, although the cases I have to recount to you on this occasion did not terminate in such a lamentable manner, yet, several of them came so near doing so, that I hope they will interest you sufficiently to bear with me during their rehearsal; but before reading their histories, it will not, I deem it, be out of place to make a few general remarks on injuries of the nature under consideration.

Gunshot wounds belong to the class of wounds called *Contused*, when penetration of the body does not take place; and to that of *Lacerated*, when it is entered or traversed by the shot. They

are, in fact, the most complicated of wounds, combining, as they do, contusion, attrition, and laceration to a high degree, occasioning all kinds of fractures, introducing extraneous matter into the body, and often giving rise to such complications as hæmorrhage, inflammation, septicæmia, erysipelas, and even gangrene. These injuries are produced by all sorts of missiles—such as small shot, bullets, grape or canister, chain or bar shot, shells, slugs, and even the powder itself, as well as fragments of wood, stone, clothing, buttons, portions of another person's body, &c.,—but as the cases to which I wish to draw your attention to-night were all produced by the ordinary cylindro-conoidal ball of common use, I will refer principally to wounds inflicted by such means. We do not now see, since the introduction of this modern form of bullet, the wonderful, yes, extraordinary, courses taken which were sometimes seen in injuries caused by the old spherical ball, such, for instance, as that spoken of by Heunen, who relates the case of a man in whom the ball, which struck the *Pomum Adami*, was found lying in the orifice of its entrance, having gone completely around the neck. The works on military surgery, written during the last century, abound in examples of just as strange deviations, but at present such instances are exceedingly rare, for it is now usual to find the missile traverse the body in the same line in which it entered, unless deflected by some of the heavier osseous structures; in fact, the conical ball is not influenced by the tissues through which it passes, and, if it has not passed entirely through, is generally found immediately under the skin at a point directly opposite to that in which it entered, or rather in the line in which it was travelling when it struck the body, and this fact is useful, from a clinical standpoint, as a guide to locating the bullet. Sometimes the place where the ball lies is plainly enough indicated by a slight reddish discoloration; generally, however, it can only be discovered by passing the hand carefully over the skin, when a hard substance will reveal its presence. (F. Hamilton.) The ball, having been grasped by the thumb and first finger of the operator, or by an assistant, is best removed by a free incision. If the above precaution is not attended to, the bullet may slip back into the track of the wound, or to

one side, and render its extraction difficult. It is usually necessary to free the ball of its entanglements before removal, and this can be done by a few cuts with the point of the knife, or by cutting firmly into the lead from end to end. As to the differences between the point of entrance and that of exit: in the old spherical ball these were tolerably distinct, as the aperture of entrance was usually round and clean, with inverted edges, while that of exit was everted and jagged; on the other hand, the wound of entrance made by the conical bullet is generally larger than the diameter of the missile, and its form much less regular, being sometimes oval, sometimes linear or crucial, and even triangular in shape, while the point of exit is very much larger and still more irregular in its outline, but, as a rule, the two wounds are much of a size, and hard to be distinguished between. Probes of various makes and some very ingenious instruments have been devised at different times to aid in the detection of bullets and their removal, but time will not allow of my referring to them. In the primary local treatment of a gunshot wound, water-dressing at or below the temperature of the patient's body seems to be generally accepted as the most suitable application.

Having given these few hints concerning the injuries of which I am about to speak, I would crave your attention to the following cases:—

CASE I.—William E., a tall, well-proportioned young man of 21, was admitted to Hospital under Dr. Drake's care on the 16th July, 1877, having received a bullet wound in the back. It appears that the patient had come to town to attend the funeral of young Hackett, who was murdered on the 12th July, 1877, and as he was going to a friend's house in the evening, was deliberately shot at, a ball entering the right side of his back. Upon examination, it was found that the bullet had pierced about $3\frac{1}{4}$ inches to the right of the spine, and about $1\frac{3}{4}$ inches below the angle of the scapula. The ball had struck a rib in its course and passed forward in a slightly downward direction, but it was not located. There were no signs of wound of the lung, but the injury was followed by a severe attack of pleurisy, which pulled the patient down in strength. He was, however, able to leave

Hospital eight days after admission, and when discharged on July 24th the wound of entrance had healed. The ball, although not discovered in this case, must have been a small one, as the orifice of admission was not over a $\frac{1}{4}$ -inch in diameter. He states that he was glancing over his left shoulder when he received the wound, so that the ball entered in an oblique direction, although the party who fired it was directly behind the patient. This was corroborated by the hole in his outside coat, which was only $2\frac{1}{2}$ inches from the centre seam, while the wound in the body was about $3\frac{1}{2}$ inches from the spine. I have since had an opportunity of learning that this patient has felt no inconvenience from the lodgment of the ball. From a medico-legal point of view, this case is interesting, for this reason, viz., that the party wounded is confident that he could recognize the person who fired the shot which wounded him, as he was glancing over his shoulder at the time. The injury being in the back, some doubt might arise upon this point.

CASE II.—John G. B., a well-built young man of 22, evidently very muscular and of good constitution, received a bullet wound in his back on Sunday evening, 10th March, 1878, at about 9 P.M., and at 10 P.M. he entered Hospital under Dr. Roddick's care, at which time he was suffering some slight inconvenience from the injury, but had spat no blood, had no cough, nor did deep inspiration produce much distress. The wound was situated about $3\frac{1}{2}$ inches from the spine, and about 5 inches below the right shoulder-blade; it could be probed for about 3 inches directly towards the spine, but the ball could not be felt, nor was it discovered at any time during his stay. The injury was not followed by any bad symptoms, and the patient was discharged in twelve days, with the point of entrance completely closed. This case is interesting from the small amount of (if any) local or constitutional disturbance which followed the lodgment of such a foreign body as a bullet. As to the direction which the ball is supposed to have taken, it might be well to state that the hole in patient's coat was $4\frac{1}{4}$ inches from the centre seam, while the entrance made in his skin was only $3\frac{1}{2}$ inches from the spine.

CASE III.—Solomon W. was admitted to Dr. Roddick's wards

Jan. 3rd, 1878, having received a bullet wound in the back part of his right leg. As the injury was incurred at the Back River, in some hotel quarrel, the leg was very much swelled before he arrived in Hospital. Upon examination, a small, somewhat circular, wound was found to exist in the central part of the posterior aspect of the right thigh, a short distance above the flexure of the knee. Having satisfied himself that the ball was lodged against the bone, Dr. Roddick cut down under complete anti-septic precautions, and removed the bullet, which I now present to you for inspection, it having been found somewhat imbedded in the femur. I have drawn attention to this case, though simple in its aspect as a gunshot injury, from the fact that the wound was very near a large joint, and that inflammation, with its accompanying swelling, prevented the surgeon locating the ball for two or three days after its lodgment. This patient made a rapid and complete recovery, being discharged from Hospital in about three weeks.

CASE IV.—James H., a robust, muscular carter of 19, having been wounded by a bullet in the upper part of the left side of his chest, in a street brawl, on the 25th April, 1878, was brought to Hospital soon after being shot, in a semi-comatose condition. Upon admission, he seemed to be suffering from intense shock; pulse weak, face pale, lips anæmic, and he could with difficulty be aroused. As the case was evidently a very serious one, I at once sent for Dr. Roddick, the attending surgeon, and a magistrate; as the affair was fraught with legal difficulties as well as vital ones. On closer examination, it was found that a bullet wound about $\frac{3}{8}$ to $\frac{1}{2}$ inch in diameter existed in the left infra-clavicular region, over 3rd rib, about 4 inches from the sterno-clavicular articulation, and $3\frac{1}{2}$ inches above the nipple. A probe could follow the track of the bullet in an oblique direction from left to right as far as the intercostal muscles, but farther it was not deemed advisable to go. Very little blood, if any, had been lost externally, and none had been spat up, nor had cough occurred. No evidence of any kind was obtained from auscultation at this time. The taking of his deposition seemed to prostrate him exceedingly, and it was with difficulty that answers

could be obtained from him. Next day, April 26th, was still semi-comatose. Breathing short and rapid. Temperature in the evening, 101°F.; pulse, 100; respirations, 44. He complained of pain about the wound, which was increased by moving him or by deep inspiration; but neither cough nor expectoration were present. A pericardial friction sound, accompanied by great dyspnoea and pain, now developed itself, having its greatest intensity about 2 inches to left of sternum, and râles, supposed to be pneumonic, were detected near the wound. The necessity of keeping the patient absolutely quiet prevented an examination of the back parts of his chest at this time. Leeches were applied to the precordial region and cold to the wound.

April 27th.—Pericardial friction most marked at left edge of sternum; pain less severe. Morning: temperature, 100°F.; respiration, 22; pulse, 102. Evening: temperature, 102°.4 F.; respiration, 28; pulse, 104.

April 28th.—Pleuritic friction was noticed to-day in left side, accompanied by severe pain. Pericardial murmur has descended and is more diffuse. Temperature, 102°F.; râles have disappeared from upper part of chest.

April 29th.—Pericardial effusion has supervened; pain in left side more intense. Ordered calomel gr. i, with pulv. opii gr. ½, 3 q. h. Morning: temperature, 98°.2 F.; respiration, 22. Evening: temperature, 100°.8 F.; respiration, 22.

April 30th.—Pleuritic pain still intense. Precordial bulging diminished. Pericardial friction again intense at point where it commenced.

May 3rd.—An opportunity occurring for examining the back, fluid was discovered in the left pleura, which proved to be a bloody serum—this fact being ascertained by the use of a hypodermic syringe. Some suppuration now took place about the wound. His temperature ran up to 103°F., and dyspnoea became a marked symptom, while pain and pericardial friction again set in, pulse being weak and irregular. Sherry wine was given. By 7th May these severe symptoms had slackened off, dyspnoea having given way to fairly natural breathing, unaccompanied by pain. Pulse much improved, but dulness persisted over the

pleuritic effusion. Wound almost healed. Was allowed a better diet. About 19th May patient had a bad turn; temperature in the morning was up to 103°F., which before had ranged below 100°F. At this time constipation seemed to be an important factor. Aspiration with a hypodermic needle again detected a bloody serum. Ordered a tonic of iron and quinine. From this time rapid improvement followed, and spontaneous absorption must have supervened, for when discharged on the 13th June, after a stay of 49 days in Hospital, the dulness had almost entirely disappeared, and his breath sounds had regained their normal properties.

I have abstained from giving too full a report of this most interesting case for fear of tiring your patience, but if you have been able to follow from my description the severe and alarming complications by which this patient's life was jeopardized, I will feel sufficiently repaid for taxing your kindness even to the extent I have.

CASE V.—Louis P., aged 32, a strong, muscular, labouring man, was admitted to Hospital under Dr. Roddick's care, suffering from the effects of a bullet wound in the left side, December 18th, 1877. Patient was one of the men engaged in a strike on the canal, and on the day on which he was wounded, he, with a number of others, assembled near the contractor's office. An altercation ensued, and one of the occupants of the office rushed out, and, while standing on a slight elevation, shot down at the patient, who was near him, but on a lower level. Patient, feeling that he was wounded, ran about two acres, and sat down. Immediately after being shot, blood had gushed from his mouth and nose, and a large quantity had escaped also from the wound. He soon felt weak, and complained of pain and faintness, but retained consciousness throughout. He was taken to a house in the vicinity, where he received temporary medical treatment, but was soon after removed to Hospital. On examination, it was found that the bullet had entered the chest in the 6th interspace, about one inch to the left of, and a little below, the left nipple. It had taken a direction downwards towards the left side, and had evidently struck the 6th rib in its course. The point of entrance

was about $\frac{3}{8}$ of an inch in diameter, circular, and somewhat inverted. Blood still escaped from the wound, but only in a slight degree. He had expectorated a large quantity of blood, while cough and deep inspiration caused pain. The wound was dressed, his chest strapped on both sides to restrain movement, and ice applied. Pb. acet. and opium were given, as well as a daily hypodermic injection of grs. v ergotine. Extensive emphysema of the tissues was noticed over the left side. The position of the ball was not made out at this examination.

Dec. 19th.—No blood oozed from the wound to-day; experienced pain in left side, but not of a severe character, also some distress upon coughing. There were no evidences of pneumonia, although carefully examined for. Same treatment continued. Temperature 101°F . Has great anxiety of mind, and had not slept well. Emphysema of tissues has almost disappeared.

Dec. 20th.—Has expectorated much less blood to-day, and coughing does not distress him much. Temperature $99\frac{1}{2}^{\circ}\text{F}$.

Dec. 21st.—Still spitting some blood. Was ordered— \mathcal{R} Acid Hydrocyan. dil. B.P. m 80; Liq. Morphiæ ʒi ; Ext. Bellad. fld. m 24; Aquæ ad ʒviii ; ʒss t.i.d. Continues to improve.

Dec. 23rd.—The position of the ball was discovered; it was found lying posteriorly between the 9th and 10th ribs, in a line with the inferior angle of the scapula, having evidently, from the above symptoms, passed through the left lung. The patient is still doing well. Temperature low. Ice was removed to-day and carbolic lotion applied to wound. Is still expectorating some blood.

