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Selections: Medicine.

CLINICAL DEMONSTRATIONS OF PHTHISIS.

*Delivered at the Hospital for Consumption and Diseases of the
Chest, Brompton.*

BY JAMES EDWARD POLLOCK, M.D., F.R.C.P.
Senior Physician to the Hospital.

LECTURE II.

GENTLEMEN,—When we last met we considered how far the modern pathology of tubercle and a clinical observation of phthisis can be made to agree. Theories change, and the fashion of the time, moulded, it may be, by the discoveries of the *jeunesse* of medicine, but the disease ever under your eyes has probably not altered from the days of Hippocrates till now. Its clinical varieties are well worthy your study, and, although you may not be able to tell at a glance the future of each, still there is a natural classification which will enable you to discriminate and assign fair reasons for your opinion. This knowledge is not to be found in a sorting of your cases into bundles, with a name attached to each, but rather to be sought in a careful clinical study. Thus you will find it abundantly demonstrable in these wards that there are many varieties of consumption, some of which become indefinitely prolonged, either from an inherent slowness to destructive change or because the local disease is limited, and the morbid action exhausted, as it were, in one circumscribed deposit, while others favour alterations in lung-tissue which convert its structure into an impervious mass, little influenced either by further inflammatory action or new deposits of morbid matters. Thus the *nature of the*

morbid products in the lung is of primary importance in your prognosis, and the fact of the origin of the attack in acute inflammatory or in slower insidious forms of disease. Again, there are modifying agents which shape, as it were, the progress of the affection; and these are found in the age and constitution of the patient, in the build and shape of his chest, in the diffusion or massing of the deposit in the lung, and in certain of the occasional events of phthisis, such as profuse hæmoptysis. I shall dwell on all of these, and show you specimens of each variety, and shall ask you to take good notice of the fact that some individuals evidence, by their plump, well-nourished condition, how tolerant the system may become of a very considerable amount of local disease, while others nearly perish from the constitutional irritative fever due to an affection, it may be, of one lung, limited in extent, but undergoing rapid softening.

The natural divisions of phthisis are, therefore, more numerous than the old three stages into which it was formerly divided; yet it is necessary to consider these, although they are erroneous guides to prognosis, inasmuch as they do not mean all that they appear to do. Many patients have strayed out of the condemned divisions, and in the third (and "last") stage have laughed at their doctors and proclaimed the fallacies of the "faculty." Patients will live with cavity in the lung for an indefinite number of years, or such an arrest of symptoms may occur in any stage as shall give time for a recovery of the nutritive processes. Only keep off the inflammatory attacks (for inflammation plays the most important part in the whole his-

tory of consumption), and if your patient preserve a healthy digestive system the stage of the disease is unimportant. Yet let us briefly examine these stages, which have their use and must be retained for purposes of study and accurate description, but do not mistake their meaning. They refer only to a state of lung, and not to a state of health. The *first* is the period of deposit or thickening of the lung, the *second* that of softening or disintegration, and the third that of *cavity*. The *first stage* of established disease of the lung—recognizable, that is, by physical signs denoting alterations in its structure—means such a block of a portion of the organ as shall render it less pervious to air. Hence the natural resonance which it gives on percussion is lost, the *intensity* of the air-sound as it enters is diminished, the *character* of the breath-sound is altered by the changed elasticity of the alveoli and minute tubes, and the air leaving the lung on *expiration* gives a more prolonged tone. The natural resonance of the voice and cough in the bronchial tubes is intensified and more directly conveyed to the ear, because the elastic and air-containing tissue of the lung is replaced by a solid medium which is a better conductor. It is obvious that this condition may be due to several causes either within or without the alveoli which have become closed up and impervious to air. An ordinary catarrhal pneumonia, resulting in proliferation of epithelial growth, will produce such an *intra-alveolar* block. The ultimate vesicles of the lung are filled up, the elasticity of their containing walls is destroyed, and what is called vesicular breathing is at an end, the entering air, when it reaches the ultimate bronchioles, being unable to penetrate further. Thus it is that the soft, gentle sound of pure respiration, which we hear in a healthy lung, is lost, and if the lung-block be considerable the breath-sounds are of necessity bronchial, being, in truth, only formed in the tubes, and not in the ultimate vesicles. It is safe to say that a large proportion of the cases which end in phthisis, or ulcerated lungs, begin in this way, by catarrhal products blocking the alveoli of a portion of the lung; and if you were to cut down on this diseased spot, you would not find the grey, semi-transparent granules of Bayle,

but the products of an inflammation. They have the same clinical history, but such alterations in the lung are not tuberculous, although you will find in practice that if not speedily liquefied and expectorated they either become caseous, and soften, breaking down the alveolar walls and ulcerating the lung-tissues, or, in certain cases, undergo the cretaceous transformation and become obsolescent. But, again, this pulmonary block may be *outside* the alveoli, and in that interstitial tissue which is spread through the lung—peribronchial and perivascular—that is, surrounding the vessels and bronchi, the *adenoid* or lymphatic tissue described by Dr. Burdon-Sanderson. It has been well demonstrated that it is capable of overgrowth from irritation, and in such circumstances it ceases to be the fine soft bed in which vessels are contained, and hardens, thickens, and compresses both the bronchi and alveoli, causing the collapse of the latter. The vessels are also enveloped, as it were, lessened in calibre, and the circulation, both of air and blood, interrupted. In a later stage, as I shall show you, this process ends in producing what is called fibroid alterations, which both harden and contract the lung. This first stage of phthisis, then, consists in a block of the lung; and two causes can produce it—the *intra-alveolar* plugging by the products of inflammation, and the extra-alveolar pressure by the natural interlobular tissue becoming thickened. A third cause is more rarely found in what are called “dust” cases—the dust of coal-mines, factories, and potteries becoming impacted in the alveoli, and mechanically blocking the lung; and this is invariably accompanied by an overgrowth of the adenoid and fibrous tissues, and all such cases, when chronic, belong to the class of fibroid phthisis. Let us consider these causes of lung-block clinically. You may not be called to see the first approaches of such a case, but very often indeed you will find a patient with this history and physical condition of a part of one lung, generally the apex. He will tell you that he has had cough after taking cold some weeks or months previously. A feverish cold, with pain in one subclavicular region; cough, slight greyish starchy expectoration, some emaciation, and generally depressed health. On examina-

tion you find the chest-walls slightly flattened to the second or third rib, lessened expansion, slight dulness, and deficient breath-sounds. There may be a whiffy character of respiration, and slightly increased vocal resonance. What is this case? I believe it to be one of *severe alveolar catarrh*: the vessels have been blocked by large granular cells which have undergone fatty degeneration and been expectorated. * But the walls of the alveoli have been damaged and collapsed, and a portion of lung is permanently blocked. This is not a tubercular case, and your patient may remain for years with the same physical signs, and without extension or even renewal of disease. We meet with them every day in practice. They are delicate, but perhaps have no cough. Yet they should live with care, for they carry with them a liability. Either a second attack may occur in a different part of the lung, or the old nidus of disease in the apex may break up, and the degenerated product be carried into the circulation, and the patient be inoculated with morbid matter, resulting in a second deposit, with accompanying hectic and all the history of phthisis. The above symptoms may also, no doubt, approach insidiously, and with premonitory conditions obscure but intelligible to the observant; and this early stage has been much dwelt on. I have long believed that there are symptoms before there are physical signs, a systemic or constitutional condition before any local disease exists; and a very serious question arises here. Do the whole train of symptoms in phthisis, the hectic irritative fever, sweating, waste, and exhaustion, only depend on a localised lung disease, of which they are the reflection, and which stands to them in the relation of cause to effect, just as the diseased joint gives rise to suppurative hectic? or is there a primary constitutional disorder, of which the local disease is only a sequence, expression, and result? Would a healthy person ever have such an alveolar catarrh as I have described, resulting simply from a neglected cold, and without any previous disorder of health? It is true that by far the most important agent in precipitating lung disease is inflammation; but is the inflammation itself idiopathic, or has it arisen out of a previous condition of blood or tissues which have im-

pressed on it a stamp and form, and made it not quite what we call a healthy inflammation? For there is a healthy inflammation, as you know, and is this it? "Certainly not," you reply, "the products of healthy inflammation are temporary, plastic, removable, not permanent, ill-vitalised, degenerative, like these blocked alveoli." Then why is it so? We all go through our severe colds and outlive them. Whence this insidious filling of the lung with epithelium granules, tubercle—what you will? or this acute localised patch of deposit after a few weeks' fever, which will not organise, nor resolve, but remains to degenerate, ulcerate, waste? It is true that the fever in phthisis is generally a measure of the irritation of the lung, but is there no fever premonitory and leading the way to these lung alterations? I must answer in the words of Latham: "Pulmonary consumption is only a fragment of a great constitutional malady, which it belongs to a higher discipline than any mere skill in auscultation rightly to comprehend." And as regards premonitory symptoms, I ask you to regard with much anxiety and grave care *the union of sub-febrile symptoms with progressive waste of the body*. Here is danger without any physical signs, but if the latter be superadded you have lung disease, and localised lung disease with fever is catarrhal pneumonia, tubercle, hyperplasia of adenoid—what you will, but, above all, it is phthisis.

In studying such a case you must exclude several causes which might mislead you. Emaciation may be due to dyspepsia, and cachexia from syphilis, diabetes, chronic abscess, joint affections, and fever, as well as other alterations of health. In all cases the rule should be to regard moderate fever of the remittent kind and wasting of the body with great suspicion.

Let us just consider the progress of a healthy sthenic pneumonia in contrast. Your patient, hitherto healthy, has been exposed to cold, generally rather severely, and after sweating. He shivers, and has an immediate rise of temperature to 103° or 104°. This is followed by moderate but rapidly-increasing dulness over one lung from the base upwards even to the apex. A fine crepitus succeeds, and the breath and voice-sounds become tubular. Dyspnoea

marks the lessened space for breath and rusty sputa the extreme congestion in the lung. There is little pain, but there is much fever and distress, and the patient has a burning skin and patches of redness on the malæ. On the seventh day, or later, a crisis occurs; the temperature drops suddenly, the physical signs alter, the dulness lessens, and a coarse crepitation replaces the fine. In an incredibly short time there is convalescence, and the lung-signs are normal. In this case no one can doubt that the lung-alveoli are blocked by exudation so thoroughly that, in fact, no tissue in the lung is pervious to air except the larger bronchi. But there is speedy resolution; the plastic exudation readily liquefies, resolves, and is absorbed and expectorated. It is plainly not the *extent*, but the *nature* of the lung deposit which is dangerous, and it is equally plain that the alveoli, although blocked and filled up, have not been injured, for we find that the recovery after such an attack is perfect, and the integrity and elasticity of their walls is complete. There is no ulceration of lung at all in the case, and the organ returns to a condition sound and pervious, with free elasticity, a perfect double circulation, and all functions unimpaired. Where, then, is the difference between this sthenic pneumonia and the alveolar disease which I have described as leading to phthisis, nay, as so often destructive of the lung and of the patient? Doubtless it is found in the nature of that diseased product which will not liquefy nor resolve, but precipitates destructive ulcerations of the surrounding tissues. And let us go a step further back, and ask why is not the product of disease a healthy, removable product? why is it low in organization, liable to degenerative change, but not liable to such a complete and rapid form of degeneration as would remove it from its dangerous impaction in the lung? We are compelled here to seek an antecedent cause, which is higher up in the chain of morbid events, and we say, here was a "constitution," or an hereditary predisposition, which caused this inflammatory block in a portion of one lung to be of infinitely greater danger than the inflammatory block of a whole lung in another individual. I wish I could explain this to you; but here are the facts, and

they are hard of interpretation, and we are driven to obscure terms like "diathesis" to cover our ignorance. But do not mistake me; up to this point all is clear, but behind it lies the field for future advances, and perhaps a lessened mortality.

Look at a case of unresolved pneumonia, and you see "phthisis." Such a case has generally not been sthenic, the temperature has not been excessive, and there have been variations looking like recovery. The dulness has not been complete, but in patches and the locality of these patches has partially changed; one has cleared up, only to be replaced by another. The rusty sputa are rarely seen. I have said the pyrexia was less marked, but the fever changes its character into a slow remittent with the diurnal variation of phthisis; low temperature in the morning, and 103° in the evening. At the end of two or three months the case has not cleared up, and your patient is weak, emaciated, and has night-sweats. His lung (one lung) may be dull in parts at the base, much more rarely at the apex or in the middle near the root of the lung, and not only is the breath-sound tubular, but there is crepitus here and there. The medical attendant is alarmed, and with reason, and says he would gladly have exchanged such a case for a true active pneumonia with much fever and high temperature, and complete block of a whole lung. In this opinion he is right. He will ask you anxiously in consultation if this be tubercle. I care not for names. It is a deposit in the lung which will not resolve, and which threatens to destroy the alveolar walls and to give rise to the train of symptoms which indicate ulcerated lung-tissue. I would have you carefully note the small portion of lung engaged as compared with a sthenic pneumonia, the deficiency in the resolution of the local disease, and the passage of pyrexial fever into hectic. Now we have brought our comparison of cases and our reasoning on them to this point, that the difference between the unresolved pneumonia and the catarrhal block of the alveoli or the old localised deposit of tubercle—call it which you will—is in the nature of the product extended into and around the alveoli, and not in the extent of lung engaged. For in the first case you have a commencing

phthisis, and in the latter you have a very acute disorder, with ten times the amount of local mischief, and yet complete recovery is almost sure to follow. Histology will not unravel the difference between the two cases, and it will not do to look through a microscope or listen through a stethoscope for the cause. The histological appearances and the physical signs are nearly identical in the two cases, and hence I ask you to examine deeply and carefully into the vital phenomena and the antecedent history of the two cases, and trace how the feeble constitution with inherited tendencies produces a distinctive product in the lung, and how the healthy is enabled to battle against an infiltration of a whole lung successfully.

It was perhaps best to consider these questions while examining what has been called the first stage of phthisis, or that which is characterized by a morbid product in a portion of the lung. If we could define the pathology of this stage, we should have accomplished the most difficult part of our task.

One symptom to note in phthisis is, that not unfrequently an hæmoptysis ushers it in; and it is true that some of the more rapid forms of phthisis are so commenced. A patient, overworked, it may be, or enfeebled by anxiety or other depressing agents, will bring up a mouthful of blood, and soon present all the physical signs and the fever and waste of phthisis. In such an event you must watch the temperature and pulse quite as much as the physical signs, and if much fever, with an evening temperature of 102° or 103° prevail, and morning sweats, the case is likely to be rapid in its changes for the worse, even without pause, till a cavity is formed; or progressive softening of the lung may occur, and the case become one of galloping consumption. This event is to be looked for, but is not an invariable sequence of a rather profuse hæmoptysis occurring as an early symptom. Its meaning is undoubtedly great congestion of the lung, and we must remember that rapid softening occurs often. Either inflammatory products block the alveoli, or, as has been said, retained clots of blood form the nuclei of degeneration, and in their changes involve the lung-tissue itself.

Not all these cases so initiated do badly, but

many pass into the chronic stage, exhibiting little tendency to degenerate or ulcerate the lung, and the symptoms, although primarily severe, may subside, and leave only the signs of a quiescent block of a portion of lung, while the patient recovers a fair condition of health. An hæmoptysis depletes the lung and relieves the congestion, as I shall have occasion to point out to you again, and its occurrence is often followed by a long period of quiescence or latency of disease.—*London Lancet.*

HOW TO CURE A COLD IN THE HEAD.

BY DAVID FERRIER, M.D.,

Assistant Physician to King's College Hospital.

Though a cold in the head gives rise to much discomfort and uneasiness, it is not usually considered grave enough to necessitate professional advice; and the unfortunate victim of nasal catarrh, with watery eyes, running nostrils, sneezing, and nasal speech, is more often regarded as a subject of ridicule rather than of sympathy or commiseration.

Being occasionally liable to severe nasal catarrh, often of prolonged duration, and having a lively sense of the inconvenience and discomfort attaching to it, and being threatened with a cold in the head one evening lately, with prospect of serious inconvenience to public speaking next day, I endeavoured to devise some plan of treatment more speedy and efficacious than the usual one of "sudorifics and lying in bed." Having succeeded almost beyond my expectations, and having since found the method equally successful in the case of others to whom I have recommended the treatment, I offer it in the hope that it may prove equally efficacious in the hands of others. As the local symptoms of cold in the head are the chief source of annoyance and discomfort, local treatment seems the most rational.

The symptoms being those of acute catarrh of the nasal mucous membrane, the treatment which seemed to me most likely to succeed was that which I have always found most efficacious in acute catarrh of the gastric mucous membranes. In the acute catarrh of alcoholism accompanied with profuse secretion of mucus, which is often vomited up in large quantities

almost without effort, as well as in the more chronic forms of gastric catarrh, bismuth alone, or in combination with morphia, acts almost like a specific.

On the same principle the topical application of bismuth to the nasal mucous membrane seemed to me the plan most likely to be followed by beneficial results. I do not know whether the plan is absolutely original, but I am not aware of its having been adopted previously. This, however, is of no importance compared with the question of its efficacy.

On the evening in question I began to suffer with symptoms of cold in the head—irritation of the nostrils, sneezing, watering of the eyes, and commencing flow of the mucous secretion. Having some trisnitrate of bismuth at hand, I took repeated pinches of it in the form of snuff, inhaling it strongly, so as to carry it well into the interior of the nostrils. In a short time the tickling in the nostrils and sneezing ceased, and next morning all traces of coryza had completely disappeared.

Bismuth alone, therefore, proved quite successful, but it is better in combination with the ingredients in the following formula. Bismuth by itself is rather heavy, and not easily inhaled, and it is, moreover, necessary that it should form a coating on the mucous membrane. It is, therefore, advisable to combine it with pulv. acaciae, which renders the bulk larger and the powder more easily inhaled, while the secretion of the nostrils causes the formation of an adherent mucilaginous coating, of itself a great sedative of an irritated surface. The sedative effect is greatly strengthened by the addition of a small quantity of hydrochlorate of morphia, which speedily allays the feeling of irritation, and aids in putting a stop to the reflex secretion of tears.

The formula which I find on the whole the most suitable combination of the ingredients of the snuff is as follows:—Hydrochlorate of morphia, two grains; acacia powder, two drachms; trisnitrate of bismuth, six drachms. As this is neither an errhine nor a sternutatory, but rather the opposite, it may be termed an anti-errhine or anti-sternutatory powder. Of this powder one-quarter to one-half may be taken as snuff in the course of the twenty-four hours.

The inhalations ought to be commenced as soon as the symptoms of coryza begin to show themselves, and should be used frequently at first, so as to keep the interior of the nostrils constantly well coated. Each time the nostrils are cleared another pinch should be taken. It may be taken in the ordinary manner from between the thumb and fore-finger, but a much more efficacious and less wasteful method is to use a small gutter of paper, or a "snuff-spoon," placing it just within the nostril and sniffing up forcibly so as to carry it well within. Some of the snuff usually finds its way into the pharynx, and acts as a good topical application there, should there be also pharyngeal catarrh. The powder causes scarcely any perceptible sensation. A slight smarting may occur if the mucous membrane is much irritated and inflamed, but it rapidly disappears. After a few sniffs of the powder, a perceptible amelioration of the symptoms ensues, and in the course of a few hours, the powder being inhaled from time to time, all the symptoms may have entirely disappeared.

I am writing this note cured of a cold in the head which I began to manifest in a very decided manner last night—viz., weight in the frontal sinuses, tickling of the nostrils, sneezing, watering of the eyes, and commencing flow of the nasal mucous.

I commenced taking the snuff, continuing at intervals for about two hours, thoroughly coating the interior of the nostrils with it. Next morning I found myself entirely free from catarrh. The effects in my own case have been twice so rapid and beneficial that I look with comparative indifference on future colds. In the case of others to whom I have recommended the same treatment equally rapid and beneficial results have followed. One of my students in King's College Hospital described the effects as quite magical and unexpected, having in this way got rid of a cold in one evening. The other day one of the officials in King's College asked me if I could do anything to check a dreadful cold in the head which he had just caught. I gave him the above prescription, asking him to note the results. A day or two after he came and told me that I had given him very marvellous snuff,

as he had not taken more than one-eighth part before he had got rid of all his uneasiness and discomfort. Though I have not yet had very many opportunities of trying this method of cure, the success so far has been such as to warrant my recommending it as a rapid and efficacious treatment of nasal catarrh.—*London Lancet.*

HEADACHES FROM EYE-STRAIN.

BY S. WEIR MITCHELL, M.D., PHILADELPHIA.

Dr. Mitchell avers that the general profession are not fully alive to the need of interrogating the eye for answers to some of the hard questions which are put by certain head symptoms, since many of the patients treated successfully by the correction of optical defects never so much as suspected that their eyes were imperfect. He submits the following propositions:

1. That there are many headaches which are due indirectly to disorders of the refractive or accommodative apparatus of the eyes.

2. That in these instances the brain symptom is often the most prominent, and sometimes the sole prominent symptom of the eye troubles, so that while there may be no pain or sense of fatigue in the eye, the strain with which it is used may be interpreted solely by occipital or frontal headache.

3. That the long continuance of eye trouble may be the unsuspected source of insomnia, vertigo, nausea, and general failure of the health.

4. That in many cases the eye trouble becomes suddenly mischievous, owing to some failure of the general health, or to increased sensitiveness of the brain from moral or mental causes.

The form of head-pain, caused by eye troubles, is rarely of the nature of megrim; and, as it soon disappears when the eyes are corrected, is lacking, happily, in the obstinacy of that distressing malady.

A number of cases are cited to substantiate the above propositions, some of which we epitomize:

Case 1. A prominent merchant first consulted Dr. M. late in the winter for pain in the upper spine and occiput. In the previous autumn,

only writing at first, and then later reading, and any near work caused pain. Finally, an over-sensitive state supervened, when a few moments spent in writing would give the patient a creeping sensation up the spine and through the back of the head, followed by giddiness and severe pain. The treatment adopted proved of no avail. Subsequently, the patient consulted an ophthalmic surgeon, who found the vision defective, owing to an optical defect. The proper corrective glasses raised the sight above the average standard, and on using them habitually, the distressing symptoms quickly disappeared. The use of the glasses, without other means, restored the patient to perfect health again.