Dec. 24th.—Without any evident cause, or any great rise in temperature (100°F .), the patient suddenly became delirious, with a strong, bounding pulse. This change seemed to depend upon his anxiety about the strike. The ball was extracted to-day by Dr. Roddick, under complete antiseptic precautions. When removed, it was found to be split and flattened on one side, which can be accounted for by its having struck a rib in its course. Was ordered— \mathcal{R} Pot. Brom. ʒss ; Chloral Hydrat. grs. x; Tinc. Hyosc. ʒss ; 4 q. h.

Dec. 25th.—Delirium has not abated; in fact, he has torn the

dressings off his wounds, and it is difficult to keep him in bed. A blister was applied to the nape of his neck. No blood in the sputa to-day.

Dec. 26th.—Delirium passed off to a considerable extent. Some pus, but not of a foetid character, appeared on the dressings to-day. Wound of entrance almost closed.

Dec. 27th.—Complains of pain in left side from wound to base of lung. Temperature 99°F. *29th.*—Seems to be improving generally. *30th.*—Some pain still persists in left side. Temperature 98½°F.

Jan. 2nd.—Patient was allowed up, feeling no pain, but well and hearty.

With the exception of a return of the pain in his side for a short time, the patient continued to improve until discharged on the 15th January, after 28 days' stay in Hospital, wound of operation having healed some time before.

CASE VI.—D. C., aged 20, a powerful young man of good constitution, was admitted to Dr. Fenwick's wards on 13th March, '78, suffering from two bullet wounds received as he was entering a dark gateway leading to his home. One ball had pierced his nose, the other his right leg. The shots, to my mind, were fired with intent to kill, as one of the balls, which was subsequently extracted, was of a size which no person would have used for the mere purpose of giving a fright; and as both bullets, evidently shot from different weapons, took effect, it is likely that more than one person perpetrated this outrage. The wound in the nose was followed by some hemorrhage; that in the leg was not, but the patient experienced a pricking sensation on its receipt. The nasal wound was situated a little above the centre of the left side of the nose, seemingly produced by a small ball, and was about a ¼-inch in diameter. The probe could be passed directly back to the pharynx in a slightly downward direction, but it was impossible to trace the bullet farther. Considerable bleeding followed this exploration. From the size and direction which the ball had taken, I happened to say one morning, in making my usual rounds, that probably he would spit it up; and strange to say, on the morning of St. Patrick's day, the

patient did cough up the very much distorted bullet which I now present to you.

The wound in the leg was situated about 1 inch to the outer side of the centre of the thigh, 7 inches below the anterior superior spinous process of the ilium, and about 10 inches above the patella. The track could be probed for about 4 inches, but the ball was not detected until some time later, when it was found lying in the outer aspect of the leg. It was removed by Dr. Roddick, under whose care the patient was at the time. The bullet, which, as you can see, was of considerable size, was very much flattened on one side, where it had evidently come in contact with the bone, but no splintering of the femur was made out at any time. The case progressed rapidly, so that the patient was discharged in 28 days.

BI-MONTHLY RETROSPECT OF OBSTETRICS AND GYNÆCOLOGY.

PREPARED BY WM. GARDNER, M.D.,

Prof. Medical Jurisprudence and Hygiene, McGill University; Attending Physician to the University Dispensary for Diseases of Women; Physician to the Out-Patient Department, Montreal General Hospital.

From the character of the International Medical Congress held in London during the past summer, it was to be expected that in the Obstetric section all the more exciting gynecological topics of the day would be discussed. Improvements in the construction and application of the Forceps; Oöphorectomy—Battey's operation—Spaying—Castration of Women, as it is variously termed (a good name for the operation is still wanting); Diagnosis of Ovarian Tumours; Operative Treatment of Extra-uterine Pregnancy; the Treatment of Puerperal Hæmorrhage; the Reparative Surgery of the Genital Tracts; Antisepsis in Midwifery; Laceration of the Cervix Uteri; Total Extirpation of the Uterus; the Mechanical Treatment of some of the Displacements and Diseases of the Uterus, were the more important of the subjects under consideration. Space will not permit more than a brief allusion to the most important of these.

Prof. Tarnier of Paris presented his forceps, and made some

remarks on improvements in its construction. The discussion which followed shewed that he has a most respectable following of eminent names who approve of his improvements to the instrument. Among these, Dr. Fordyce Barker of New York, Prof. Simpson of Edinburgh, Dr. Budin of Paris, and Dr. Robert Barnes of London, may be mentioned. Dr. Matthews Duncan (London), Prof. Stephenson (Glasgow), and Dr. Lombe Atthill (Dublin), were opposed to it chiefly because of its continuous compression of the head.

The ever-interesting subject of the treatment of puerperal hemorrhage had a due share of attention. Dr. Robert Barnes of London reiterated his well-known views. In the course of his address he spoke of physiological puerperal hemorrhage, viz., the loss of the excess of blood, which, having served in the nutrition of the foetus, is expelled from the uterus during and after detachment of the placenta. Any loss beyond this is extra-physiological hemorrhage, and is to be checked by the assistance of the physician. He concluded by asserting that in a certain number of cases, when uterine contraction fails, we have no reliable alternative but the intra-uterine injection of perchloride of iron, the peculiar dangers of which over other intra-uterine injections he believed to be few and mostly avoidable.

Dr. T. More Madden of Dublin read a paper on the same subject. He believed death from post-partum flooding to be generally preventable, and thought that in the future it would be unknown. We may almost always obviate, though we cannot yet always arrest, flooding. The more children a woman has borne, the more likely she is to flood. When we have reason to anticipate hemorrhage, he had firm belief in the efficacy of a course of any astringent preparation of iron during the last months of pregnancy. In such cases in labour he would rupture the membranes early to allow the uterus to contract, and would give a dose of ergotine or fluid extract of ergot hypodermically before the head comes to press on the perineum. He believed injection of both hot, cold and iced water to be unreliable. Injection of perchloride of iron was effectual, but dangerous. He strongly recommended the introduction of a sponge soaked in

the solution of perchloride of iron to the uterus, and there retained till it and the hand in which it is held are expelled from the uterine cavity. When collapse had come on, he had little faith in transfusion, as now practised, but advocated instead hypodermic injection of ether in large doses, as recommended by Von Hecker of Munich. He believed he had seen it save a number of hopeless cases. The value of ether was also affirmed by Prof. Winckel of Dresden and others. The iron injections had a number of advocates in the Dublin School of Midwifery, and amongst others. All admitted its dangers, but considered that desperate cases justified its employment. Dr. Matthews Duncan regarded intra-uterine injection of perchloride of iron as more dangerous than the condition it was intended to obviate. Dr. McClintock thought that promptitude and energy in applying the remedies were of the greatest value. He admitted the danger of the perchloride of iron injections, but desperate cases required desperate remedies. He believed that chloroform to a considerable extent predisposed to hemorrhage. As a preventive, he had seen great benefit from gallic acid given a few days before labour. A number of the speakers emphasized the importance of preventive treatment by proper management of the third stage of labour. The great object is to keep the uterus duly contracted by pressure and friction during and for an hour after the expulsion of the placenta.

The celebrated Prof. Otto Spriegelberg of Breslau had prepared a paper on *Antisepsis in Midwifery*, but as he was unable to be present from illness (he has since died), it was read in abstract. He began by stating that the great reform in surgery brought about by the antiseptic treatment could not fail to have a deep influence upon the treatment of the complications in childbed, as it was well known long ago that the latter are the same as those which arose from wounds. If, however, scrupulous cleanliness, which had been advocated long ago, favoured a normal course of the puerperium, the practical gain was not very great. The idea that the puerperal wounds are infected, and the inflammations of the genital organs are initiated by germs coming from outside, became more in vogue, and in consequence,

the idea that phlogogenous matter might be produced spontaneously within the genital tract was almost abandoned. The consequence of this idea was, recommending the most scrupulous cleanliness of hands and instruments; forbidding practitioners of midwifery to attend other patients; forbidding students who dissect from attending midwifery cases; and forbidding nurses attending cases of puerperal fever to attend normal cases at the same time. But these measures had but little effect in reducing the number of bad cases. This fact originated the idea of secondary antisepsis. Intra-uterine irrigations and drainage came into use, but without much avail. The failures can be understood. Lister's system is founded on the view justified by experience, that infection of wounds is caused by germs floating in the air around a wound, and falling on the recently made wounds. It is therefore necessary to clean the surroundings from germs; if that cannot be done, then to destroy the efficiency of these germs while the wound is open, and to keep the wound subsequently closed as much as possible. The application of these rules upon the puerperium means the strictest cleanliness and antisepsis during the time in which the puerperal wounds arise—that is, during birth—as well as from the part of the persons attending the mother as from the mother herself; prevention of air entering the genital tract, and as this cannot be done absolutely, disinfection by frequent vaginal irrigation with antiseptics during birth. After birth, care is to be taken to secure perfect rest for the genital tract, to encourage involution, avoiding every intra-vaginal or intra-uterine manipulation not absolutely necessary. If such be necessary, it must be done under antiseptic precautions. Antisepsis after the infection has taken place is not of much use. It is only directly useful in processes of decomposition, so long as they have not passed the surfaces of the tract, and not yet attacked the parenchyma of the organs. If this have occurred, antisepsis is not a trustworthy remedy, it is only palliative, since drainage and irrigation do not touch the deep seats of the disease, and do not remove or destroy the germs.

Prof. Winckel said that all the midwives under his direction were under instructions to keep all catheters, vaginal tubes,

diapers for washing the genitals, &c., lying in a two per cent. solution of carbolic acid. Two per cent. carbolic oil is used to lubricate the finger.

Dr. Fancourt Barnes said that in the British Lying-in Hospital all his patients were delivered under the carbolic spray. The vagina was syringed with a one-to-forty solution. A one-to-eighty spray was always playing in the wards. All washings of the genitals were done with a one-to-eighty solution. The results showed great diminution of feverish attacks.

Dr. Graily Hewitt said that as regards prevention of introduction of septic matter from without, the rule should be to use the nail-brush assiduously in all midwifery cases. Many cases he thought were due to septic action from within. Some cases resulted from too complete rest on the back during the first few days after labour. Septic fluid collected in the vagina and was absorbed through lacerations that might exist. Dr. Goodell had done good service, he thought, by insisting on the necessity for drainage of the vagina by changing the position of the patient. An important point was to secure good uterine contraction. To secure this the patient's strength must be kept up by food of good quality.

Dr. Edis followed somewhat in the same strain.

Prof. Tarnier had made an experiment with reference to disinfectant solutions. He had placed pieces of placenta in the following solution: Liquor of Van Swieten (bichloride of mercury at one-thousandth), boric acid (forty grammes per litre), and in others. In all except the mercury and boric acid solutions, living organisms appeared in a few days. He had great confidence in the parasitocidal action of bichloride of mercury solution. Whenever he had reason to think his hands "suspicious," either at the hospital or at home, he washed them in the bichloride solution. His pupils did the same. No instance of mercurialism had occurred. To prevent implantation of the germs in the air into wounds produced at the moment of expulsion, he made the midwife anoint the foetal hand with a one-tenth solution of carbolic acid each time it appears at the vulva. He thought this better than the spray, which was too cold for the patient.

Dr. J. Henry Bennet (Nice) read a paper on *Laceration of the Cervix Uteri: its causes and treatment*. Dr. Bennet agreed with Drs. Emmet and Pallen of New York and others as to the frequency of this lesion during labour. He had himself pointed out the fact so long ago as in 1849. He then stated that the principal cause was previous inflammation and induration of the cervix, non-softened during the latter period of pregnancy. This condition during labour gives rise to rigidity of the cervix, and subsequently to laceration. He had attended to many hundreds of such cases, slight and severe, and had never operated. He always found that under the treatment of the inflammatory state which attended them, the ulcerated edges healed, and all that was left was a mere notch.

Dr. Playfair (London) believed in the operation, and regretted that it had received so little consideration at the hands of British obstetricians. The fact that men like Emmet, Thomas, Pallen, Sims and Goodell performed it from deliberate conviction of the serious uterine disease it led to, spoke strongly in its favour. He had performed the operation himself with success.

Dr. Goodell had operated 107 times without a death, and with great benefit to nearly all the patients. Ectropion of the cervix could be cured by nothing but operation. He believed cancer of the cervix started from the raw irritated surface of a cervical rent. Acting on this knowledge, he had operated on a lacerated cervix when no constitutional symptoms were present, simply because cancer was hereditary in the patient's family.

Dr. J. Braxton Hicks (London) made some further remarks on the "Use of the Intermittent Contractions of the Pregnant Uterus as a means of Diagnosis." He referred to his paper published in the London Obstetrical Transactions for 1871, vol. xiii., p. 216, in which, after showing that the uterus contracted usually at intervals of from five to twenty minutes during the whole of pregnancy, and that these contractions were readily recognizable by the hand, he wished now to emphasize what he then said as to the value of the fact as a means of diagnosis. He gave difficult cases where the diagnosis had been set at rest.