Case 2. The patient, an accomplished and energetic single lady, aged 30, with heavy household cares, and additional literary work, began some five years previously to have evening headaches, pain in the back of the head and neck, sense of extreme fatigue, &c., if she persisted in exerting her mind in reading or writing, though without any sense of trouble in the eyes. At last she became feeble, nervous, and anæmic, sleeping little and having almost constant headache, and the use of the eyes caused pain in them and a sense of fatigue. For nearly two years Dr. M. was at fault, but at length referred her to a specialist, April 19, who found the sight impaired, owing to an optical defect, and prescribed the corrective glasses. On May 26, the headache and sleeplessness had gone, patient could read and write without pain; used her glasses constantly. The relief of the ocular defect sufficed to restore the patient.

Case 3. Patient, a well-nourished intelligent lady, with intense and frequent headaches, usually frontal, without sense of ocular fatigue. Long after the headaches had begun, reading was found to aggravate them, and only rarely to cause fatigue or pain in the eye itself. The correction of an optical defect by suitable glasses gave almost immediate relief, and ere long put an end to the headaches.

Case 4. No eye-pain, but violent headache, described as neuralgic, with nausea and vomiting; optical defect present; prompt and absolute relief by correcting glasses.

Case 5. History of headaches, and later on of vertigo with insomnia; the subjective symptoms subsiding on wearing correcting glasses.

Case 6. Patient, a lawyer aged 51; a long lifetime of active work and constant use of the eyes, but no trouble until one night of intense anxiety gave rise to threatening but brief cerebral symptoms, which at once seemed to make the use of the eyes painful. The cerebral symptoms (vertex headache, excitement of mind, &c.) were such as to point rather to cerebral troubles than to the eyes as the cause of distress. On neutralizing an optical defect, by proper glasses, entire relief was afforded. A good example of the way in which a permanent unfelt defect is lifted into evil influence by some brief but potent disturbance of the cerebral centres.—*The American Journal of the Medical Sciences.*

THE OPIUM TREATMENT OF DELIRIUM TREMENS.

In the *British Medical Journal*, Surgeon Edward Nicholson writes:—

At the outset of my military life I adopted, for the cases of delirium tremens so common among soldiers, the morphine treatment recommended by Prof. Roser, of Marburg. He pointed out that patients are lost by timidity in not prescribing opium in sufficiently large doses, under fear of poisoning; he advised energetic doses of morphine, commencing with one or two grains, and giving one grain hourly until deep narcotization occurs. I cannot say exactly how many cases I have treated on this plan, but I may say roughly about fifty, and have always found it safe, quick, and attended with the minimum of trouble. I have had but two fatal cases of alcohol-poisoning: one was alcoholic apoplexy in a man detained under suspicion of approaching delirium tremens; the other was a man who, having been successfully treated twice within a few weeks, had a third attack of delirium tremens, was brought to hospital in an insensible state, and died in a few minutes after I saw him. Neither of these cases had any narcotic treatment.

In a case of evident delirium tremens I give at once two grains of morphine; in violent cases as much as three grains: this is repeated after

two hours if no effect is apparent. A third dose, making a total of eight grains within four hours, has sometimes been required. The patient generally falls to sleep after the second dose, and awakes cured. Sometimes a further small dose (one grain) may be required, but the patient is reasonable, and all trouble at an end.

After quoting some cases in point, he adds:—

These cases show that the danger is precisely in these ordinary doses of opium, and that the beneficial effects are obtained by giving at once such a dose as would endanger the life of a healthy person, and repeating it rapidly until sleep is produced. I may recall Orfila's opinion that "opium employed in strong doses ought not to be ranked among the narcotics or the stimulants; it exercises a peculiar mode of action which cannot be designated by any of the terms at this moment employed in the *materia medica.*" Of course this is meant as applying to the diseased, not to the healthy state. An analogous difference of action is to be seen in the case of ipecacuanha when given in high doses as a remedy for dysentery, or even better in the use of the tincture of digitalis in half-ounce doses against delirium tremens. The digitalis treatment has one advantage—that the remedy is nearly invariably used in the full doses recommended at the time of its discovery: hence its general success. While the morphine treatment, which is, when properly conducted, the safer of the two, is apt to be discredited, in consequence of the substitution for it, by the timid, of the dangerous system of trifling with small or ordinary doses. The digitalis treatment is far more likely to be carried out, and there is little fear of ten or twenty drops being substituted for the proper half-ounce dose. It is to this very plain treatment that I might, perhaps, ascribe the diminished fatality of delirium tremens in the army.

At St. Mary's Hospital there has just occurred a case of recovery from rabies. The boy now is apparently well, and is walking about, but the details are not published yet. The plan of treatment adopted was that of injections of chloral hydrate. The details will be very interesting, and I will refer to them when Dr. Broadbent publishes them.—*Phil. Med. Times.*

A CASE OF CONGESTION OF THE LIVER WHERE PUNCTURE WAS RESORTED TO, WITH RELIEF OF THE SYMPTOMS.

A Burmese convict was admitted into hospital on the 19th of June last, with intermittent fever. On the 22nd of June, while under the care of Surgeon-Major Blanc, of the Indian Army, he showed symptoms of an affection of the liver, that organ being enlarged and sensitive to pressure, and extending some four inches below the tenth rib. The general symptoms accompanying the affection not moderating, but the swelling increasing, it was resolved in consultation, and relying on the favourable report of Professor Maclean, of Netley, to puncture the liver with the needle of an aspirator. Accordingly, needle No. 2 of Potain's aspirator was introduced into the most prominent part of the swelling, which was three and a half fingers' breadth below the right false ribs, and four fingers' breadth from the median line. About an ounce of black blood was withdrawn, in which were mixed a few pus-corpuscles, as shown by the microscope. The operation afforded the patient undoubted relief, the respiration falling from 34 to 26, though the pulse and temperature were not specially influenced, the latter rising two degrees on the day following, but falling to its former standard on the second day. The liver, however, commenced contracting, and continued to do so for five or six days. About this time general oedema began to make its appearance in the limbs, and becoming general, the patient gradually failed until death occurred, seventeen days after the operation. The autopsy showed that death was due to anasarca, the result principally of excessive fatty degeneration of the heart, while the liver appeared to have nearly recovered its normal condition; so that although the case terminated fatally, the operation was thought to have been beneficial rather than otherwise, the withdrawal of this small quantity of blood relieving the distended hepatic vessels from over-pressure, and so restoring them in a measure to their normal condition.—*The Lancet*, Sept. 25, 1875.

MR. CAMPBELL DE MORGAN, Senior Surgeon to the Middlesex Hospital, died from pneumonia on April 12th.

CLINICAL STUDIES ON PERTUSSIS.—By Dr. Noël Gueneau de Mussy ('*L'Union Méd.*,' Nos. 81, 82, 83 and 85, 1875.) Dr. Mussy here demonstrates a new theory of his own on the mechanism of the convulsive cough which characterizes this disease. According to him every whooping-cough is accompanied by bronchial adenopathy characterized by particular signs, which present nothing special as regards the species of enlargement. It is this lesion which is the determining cause of the spasmodic phenomena, in provoking the excitation of the pneumogastric nerves, and compressing the bronchi. To this anatomical condition the author refers chronic whooping-cough, and all bronchitic affections characterized by fits of painful, fatiguing and obstinate cough, but without respiratory whistling, affections which he designates under the name of "coqueluchoides" pertussoid. Bronchial adenopathy develops from the first period of the disease; but it is especially in the second that it becomes well marked and readily appreciable by the physical means of chest exploration. Dr. de Mussy also attributes to the ganglionic tumefaction the moanings emitted by the patients during sleep, a phenomenon to which he was the first to draw attention, and which he has observed in the absence of whooping-cough when the same anatomical conditions have been present. The way having been opened, Dr. de Mussy develops his ideas on the nature of pertussis; a malady essentially contagious, comparable to the eruptive fevers, always accompanied by a specific exanthem situated in the isthmus of the throat and pharynx; this eruption disappears towards the end of the third week.—*British and Foreign Medico-Chirurgical Review*.

CHLORAL BATHS IN VARIOLA.—Dujardin Beaumets reports that he has obtained excellent effects from general baths of chloral, in cases of confluent variola at the period when the epidermis, detaching itself *en masse*, leaves the dermis exposed. The quantity of chloral used in each bath has not exceeded twenty grammes. In this manner is obtained not only the disinfection of the patient, but also a prompt cicatrization of the skin.—*Bull. Gén. de Thérapeutique*, November, 1875.

Surgery.

SURGICAL DIAGNOSIS.

THE following admirable summary on the subject on Surgical Diagnosis, is so little susceptible of condensation that we republish it almost unabridged from the *British Medical Journal* of October 13th, 1875, omitting only the opening remarks. It is from Mr. Christopher Heath.

And now I bring before you a man with no special deformity or ailment, in order that I may be able to show you a few note-worthy points which you can readily appreciate at a little distance, and which will assist you in studying disease and injury in the wards. With his back towards us, you have the opportunity of examining a healthy spine; and you may notice that, while the spinous processes are readily visible in the dorsal region (and particularly when the arms are folded), they are not so visible in the lumbar, and still less so in the cervical, region, where they are covered by muscles and ligament, the seventh, or *vertebra prominens*, being the only one really seen or felt. Here, in a healthy adult, we have the average anterior and posterior curves in the lumbar and dorsal regions; but you must remember that, in young children, the spine is nearly straight, while in disease we may have great exaggeration of either curve. Thus, in the back, we find *cyphosis*, or angular curvature, the result of caries of the vertebræ; while in the loins we have *lordosis*, an exaggeration of the healthy curve, and generally connected with old hip-disease.

The model is now standing at "attention," with his knees straight; consequently the two sides of his pelvis are perfectly even; and you see that a tape carried between corresponding points on the two sides is horizontal. Let us now make him "stand at ease," with the left knee bent and foot slightly advanced, and you see that at once the left side of the pelvis is lowered. But this is not all. Corresponding with the obliquity of the pelvis, we have a lateral deviation of the spine to the left in the lumbar region; and if the man could sufficiently relax his muscles at the moment, we should

have a curve in the opposite direction—to the right—in the dorsal region. By placing a book beneath the right heel, and thus increasing the obliquity of the pelvis, I exaggerate the lumbar curve; or, of course, by tilting the pelvis in the opposite direction, I could throw the spine over to the opposite side. Of course, the same thing holds good if the patient be seated instead of standing; for, by tilting his seat, we are able to produce a marked lumbar and a certain amount of dorsal curve at will. Fortunately, we have here to-day also a case of old hip-disease, in whom the obliquity of the pelvis is well-marked, and the resulting twist of the spine better seen than in the healthy subject. You see, then, how important it is in any case of lateral curvature to ascertain whether it depends upon some obliquity of the pelvis (from atrophy of one leg or old hip-disease), or upon other causes; and you also see what effect upon an existing curve may be produced, as has been well pointed out by Mr. Barwell, by raising the side of the pelvis by means of a thickened sole or a sloping seat.

Turning, now, to the neck and shoulder, I pass my finger along the clavicle, which is subcutaneous, and shows its curves well enough in a thin muscular subject. The notch between the clavicles is important in connection with aneurisms of the great vessels of the neck; but the inner end of the bone is very rarely dislocated, except by extreme violence. The outer end of the clavicle is continuous with the acromion process, and I now run the chalk along them; but it may be dislocated (as we have lately seen), and then the flattened end of the bone is readily felt beneath the skin. If I make the man swing his arm round, you will be able to appreciate better than you perhaps have hitherto done the great range of motion in the sterno-clavicular articulation, which, in fact, admits of "circumduction," and has a most important relation to the movements of the arm.

There is no joint, I suppose, about which more errors are made than about the shoulder. An "obscure injury about the shoulder" has often damaged a surgeon's reputation, because he has not sufficiently studied the anatomy of the part to be quite sure of his diagnosis and

treatment. The chalk-line I have already made marks the bony arch formed by the clavicle and acromion; but you will notice that the head of the humerus projects beyond this in front, and gives the roundness to the healthy shoulder. There is a hollow immediately behind the head of the humerus and below the prominent acromion; and another in front, to the inner side of the head, in which the coracoid process can be more or less distinctly felt, according to the muscularity of the subject. In the healthy subject, there is just room to lay the finger between the coracoid process and the head of the bone. When the head of the humerus is *dislocated*, the roundness of the shoulder is lost, and the acromion stands out prominently beneath the skin, with a depression below it; while the head can be felt in some unnatural position, and out of its proper relation to the coracoid process. The direction of the whole limb is altered, too; so that the patient cannot place his hand on the opposite shoulder with the elbow touching the chest-wall, as he can in health. In a *fracture* of the neck of the humerus, the roundness of the shoulder is not lost; but there is a depression below the head, which does not move when the arm is rotated, unless, indeed, the fracture be impacted. The two accidents may be combined; but this is a rare complication.

When I turn the model with his back to you, and make him raise his arm, you will appreciate how important the movements of the scapula are. The deltoid alone can only raise the arm to a right angle with the trunk; and the subsequent elevation of the limb depends upon a rotation of the scapula on the ribs, so that the angle comes forward to the margin of the axilla. The scapula is held in its place by the muscles passing from the spine to its base, and by the serratus magnus. If these be paralyzed, the scapula falls forward, and the power of the arm is greatly lost.

Let us pass on to the elbow. With the forearm bent, you see at once the prominent olecranon process of the ulna. When this is broken off by falls on the elbow, the fragment is drawn up by the triceps, and an interval can be felt between it and the bone, which, however, is rapidly filled up by the effusion imme-

diately following any injury to the elbow-joint. A much more common result of a fall on the elbow, however, is an injury to the bursa which lies between the subcutaneous triangle of the olecranon and the skin. In health this bursa cannot be recognized, except in individuals whose occupation has produced enlargement of it—*e. g.*, miners or sweeps; for though it is technically called the "student's bursa," I must confess to have never seen an enlargement of it due to long poring over medical treatises. When the bursa is inflamed, it causes a swelling over the olecranon, which is evidently quite superficial, and does not mask the general outline of the joint, as would be the case were the effusion in the articulation. You may remember that, last week, a patient with suppuration of this bursa was treated by an early and free incision in Ward 1.

The condyles of the humerus are readily felt in this arm; and you will notice that the internal is the most prominent, and stands out beneath the skin. Immediately behind it is the groove in which the ulnar nerve lies, as you may ascertain for yourselves by "twanging" it; and then comes the olecranon, with only just space for the nerve between the bones. This close relation of these two prominent points of bone is of great service in the diagnosis of dislocation of the forearm; for, so long as they lie close together, the deformity cannot be caused by a dislocation of the ulna. The outer condyle is more rounded; and immediately below it is the head of the radius, which can be felt rotating when the forearm is pronated or supinated. It is not often dislocated, for it is firmly held by ligaments; but it is sometimes thrown forward, and then prevents complete flexion of the forearm, by coming against the front of the lower end of the humerus.

At the wrist, you may notice, that the end of the radius is lower down than that of the ulna, and that the styloid processes of both bones are to be felt. Dislocation of the carpus from the radius is rare; but separation of the lower epiphysis of the radius is by no means uncommon in young persons, and is sometimes mistaken for dislocation. The triangular fibrocartilage which binds the radius and ulna together at the wrist, sometimes becomes dis-

placed in children who are dragged forcibly by the hand, and then the little patient cannot supinate the forearm and hand ; but if you hold the hand firmly, and then supinate, you hear a slight click, and all is well. It is well always to bear in mind that, in supination, the bones of the forearm are parallel, and in pronation are across one another ; so that supination is the posture in which fractured bones of the forearm should be set, although it is convenient, when the bones are firmly held by splints, to turn the thumb upwards—*i. e.*, to place the hand midway between the pronation and supination.

In the hand, I need only point out that the superficial palmar arch does not correspond precisely to any one of the lines in the skin of the palm ; but its convexity reaches generally to the middle one of the three, while the deep arch is much nearer the wrist. The bifurcation of the digital arteries is between the heads of the metacarpal bones, and about midway between the line to which I have referred and the web of the fingers ; so that incisions should always be made in the line of the fingers, and not between them. As you may have, early in your career, to amputate a crushed finger, I would remind you, also, that the prominence of each knuckle is formed by the proximal bone of the articulation, and that the joint through which the knife must pass is below this in every case.

Descending to the groin, you see that the fold of the groin corresponds to Poupert's ligament ; and an inguinal hernia is above, while a femoral hernia is below—at least at first. Of course, a large inguinal hernia will descend into the scrotum, and a large femoral hernia may turn up over Poupert's ligament, and closely simulate the inguinal variety. But you ought to have little difficulty in distinguishing them if you will invaginate a piece of scrotum (or labium in the female) on the forefinger, as you see me doing, so as to carry the finger into the external abdominal ring. This will enable you to settle at once whether the protrusion has taken place through the inguinal canal or not. Let me also remind you to ascertain the presence of two testicles in the scrotum ; for an undescended testes may closely resemble a hernia, especially if inflamed.

The pelvis is so firmly bound together, that a dislocation of one of the innominate bones can only be produced by extreme violence ; but disease of the sacro-iliac joint is by no means uncommon, though often overlooked ; and one leading symptom is lameness, which is erroneously referred to the hip-joint. But if I make the man before us stand on one leg, you will see at once how the whole weight of the body falls upon the corresponding sacro-iliac joint while he is throwing the other leg forward ; and it is this which gives rise to the pain, and prevents the walking of a sufferer from sacro-iliac disease. Taking this man, who has a healthy pelvis, I may compress his two innominate bones without giving any pain ; but a woman who has recently had a severe labour, and has, perhaps, incipient sacro-iliac mischief, will cry out at any such rough treatment, though the steady support of a good pelvic-belt would give her great comfort, and restore her powers of locomotion.

The hip-joint in health is freely movable in all directions, as you see, and independently of the pelvis ; but, the moment the joint is inflamed, the muscles instinctively contract, and fix the joint to some extent ; and then, when the limb is moved, it carries the pelvis with it. This man's back is naturally more curved than a child's ; but even in him, if I make him lie flat on the table, you will see that the thigh can be fully extended without tilting up the pelvis, and so increasing the curve of the lumbar spine. In a child, whose back is naturally flat on the table, the effect of early hip-disease is readily seen (as I have frequently demonstrated to many of you) ; for the attempt to bring the thigh down at once elevates the pelvis and causes that curvature of the lumbar spine which, in old hip-disease, becomes permanent.

The prominence of the great trochanter will vary in different individuals, according to the muscularity of the buttock and the length of the neck of the femur ; and it is important, therefore, to compare the two sides in every case of suspected disease or injury. The head of the femur can be indistinctly felt on deep pressure, either in front of or behind the trochanter ; and, in health, the two move together ;

for if the trochanter can be freely moved by rotating the femur without affecting the head of the bone, it is clear that the neck must be broken. The length of the neck will very much affect the power of rotating the limb; thus if the neck be shortened, either by an impacted fracture or the absorption of old age, the arc in which the upper part of the thigh moves will be found to be much smaller than in health. When I stretch a tape from the anterior superior spine of the ileum to the tuberosity of the ischium, you see that, in health, it touches the top of the greater trochanter; now, if the bone were dislocated or the neck broken, the trochanter would be above or below this line.

When the knee is extended, you see the patella forming a prominence in front of the femur; but, when the joint is flexed, it sinks into the hollow between the condyles. With the leg fully extended and the muscles relaxed, there is, as you can prove in your own limbs, considerable lateral movement of the patella possible in the healthy joint; and the mistake is sometimes made of attributing this mobility to the presence of synovial effusion. When fluid is poured into the knee-joint, however, not only does the patella float so as to be freely movable in any position of the limb, but the synovial pouches on each side of and above the patella are distended, and give the characteristic roundness to the knee. If one kneel down on a flat surface, and particularly if the body be bent forward, as in scrubbing a floor, the patella and the bursa between it and the skin are exposed to considerable pressure; and hence the chronic enlargement of that bursa, termed "housemaids' knee," which causes a globular swelling in front of the joint, altogether different from that of effusion. Kneelers on hassocks or foot-boards do not run any risk of the housemaids' fate, for the pressure in their case comes on the tubercle of the tibia, and the bursa between it and *ligamentum patellæ* would suffer if the pressure were sufficiently prolonged—but I never met with such a case. In falling with the knee bent the patella reaches the ground first, and receives the force of the impact, which may simply bruise or cut open the bursa; or, if very severe, may "star" the patella itself. The

transverse fracture of the bone is produced through the effort of the patient to save himself, by which the great extensor muscles catch the bone across the condyles, and either break it or rupture the ligament; then the upper fragment is drawn up in front of the femur, and a space is left in which the condyles can be felt, as in a patient recently in the wards.

With the knee flexed, the rounded outlines of the condyles can be readily felt resting on the top of the tibia; and a little distance below the outer condyle can be seen the head of the fibula—which bone, let me remind you, does not enter into the formation of the knee-joint. The existence of the semilunar fibro-cartilages between the femur and tibia is hardly appreciable in health; but their existence must not be forgotten, as occasionally, in violent wrenches of the knee, one of them becomes displaced, giving rise to extreme pain and inability to use the joint, which are most satisfactorily treated (as also are dislocations of the patella) by a little of that judicious violence for which "bone-setters" have a reputation.

At the ankle, we see at once the prominence of the two malleoli, between which the astragalus fits closely when the foot is at right angles to the leg, less so when the foot is pointed; so that, in this position, some amount of lateral movement of the foot is possible. The fibula is altogether posterior to the tibia, and its malleolus is longer than the internal. The lower third of the fibula is subcutaneous, and its fracture (Pott's fracture) is therefore readily recognised. The tendons of the various muscles surround the ankle-joint, but the only one to which I need call your attention is the *tendo Achillis* at the back, in which, when ruptured, the division is readily both felt and seen. When I flex the knee and point the toes, you can see how completely the muscles of the calf are relaxed; and this is an important point in the treatment of a divided tendon, or of a dislocation of the foot, or oblique fracture of the tibia.

The prominences of the foot are chiefly important as guides to the amputations; thus the tuberosity of the scaphoid on the inner side marks the transverse tarsal joint, or site of Chopart's amputation; whilst the base of the first metatarsal on the inner or prominent

fifth metatarsal bone on the outer side, marks the position of Hey's amputation. The metatarsophalangeal joint of the great toe is not unfrequently diseased through gout or the pressure of boots which have developed a bunion; and other toes are not unfrequently deformed from the same cause. The only surgical point with regard to the toes that I need mention is that the base of the first phalanx is more expanded and more deeply placed than young operators are apt to imagine.

I have thus run briefly through the more salient points on the living body, which it is important for you to recognize thoroughly in health, before attempting to treat disease; and, in future lectures, I shall have to direct your attention to matters regarding which the knowledge required to-day will be of service in enabling you to recognize deviations from the standard of health.—*British Medical Journal*.

NOTES ON THE LOCAL TREATMENT OF CERTAIN DISEASES OF THE SKIN.