1. Suspected extra-uterine pregnancy.
2. In hydramnios, where

ovarian cyst was supposed to exist, and paracentesis abdominis had been performed through the uterine wall. 3. In cases of pregnancy where tumor was supposed to co-exist. 4. Hydramnios with twin conception. Dr. Matthews Duncan pointed out that the value of this sign as a diagnostic one was diminished by the fact that soft fibromas contracted quite as marked as the gravid uterus. Prof. Hennig (Leipzig) said the diagnosis was still more difficult when fibroma and pregnancy co-existed.

Dr. Robert Battey (Rome, Georgia) read a paper on Battey's Operation. He said: "The operation is peculiar, in that it has for its primary object, not the removal from the body of a diseased organ, but the abrogation of a physiological function. Whilst it is undoubtedly true that the ovaries extirpated, in the majority of instances, are structurally diseased, the end aimed at is not the removal of diseased ovaries, but it is the production of the change of life by art." He had foreseen the wide sphere of the operation in exceptional cases. To cover the ground fully, and give a key for the selection of suitable cases, it was proposed: "Ovariectomy to determine the change of life; and the change of life for any grave disease, which is incurable without it and which is curable with it." He thought the safest rule was embodied in the three questions: Is this a grave case? Is it incurable by any of the resources of art short of the change of life? Is it curable by the change of life? If all these three questions can be answered in the affirmative, the case is a proper one; but if not, the operation is not to be justified. The operation opens a door for wide-spread abuse. It is in no case to be received as an alternative for any other means of cure, but as a *dernier ressort*.

Operation—Mode of Access.—In America, both vaginal and abdominal methods are in use; in Europe, the abdominal alone finds favour. For the vaginal it is claimed (*a*) the mortality is less; (*b*) it favours perfect drainage; (*c*) less air is admitted to the peritoneal cavity; (*d*) the intestinal mass is but little exposed to mechanical irritation. The objections are the frequency of adhesion and the difficulty of dealing with them, and completely removing the ovaries. This, however, is an excellent

method, and not to be abandoned in properly selected cases. *Dealing with the Pedicle*—The ligature, simple or carbolized, with ends cut short, is well-nigh universal. The author has in 13 instances severed the pedicle with the ecraseur alone; in no case was there troublesome hemorrhage. *Proximate results*—1st, Mortality—In the cases collected, the death-rate has been 22 per cent. for the complete operations and $9\frac{1}{2}$ for the incomplete. 2nd, Menopause—It is well known that exceptionally after double ovariectomy the menses have reappeared, not occasionally only, but regular in occurrence and normal in characteristics. In none of these cases, however, has it been shown that a third or supplementary ovary did not exist, or that fragments of ovarian stroma were not left behind. In the author's cases, even when small fragments of the ovaries were left, the menses invariably continued, and in one instance a child was born. *Ultimate results*—1st, Aphrodisia—Patients on whom the operation has been performed have in no case complained of the loss of this power, but, on the contrary, have, in a number of instances, borne testimony to their full competency. 2nd, Female graces—These have not been impaired in any case, but a positive gain has often been noted. 3rd, General health—As the operation is proposed as a *dernier ressort* and in desperate cases, whatever of benefit is to be secured must be accounted actual gain. In a number of cases there was no benefit for a few months or a year or more, after which were much improved, and in some instances quite cured.

Dr. Savage of Birmingham also read a paper on the same subject. He gave a record of thirty successful operations during the last two years, for various conditions, which were detailed; ten were for long-standing and painful ovarian prolapse, and four for myoma. In these last-mentioned conditions the author thought there was a good field for successful and beneficial practice. In ovarian dysmenorrhœa, it is more difficult to come to a conclusion as to the cases where it will be most useful.

Dr. Priestley (London) thought favourably of the operation, especially in cases of myoma with hemorrhage. Mr. Knowsley Thornton had not had much experience; his results had been

various. He thought there was a good field in the direction of the checking of hemorrhage by the operation. Mr. Lawson Tait (Birmingham) had operated 70 times, with a mortality of from 3.1 to 14.7 per cent., according to the class of cases. In two cases of epilepsy the results are extremely satisfactory. The secondary results, in the great majority of his cases, have been very satisfactory. He believes that complete removal of the Fallopian tubes, as well as of the ovaries, is most important in completely arresting menstruation. Drs. Pallen of New York and Goodell of Philadelphia had each performed the operation a good many times. Dr. Goodell believed the operation would be useful in insanity, with monthly exacerbations. Dr. Matthews Duncan differed from the general tenor of most of the speakers. He regarded the operation as being in the earliest experimental stage. He pointed out, with reference to oöphorectomy for bleeding uterine myomata, that a series of cases had been laid before the meeting by Mr. Lawson Tait, with five deaths in twenty-six cases. He knew of no such bad results in fibroids under any kind of treatment, and was sure that such disasters were unequalled in the history of the subject. As regards pain, for which the operation is sometimes performed, the sufferings of neurotic women were often exaggerated. He had seen patients by whom indescribable agonies had been endured during the day go to concerts and balls in the evening. He knew of no death from ovarian pain.

Dr. Graily Hewitt (London) read a paper on "The exciting cause of attacks of Hysteria and Hystero-Epilepsy." The object of the paper was to show, by the results of clinical observation, that in cases of hysteria and hystero-epilepsy, the exciting cause of the attacks is distortion of the uterus, produced by ante flexion or retro flexion. Irritation consisting in the physical compression and tension of the uterus, consequent on forcible bending of the organ, is reflected, and results in the attacks. The flexion further causes congestion of the whole organ from interference with the circulation. As evidence in support of his statements, the author recited eighteen cases of hysteria and hystero-epilepsy. In all, the uterus was markedly distorted. Complete relief from

the attacks and hysterical symptoms was obtained by treatment directed to a removal of the uterine distortion. Of 18 cases, perfect relief is known to have been obtained in 17 cases. Of the 18, twelve were anteflexions and six retroflexions.

Dr. A. W. Edis (London) read a paper on "The Influence of Uterine Disorders in the production of numerous Sympathetic Disturbances of the General Health and Affections of Special Organs." Dr. Edis directed attention to the frequency of sick headache, often extending over many consecutive years, due entirely to some uterine disorder. This was shown by headaches of many years duration disappearing when some unsuspected uterine disorder was removed, other more general remedies having failed to give relief. The morning sickness of early pregnancy was shown to be frequently dependent upon some flexion, inflammatory condition of the body or cervix of the uterus, or some well-recognized uterine disorder. Relief was obtained by directing appropriate treatment to this latter condition. Uterine epilepsy frequently depended upon ovarian irritation, flexion producing dysmenorrhœa, or other well recognized form of uterine or ovarian disorder. Other nervous affections, such as asthma, neuralgia, and chorea were not infrequently dependent on some overlooked uterine disorder. Amaurosis, asthenopia, and many other pathological conditions of the organs of vision, were often found to be due to morbid conditions of the uterus. Aphonia, spasm of the glottis, sensation of choking, and other similar reflex phenomena, were often traced to alteration in the position or condition of the uterus.

Dr. Mundé (New York) said it could hardly be doubted that displacements and flexions of the uterus often produce reflex nervous and neuralgic affections of different parts of the body, and more or less pronounced mental aberrations. But other diseases, such as areolar hyperplasia or choreic metritis, played quite as prominent, perhaps a more prominent part than flexions and displacements. He related a case in which laceration of the cervix appeared to be the cause of syncope during coition and digital examination. Compression of the ovarian region (Charcot) always roused the patient from her paroxysm, This and other

hysterical phenomena were removed by Emmet's operation.—*American Journal of Obstetrics*, October, 1881, and *British Medical Journal*, Sept. 3, 1881.

Hospital Reports.

MEDICAL AND SURGICAL CASES OCCURRING IN THE PRACTICE OF THE
MONTREAL GENERAL HOSPITAL.

MEDICAL CASES UNDER THE CARE OF DR. GEORGE ROSS.

Two Cases of Tubercular Meningitis.

CASE I.—A. R., female, aged 25, admitted into Hospital to be treated for headache, which had lasted two weeks. Family history good. Was a healthy girl till one year ago, when she began to ail; nothing definite about her illness at this time. Had a child six weeks ago.

No definite history can be obtained of her present illness, except it has lasted two weeks. At present she lies in bed with her eyes closed, moaning lowly as if in pain. When questioned, rouses up and answers apparently in a rational manner, but makes contradictory statements. Says she has been ill fourteen days, with pain in head, back and limbs, and unable to move in bed. As she lies in bed moaning, her hand is frequently raised to her head, as if in pain. During the night was very noisy and restless, and made frequent attempts to get out of bed. By turns she would cry, laugh, or scream out as if frightened. Toward morning, slept for four hours.

Patient is a thin, sallow woman, with sunken eyes. Lies principally on right side, with eyes closed, though, when told to, will open them readily, when it is seen that the right lid does not open quite so wide as the left. Pupils equal and about normal size; respond readily to light. Tongue heavily coated. Abdomen retracted. Bowels constipated. No vomiting. Patient asks for anything she wants, and swallows without difficulty. Tache cerebrale well marked. No paralysis except that noticed in right upper lid. Appears to be general hyperæsthesia. Temperature 100°F.; pulse 96, regular, small and weak; respirations 24. Nothing abnormal found in lungs or heart. Urine

throws down a very small deposit containing pus ; no casts ; slight trace of albumen.

Dec. 9th.—The hyperæsthesia spoken of above is perhaps not correct ; her cries when touched appear to be due to great nervous irritability. No further evidence of paralysis. No change in delirium. To have Potass. Iod. gr. v ; Potass. Bromid. gr. x ; 4 q. h. *11th.*—For last few hours has been quiet, evidently becoming comatose ; up to that time delirium remained as on first day. Bowels well moved by a purgative ; stool passed in bed. Urine retained to-day for first time. Pulse very weak and small, 126 ; temperature 100° F. *12th.*—Becoming more comatose ; cannot now be roused. Pupils equal, dilated and oscillating. Pulse 150 ; temperature 103° F. Lungs normal. Sinking rapidly. *13th.*—Died early this morning.

Autopsy.—*Brain* : Membranes at base much infiltrated, turbid and œdematous. Matting and some thickening of pia in Sylvian fissures, and numerous small, grey granulations could be seen scattered over the membrane. On removing the arteries and washing in water many small fusiform enlargements could be easily detected with the naked eye, and with the microscope presented the usual appearance of miliary tubercles. A considerable quantity of fluid in ventricles ; marked central softening ; fornix and septum quite diffuent. *Lungs* crepitant throughout ; no tubercles. One small cretaceous nodule in middle lobe of right lung. *Heart* normal. Abdominal viscera presented nothing-special ; no miliary tubercles. *Kidneys* enlarged, and presented many greyish-white elevations beneath the capsule. On section, presented (1) localized caseous abscesses ; (2) extensive areas of disease in the apices of pyramids ; (3) pyelitis ; a large part of the mucosa on each pelvis presented a thickened infiltrated appearance and a rough, caseous surface. Each ureter was in much the same state. Bladder normal.

CASE II.—C. M., aged 37, admitted to Hospital Dec. 5, 1881. Present illness began November 25th with a chill, followed by severe vomiting and headache. Vomiting lasted four days ; headache continued bad till December 2nd, when he began to wander a little in his mind, but would still give an intelligent

answer when spoken to; bowels very constipated. Since admission lies almost constantly quiet in bed with closed eyes. On being questioned answers rationally, but slowly and hesitatingly, and cannot depend on his answers to questions about his previous history. Makes no complaint of pain anywhere; says he has no headache, no evidence of paralysis. Urine obtained by catheter is very scanty, sp. gr. 1024; no sugar or albumen. Right lung, nothing abnormal found. At base of left lung from lower angle of scapula down is dullness, with feeble breathing. Front and axilla normal; tongue dry and heavily coated; abdomen retracted.

Dec. 7th.—Not much change in condition since his admission except that he is rather more delirious. Can still be roused and will answer questions though in a dull, dazed manner. Temperature, 100°F.; pulse, 84, small and weak; respiration, 28; optic disks slightly congested.

Dec. 8th.—Was very delirious last night, talking continually and attempting to get out of bed. If allowed to walk, staggers always to right and is inclined to fall backward and to right. No paralysis of face or extremities; ankle clonus well marked on left side; not present on right. Bowels not moved since admission; urine has to be drawn off; no change in condition of lungs; pulse, 88; respiration, 32; temperature, 99°.

Dec. 9th.—Continued delirious during night but this morning became suddenly cyanotic and inclined to coma. Respirations increased to between 50 and 60; pulse so small that could not be counted, about 150 to minute; large bubbling râles all over front of chest; right pupil dilated more than left. Patient is quite unconscious and evidently sinking fast. Died at 10 P.M. quite comatose.

Autopsy—*Brain*: Much sercsity escaped in removal. Base infiltrated; membranes turbid and present many small miliary tubercles, particularly in the Sylvian fissures. There was no congealed lymph or purulent exudation. Ventricles were dilated and septum very soft. *Lungs*.—Universally adherent. At base of left lung pleura was much thickened, and there were numerous flakes of yellowish white lymph, dry and firm. The

base of this lung was collapsed, the rest of it and the right one crepitated. On section both are thickly studded with small grey tubercles, chiefly isolated but here and there in groups. No cavities and only two small cheesy masses in the apex of left lung; heart normal. No tubercles in abdominal organs; *spleen* a little enlarged; kidneys healthy.