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

Physician to the Skin Department, Demilt Dispensary, New York, etc.

It has so frequently occurred to me to meet with cases of skin disease where the local treatment which had been previously employed by the physician in charge was decidedly injurious, not simply inefficient, but positively harmful, giving pain to the patient and causing the eruption to persist or increase, that I cannot but feel that a few words upon the subject of local applications to the skin may be of value to the general practitioner.

The greatest number of errors are committed, I think, in the way of over stimulating with irritating applications. There seems to be a very prevalent idea that there is a something requiring to be overcome, a disease which must be met by something more powerful, and the expressions "subdue the inflammation," "overcome the morbid action," "kill the itching," and the like attest the truth of this. Now the real state of the skin in most cases of acute disease is one of irritation; blood vessels, nerves and cells are in a condition of excitement, and

require, not stimulant applications, but those calculated to soothe and quiet, and yet it is not at all uncommon to see the harshest applications being made to acutely inflamed surfaces, as eczema. Thus, I have repeatedly had cases of exuding eczema of the genitals, where the itching was terrific and where more and more severe applications had been made, most commonly of the stronger mercurial ointments, or washes of the mineral salts, or strong tarry preparations, each of which would drive the sufferer almost frantic with pain, which, however, was borne because the remedy "*killed the itch.*" But these measures were at the same time aggravating the disease. The basis of this harsh treatment is undoubtedly the clinical observation that the eruption itches more when there is no exudation, whereas when a free secretion from the surface occurs, the itching is for a time relieved.

And this clinical fact has been taken advantage of by Hebra, who is perhaps the most strenuous advocate for the severe local treatment of diseases of the skin, and he has introduced largely into his practice the use of a potash soft soap, and also other stimulating agents which remove the outer layers of epidermis, and in his hands these have yielded good results. But experience has shown me that we cannot employ precisely the same measures in the same way here as are used in Vienna, or rather that we cannot always get the same success with them, partly because a description of their use in words, or even a moderate acquaintance with their application from actual witnessing of Hebra's treatment, does not suffice to permit of their intelligent and successful application here, and partly because the treatment applicable to patients with diseases of the skin in Germany is not suited to those in this country. First, the conditions are different, the patients from whom German experience is drawn are largely in hospitals, public or private, or are made to remain quiescent while under treatment, whereas in this country few go to hospitals for these troubles, and it is extremely difficult to keep our patients at home unless very sick; and, Second, the people in this country differ much in constitution from those of Germany; the nervous, excitable temperament belonging

to our people, whether native or naturalized, impresses itself upon skin diseases as upon those of any other organ.

Thus much in explanation of the necessity for caution in regard to the methods and means used in the local treatment of diseases of the skin.

Before entering upon any special consideration of individual remedies or diseases I must first remind the reader, what is already well known, but too often quite forgotten, that there is nothing peculiarly and intrinsically difficult in the knowledge and treatment of this class of affections, although one would judge that there was from the expressions and therapeutics of many. The pathological changes occurring in the skin are the same as take place in other organs, most of them coming under the head of inflammations, and the means of meeting them are much the same as are employed in treating other affections. No one would think of making harsh applications to the erythematous skin of scarlatina or measles, but localized erythema and urticaria are often submitted to very severe measures, and the remedies used on acutely inflamed eczema defy all scientific explanation as based on pathology; only the most soothing medicaments would be put on the inflamed skin of variola or pustular syphilis, and yet pustular acne and impetigo or impetiginous eczema are continually stimulated and inflamed.

It is true that parasitic affections require remedies to destroy the life of the parasite, and chronic diseases of the skin demand more or less severe treatment, but my experience has been that discrimination as to the proper use of severe remedies is not generally made, and that more harm than good is commonly done by the severe applications, and that better results could often be obtained if milder measures were first employed, increasing the strength of the applications as the case seems to demand. To illustrate this latter—a lady was recently brought to me by one of the older practitioners in this city, with a patch of moist eczema on the middle of the left lower leg, near the outer side. The spot was an inch and a half in diameter, and had commenced from a small point, to which she had applied camphor, turpentine, ect., and for the last two months had been having

applied an ointment made with 20 drops of the oil of tobacco to the ounce, to which white precipitate had been added at one time. The effect of these measures had been to make the diseased patch increase steadily in size and to irritate it greatly. She was ordered to keep oxide of zinc ointment (*zi ad zi*) made with the cold cream, (*unguentum aquæ rosæ*), continuously applied on waxed paper, renewing it night and morning, without washing; only *wiping off* the old ointment very gently. At the end of three or four days the inflammation had entirely subsided, and she was ordered the compound tincture of green soap of Hebra (*R. Saponis Viridis, Picis liquidæ, Alcohol, āā zi*), with the same ointment, applied in the same way. The point I wish to make is that a sedative and soothing application is often called for to allow inflamed parts to rest, and after a brief stimulation, as with a slight rubbing with such a lotion as the one ordered, the parts must be again protected continuously by some bland covering; often mutton tallow, with equal or more parts of cod liver oil, forms the most grateful covering.

I would here again call attention to the great value of the waxed paper as a local dressing in certain skin affections, as noted by Dr. Duckworth in an article in the *Archives of Dermatology* for January, 1875. Most druggists keep it for covering the tops of ointment jars, and it forms a cheap and useful dressing. Care should be taken to have but very little ointment smeared upon it (it is, as a rule, better in inflamed eruptions to have the ointment applied to a covering and not to the sore), and if the paper and ointment are nicely adapted to the part they will very effectually exclude the air and form a very comfortable and effective dressing.

In the above I have advocated the employment of milder measures than are commonly used to the skin. I would make exception, however, of one application, which is very commonly supposed to be very mild, and which often affords much temporary comfort, but which should be used very sparingly in the practice of Dermatology—I allude to poultices. I am almost daily observing the bad effects which have occurred from poulticing diseases of the skin, and can hardly speak too strongly on the sub-

ject. There are but two conditions in which I ever ordered poultices in my practice; first, where there is phlegmonous inflammation and pus must be formed and evacuated, a poultice both hastens the process and assists in softening the integument and facilitating its exit; this is rarely the case in pure dermatological practice; and second, where there is a hard incrustation which oily applications have failed to remove, a poultice is *sometimes* of service. I must make one more exception, which, however, is of a state akin to that first mentioned, and that is, after the use of a deep escharotic, as Marsden's mucilage in epithelioma, a poultice applied continuously, with frequent changing, hastens the separation of the slough and the subsequent granulation and cicatrization. But, as I have stated, these are the exceptions, and poultices should be very sparingly used in treating diseases of the skin. The practice, so common, of ordering poultices in the eczema of the head of infants, and in the eczema affecting the lower limbs in middle aged and elderly persons, is quite at variance with the teachings of science and the successful treatment of the disease. The parts are already debilitated and relaxed, and what is called for is not the further maceration of tissue by warmth and moisture, but the tonic effect of astringent and slightly stimulating remedies, within proper bounds, of course; these will be indicated later.

One more local measure of general character demands mention here, and that is, the use of proper medical baths, as, alkaline, starch, sulphur, etc. It is to be borne in mind that simple water is irritating to the diseased skin, but when medicated, baths may become a very valuable adjunct to the practice of Dermatology, as European experience abundantly testifies, and as I have occasion to verify almost daily.

On another occasion, when speaking of special diseases, I will give some of the indications and contra-indications for their use. I allude to the general subject now because of its great importance and its common neglect. I should not omit to mention the daily cold sponge bath, of which I make much use.—*Archives of Dermatology*

REMOVAL OF FOREIGN BODIES FROM THE EAR.

Mr. W. Rivington says, in the *British Medical Journal*:—

From the time of my first connection with the Aural Department at the London Hospital, I have used no other means of extraction of foreign bodies than the syringe, aided occasionally by chloroform, the dependent position of the organ, and the use of a small pair of curved forceps as soon as the substances appeared near the external end of the meatus; and I have never failed in procuring their ejection. Various kinds of foreign bodies, including peas, beans, pebbles, glass-beads, and pins, etc., have been removed in this way, and on several occasions after previous efforts by the same method or other methods had been unrewarded by success. It is the custom, I know, to make use of special forms of extractors, and instrument-makers vend a rude implement with a bent steel eye, which finds its way into cases of instruments, fitted up for the receiving rooms at hospitals. From the incautious use of such a weapon, I have seen irreparable damage done to the membrana tympani, combined with displacement of the malleus and incus, and I cannot but think that it should be banished from the surgical armamentarium.

To sum up, the procedure in cases of foreign body in the ear should be as follows:—

1. Examine the ear carefully by direct light and with a speculum and mirror, to determine the presence, position, size, nature, and peculiarities of the substance.
2. If the patient be a child, and refractory or timid, place him on the couch, give ether or chloroform, and use the syringe, turning the affected ear downward. This manœuvre may be aided, as Mr. Field suggests, by drawing the auricle upward and backward, and applying the nozzle of the syringe to the upper wall of the passage.
3. If the foreign substance do not fall out, as it usually does, after a little patience, but stops near the orifice of the meatus, a fine pair of forceps may be used to withdraw it.
4. A needle or a pin, or other elongated body which does not fill the passage, may be readily taken out with forceps through the speculum, or by the aid of a direct light.

Midwifery.

THE CHANGES IN MIDWIFERY PRACTICE AND IN THE TREATMENT OF UTERINE DISEASES DURING THE LAST TWENTY YEARS IN THE ROTUNDA HOSPITAL, DUBLIN.

BY LOMBE ATTHILL, M.D.,

Master of the Hospital; Vice President of the King and Queen's College of Physicians in Ireland.

(Concluded.)

The third rule is the only one on which a difference of opinion now exists among practitioners. No one of any experience as an obstetric practitioner now denies that cases will from time to time present themselves in which the forceps may, with perfect safety, be applied before the os uteri is fully dilated; and further, that from the presence of urgent symptoms, such as the occurrence of convulsions, hæmorrhage, &c., delivery by means of the forceps should, without doubt, be effected before the os uteri is fully dilated. But here agreement ceased. Some—and principal among these, the late Master of this hospital, Dr. George Johnston—hold that the forceps may be applied with nearly as much impunity before the os is fully dilated as at any subsequent period of labour. But from this view I must dissent. I hold that the application of the forceps before the os uteri is dilated is a proceeding not free from danger, and that it should not be undertaken unless grave symptoms likely to compromise the safety of mother or child exist; but on the other hand, when such do occur, I without hesitation have recourse to its use before the os is dilated.

Gentlemen, let me add a warning before I leave this subject. There is a great tendency in human nature to run from one extreme to the other, and this holds good in the present instance; thus, when I was a pupil the forceps was looked on with dread, only used as a last recourse; now it is considered by some as an absolutely harmless instrument, and is had recourse to on every occasion. Against such a principle and such a practice I enter a strong protest. I have known serious injury inflicted by the forceps when injudiciously and unskillfully used, and I am satisfied that injury will

often follow if the tendency which at present exists to apply it when unnecessary be not checked.

In one other respect the practice of the present day has also changed. Twenty-five years ago what are known as "the short straight forceps" alone were used. This instrument, which in many cases is very efficient, measures about $11\frac{1}{2}$ inches in length. To the long forceps "the most decided objection" was made; but in this hospital Barnes' double-curved forceps, an instrument 15 inches in length, is now, and in my opinion most justly, preferred. Without doubt a living child can be safely extracted with this instrument where delivery could not have been possibly effected by the old one. I believe that the lives of not a few children, who would otherwise have perished before birth, are now by this means annually saved.

Next in importance to the improvement in practice with reference to the use of the forceps may, I think, be ranked that which has occurred in the treatment of uterine hæmorrhage, whether *post-partum* or depending on the attachment of the placenta to the lower zone of the uterus.

The aim of all treatment adopted with the view of checking *post-partum* hæmorrhage is, and ever has been, to bring about such an amount of contraction of the muscular fibres of the uterus as will be sufficient to close the orifices of the uterine sinuses, and at the same time to shut off the increased flow of blood, which, necessary for the requirement of the fetus during the continuance of utero-gestation, once parturition has occurred, is no longer needed. With the intention of bringing about this much desired object, the application of cold externally, and the internal exhibition of ergot, were relied on almost exclusively. These agents are not discarded, nor is their value questioned; but cases do from time to time occur in which they fail, and valuable lives are consequently lost. In such cases we now employ, with the greatest success, the perchloride of iron, or some similar stringent, injecting five or six ounces of a solution containing about one part of the liquor ferri perchloridi fort to three of water into the uterus. This treatment I have employed repeatedly and can unhesitatingly bear testimony to its value. I believe that through its means

lives are annually preserved which would otherwise be lost. Our knowledge too of the causes producing hæmorrhage when the placenta is attached close to, or over, the os internum, is now much greater than it was in former days, and consequently the treatment of these cases is modified and improved. The theory generally held was that when the placenta was attached to the lower zone of the uterus it underwent a continuous separation, corresponding to the gradual expansion of the neck, and it was laid down as an undisputed axiom that "the more the labour advanced, the greater was the hæmorrhage;" consequently it was held "that manual extraction of the fœtus by the feet was absolutely necessary to save the mother's life."

To Dr. Robert Barnes we are mainly indebted for disproving this theory, and basing our practice on a sounder footing. It would be impossible for me, in a cursory retrospect, to enter into the discussion of this important subject. At a future time I hope to invite your attention to it more in detail. On the present occasion I can only say that it is to my mind clearly established that the blood flows, in cases of unavoidable hæmorrhage, not from the placenta, but directly from the uterine sinuses; that the old practice of endeavouring to effect delivery by turning is, in many of these cases, a dangerous one; for serious injury is likely to be inflicted, and possible rupture of the uterus occur, from an attempt to force the hand through the undilated, and often undilatable, cervix. Now in the great majority of cases we rely on rupturing the membranes, effecting this by guiding a probe, stilette, or some similar instrument, through the os uteri, and then waiting until uterine action sets in. It is very seldom that much blood is lost after the membranes have been punctured: if it occurs we endeavour to dilate the cervix gradually by means of Dr. Barnes' bags, as his hydrostatic dilators are commonly termed. But it is not very often we are obliged to have recourse to these, and in these cases the less Nature is interfered with the better.

Again in the treatment of puerperal convulsions our practice is greatly changed. Bleeding was formerly relied on almost exclusively. It was practised in these cases long after it ceased to be employed in others. I am far

from saying that in certain cases of convulsions bleeding is not useful, but it is not often necessary. The exhibition of chloral, or the inhalation of chloroform, is now with justice relied on.

Chloral, too, is now used with great advantage in cases in which the cervix uteri is unyielding, and where delay in the first stage occurs from this cause. In these cases it was formerly the practice to administer tartar emetic in nauseating doses. This, though often very efficacious, is objectionable in several respects; it is most irksome to the patient, who for many hours is kept in a state of nausea; then it is liable to reduce the patient's strength, and sometimes gives rise to troublesome diarrhœa; while with respect to patients who are weakly, or in delicate health, its use is altogether forbidden. Chloral, on the other hand, administered in ten grain doses, at intervals of fifteen minutes, not only gives rise to no discomfort, but sometimes produces refreshing sleep, and seldom fails to induce relaxation of the rigid cervix. The quantity administered in these divided doses should not exceed sixty grains, ten grains being given every fifteen minutes, and a much less quantity is often sufficient.

It is impossible for me, within the limits of an introductory lecture, to do more than name some of the other important improvements which have taken place in the treatment of difficult and complicated cases of labour. Thus I can but allude to the introduction of the cephalotribe, and of the operation of decapitation, which enable us to contend successfully with cases presenting features of the greatest difficulty; while transfusion, as recently practised, has undoubtedly saved lives which would otherwise have been lost.

The advance which has been made in our knowledge of the pathology, and consequently the improvement which has taken place during the last twenty-five years in the treatment of THOSE AFFECTIONS WHICH ARE PECULIAR TO WOMEN, has been, if possible, more marked than that which has occurred in obstetrics. Indeed, I hardly know how to institute a comparison. At the time to which I refer the cervix uteri was considered as being that portion of the uterus which was almost exclusively the sub-

ject of disease, and the os uteri being exposed through the speculum, the patient was generally pronounced to be free from any uterine ailment if the lips of the os uteri proved to be free from abrasion, or to be the subject of ulceration if the exposed surface of the cervix was abraded. Now we are well aware that the body of the uterus, and especially its intra-uterine surface, is far more frequently the seat of disease than the cervix. Formerly the cavity of the uterus was deemed inaccessible to treatment, and the idea of venturing to introduce any medicinal agent into it would have been looked on with horror. Now we, without hesitation, introduce solid nitrate of silver or sulphate of zinc up to the very fundus, while we also apply—not only with impunity, but with absolute advantage—such strong caustics as the fuming nitric acid to all parts of the uterine cavity.

But probably the greatest improvements of all are those which relate to the exploration of the interior of the uterus, and the removal of intra-uterine polypi. Formerly, if from any reason a suspicion existed as to the possible presence of an intra-uterine tumour, we were without the means of verifying our diagnosis, and the patient was in the majority of cases left to linger on till, worn out by repeated hæmorrhages, she sank into a premature grave. But now by the use of sponge tents, or of compressed sea-tangle, we can dilate the uterus, thoroughly investigate every portion of the interior of that viscus, and, if needs be, remove any abnormal growth which may be found within its cavity.

But tumours are also developed in the structure of the uterus, and such are often incapable of being removed by surgical means. These frequently give rise to profuse hæmorrhage which it is necessary to control, and this we now know can be effected by the injection of astringent solutions into the cavity of the uterus, or, in some cases, by the hypodermic injection of ergotin; the latter treatment, too, sometimes producing a marked diminution in the size of the tumor. Then, again, in the treatment of ovarian disease, the splendid success which often follows on the operation of ovariectomy would alone suffice to stamp our age as

one of great progress in the treatment of those affections which are peculiar to women.

Time does not permit me to follow this subject further. It would be impossible for me to recapitulate, even in the most superficial manner, all that has been done within the last twenty years to advance our knowledge of the pathology, and to improve the treatment of uterine diseases, using that word in its most extended sense. My object has not been so much to give you an insight into this subject as to show you how extended it is; and yet I have named but a few out of a host of affections, all of equal importance. Reflect, I beg of you, on how much you have to learn while students of this hospital, and remember how short your time is. Remember, too, that your future rests with yourselves. All things are possible to the diligent. Work now while you are students, but, believe me, your work will not be done even when you have passed your final examination.

That I stand here to day is, I believe, due to the fact that early in my professional career I became aware of my own deficiencies, and that I set to work earnestly to improve myself in the knowledge of my profession; and now I find that I am but a learner still. I am aware that while endeavouring to teach you I shall learn much myself. I look on myself as your fellow-student, and I trust we will work together to our mutual advantage, and that we will be able to look back with pleasure on the session which commences to-day as one of great progress and improvement in our knowledge of our common profession.—*Dublin Medical Press and Circular.*

TREATMENT OF PRURITUS.—Recently I had a most obstinate and severe case of pruritus of the vulva, clitoris, and mons veneris of a fat woman more than sixty years old. So severe was it, that she would cry from the distress. It so overcame her, every way, that she was nearly helpless. After trying a great number of remedies, both internally and externally, for several months, with very little relief, at length, with only the external application of the essence of peppermint to the itching parts, she was almost instantly relieved, with an occasional use of the same. She remains happy.—*Med. and Surg. Reporter.*

THE MANIPULATION OF ADHERED PLACENTA.

BY JOSEPH HOLT, M.D.

The following directions are given by Dr. J. G. Swayne, in the *British Medical Journal*:—

If the cord be tightly encircled by the os uteri, the constriction should be overcome by insinuating the tips of the fingers into the os in a conical form; whilst the right hand all this time is making counter-pressure upon the fundus uteri, so as to steady that organ. Should these precautions be neglected, the connections between the vagina and the uterus may be put very injuriously on the stretch, especially if the circular fibres of the os oppose much resistance to the introduction of the hand. As the tips of the fingers pass through the os, they should be gradually expanded and separated from one another, until, by sheer fatigue, they overcome the contraction of the uterine fibres, so as to allow the passage of the entire hand into the uterus. When this is accomplished, the next step is to pass up the hand sufficiently high to reach the placenta. The distance which it has to pass before this can be felt will depend very much upon the position of the placenta and the degree of contraction of the uterus. If the placenta be attached, as it usually is, to the fundus uteri, or if the uterus be in a flaccid condition, it will be necessary to pass the hand much further than when the placenta is attached lower down, or when the uterus is well contracted. I have sometimes had to pass the hand quite into the epigastric region, in search of a retained placenta. As soon as the placenta is arrived at, the fingers should be spread out, taking care not to entangle them in the membranes, until the circumference of the placenta can be felt. If any portion of the circumference be already detached, the tips of the fingers should be cautiously inserted between this portion and the inner surface of the uterus, and the placenta gradually peeled off. All this time the right hand, externally applied, steadies the portion of the uterus from which the left hand is detaching the placenta, and enables the accoucheur to estimate the exact thickness of the uterine walls included between the hands, so that he can avoid digging his nails into the substance of the

uterus. There is sometimes considerable danger of an accident when the adhesions are very firm and close. There is also considerable danger of leaving portions of placenta behind; a risk that one can readily comprehend in such cases as those described by Dr. Ramsbotham, who states: "I have opened more than one body where a part was left adherent to the uterus, and where, on making a longitudinal section of the organs, and examining the cut edges, I could not determine the boundary line between the uterus and the placenta, so intimate a union had taken place between them." In all such difficult cases, it will be necessary to sever the adhesion by using the finger nails with a kind of sawing motion from side to side. The tips of the fingers are placed in a line like the edge of a saw, keeping the palm toward the placenta and the knuckles toward the uterus, and the sawing motion is continued very slowly and gradually, until the entire placenta is separated and falls into the hollow of the hand. This proceeding sometimes requires a great deal of patience, and is exceedingly tiring; but the accoucheur should take his time about it, working with both hands, and making his ground sure as he goes on, and not withdrawing his hand with the placenta until he is certain that he has brought away every part of it that can be safely separated. It is very seldom, comparatively, that the adhesions are so firm that this cannot be done. Should this, however, be the case, we should have a choice of evils: either to run the risk of causing secondary hæmorrhage and septicæmia by leaving portions behind, or of causing metritis from injury to the uterus in bringing them away. For my own part, I think that the last of these two is the least dangerous, except in very unusual cases. I have notes of only two instances in which it was necessary to leave any portion of consequence behind. Fortunately, in both, the pieces were expelled on the third day, without having caused any untoward symptoms, although in one the piece expelled was as large as a hen's egg. Of course, in all such instances the dangers of septicæmia should be guarded against, as much as possible, by the frequent use of vaginal injections containing Condy's or other disinfectant fluids.—*Medical and Surgical Reporter.*

THE FORCEPS APPLICATION.