Reviews and Notices of Books.

Photographic Illustrations of Cutaneous Syphilis.—By GEORGE HENRY FOX, A.M., M.D., Clinical Lecturer on Diseases of the Skin, College of Physicians and Surgeons, New York. Surgeon to the New York Dispensary, Department of Skin and Venereal Diseases. Nos. X, XI and XII. New York: E. B. Treat.

These three numbers complete this admirable and original work. The high artistic merit which has characterized the previous numbers is maintained in these. They illustrate the following conditions, viz.:—Syphiloderma Ulcerativum, Chancre, Chancroid, Periadenitis, Condylomata lata, Syphilis hereditaria, and Dactylitis Syphilitica. In concluding our notice of this atlas of cutaneous Syphilides we can only once more congratulate the author upon the excellence of the work, which furnishes a far more real and reliable illustration of these disorders than any other similar set of plates extant, and we would advise every one interested in these highly-important affections to furnish himself with a copy.

Essentials of the Principles and Practice of Medicine; A Handbook for Students and Practitioners.—By HENRY HARTSHORNE, A.M., M.D., lately Professor of Hygiene in the University of Pennsylvania; Editor of American Edition of "Reynolds' System of Medicine," &c. Fifth edition, thoroughly revised and improved; with 144 illustrations. Philadelphia: H. C. Lea's Son & Co. Montreal: Dawson Brothers.

This is a concentrated extract of a text-book upon medicine.

The endeavour is made to condense into as few words as possible the essential facts which can be considered established concerning almost all the important diseases. It will therefore be most valued by students who wish to rapidly master the outline features of any given complaint without being compelled to peruse an entire article in one of the more voluminous treatises. It can hardly be supposed that practitioners of medicine can be satisfied with any such skeleton outline,—one would expect to find them past this stage, and rather seeking the filling in of many important points upon such a picture already present in their mind's eye. That there is a large demand for the book is, however, clear, from the many editions it has already gone through, and, certainly, the work is well done. The main objection quite inseparable from a compilation of this kind is, that many statements are necessarily made in a dogmatic way, which those of experience know well require to be much modified in order to be consonant with the truth. A well-arranged Formulary is added, along with metrical and other weights and measures, and numerous recipes for the preparation of food in tasteful ways for invalids and convalescents.

A System of Surgery, Theoretical and Practical, in Treatises by Various Authors.—Edited by T. HOLMES, M.A., Cantab, Surgeon to, and Lecturer on Surgery at, St. George's Hospital. First American from second English Edition, thoroughly revised and much enlarged. By JOHN H. PACKARD, A.M., M.D., Surgeon to the Episcopal and St. Joseph's Hospitals, Philadelphia, assisted by a large corps of the most eminent American Surgeons. In three volumes, with many illustrations. Vol. I. Philadelphia: Henry C. Lea's Son & Co. Montreal: Dawson Bros.

The plan now so frequently followed of having an American edition of a standard English author prepared by some well-known writer of the former country has become extremely popular. The advantage, of course, consists in the fact that by this means one gets not only a reprint of the latest British edition, but also such additions made by capable men as

brings the book abreast of the most recent teachings and writings. The improvements found in the second edition of Holmes' Surgery over the first are very great—the addition of many valuable woodcuts and chromo-lithographs having of itself very materially enhanced its value and usefulness. All this is reproduced in the present work which it is proposed to complete in three volumes. These are not too large—containing 1,000 double-column pages—and are gotten up in the very best typographical style and handsomely bound in half-Russia, after the manner now become so familiar to us through the many publications of Henry C. Lea's Son & Co. According to this arrangement Vol I. contains the articles under the following headings, viz.: General Pathology, Morbid Processes, Injuries in General, Complications of Injuries, Injuries of Regions. It is unnecessary to add more than this; that, after careful examination of many of the sections of the work which have been added by the American writers, we can say that the interpolations appear to have been completed with great care and judgment, nowhere unnecessarily introduced, and have evidently been entrusted to such experienced hands that the new text does not lose by comparison with the old. Any one desirous of possessing what is now probably the best modern standard work of reference on Surgery cannot do better than purchase this latest edition of the well-known "Holmes'."

The Science and Art of Midwifery.—By WILLIAM THOMPSON LUSK, A.M., M.D., Professor of Obstetrics and the Diseases of Women and Children in the Bellevue Hospital Medical College; Consulting Physician to the Maternity Hospital. With numerous illustrations. New York: D. Appleton & Co. Montreal: Dawson Brothers.

This treatise upon obstetrics is a work of a decidedly modern type. The author aims, as his preface says, "at showing that with advancing knowledge the art of midwifery has ceased to rest upon empirical rules, and is already, with rare exceptions, the natural outcome of scientific principles." The whole range of the wide field included in the subject matter will here be found

to be carefully traversed in this treatise. Although the scientific descriptions of the development of the ovum and the changes in the uterus are very thorough and complete, it may, perhaps, still more interest the practical physician to know that its greatest excellence consists in the admirable manner in which the chapters on the art of successful delivery are conceived and written. Nothing which it is useful for the practitioner of midwifery to know is lost sight of in the directions for managing labour of all kinds, as well as those troublesome accidents, abortions. Not only so, but copious references are given to native and foreign authors for all important statements made, so that any one may for himself refer for confirmation and further information to these authorities. We know of no modern work which can be more conscientiously recommended both to students and to physicians.

Transactions of the American Gynecological Society. Vol. V.
For the year 1880. Boston: Houghton, Mifflin & Co.

This elegantly-prepared volume comes to hand containing as usual an immense amount of carefully elaborated matter. The papers are many and of varied interest, covering great part of the ground of all the questions at present occupying the minds of those specially occupied in this particular branch of Medical Science. Amongst the numerous articles we can only select a few for special mention: "What is the proper field for Battey's operation?" by Dr. Robert Battey. This question of course is one of the unsettled ones of the day. The author endeavors to explain more fully the boundaries of suitable cases which he had hitherto limited by insisting upon affirmative answers to the three following questions: (1.) Is this a grave case? (2.) Is it incurable by other means? (3.) Is it reasonable to expect a cure by this method? The treatment of uterine enlargement by massage applied to the womb is introduced by Dr. Jackson, of Chicago, and is made the subject of considerable discussion. Dr. George J. Engelman, of St. Louis, contributes a paper on "Posture in Labour," in which he studies with much minuteness and after great research the various positions habitually assumed by the women of different races during the act of par-

turition. This treatise is illustrated by a large number of outline woodcuts. It is of interest in many respects and leads the writer to the conclusion that the decubitus usually adopted in England and Continental countries is wrong and should be modified. Some curious stories were related by those who joined in the discussion. Amongst others, this one: A woman in her 60th year was to be confined of her 18th child. She declared she would not be delivered till she was in the lap of her husband. She weighed 250 lbs. and her husband only 95 lbs. The Doctor insisted that she should have her baby without the aid of the old man and like other women. At the end of sixty hours he was obliged to give up and the little old crooked-back husband was brought in and put into a chair, and the old woman was put into his lap, and they had the baby in a trice! Dr. Chadwick's observations on the value of the hot rectal douche are already widely known. The volume concludes, as always, with a complete list of Gynecological and Obstetric Journals, and a "Gynecological Index," giving references to the whole of the world's literature on this branch for the year. This volume is fully equal in every respect to any of its predecessors. We can only regret that it is not possible to have it appear earlier in the year succeeding the annual meeting.

A Text-book of Physiology.—By MICHAEL FOSTER, M.A., M.D., F.R.S. Second American from the third and revised English edition; with extensive notes and additions by E. T. REICHERT, M.D., Demonstrator of Experimental Therapeutics, University of Pennsylvania. Philadelphia: Henry C. Lea's Son & Co. 1881.

It is gratifying to see that Dr. Foster's work is being appreciated in America. Let us hope that the exhaustion of a large edition within a year means the acquisition of a solid knowledge of the laws of life by many hundreds of the young students throughout the country. Praise of the book is at this date superfluous. Dr. Reichert's additions are just such as were needed for the general wants of the American student who wishes to have the histology and physiology in one volume. On the whole,

his part is well done. There are not many changes of importance in this edition, though in places we notice the sections have been rearranged and new woodcuts inserted. Why Pfluger's figure of termination of nerve fibres in cells of salivary glands? Who believes it? We should like to have seen the sources of the drawings more generally acknowledged. McMillan & Co.'s American edition from their New York house has evidently been run off the field. It was a foreign bantling, and no wonder it could not thrive in the absence of the gentle touch of a native editor. Let us hope that Dr. Foster will receive something more substantial than praise to remind him of the success of his book in America.

Books and Pamphlets Received.

ON SPERMATORRHEA: ITS PATHOLOGY, RESULTS AND COMPLICATIONS. By J. L. Milton. Eleventh edition. London: Henry Renshaw.

THE OPIUM-HABIT AND ALCOHOLISM. A treatise on the habits of Opium and its compounds, Alcohol, Chloral-Hydrate, Chloroform, Bromide Potassium, and Cannabis Indica, including their therapeutical indications. By Dr. Fred. Heman Hubbard. New York: A. S. Barnes & Co.

THE PREVENTION OF STRICTURE AND OF PROSTATIC OBSTRUCTION. By Reginald Harrison, F.R.C.S. London: J. & A. Churchill.

FAVOURITE PRESCRIPTIONS OF DISTINGUISHED PRACTITIONERS. With Notes on Treatment. By B. W. Palmer, A.M., M.D. New York: Bermingham & Co.

A STUDY OF THE TUMOURS OF THE BLADDER. With original contributions and drawings. By Alex. W. Stein, M.D. New York: Wm. Wood & Co.

Extracts from British and Foreign Journals.

Unless otherwise stated the translations are made specially for this Journal.

Uterine Chloasma, in Contrast With Addison's Disease.—GENTLEMEN—I will call your attention to-day to an obscure case sent to us for diagnosis, a case which has been very perplexing, and which, I am sure, will be of great interest to you. The patient, Jennie C——, is forty-one years of age, of Scotch extraction, and married. Her family record is good, free from any syphilitic, tuberculous, cancerous, or other taint; and there is no history of any exposure

to unusual hardships or anxieties. She has never had any children. She always enjoyed good health until the outset of the present illness, which began twenty-one years ago, or one year after marriage, and without any apparent cause. It commenced with a feeling of general weakness, pain in the back and abdomen, and a profuse muco-purulent discharge from the vagina. The weakness did not cause her to go to bed, but made her indisposed to perform any active household duties. There was decided loss of flesh. Ten years later, the symptoms still continuing, but subject to periods of improvement and relapse, she noticed, for the first time, an arched band of bronzed skin on the forehead, and shortly afterward patches of the same color appeared on the cheeks and abdomen. With the appearance of this discoloration there was no alteration in the other symptoms, for the pain in the back and the sense of weakness were still felt, and the loss of flesh had not been regained. During the last ten years her condition has gradually grown worse. The weakness and emaciation have slowly progressed, the discoloration of the skin has become more marked, and the pain in the back more intense. In addition to these, she has suffered during the last eight months from several attacks of palpitation of the heart, and has fainted a number of times without any apparent cause. The weakness complained of has been greater at some times than at others, and has presented remarkable fluctuations, but always with a tendency to become worse. The periods of weakness would come on without any evident cause, and would generally last three days.

The emaciation has been subject to no fluctuations, but has been steady and progressive. The appetite and digestion have been poor, the bowels occasionally loose, but not sufficient to produce the weakness and wasting.

Careful examination of the patient yesterday disclosed no disease whatever of the nervous system, nor any sign of any pulmonary lesion. The heart is healthy, the pulse moderate in frequency and strength. The lymphatic system presents nothing abnormal, and the liver and spleen are of natural size.

The urine is acid in reaction, and a special gravity of 1.017,

and is free from either albumen, sugar, or any deposit. The uterus is enlarged, congested, and retroverted. Its cavity measures three inches in length. The left ovary is prolapsed, and lies behind the body of the uterus. The catamenia are regular, last three days, but are attended with pain. The blood, as drawn from her finger and examined by my assistant, is paler than usual, from diminution of its colouring matter; but an enumeration of the blood-corpuscles with a hemacytometer, shows one cubic millimetre of blood to contain 4,450,000 red cells, and 1 white cell to 224 red ones, which, you know, is about normal. The discoloration of the skin is quite evident. There is a bronzed arch on the forehead and patches of like colour on the cheeks. The backs of the hands and forearms are also discolored. These patches, the patient says, vary in shade from day to day, and are separated, you see, from the naturally coloured skin, by a distinct line of demarcation. There is no discoloration of the axillæ, nor around the nipples, nor at the flexures of the joints. Lastly, there is decided weakness and emaciation.