When forceps are properly adjusted to the fetal head, and locked, *can* they slip? that is, *off the head of the fetus?* We once in a while hear of forceps slipping, but I have always had a doubt whether they have been correctly applied. In the course of a long practice, I have frequently used forceps, and with the knowledge and experience thus acquired, am only sorry I didn't use them more frequently; I might have averted hours of anguish, and quite possibly saved infantile life. But my forceps never "slipped," nor can I quite understand how they could; of course they couldn't slip within the bony pelvis. I have, on more than one occasion, applied force enough to make them slip, if it were possible for this to happen.

Some years ago I saw a lady, in consultation, who had been in labour for more than forty-eight hours, with an arm extended more than half the time. The doctor, in reporting the case to me, placed his own arm upward, alongside of his head, and remarked, "doctor, it is coming this way." I, however, doubted his illustrated diagnosis, and proceeded to investigate the case, when I found a shoulder presentation. Under the influence of an anæsthetic I turned and delivered by the feet. During the night previous to my seeing the patient, the doctor had made several unsuccessful attempts to use his forceps, but they "slipped" every time. It might be well, too, to have a thought of the injury that might be inflicted on the accouchee by this imperfect application and slipping of forceps.—(L. G. Harley, M.D., in the *Medical and Surgical Reporter*.

EXTENSIVE LACERATION OF THE PERINEUM; CURE.—Dr. Jas. Young, Vice-President of the Obstetrical Society of Edinburgh, relates the following interesting cases of this accident:—"On the 28th June, 1875, I was summoned to see Mrs. M., æt. 35, a primipara. At 6 p.m. the os uteri was small (size of a shilling), although the patient had been in labour for twelve hours. I was again called at 6 p.m. next day, when I found the first stage

almost over, and the head presenting in the occipito-anterior position. The woman had been twenty-four hours in labour, and as I considered it unjustifiable to leave her longer I sent for the forceps. The vagina was hot, and the pains were becoming feeble. While under chloroform, I used steady traction during each pain, allowing the external parts time to dilate slowly. Notwithstanding every care, the perineum ruptured right along through the sphincter ani, and into bowel three inches, my whole index finger easily passing from bowel into vagina. When the placenta was expelled, and the uterus contracted, the wound was carefully sponged. The anæsthesia being maintained, the torn parts were brought together with the interrupted suture. Seven ligatures were used, which had been dipped in carbolic oil, and the wound was left in perfect approximation. The urine was drawn off every twelve hours. The thighs were tied together, and by the administration of opium the bowels were confined for six days. No local dressings were used. The patient made a perfect recovery; the wound healed throughout at every point; and on the fourteenth day she was left to her own care. Several weeks ago, I examined the patient by placing one index finger in the bowel, and the other in the vagina, and found the recto-vaginal septum complete. Let me here mention, in connection with her history, that when Mrs. M. was married I understood that perfect sexual intercourse was precluded for some months in consequence of the extreme rigidity of the vagina, and four years elapsed ere this child was born." Dr. Y. says that that in severe perineal rupture the immediate closing of the wound is of paramount importance, so as to secure healing by the first intention. The interrupted suture of carbolized catgut should be used; and the entire rupture must be brought into exact approximation. Careful and frequent sponging must be attended to by the nurse, to avoid any irritation from the lochial discharge. The urine must be drawn off every twelve hours; no dressings applied; the patient kept in the horizontal position; the thighs kept together; and the bowels must not be allowed to move for six days.—*Edinburgh Medical Journal*.

WHEN SHOULD THE UMBILICAL CORD BE LIGATURED?—By Dr. Budin, ("Bull. Gen. de Therap," Feb. 1876). To this simple enquiry a very prompt reply would probably be given by the majority of practitioners, and that to the effect that it should be done as soon as possible; and yet, as Dr. Budin's excellent memoir shows, the question should be well weighed before so ready and positive a reply is given. Dr. Budin, who is a rising young physician of much promise, read his memoir before the Société de Biologie, of Paris, where it was well received by the members present, including Claude Berrard and other celebrities. Dr. Budin made two series of experiments, each comprising a number of observations. In one he did not cut the cord until pulsation had ceased, and in the other the section was made immediately after birth. In both the blood escaping from the placental end of the cord was collected, and it was found that whilst in the first series it amounted to twelve cubic centimètres, in the second it was no less than one hundred cubic centimètres. Dr. Budin concludes, therefore, that it is best to wait until pulsation has ceased in the cord before it is ligatured and cut, because if the section be made sooner the foetus is deprived of eighty-eight cubic centimètres of blood. Dr. Budin, moreover, states that the fœto-placental circulation is a completely closed one, and therefore in the normal condition of things no blood escapes from the placental tissues externally.—*British and Foreign Medico-Chirurgical Review*.

METHOD OF OPENING ABSCESSSES WITHOUT CAUSING PAIN.—Dr. Borg ezini, of Boulogne, recommends for this purpose the application to the skin, for from three to five minutes, of a solution of two parts of carbolic acid in one part of glycerine. If the skin is inflamed, as it usually is in acute abscesses, the anæsthesia should not be too long applied. Dr. B. thinks that this anæsthetic may be utilized in autoplasmic operations, and for superficial neuralgias.—*La Tribune Médicale*, 26 Dec. 1875.

[Dr. Bill four years ago demonstrated the anæsthetic properties of carbolic acid locally applied, in his elaborate and interesting article published in the July (1872) number of the *Am Journal of Medical Science*, page 35.—ED.]

Materia Medica.

THE PHYSIOLOGICAL ACTION OF ALCOHOL.

The Nos. of the *Practitioner* for January and February of the present year contain an instructive paper on this subject, by Dr. T. Lauder Brunton. The direct points in this paper are summed up as follows:—

1. Alcohol, in small quantities, increases the secretion of the gastric juice and the movements of the stomach, and thus aids digestion. Although unnecessary in health, it is useful in exhaustion and debility.

2. It increases the force and frequency of the pulse, by acting reflexly through the nerves of the stomach.

3. In large doses it impairs digestion by over-irritating the stomach.

4. It may produce death reflexly by shock.

5. After absorption into the blood it lessens the oxidizing power of the red blood corpuscles. This property renders it useful in reducing temperature. When constantly, or even frequently, present in the blood, it causes accumulation of fat, and fatty degeneration of organs.

6. It undergoes combustion in the body, maintains or increases the body weight, and prolongs life on an insufficient diet. It is therefore entitled to be reckoned as a food.

7. If large doses are taken, part of it is excreted unchanged.

8. It dilates the blood-vessels, increases the force and frequency of the heart by its action on the nervous centres, to which it is conveyed by the blood, imparts a feeling of comfort, and facilitates bodily and mental labour. It does not give additional strength, but merely enables a man to draw upon his reserve energy. It may thus give assistance in a single effort, but not in prolonged exertions.

9. The same is the case with the heart; but in disease alcohol frequently slows instead of quickening the pulsations of this organ, and thus economizes instead of expending its reserve energy.

10. By dilating the vessels of the skin, alcohol warms the surface at the expense of the internal organs. It is thus injurious when taken

during exposure to cold, but beneficial when taken after the exposure is over, as it tends to prevent congestion of internal organs.

11. The symptoms of intoxication are due to paralysis of the nervous centres; the cerebrum and cerebellum being first affected, then the cord, and lastly the medulla oblongata. It is through paralysis of the medulla that alcohol usually causes death.

12. The apparent immunity which drunken men enjoy from the usual effects of serious accidents, is due to paralysis of the nervous mechanism, through which shock would be produced in a sober condition.—*American Journal Med. Science.*

EXPERIMENTS ON ERGOT OF RYE.

Dr. G. Leir, ('Le Sperimentale' Nos. 8, 9, and 10, 1875), concludes from experiments undertaken by him that it is to the phosphoric acid it contains that Ergot of Rye owes its properties. After having shown the effect obtained in three bitches by the employment of medicinal phosphoric acid he related two observations made at the Maternity of Pisa, by Dr. Garzella, on two women aged respectively twenty-five and twenty-eight years. The following are Dr. Leir's conclusions:—

(1) The therapeutic effects derived from Ergot of Rye are due to the phosphoric acid it contains.

(2) In diseases in which the employment of Ergot of Rye is useful, the employment of phosphoric acid renders identical service.

(3) Phosphoric acid acts with equal intensity and rapidity with Ergot of Rye.

(4) The quantity of soluble phosphoric acid found in recently powdered Ergot of Rye is in proportion to the activity of the drug.—*British and Foreign Medico-Chirurgical Review.*

In two cases of diabetes mellitus, Von Hasse has seen great improvement resulting from the administration of ergot. His formula was as follows:

R. Ext. Secale Cœniti.	
Ext. Hyoscyami.	aa. grs. xvi.
Liq. Potassæ Acetat	ʒi.
Aq. Fœniculi	ʒiil.

A large dessert-spoonful to be taken every three hours.

Medical Jurisprudence.

THE EXAMINATION AND COMMITMENT OF THE INSANE.*

BY A. E. MACDONALD, M. D.,

Medical Superintendent, New York City Asylum for the Insane.

The examination of patients, supposed to be insane, with a view to their commitment to an Asylum, is a duty, to the performance of which any gentleman in general practice is liable to be often summoned, and one for which he should be always prepared by a knowledge of his powers and duties, under the law of the State in which he resides, and by a knowledge of the disease and its manifestations. To deprive any person of his liberty for a greater or shorter period, to bring to his family the grief which their separation causes and to entail upon him and them the reproach which commonly, though improperly, attaches to the fact of such confinement, is certainly a serious matter, and the law very justly subjects to penalty any physician who makes any improper commitment.

The laws of the various States differ materially as to the manner of the commitment of the insane, and as to the part which the physician plays in the process. In some States he is not called upon at all, the parents or guardians, or near relatives of an insane person, being empowered to commit him, without medical evidence as to his insanity. In others, the certificate of but one physician is required; but in those States where legislation upon the subject is farthest advanced, no patient can be deprived of his liberty, save upon the sworn testimony of two reputable physicians, that he is insane, and unfit to be at large. The State of New York has, by recent revision and codification of its statutes, under the supervision of the State Commissioner in Lunacy, Dr. Ordronaux, placed them upon a very satisfactory footing. I shall refer to these statutes and the forms which they prescribe, in treating of the matter, as they sufficiently represent, in a general way, the legislation of other States upon the subject. I may tell you here, though, for

* A Lecture delivered before the students of the University of the City of New York, Medical Department, March 10th, 1876.

the comfort of such of you as, being under-graduates now, propose to practise in this State after your graduation, that you are not likely to have speedy occasion to exercise your knowledge in this special direction, as by the law of the State, a physician must be a graduate of three years' standing in order to take out commitments for the insane.

The statutes, then, of the State of New York regulate the commitment of the insane by the following enactments :

SECTION 1. No person should be committed to, or confined as a patient in any asylum, public or private, or in any institution, home or retreat, for the care and treatment of the insane, except upon the certificate of two physicians, under oath, setting forth the insanity of such person. But no person shall be held in confinement in any such asylum for more than five days, unless within that time such certificate be approved by a judge or justice of a court of record of the county or district in which the alleged lunatic resides, and said judge or justice may institute inquiry and take proofs as to any alleged lunacy before approving or disapproving of such certificate, and said judge or justice may, in his discretion, call a jury in each case to determine the question of lunacy.