I have been especially particular in detailing these symptoms, gentlemen, because you will appreciate their value and importance when we endeavor to arrive at a diagnosis. The case is, as you no doubt perceive, an obscure one, and yet upon its correct diagnosis will, of course, depend the treatment to be pursued, and the amount of good that we can do our patient.

The discoloration of the skin is the sign that would first attract your attention, and this, in conjunction with the progressive weakness and emaciation, would immediately raise the query: Have we to deal with a case of Addison's disease? But you should be aware, gentlemen, that a like discoloration of the skin sometimes occurs in chronic diseases of the liver, spleen, stomach, uterus, intestines, or peritoneum, due to long-continued irritation of the abdominal sympathetic centres. Hence, in a case such as the one before us, we should be careful to search for the existence of any local irritation of the abdominal organs, to study the progress of the disease, and to analyze most minutely the various symptoms present. Addison

described the disease which now bears his name, as a progressive, idiopathic anæmia, accompanied by a general languor and extreme debility (but without much loss of flesh), and by a bronze discolouration of the skin. The heart's action he stated to be remarkably feeble, the pulse weak, much shortness of breath to occur on the slightest exertion, and death to result from asthenia in the course of from one to several years. It is a disease essentially of the suprarenal capsules, bodies without any definitely known function. They become the seat of a chronic inflammation, are enlarged, and later undergo a cheesy degeneration, and their capsules thicken.

Lying in close contact to the semilunar ganglia and their nerve-prolongations, a constant irritation of these great centres is produced; it is by reference to the long-continued irritation of their numerous and varied plexuses that the different symptoms, such as pigmentation of the skin, palpitation of the heart, dyspepsia, breathlessness upon exertion, etc., are to be explained. The cheesy mass may also act as a centre of infection, and occasionally tuberculosis may result.

Having given the symptoms of Addison's disease, let me again direct your attention to the case before us, so that we may compare the two, and see in what they differ. The bronzing in the patient here is not uniform or diffused, but is separated from the naturally coloured skin by distinct lines of demarcation; it has not progressed, and there is no discolouration around the joints, umbilicus, genitals, or armpits. It is true that, in cases of discolouration of the skin due to chronic disease of the abdominal viscera, it is usually limited to the face and abdomen, and does not, as in this instance, occur on the hands. But this is not a constant rule. I have known almost universal bronzing of the skin to attend chronic peritonitis, without any disease of the capsules; while, on the other hand, in the present case there are no purplish spots on the mucous membrane of the mouth, and no bronzing about the genitals or flexures of the joints. The latter points are of value as being unlike what are apt to occur in true Addison's disease.

The feeling of debility has not been so extreme as in the lat-

ter disease ; the tendency to palpitation of the heart has been very slight ; and the gastric disturbances have been very mild. Lastly, the patient has chronic endometritis with prolapse of an ovary, with which condition there is often associated such irritation of the abdominal sympathetic ganglia as to prove the source of weakness and debility.

Progressive, causeless, and irregular debility (not accompanied with marked loss of flesh) is the most prominent symptoms of this peculiar disease of the suprarenal capsules. The prostration and loss of muscular power cannot be explained by any functional disturbance that a patient may present, nor will diligent inquiry find any special lesion as a cause of the constitutional change. It seems that in the case before us we can develop a debility not due to any organic disease except a chronic endometritis with prolapse of an ovary. Now, in some women, a slight uterine catarrh will produce marked debility and disturbance of health, whereas in others a more serious disease of the womb will cause no bad symptoms whatever. Again, we have the weakness in our patient accompanied with emaciation, while in Addison's disease the latter is not at all commensurate with the former. In Addison's disease we usually have vomiting, dyspepsia, or other symptoms of a disordered condition of the stomach ; but in this case, although there has been some irritability of the stomach, it has been very slight, and the uterine condition is sufficient to explain it. Palpitation of the heart, feeble pulse, and breathlessness upon exertion, have not been at all prominent in the present case, as they are in disease of the suprarenal capsules ; and those attacks which have occurred the morbid state of the uterus could readily produce. I would ask especial attention to the analysis of the blood in this case. The state of this fluid differs greatly in different cases of Addison's disease. As will have been seen, Addison regarded the disease as essentially one of progressive anæmia ; and so in some cases there is a very marked degree of anæmia, probably due to some deteriorating influence by the focus of degenerating exudation and to the reflex disorders of digestion. But in other cases the force of the disease expends itself on the nervous con-

nections of the suprarenal bodies, and the composition of the blood undergoes but little change. Hence it is evident, that no diagnostic importance can be attached to the absence of anæmia in the present case. Lastly, the course of Addison's disease extends over a period of from two to five years, while the woman before you has been ill twenty-one years.

The case, gentlemen, you perceive is not clearly defined, but lies, as I may say, on the border-line. I think, however, that from the careful analysis and differentiation of its history, symptoms, and progress which have been made, we are safe in considering it as one of uterine chloro-anaemia with debility, due to chronic endometritis and prolapse of an ovary.

The prognosis, therefore, is favourable, and the woman will be benefitted by local treatment applied to the womb, for which purpose she will be placed under the care of my colleague, the Professor of Gynecology. In addition to this, careful attention must be paid to her diet and mode of life, and internally a course of ferruginous tonics must be directed. Among the best of these would be :

R. Acid. phosphorici diluti,

Tr. ferri chloridi - - - - - āā f. ʒj.

M. Sig.—Twenty to forty drops in a wineglassful of water, through a glass tube, three times daily, after meals.

Or,

R. Elix. ferri pyrophosphat., quiniæ et

strychniæ - - - - - f. ʒ ij.

Sig.—Teaspoonful after meals, in water.

Hence you see the importance of a direct diagnosis in such cases.

In Addison's disease there is no direct line of treatment, as we have no means by which we can influence the morbid process in the suprarenal capsules, and our remedial measures are consequently only palliative. I will merely indicate the leading ones. They are as follows: 1st, Rest. Especially during the periods of intense weakness, which occur at irregular intervals during the course of the disease. 2nd, Regulation of the diet; only nourishing and easily assimilated food, such as milk, soups,

eggs, farinaceæ, and oysters, should be allowed. 3rd, Counter-irritation over the region of the suprarenal capsules by irritating liniments and dry cups; but, best of all, by the actual cautery. 4th, Electricity—either the faradic or galvanic current may be used. 5th, The use of alteratives. Minute doses of bichloride of mercury, iodide of potassium, nitrate of silver, and arsenic, have seemed to do good. Cod liver oil, iron, extract of malt, and the hypophosphites, may be used to influence nutrition, but exert no influence over the morbid process proper. 6th, All specifics are without value.—*Dr. Pepper in N. Y. Medical Record.*

Frothing Urine.—Dr. Southey, in his valuable Lumleian lectures on Bright's disease, has quoted the aphorism of Hippocrates, to the effect that "bubbles maintained upon the top of the urine signify a disease of the reins, and likewise its long continuance," a fact, Dr. Southey remarks, which remained "unimportant until the end of the last century, when it was ascertained that albuminous urine held a froth of bubbles on its surface." That the persistent presence of air-bubbles on the surface of urine may be noted in most cases of albuminuria is undoubted; but, since the same condition occurs in a variety of other cases, it cannot be relied on as a test of the presence of albumen in urine; and, when so interpreted, it will in many cases prove misleading, and give rise to unnecessary alarm. I have frequently met with urines which have retained a froth on their surface, from the moment of being passed for 12 and even 24 hours, and which have not contained a trace of albumen. I have at the present time two cases under my care in this town (San Remo); the one of diabetes, and the other of dyspepsia. The froth in the diabetic case is certainly not due to decomposition of the sugar, since the froth forms upon it immediately it is voided; while the only noticeable features in the second case are, that the urine contains an excess of earthy phosphates, and its acidity is beyond the normal standard. I believe that the occurrence of retained and persistent air-bubbles on the surface of urine is always of pathological significance;

and that their presence, when rightly understood, is capable of affording valuable practical information, although, so far as I am aware, the subject has not hitherto been followed out with the requisite care and minuteness. In some cases the frothing appears to be connected with the high density of the urine; in others, with its feeble acidity or alkalinity; and again, in others, with an excess of mucous.—*Arthur Hill Hassall, M.D., in the British Medical Journal.*

Aural Affections in Exanthematic Diseases.—In the *Archiv fur Ohrenheilkunde*, Vol. XVI, Dr. Gottstein has a paper on this subject. He refers to the rarity of observations, by competent observers, of the earlier stages of the ear diseases which occur during the exanthemata. From the statistics of Burckhardt Merian it is seen that of all the cases of ear disease which were referred to the exanthemata, but 16 to 18 per cent. were seen within the first six months of their development; and Gottstein's own statistics are not any more favorable for the observation of the acute stages of disease, and for the determination of the question of how the great destruction which is so often seen in such cases occurs. Wreden, of St. Petersburg, from his connection with the large children's hospital of that city, had most unusual opportunities for early observations. He has reported diphtheritic inflammation of the middle ear as very common in scarlet fever, but his observations have not been confirmed by others, as Gottstein thinks, owing to the ear disease being seen only in its later stages. According to Wreden, the diphtheritic exudation continues only fourteen days, and is succeeded by suppuration, the stage in which the disease usually comes under treatment. As contributions to this subject, Gottstein narrates three cases—one of croupous inflammation of the velum, pharynx, nose, and both middle ears, in the second week of scarlet fever; one of diphtheria of the throat, with diphtheritic inflammation of the left tympanum, in the second week of measles; and one of acute desquamative inflammation of both tympanic membranes, with perforating tympanic inflammation, in the course of measles. In

the first case, two days after the appearance of diphtheritic membranes in the pharynx and nose, great deafness was noticed, and examination showed diphtheritic membranes over both drumheads, which were already perforated, and the same exudation covered the tympanic mucous membrane. From the history, the presence of membrane first in the nose and later within the tympanum, Gottstein concludes that the exudative process extended up through the Eustachian tube to the tympanum and produced the destruction from within outward. In the second case, soon after the appearance of diphtheritic membranes on the uvula, palate, and tonsils, great deafness, without pain or discharge, was noticed in the left ear, and the deeper meatus was found to be covered by similar membrane. After removal of this, the membrana tympani was found perforated and the tympanic cavity in a state of suppuration, but without any membranous deposit, and Gottstein feels uncertain whether the exudation of the ear was an extension from the pharynx or was an independent deposit. In regard to the treatment of diphtheria, Gottstein has never seen the diphtheritic process shortened by cauterization, and considers that therapeutic efforts should be directed to removal of the exudation and to disinfection of the mucous membrane. He advises prolonged baths in aqua calcis, and powdering the diseased surfaces, after removal of the membranes, with salicylic acid.—*Medical and Surgical Reporter.*

Suprapubic Lithotomy.—Langenbuch of Berlin advocates this method in preference to all others in removing stone, claiming that the risk of wounding the peritoneum is not so great as is supposed, and that the antiseptic method is applicable, whereas in perineal lithotomies it is hardly possible to carry out the details of that method vigorously, in consequence of the anus being so near the wound. Of 478 cases of suprapubic lithotomy, collected by Dr. Dulles, only 13 were complicated by a wounded peritoneum, three of which were fatal. The author showed that a stone weighing more than two ounces could be extracted with less risk by the high than by the perineal method. The comparative advantages of perineal and suprapubic lithotomy

are considered by the author, who states that urinary infiltration of connective tissue, it is pointed out, is a danger common to both operations, which, however, in the high operation can be prevented. The danger of this infiltration when it has occurred is much less after the high than after the perineal operation, since the epicystic is more accessible and less confined than the periprostatic and circumrectal connective tissue; can be more readily incised and disinfected, and, as it is not connected with any large venous plexus, is less likely, through its decomposition, to set up general septic infection. In the high operation the incisions can be made carefully and precisely, and through structures that are freely exposed to view, and there is no necessity for forcible laceration and contusion of connective tissues and other soft parts. It may be said the author suggests that it is as difficult to set up urinary infiltration after the high operation as it is to prevent such infiltration after lithotomy by the perineum. For the removal of a large stone—one with the maximum diameter of about two inches—the safest proceeding, Langenbuch thinks, is the high operation performed in two stages and under strict antiseptic conditions. To meet the case of a monster stone, measuring from 4 to 7 inches in diameter, the extraction of which in the second stage of the high operation would probably cause much laceration of the recently healed superficial parts, and also of the peritoneal fold, he proposes a complicated proceeding. In the first stage, the anterior surface of the bladder is freed to some extent of its layer of peritoneum, and a plastic operation is performed on this membrane. In the second stage—that of extraction performed after an interval of from five to eight days—elaborate preparations are taken to disinfect the bladder.—*Boston Med. & Surg. Journal*.

A New Theory of Uræmia.—MM. Feltz and Ritter have recently announced that the real cause of uræmia is a change in the proportional quantity of potassa in the blood. The amount of the potassic salts in the blood, as in the urine, varies with the quantity and quality of the food. A special alimentation, in which the sodic salts preponderate, long-con-

tinued, has the same effect upon the quantity of the salts of potassium, as a poor and insufficient diet. The quantity of the salts of potassium contained in the blood influences in a certain degree the amount of urea necessary to produce grave or fatal results. Suppression of the renal function by the simultaneous ligation of the ureters determines in the blood and in the serum a sensible increase in the potassic salts except the supplementary gastro-intestinal excretion. In this respect the alkaline salts obey the same law as urea and extractive matters, which increase in the blood under the same conditions. The most serious results of experimental uræmia are not connected with the retention and accumulation in the blood of the urea or extractive matters of the urine, but, on the contrary, are produced by the injection of fresh, normal urine, or of equivalent solutions of the salts of potassium in distilled water. We think it must be admitted that the real agents of the toxæmia are the salts of potassium which accumulate in the blood.—*Bull. Gén. de Thérap.*, Sept. 15, 1881. *Medical News*.

Acute Diabetes Mellitus.—Dr. George Harley states in his work on the urine and its derangements, that “there are such things as *acute*, as well as *intermittent diabetes*,” and quotes briefly from a report made by Dr. Noble in the *British Medical Journal*, January 17, 1863, of two cases of the former: one a boy of seventeen years of age, who died three days after the disease was discovered, and only a few weeks after he first felt ill; the other, a young lady, who died on the tenth day after the nature of her malady had been diagnosed.

Dr. Brunton, in Reynolds’ “*System of Medicine*,” says: “Cases have been recorded in which the disease seemed to run a course of only a few weeks before phthisis set in,” but Dr. Noble’s report is the only one I can now find in several treatises on diabetes mellitus, where the disease ran its course with such shocking celerity. This being so, it must be of interest to the profession to hear one other detailed, which came under my notice last Thursday, and terminated fatally within sixty hours.

M. C——, a young man thirty-two years of age, tall and stout, weighing in health 240 lbs., came to my office for treatment on the afternoon of December 8th, complaining of what he called malaria, and for which he said he had taken quinine without benefit. He was then in a state of exhaustion, with a tongue dry and irritant as a rasp, and tortured by fiercest thirst. Upon inquiry, I learned his health had been excellent to within three weeks, when, without apparent cause, he began to pass enormous quantities of urine, and consume an extraordinary amount of liquid. He had lost 25 lbs. in weight in about fifteen days. His appetite had not failed him until two days before, when the bowels had been moved copiously, after taking repeated cathartic doses to overcome an obstinate constipation, since which time he has lost all desire for food, and felt more than usually wretched. His breath had an odor of hay. He stated that, when voiding urine, if a drop should fall upon his boot or clothing it would leave a white spot, and showed me several recent spots on a corner of his overcoat.

I found the urine to have a specific gravity of 1040, and with the copper test to show a large amount of sugar. Examined since, under the microscope, abundant crystals of diabetic sugar have been exhibited.

My patient called at the office on Friday, but was now in an almost incoherent condition, skin hot and dry, heart labouring hard, nausea, constipation, excessive diuresis. He told me he had probably passed twenty pints of urine, as nearly as he could estimate, during the past twenty-four hours. I directed him to return home at once and remain there, continuing the prescribed treatment, with supporting measures added, when I would call and see him the next morning.

During the night he ate ravenously of ice, and, ascertained by subsequent measurement, passed about a pint of urine every hour until 3 A.M., when, being hastily summoned, I found him vomiting, breathing heavily between whiles, sighing, and in great apprehension of mind. He complained of gastric pain, probably caused by the ice, which, with the vomiting, was soon ameliorated. Calling again at 9 A.M., I found he had taken

hourly doses of medicine, and, in answer to my questions, stated he felt better. No more urine had been passed. At 2 P.M. Drs. Arrowsmith and Hodges met me in consultation. The patient was in profound coma when we reached the house, and died in that condition at 3 A.M. on Sunday, the 11th inst., sixty hours after his disease was first diagnosed. His system did not respond to galvanism, revulsives, or hypodermic measures after coma began. I introduced a catheter into the bladder, but drew off only about eight ounces of urine, and a subsequent use of the catheter some hours afterward did not bring so much.

Any intelligent physician will see that, in a case sliding so rapidly into the grave, scarcely any of the remedies appropriate to saccharine diabetes could be used. The appetite being gone entirely, it was useless to speak of diatetic measures, and beyond tonics, acids, and supporting measures, there was scarcely time to look about one before life had hurried away. No autopsy was obtainable.—*Dr. Welch in N. Y. Med. Record.*

Primitive Physic.—It is curious to think of a whole religious organization medicinally treated according to the notions of the founder of the sect. Yet this is precisely what happened to the English Methodists. John Wesley was not content with caring, as he only could, for the souls of his followers, but he thought that it was within the line of his duty to care for their bodies. He therefore prepared and published his “Primitive Physic: or, an Easy and Natural Method of Curing Most Diseases.” The book had a tremendous sale among the connection. My edition, dreadfully shabby, looking as if some of the reverend man’s medicine had been spilled upon it, is the twenty-fourth; it was published in London in 1792, and it was “sold by George Whitfield, at the Chapel City Road, and at all the Methodist Preaching Houses in town and country.” Wesley takes care to assert in his preface that “love of God, as it is the sovereign remedy of all miseries, so in particular it effectually prevents all the bodily disorders the passions introduce, by keeping the passions themselves within due bounds.” Wesley had gathered together from old wives and highly religious old

valetudinarians, a quantity of the most hopeless prescriptions which were ever entertained by the votaries of dosing. He is good enough to omit from his list of remedies "the four Herculean medicines—opium, bark, steel, and mercury, together with antimony." So much the better, it may have been, for the Methodists of the period, and of subsequent periods, down to those who bought the twenty-fourth edition of the "Primitive Physic."

His prescriptions, as a rule, are singularly speculative. For the ague he orders "a large onion, slit, to be applied to the stomach." For the tertian ague, he directs that a plaster of molasses and soot shall be applied to each wrist; for apoplexy a handful of salt in a pint of cold water, poured down the throat of the patient. This remedy is also sovereign "for one who seems dead by a fall." "For a convulsive cough, eat preserved walnuts; for deafness, put a little salt into the ear; for dropsy, drink six quarts of cider every day; for the falling sickness (epilepsy?), drink half a pint of tar water, morning and evening; for the gravel, eat largely of spinach; for the headache, take a little of the juice of the horse-radish." Wesley even prescribed for lunacy. The patient, however crazy, had only to take "a decoction of agrimony four times a day." If this did not collect his scattered wits he was to rub his head several times a day with an infusion of ground ivy leaves and vinegar. For "raging madness," the patient "was to be set under a great water-fall as long as his strength could bear." This is varied by a recommendation to "pour water on his head out of a tea-kettle." The most wonderful of Wesley's prescriptions are those which he gives for old age, a disease which has not usually been regarded as curable. The octogenarian is to drink tar water morning and evening; he is to chew cinnamon daily; he is to swallow a decoction of nettles. Much of what he recommends would either prove inert or injurious.—"*Recollections of a Reader,*" in *N. Y. Tribune*.—*Coll. and Clin. Record.*

Milk.—Dr. Dyce Duckworth, in the *Popular Science Monthly*, says: "Milk is a food that should not be taken in

copious draughts like beer or other fluids, which differ from it chemically. If we consider the use of milk in infancy, the physiological ingestion, that is, of it, we find that the sucking babe imbibes, little by little, the natural food provided for it. Each small mouthful is secured by effort, and slowly presented to the gastric mucous surface for the primal digestive stages. It is thus regularly and gradually reduced to curd, and the stomach is not oppressed with a lump of half-coagulated milk. The same principle should be regarded in the case of the adult. Milk should be slowly taken in mouthfuls, at short intervals, and thus it is rightly dealt with by the gastric juice. If milk be taken after other food, it is almost sure to burden the stomach, and to cause discomfort and prolonged indigestion, and this, for the obvious reason that there is insufficient digestive agency to dispose of it. And the better the quality of the milk, the more severe the discomfort will be under these conditions. Milk is insufficiently used in making simple puddings of such farinaceous foods as rice, tapioca, and sago. Distaste for these is engendered very often, I believe, because the milk is stinted in making them, or poor, skimmed milk is used. Abundance of new milk should be employed, and more milk, or cream, should be added when they are taken. In Scottish households this matter is well understood, and a distinct pudding-plate, like a small soup-plate, is used for this course. The dry messes commonly served as milky puddings in England are exactly fitted to create disgust for what should be a most excellent and delicious part of a wholesome dinner for both children and adults."

On Tapping the Bladder from the Perinæum through the Hypertrophied Prostate.

—Tapping the bladder is an operation which is not often necessary; I believe it may occasionally be resorted to even when a catheter can be passed. Assuming it to be required, how is it to be done? Tapping with the aspirator-needle above the pubes is a safe proceeding, and, for affording temporary relief, is to be recommended. A surgeon who finds himself in difficulties with a distended bladder, a large prostate, and false passages, is likely to do less harm with the needle than with the

with the catheter, and is sure to give relief. Taking off the tension by withdrawing the urine generally permits the instrument to pass on the next trial. This method, however, can only be used for temporary purposes.

Tapping the bladder above the pubes with a trocar, for the purpose of establishing a more or less permanent drain, is very much like opening an abscess at its least dependent spot. Urine ascends the canula against gravity, and the products of inflammation of the bladder, usually present in some degree, remain behind in the pouch, undischarged. Tapping through the rectum requires the retention of the canula in the intestine, and is thus an obstacle to defæcation. Forcing the end of the catheter through the enlarged prostate is an unsurgical proceeding, not to be entertained. Tapping the membranous urethra leaves us in the position of having the obstructing prostate behind the opening. There is a point in the wall of the bladder, unconnected with peritoneum, through which a trocar and canula may safely be passed: I refer to the prostate gland, which in old men, where paracentesis is more frequently required, often affords a considerable area for the operation. I will illustrate this method by the following case, only premising that over twelve months ago I recognised its propriety, and tested it on the dead subject. I then had the instrument made for the purpose; but, though having considerable opportunity for dealing with retention of urine under all circumstances, it was not till quite recently that a case in point presented itself. I mention this as explaining how I came to be prepared, instrumentally, for doing that which I will briefly describe:—

N. D., aged 84, was admitted into the Liverpool Royal Infirmary at 2 A.M. on Nov. 4th, 1881. My house-surgeon, Mr. Laimbeer, found him bleeding from attempted catheterism, with a large prostate, and a distended bladder. Recognizing the urgency of the case, and finding catheterism impracticable, he emptied the bladder with the aspirator above the pubes. I saw the patient a few hours afterwards, and found that he had not passed urine since, and that no catheter could be introduced. His tongue was brown and he was much exhausted. Later on,

I again visited him, when the bladder had become fully distended. I then had him placed under ether, and succeeding in passing a gum-elastic prostatic catheter. Beyond demonstrating that the difficulty had been overcome, I declined letting any more urine be drawn off, for a reason arising out of recognizing that either the catheter must be retained, or reintroduced when required; neither of which proceeding I was disposed to recommend.

Retaining a catheter in the bladder of an old man, somewhat childish and disposed to remove any appliance if not closely watched, is not easy; and when it is done, it often ends with death from cystitis, pyelitis, and exhaustion. This was a case where, in my judgment, it was wisest to establish a permanent drain; and to do this in the manner on which I had determined required a tense, and not a flaccid, bladder. Taking a trocar which had been made for the purpose, with a silver canula, I introduced it in the median line of the perineum, three-quarters of an inch in front of the anus, and pushed it steadily through the prostate into the bladder, at the same time retaining my left index finger in the rectum for a guide. On withdrawing the trocar, a large quantity of ammoniacal urine escaped. The canula, being provided with a shield, was secured in its place by tapes much in the same way as a tracheotomy-tube. A piece of India-rubber tubing was attached to the portion of canula which projected beyond the shield, and conveyed the urine into a vessel placed at the side of the bed. Through this tubing urine continued to dribble. The patient was at once made comfortable by this arrangement, and in 48 hours he was up, sitting in an easy-chair—an important matter with old persons. To permit of this, the rubber tubing is shortened during the day-time, the end of it being tucked through a light abdominal belt, where it is compressed by a small pair of bulldog-forceps, which are removed when the patient desires to pass urine. He is quite as well as most men of 84 years of age are. He gets up daily, takes his food, and sleeps comfortably, either on his back or his side, without any narcotic, and is quite free from any urinary inconvenience other than wearing his tube. During the night, his sleep is not broken by calls to micturate or pass catheters, as his urine

runs off by the tubing as it is excreted ; whilst in the day-time, when he is up and about, his act of micturition practically resolves itself into something equivalent to the turning of a tap. His urine, which had been fetid and ammoniacal, is now nearly normal, the bladder being readily washed out by applying a syringe to the canula twice a day. On two or three occasions the canula has accidentally slipped out whilst the tapes were being changed, but has been readily replaced by the nurse. The somewhat enthusiastic manner in which the patient compares his present with his past condition, cannot be passed by entirely unnoticed.

The operation was devised much on the same lines I endeavour to take in commencing my lithotomy incision—namely, the selecting of a point in the perineum which endangers no vessel of importance. My object in planning the operation was to obtain what I can best describe as a short low-level urethra, adapted to the altered relations of the bladder to the prostate when the latter becomes enlarged, for the purpose of securing the most complete drainage. I should add that since the tapping, as far as we are aware, the patient has only passed a few drops of urine by the urethra. —*Reginald Harrison in Brit. Med. Journal.*

A Modification of Lister's Antiseptic Dressing.—In a paper on Lister's "Antiseptic Method of Treating Surgical Injuries," which appeared in the "American Clinical Lectures" for 1878, I called the attention of the profession to a modification of this procedure, which I was then using in the treatment of small wounds, especially those of the hand and fingers. I have since continued its use, and have found its results, in a large number of cases, so satisfactory that I have deemed it of sufficient interest and importance to justify my calling your attention to it in a short paper this evening. Although having full confidence in Mr. Lister's antiseptic method, I, like many others, have long recognized the great difficulty that must needs be experienced by the general practitioner in attempting to carry out the minute details of the dressing, and have for a long time been hoping that a more simple method, equally efficacious, might be devised.

Dr. Markoe's "through drainage" was a decided step in

this direction—antiseptic in character, simple in detail, and successful in result. This method, however, is appropriate only where drainage is necessary, but, simple and efficient as it is, it requires a certain degree of attention, which, while easy for the hospital surgeon, is not sufficiently so to guarantee its extended use by the physician in charge of a large general practice. Aside from the difficulties incident to the application of Mr. Lister's dressing, it has been found that surgeons in country towns distant from large cities have great trouble, and often are unable to procure good antiseptic gauze at the time when it is needed. This would not be so embarrassing if, in the first place, the gauze was fresh when obtained from the dealers; and, in the second, if it could be kept for a reasonable time without spoiling. This, however, is not the case. The gauze sold in most of our stores is frequently not in an antiseptic condition. As to its keeping fresh, Dr. R. F. Weir has demonstrated conclusively that even when kept wrapped up in rubber cloth and in a box it will deteriorate in a few months. In assisting in surgical operations, I have in several instances found that the gauze used had no odor whatever of carbolic acid, although it had just been purchased from a responsible dealer in this city. In my own practice I have been obliged to depend for a reliable gauze on the kindness of the authorities of one of the hospitals with which I am connected. Furthermore, the materials necessary for fully applying Mr. Lister's dressing are somewhat expensive, a very important fact when we consider that the majority of accidents and operations that call for this procedure occur among those who are able to bear but little expense.

I have for several years been surgeon to a large factory in this city, in which three thousand hands are employed, and where injuries by machinery are quite frequent. These injuries consist chiefly of wounds of the hands and fingers, caused by their being caught in the cog-wheels and other parts of the machinery. In many cases the fingers are torn off, tendons are pulled from their sheaths, joints are opened, and the hands are often severely crushed and lacerated. In all of these cases I have, for the past six years, been using the following simple

antiseptic dressing: Having put the parts in a condition for dressing, I wash the wound in a solution of carbolic acid of the strength of one to twenty; I then cover the parts with a thick layer of borated cotton, and then snugly and evenly apply a simple gauze bandage. At first I used bandages made of antiseptic gauze, but for the past three years have used those of plain uncarbolized cheese-cloth. These thin bandages distribute the pressure more evenly over the cotton, and are more easily saturated with the fluids than those made of unbleached muslin. The patient is instructed to keep the outside of the dressing wet with a solution of carbolic acid of the strength of one to one hundred. I frequently employ Squibb's solution of impure carbolic acid, which is of the strength of one to fifty, and which, when mixed with an equal bulk of water, gives a solution of the desired strength. The parts should be kept at rest, and the dressings may be left undisturbed for several days, unless there is pain, rise of temperature, or discharge through the dressings. These conditions are always to be considered indications for redressing. In many cases where rubber drainage tubes have been used they may be removed at the second dressing, and, if catgut has been used for sutures, this second dressing can be allowed to remain on for an indefinite period. In a number of cases of lacerated wounds I have allowed the first dressing to remain on until the wound has entirely healed. In these cases the external use of carbolic lotion was discontinued after the fifth or sixth day, and the dressings would become dry and hard, the wound healing, as it were, "under a scab." The patient should be instructed to loosen the bandage at once if any pain occurs. My experience with this dressing covers, as I have said, a period of about six years, during which time I have treated nearly three hundred cases of open wounds. Not one of this number has been followed by inflammatory symptoms. Extensive lacerated wounds have healed, and dead tissue has sloughed away, without giving rise to any of the so-called symptoms of inflammation. Neither pain, redness, heat, swelling, nor constitutional disturbance has resulted. In no case has there been reddening of the lymphatics or tenderness of the

glands. No counter-openings have been necessary. Pain has been entirely absent, so that anodynes have not been needed, save in a single case, and that for one night only, to control slight restlessness. These results are the more remarkable from the fact that many of these patients were in an unhealthy condition, some suffering from anæmia, some from cardiac disease, phthisis, and the like.

Recently I used this modified dressing in St. Vincent's Hospital, in a case of amputation of the leg. The history of the case is as follows :

The patient, a boy nine years of age, was run over by a dummy engine, on September 28th. His left foot was crushed so that it was necessary to amputate the leg at the junction of the middle with the lower third. The operation was performed by Dr. John F. Luby, the House Surgeon, in my presence. The method of amputation was that by lateral skin flaps and circular incision through the muscles. All the details of Lister's method were employed except the spray. Catgut was used for ligatures and sutures. Short drainage tubes were placed in the anterior and posterior angles of the wound. After the wound was washed with a one-to-twenty solution of carbolic acid, it was dressed with several layers of dry borated cotton and a gauze bandage was applied. The outside of this dressing was kept constantly wet with a one-to-forty solution of the carbolic acid. The great and the second toe of the right foot were also crushed, so as to require amputation at the second joint of the great toe and at the metatarso-phalangeal articulation of the second toe. These wounds were dressed in the same manner.

October 2nd.—Four days after the operation. Patient has not complained of any pain. His highest temperature has been 99.8° F. Has slept well and has a good appetite. On removing the dressing, the cotton was found not to have been wet through by the carbolic acid lotion. The layer in direct contact with the wound was saturated with a watery discharge. The wound was in a perfect aseptic condition. The drainage tubes were removed and fresh borated cotton was applied.

October 7th.—The boy has been perfectly comfortable during

the past five days. On removing the dressings very little discharge was found on the cotton. The wound was entirely healed, except at the points where the drainage tubes were inserted. The external application of the carbolic lotion was discontinued.

October 15th.—Dressings removed, and the wound found to be entirely healed, except at a point in the lower angle. The wounds of the right foot were dressed simultaneously with that of the stump. Although a small portion of the integument sloughed, there was no trace of inflammatory action. Granulations sprang up and the wound rapidly closed, so that on October 17th the cotton dressing was discontinued and unguentum resina was applied.

This case did as well as any case could have done under the most rigid Lister dressing. The value of cotton-wool as an antiseptic dressing is, I think, not fully appreciated by the profession. M. Guerin, of Paris, in 1872, and since then Mr. Gamgee, of Birmingham, England, have called attention to its great value. Used in the way I have indicated, it seems to me to be as perfect an antiseptic dressing as the gauze and other materials recommended by Mr. Lister, while at the same time it is free from all objections that pertain to the latter, and which materially hinder their use by the general practitioner. If applied in sufficient quantities around an open wound, it protects it thoroughly from the "floating matter of the air" which is supposed to be the real inciter of suppuration. It is the best germ filter known to us. Tyndall, whose experiments were very carefully made, found that while filtering the air, and endeavoring to get it perfectly pure, atmospheric dust, which would readily pass through sulphuric acid and a strong solution of caustic potash, was completely stopped by ordinary cotton-wool. I have used the very excellent borated cotton made by Mr. van Ende, of Hoboken, containing 15 per cent. of boracic acid* Keeping it wet externally with the solution of carbolic

* A great deal of the so-called borated cotton sold by dealers is made with a solution of borax, instead of boracic acid, which can always be ascertained by burning a piece of the cotton; if the cotton has been properly prepared with boracic acid, the flame is of a bright green color, but, if, as is generally the case, borax has been used, the flame will show very little of the green tint.

acid, in the manner already described, renders it more surely antiseptic. To insure success in the cases where the dressing is used, full precautions as to rendering the instruments, sponges, and the hands of the surgeon aseptic, and the use of drainage tubes if necessary, should not be neglected. Catgut or torsion should be used to arrest hemorrhage. The spray may be resorted to, if thought necessary, at the second dressing. I now usually apply carbolized oil, of the strength of one to twelve, to the wound to facilitate the removal of the cotton, which is otherwise apt to adhere after the first dressing.

I would state in conclusion, that my experience thus far seems to show that this simple dressing, so easy of application, is as thoroughly antiseptic as Mr. Lister's appliances, and that it has the very decided advantage of doing away with the necessity for using costly "protective oil-silk," "Mackintosh cloth," "carbolized gauze," etc., and gives us a dressing that can be used by any one under any circumstances, be it in the city or in the country. The borated cotton is easily kept for months unchanged. The fact that the dressing need not be done oftener than once in several days will especially commend it to the country physician. The success of this procedure in the treatment of large wounds after accident or amputation will increase its importance, and materially extend its field of usefulness.—*Dr. James L. Little in N. Y. Med Journal.*

Meat-Bread.—M. Scheurer-Kestner has discovered the remarkable fact that the fermentation of bread causes the complete digestion of meat. He found that a beefsteak cut into four pieces and mixed with flour and yeast, disappeared entirely during the process of fermentation, its nutritive principles becoming incorporated with the bread. The meat would also appear capable of preservation for an indefinite period in its new state; for loaves of meat-bread made in 1873 have been submitted to the French Academy of Sciences, where not a trace of worms or mouldness was observable. At the beginning of his experiments, M. Scheurer-Kestner used raw meat, three parts of which, finely minced, he mixed with five parts of flour and the same quantity of yeast. Sufficient water was added to

make the dough, which in due time began to ferment. After two or three hours the meat had disappeared, and the bread was baked in the ordinary manner. Thus prepared, the meat-bread had a disagreeable, sour taste, which was avoided by cooking the meat for an hour with sufficient water to afterwards moisten the flour. The meat must be carefully deprived of fat, and only have sufficient salt to bring out the flavor, as salt, by absorbing moisture from the air, would tend to spoil the bread. A part of the beef may be replaced with advantage by salt lard, which is found to improve the flavour. The proportion of meat to flour should not exceed one-half, so as to insure complete digestion. Bread made with a suitable proportion of veal is said to furnish excellent soup for the sick and wounded.—*Sanitarian*—*Canadian Pharmaceutical Journal*.

Bicarbonate of Soda in Tonsillitis.—

Dr. Giné, Professor of Clinical Surgery at Madrid, states that bicarbonate of soda, applied topically and repeatedly to the tonsils, is of incontestable efficacy in quinsy. The remedy may be employed by insufflation through a paper tube, or may be applied by the finger, even by the patient himself. Dr. Giné has rapidly cured dozens of cases by this procedure. In no single case was the application entirely without effect; most commonly a cure was obtained in 24 hours. Alleviation took place, ordinarily, at once. In none of his cases was it necessary to wait long for relief. But he especially recommends this remedy in the prodromic period to abort the disease. Dr. Giné considers tonsillotomy for enlarged tonsils as an entirely useless operation, for this affection is always overcome in a relatively short time by the frequent application of bicarbonate of soda.—*La Presse Méd. Belge*, July 17, 1881.

Small-pox and Anti-vaccinators.—The wickedness of encouraging the anti-vaccination agitation could not, it is opportunely pointed out by the *Globe*, be more strikingly proved than by an account it printed of the origin of an outbreak of small-pox in Rotherhithe. "A leading anti-vaccinator," Escott by name, who had none of his children vac-

cinated, had lost his wife and two children by small-pox, and four others have had the disease. Escott borrowed a suit of mourning from a friend named Angus to attend his wife's funeral, and returned the clothes without disinfection, with the result that the lender caught small-pox and died. Since then nearly every house in the neighborhood has been attacked, and sixteen patients have been removed to the hospital.—*British Medical Journal*.

Lactic Acid in Phthisis.—A. D. Macdonald, M.B., C.M., writes as follows to the *British Medical Journal* :

“ I have been struck by the observation that in some cases where there was a strong hereditary predisposition to phthisis, acute rheumatism had supervened early in life, and by middle age phthisis had not yet appeared. Besides, I understand that in Madras, for example, there is a large proportion of rheumatism to a comparatively smaller proportion of phthisis. May there not then exist some degree of antagonism between these diseases, and is there not in the latter a deficiency of the lactic acid poison of the former? On the 5th of June last I administered 10 minims of lactic acid thrice a day to a patient who had a vomica in the apex of the right lung, and the left apex had a deposit of tubercle. On the 11th the patient expressed herself as feeling better, but she complained of rheumatic pains in her joints for about two hours after each dose, and this in the absence of being informed as to any effect to be produced. Another patient to whom I gave the acid stated that it relieved her cough more than anything else she had taken. Both thought the acid very agreeable as a thirst-quencher.”—*Med. Record*.

Capsicum in Uterine Hemorrhages.—Dr. J. Chenon (*Le Progrès Médicale*) says: From a large number of physiological experiments, I concluded that capsicum is a vascular remedy, acting especially on organs whose circulation is singularly active, such as the utero-ovarian, respiratory, and encephalic. Cayenne pepper acts like ergot of rye on the smooth fibre of the vascular coats, either directly or through the vaso-motors. But it presents a great advantage over ergot, in

that it is well borne by the stomach, whose functions it simply stimulates. I have used it for several years in uterine hemorrhages with the best success, whether these hemorrhages were due to fibroid tumours, fungous endometritis, or even to epithelioma. The formulæ at which I have arrived are as follows:

R Powdered capsicum, 5 grammes. Make thirty pills. One before each meal, increasing to six pills a day.

R Aqueous extract of capsicum, 5 grammes. Make thirty pills. To be given in the same dose as No. 1.

R Tincture of capsicum, 5 grammes; rum, 30 grammes; gum julep, 120 grammes. Take by spoonfuls every two hours.

I have also successfully used capsicum in congestive headaches so common in the gouty, and in the hæmoptysis of tuberculous patients.

Pericardial Drainage.—Rosenstein, of Leyden (*Lancet*), reports the case of a child ten years old who had pericardial effusion, for which the pericardium was aspirated. A second aspiration was soon again required. A relapse occurred, whereupon an opening an inch and a half long was made in the fourth intercostal space. The soft parts were divided under antiseptic treatment, and two drainage tubes inserted. After four months of treatment the patient left the hospital in good general condition. An incision into the pleura was also required. The effusion was purulent.—*Chicago Med. Review.*

Epigastric Pressure in Obstinate Hiccough.—The *Journal des Sciences Médicales de Louvain* relates that M. Deghilage, of Mons, was called to a young lady suffering from very violent hiccough, with spasm of the glottis. The patient had been over an hour in this state, and was unable to articulate a syllable. There was no fever—no sign of heart trouble. The only cause that could be assigned was that the patient had the lower limb chilled a few days previously during her menstrual period. Inhalation of vinegar and Hoffman's anodyne and the application of sinapisms had been tried, without effect. Recalling Rostan's precept for such cases, M. Deghilage applied the palm of the hand to the epigastrium and exercised

strong pressure. There was slight amelioration, the movements were less convulsive, and the dyspnœa less intense. A large pad of linen was then applied over the epigastric region and pressed strongly inward by means of a bandage passed around the body. In a very short time complete relief was obtained. The pad was left several hours in position, and when it was removed the symptoms did not return.—*Med. & Surg. Reporter.*

Benzoate of Soda in Whooping Cough.

—Dr. Tordeus of Brussels writes that he has prescribed the benzoate of soda in a number of cases of whooping-cough, and that in all the cases the parents reported that the coughing fits began to diminish in force and frequency after one or two days of treatment. He gives four grains of the salt every hour to a child of two or three years. The drug seems not alone to diminish the force and frequency of the paroxysms, but also to exert a favourable influence on the mucous membrane of the respiratory tract, and to prevent the development of serious pulmonary complications.—*Journal de Med., etc., de Bruxelles.*

Salicylic Acid in Diphtheria.—Dr. Weise recommends very highly a two per cent. solution of salicylic acid in diphtheria. This is a strongly antiseptic solution, but not a dangerous one. He employs the following formula:—

℞ Acid salicyl., 1.09 ; sp. vini rectific., glycerine, āā 25.00.
At the same time he uses benzoate of soda internally.

Neuralgic Headache with Constipation.

℞ Quiniæ disulph., - - - - gr. xij
Acid. sulph. dil., - - - - ʒ ss
Tinct. ferri perchlor., - - - ʒ ij
Sp. chloroformi, - - - - ʒ ij
Magnes. sulph., - - - - ʒ jss
Syr. Zingiberis, - - - - ʒ j
Aquæ - - - - - ad ʒ xij

M. Sig. Two tablespoonfuls three times a day.

CANADA

Medical and Surgical Journal.

MONTREAL, JANUARY, 1882.

THE BILLS FOR MEDICAL SERVICES.

If from feelings of personal delicacy, or from other equally unreasonable considerations, the physician has deferred sending his bill for services rendered to his patients, the time has arrived when the accounts for the year must be settled in some way or other. He knows full well that the general sentiment of the people whom he has attended is adverse to the prompt settlement of medical bills, and that too generally the latter are paid eventually under protest. While, according to the general law of domestic economy, the physician must live as well as the butcher and baker, each debtor to the doctor would much prefer to change places with any others who were free from such obligations. Thus, the medical man is often impliedly placed in the position of one who is tolerated rather than encouraged, who is supposed to belong to the class of individuals whose pay, in great part, should be taken in the mere consciousness of doing good to his suffering fellows. These are privileges denied to many, but in order to be properly appreciated by the physician he should be a trifle beyond want himself. These are our higher humanities, which can never attain their full function with an empty stomach. The smell of the lily may be a reasonable dessert after a hearty meal, but it is not specially tempting to the man who is forced to descend to the prose of an ordinary bread-and-butter struggle.

Physicians, as a class, are too often tempted to look on the soft side of charity, and suffer in consequence. Hence the practical business man makes allowance for him, and is ever ready

in a patronizingly considerate way to take advantage of him. Of course this is the fault of the doctor as well as of his debtor. The readiness with which deductions are made from medical bills proves this. There is no doubting the fact that the prevalence of the practice has helped to create the too-widely entertained impression that medical services have no positive value, and that they should be paid for only after a heavy discount has been allowed. All these general considerations must have their bearing upon the medical men who are now making out their bills, and should help them to determine the amount of charges in given cases. It is well to recollect, while due allowance should be made for those who can pay little or nothing, that the maximum charges should be reasonably high. Physicians, as a rule, do not place enough pecuniary value on their services. Generally they are considered by their patrons worth no more than the small sum usually asked for them. The rich, as a rule, are of this opinion, and are usually disappointed in their estimate of the real value of the services of a doctor if a really small bill is presented. High charges are generally the only means by which the value of services rendered can be proven to such as are able to pay for them. There is far less likelihood of charging these persons too little than too much. An opportunity for practically testing this point is doubtless presenting itself to many of our readers engaged in bill-rendering. Another matter worth considering in connection with the squaring of accounts for the year, is how few patients shall be placed on the free list. Every physician who has a greater or less number of patrons whom he is not in the habit of charging, who occupy toward him the anomalous position of being his friends so long as they can use him to their advantage, or who, possibly, in consideration of some slight service rendered by them, give them a claim upon his good will and good deeds. It goes without the saying that these patients are the most troublesome and least profitable of the entire clientele of the physician. The best friends of the practitioner are those who pay him for what he does for them, and the sooner all services—no matter to whom rendered—can be placed on a cash basis, the better. It

is quite easy to anticipate what may be the effect of cutting off worthless hangers-on by a formal bill. If they discharge their doctor in consequence of the insult of receiving his bill, they are the only ones that can possibly suffer by the change. At least the physician is relieved from the obligation of spending his time and his energies for naught.—*N. Y. Medical Record.*

Obituary.

DR. DRAPER.—This eminent scientific man died on the 4th inst., at his residence, Hastings-on-Hudson, N. Y. Born near Liverpool in 1811, and partially educated at University College, London, he came to America in 1833, and in 1836 was graduated in Medicine at the University of Pennsylvania. Shortly after he was called to the Chair of Natural Sciences at Hampden-Sidney College, Va., and in 1839 to the University of New York, with which he remained connected until his death. He took an active part in the establishment of the Medical Faculty, and was the last of the six original founders. He lectured on Chemistry and Physiology for many years, and was an exceedingly popular teacher. His experimental investigations constitute some of the most important contributions to science made in the United States. He was one of the early workers at photography, and was the first to photograph the human face. Researches on light and the spectrum gave him a world-wide reputation, and he carried on at the same time many investigations into the mode of growth of plants and animals. In 1856 he published a Text-book of Physiology, which for many years was deservedly popular. He is best known to the public by his many purely literary works: "History of the Intellectual Development of Europe" (1862), "Thoughts on the Future Civil Policy of America" (1865), "The History of the American Civil War" (1867-70), and "The Conflict between Religion and Science" (1877). His death, we believe, was from kidney disease. Three sons survive him, all in the ranks of science; one, John C., is the Professor of Chemistry in the University of New York.

Medical Items.

TALL OAKS FROM LITTLE ACORNS.—Since the report that the child of the mother who, during gestation, carried a copy of Moore's Melodies, became a poet, "pre-natal culture" has become a study and the American Institute of Heredity is the result; most of its members are old maids.

HOW TO GIVE A SAVAGE DYSPEPSIA.—When a medical friend who could never resist disputing every pet theory of Sydney Smith, and always disagreed with him, accepted a professional call to Australia in the days of its savage condition, the clerical wit accompanied his friend to the ship, and, taking leave of him, remarked, "Good-bye, doctor; you have never failed to disagree with me, and I believe you will disagree with the savage who eats you."

TELEPHONIC TROUBLES.—Mistakes may happen even in the best regulated families. Here is an example. Chicago is blessed with a druggist of great experience and staid, modest habits of demeanour. It is his custom to replenish his stock when necessary, by ordering by telephone from other houses in the same line of business. With this purpose in view he called up such a house, and supposed he had it, when in fact he was still speaking to the telephone office. He was overwhelmed with chagrin and shame when, in reply to his question "Have you large black nipples?" only a hearty soprano cacchination was returned from the female operator in the office. For a number of days thereafter he was compelled to repeat his blushes as he caught the lady's laughter whenever she heard the tones of his voice on the wire.—*Chicago Med. Review.*

CHINESE REWARDS FOR MEDICAL SERVICE.—A correspondent of the *Globe* adds that this same decree throws some curious light upon the position which practitioners of the healing art hold in China. When the empress's illness became serious, several of the leading provincial governors were directed to seek out the most skilful doctors in their respective jurisdictions and send them on to the capital to consult with the medical college there as to

the course of treatment to be pursued. About half-a-dozen were forwarded, and as the result has been so eminently successful, they are now all to get substantial government appointments. One is to be made a taotai, or intendant of circuit, upon the first vacancy ; another a prefect ; another a district magistrate, and so on. Suppose, after the recovery of the Prince of Wales, Sir William Jenner had been made a county court judge, and Sir William Gull a stipendiary magistrate, we should have a somewhat analogous case in England.—*Brit. Med. Journal.*

ÆSTHETICS AND CATHARTICS.—Bunthorne, the “fleshy poet,” in the new opera, “Patience,” gives the following as a “wild, weird, fleshy thing, yet very yearning, very precious. To understand it, cling passionately to one another and think of faint lilies” :—

What time the poet hath hymned
The writhing maid, lithe limbed,
 Quivering on amaranthine asphodel,
How can he paint her woes,
Knowing, as well he knows,
 That all can be set right with calomel ?

When from the poet's plinth
The amorous colocynth
 Yearns for the aloe, faint with rapturous thrills,
How can he hymn their throes,
Knowing, as well he knows,
 That they are only un-compounded pills ?

It is, and can it be
Nature hath its decree.
 “Nothing poetic in the world shall dwell ?”
Or that, in all her works
Something poetic lurks,
 Even in colocynth and calomel ?
 I cannot tell.

—Heister, in his system of Surgery, whilst describing imperforate vagina, tells the following amusing story : “ We have a merry recollection of a girl that was imperforated after this manner, who, when she became sensible that she could not be debauched by any one, enlisted a great many to her service, particularly

some stout soldiers, who, upon trial, were all disappointed in their expectations, bilked of their money, and derided by the girl, who remained as much a maid as ever. Sometime afterwards this girl committed herself to the care of a surgeon, in order to be freed from the impediment; the case succeeded so well, that in a little time afterwards he got her with child, and she brought him twins into the world, as a testimony of his skill and a reward for his trouble.

PHYSICIANS.—Zimmerman says, if you need a physician, employ these three: A cheerful mind, rest, and a temperate diet. Pope declares that

“A wise physician, skill'd our wounds to heal,
Is more than armies to the public weal.”

Butler says:

“For men are brought to worse distresses
By taking physic, than diseases,
And therefore commonly recover
As soon as doctors give them over.”

—*Medical Bi-Weekly.*

—“What acid do we get from iodine?” asked the medical professor. “We get—a-n—usually get idiotic acid,” yawned the student. “Have you been taking some?” quietly asked the professor.

VASELINE.—The attention of our readers is called to this valuable product obtained from petroleum. As a base for ointments, it is to be preferred to lard, as it never becomes rancid. There are also many valuable toilet preparations now manufactured from this base, amongst others being the *Vaseline Cold Cream*, one of the most soothing and elegant preparations obtainable at this season of the year.

—A new Pepsin, called *Pepsina Prorsa*, is being introduced to the notice of the profession by Kenneth Campbell & Co. The makers claim it to be an absolute Pepsin, without the addition of sugar of milk, starch or other dilutant. We have seen a sample that has been proved to us to answer the test given by the makers—one grain being capable of dissolving 220 grains of coagulated albumen.