§ 2. It shall not be lawful for any physician to certify to the insanity of any person, for the purpose of securing his commitment to an asylum, unless said physician be of reputable character, a graduate of some incorporated medical college, a permanent resident of the State, and shall have been in the actual practice of his profession for at least three years, and such qualifications shall be certified to by a judge of any court of record. No certificate of insanity shall be made, except after a personal examination of the party alleged to be insane, and according to forms prescribed by the State Commissioner in Lunacy, and every such certificate shall bear date of not more than ten days prior to such commitment.

The following is a blank form of medical certificate, as prescribed by the State Commissioner in Lunacy.

STATE OF NEW YORK, }
 COUNTY OF _____, } ss.

I, _____, a resident of _____, in the county aforesaid, being a Graduate of _____, and having practised three years as a Physician, hereby certify, under oath, that on the _____ day of _____, I personally examined

* [Here insert sex, age, married or single, and occupation.]

and that the said _____ is Insane, and a proper person for care and treatment, under the provisions of Chapter 446, of the Laws of 1874.

I further certify that I have formed this opinion upon the following grounds, viz : *

* [Here insert facts upon which such opinion rests.]

And I further declare that my qualifications as a Medical Examiner in Lunacy have been duly attested and certified by *

* [Here insert the name of the Judge granting such certificate.]

Sworn to and subscribed before me, }
 this day of _____, 187 . }

The chief improvement in this certificate, as compared with those formerly in use, is that it requires the physician signing it to state his reasons for considering the patient insane. It is not enough, as formerly, to give the conclusion ; the grounds for the conclusion are to be furnished also. The object of this is to insure careful personal examination, and to furnish the officers of the institution to which the patient goes with information which will be of value to them in determining his treatment, and hence its importance. I am not aware that this is required under the laws of any other State of the Union. A compensating difference to yourselves may be found in the fact, that in no other State is it required that any prescribed length of time shall have elapsed since his graduation, before a physician is deemed competent to commit lunatics, so that such of you as intend to practise elsewhere, may enjoy the privilege and its resulting emoluments from the outset. I would call your attention to the wording of the commitment used in most States, but not now in New York, with regard to the condition of the patient, which justifies you in secluding him. He must be "insane, and so far disordered in his senses, as to endanger his own person, and the persons and property of others if permitted to go at large," so that a man must not only be insane, but dangerously so, before you can commit him, and, conversely, it is not necessary to send every person who is insane to an asylum, if he is at the same time harmless. This exempts such cases of chronic and harmless insanity as can be properly cared for at their homes, and it also gives you the right to retain the few patients, those with puerperal insanity for instance, who can as well

or better be treated there, and whom it would be unwise to expose to the dangers of removal while their disorder is in the height of its acute stage. On the other hand it may be construed to embrace almost any case, certainly any acute case, for the man who is so insane as to prevent the proper remedies being administered and applied elsewhere than in a building, and among agencies specially prepared for the purpose, may certainly be considered to endanger his own person.

We will suppose, then, that you are called to examine a person alleged to be insane, with a view to his commitment to an asylum. Unless you are yourself the family physician of the patient in question, the summons will likely come, either from the gentleman who fills that office, or from a relative of the patient, and to the form of that summons, I believe, are attributable the mistakes which sometimes *do* attend the commitment of supposed lunatics. Nine times out of ten, you will be asked directly to *commit* the patient, not to *examine* him. Your brother practitioner will say to you "come with me and commit a lunatic," or the family will write to you that your services are desired, that they may send their relative to an asylum. You would not receive a summons to come and prescribe quinine for a patient, or administer any specified form of medical treatment, in a case of some other disease, and yet here the whole thing is decided for you beforehand, and the course you are to pursue laid down for you. Consequently when you go, either you fall insensibly into the spirit in which the summons is sent, and do what you are directed to do, after a very cursory and imperfect examination; or else, if you do make an examination, and conclude not to commit, you feel that you have somehow obtained admission under false pretences, and have not done what people had a right to expect of you, and generally, you are made perfectly sensible of the fact, that they entirely agree with you upon the latter point. I have even known some practitioners in this city, who did not ask or expect a fee, in cases where they failed to satisfy themselves of the propriety of committing, although such cases naturally occupied more of their time, and taxed their knowledge and experience, more than

those in which the presence of insanity was patent at a glance. Apart from the glaring impropriety of neglecting to obtain a fee whenever possible, this course has the demerit of sanctioning the form of engagement of which I complain, and recognizing a sort of "no cure, no pay" system. Properly a medical man should be called to a case of insanity, as to a case of any other disease, to examine, and, having examined, to prescribe as he sees fit. Sequestration in an asylum is as purely a therapeutic agent as any in the *materia medica*, and its prescription and exhibition should come from the medical attendant, not from the bystanders. In the way in which you accept such summons, and invite to such consultations, you can do much to alter this state of affairs, and so assert the proper function and dignity of yourself and your profession.

If you happen to be the family physician of the patient, a formal visit will be scarcely needful. You will have observed the gradual approach of the disease, and have seen reason to anticipate the call. More than likely you have been the one to first appreciate the necessity of the step and to urge its being taken. In this you have very probably been met by the opposition of the relatives and friends of the patient. They have refused to see things as you have seen them. The patient is in their eyes only a little cast down, a little excited, a little eccentric, it will be time enough to take active measures if the trouble increases. They are unwilling to take the responsibility of authorizing the patient's removal without consultation with other, and perhaps distant relatives. They are sure that confinement with other lunatics would make him worse; they fear that he will never forgive them should he recover. Thus in a hundred ways they thwart your purpose and plead for delay. It will be your duty to tell them that each day's postponement, by so much, lessens the probabilities of recovery; that insanity, under timely and efficient treatment, is commonly recovered from; that in nine cases out of ten the patient will not know where he is, appreciate his surroundings, or recognize the fact that his comrades are lunatics—at any rate restraint and discipline applied in an asylum will be less irksome to him than if he is called

to endure them in his own home. You must impress these points upon them firmly and forcibly, and make them fully understand the great responsibility that will rest upon them, if, through their unwillingness to follow your advice, the patient passes, for want of prompt and energetic treatment, into a condition of permanent mental alienation. And yet more than likely, your advice and your warning will be disregarded. Of the thousands of hopeless lunatics who crowd our asylums a large proportion owe the incurability of their disorder to the procrastination of their friends.

If, instead of being the family physician, you are merely called in when the necessity of the patient's confinement can no longer be disputed, this duty and this trial will be saved you. If the call is to unite with the family physician in perfecting the necessary legal formalities, your task will be relatively easy, for from him you can obtain particulars which will simplify it. It is possible, however, that your associate may be as much a stranger to the patient as yourself, and as a case of this kind will present the greatest difficulties and require the greatest tact and caution, I shall suppose such an one in my description.

Your first encounter will be with the patient's relatives—and generally with his female relatives, who will tell you a great deal that bears upon the case, and a great deal more that does not. As a rule you may divide the relatives of an insane person into two classes, those who want to send him to an asylum at all hazards, and those who want to keep him out at all hazards. Those who have no predetermination in either direction, who simply wish to see what *you* think, and do what *you* advise, are very much in the minority. Fortunately, as a general thing, you are likely only to meet those of your way of thinking, in whichever direction their pre-conceived opinions may tend, but this is not always so. Now and again there will be two sides to the question, and then your difficulties will increase. Take, for instance, the case of a young wife who becomes insane; on the one hand you have the husband, on the other her family. Each side is perfectly convinced that the misfortune which has overtaken the beloved one is distinctly traceable to some ne-

glect or interference of the other, and there is as wide a difference in their views as to what is proper to be done under the circumstances.

It will be necessary for you, as I have said, to listen to a great deal of information, and to a great deal of theory and surmise. Much of what is told you will be useless, and much of it untrue. If you can manage it, it will be better to gain your information from one comparatively disinterested—say an inmate friend or an intelligent servant—than from a near relative of the patient. At any rate you will want to learn certain facts, and you must try to get your informant to simply answer your questions without being discursive. You will ask first, for instance, the patient's age—the sex you will already know—then his or her civil condition, whether single or married or widowed. The occupation which has been followed will sometimes be a guide to you, and it will be well to inquire as to the religious belief, and the habits with regard to church-going and such like. The general habits then are of great importance,—has the patient been temperate or intemperate, disposed to enjoyment or solitude, have there been venereal excesses or addiction to self-abuse? You may pass next to the bodily health—what has been the patient's history? Has there ever been a previous attack of insanity or any nervous disorder? What diseases has he or she had? And, if a female, what has there been of irregularity in menstruation, parturition, or at the climacteric? Another question, and a most important one, what is the family history? Have there been insane members or sufferers from epilepsy, paralysis, or other nervous disease? Have there been marriages of consanguinity? Were the patient's parents healthy? Were they intemperate? So you may pass to his present condition? Ask first how long he has been ailing, and receive the answer with a grain of allowance, for almost invariably the period assigned for the invasion of the disease will be much more recent than the real one. Ask next the supposed cause. Has the patient had business reverses, family troubles or afflictions, or has there been religious or political excitement? What recent illness or injuries have there been, or has there been prolonged dissipation? If the patient is a

young girl, has menstruation commenced, and is it regular; if a young boy, is there reason to suspect masturbation? Ask then what symptoms were first noticed. In what did the patient first commence to depart from his customary habits and demeanor, and in what manner has the departure increased? What is his present state, and how long has been its duration? What delusions has he manifested, and if he is disposed to talk, what subject seems uppermost in his mind? Remember that these questions should be asked before you visit the patient, in order that the answers may assist you in personally examining him. They are to be taken only for what they are worth, as confirmatory of what you may yourself observe, not as sufficient in themselves to determine your diagnosis. Your informant will probably consider them all sufficient, and will perhaps resent your seeking further, or giving the patient more than a hasty and cursory examination. No matter, your affidavit will be that you have examined the patient and found him insane, not that you have been so informed by his friends. If you omit anything before you visit the patient, do not seek to remedy the omission by asking the question in his presence, unless it be something that you are perfectly willing that he should hear. The most absorbed and distraught appearing patients, are often keenly observant of all that passes about them, and though you may fail to get them to reply to your questions, you must not think that it is because they do not understand both them and all else that you say. In insanity, at the commencement, the senses are more often sharpened than dulled, and you will find that there is a good deal of cleverness and cunning. It will be well for you also to see the patient's letters and other writings.

(To be continued.)

IN his Croonian Lectures, Dr. Dickenson relates a curious case of congestion of the kidneys, brought on by a cold drive over a Yorksire moor, where the swelling induced was so great that the capsules of both kidneys were rent, and a massive coagulum of blood was found in the gaping tear. In this case the pain in the loins was so great that it was supposed there must be a renal calculus.

Translations.

CHRONIC CONSTRICTION OF THE AORTA IN A CHILD TWO YEARS OLD.

BY MOUTARD MARTIN.

Eugene M—, aged two years, comes into the Salle St. Jean with the following antecedents: he has been swollen for several months, and since he has been weaned, has been oppressed [in breathing].

At the time of his entrance, we find in him hypertrophy of the heart with increased impulse; in the middle of the precordial region, a rubbing, revealed both by palpation and auscultation, indicates pericarditis; at the same time a very loud, rough souffle, most intense at the base of the heart, marks this first sound, and indicates an aortic constriction. This souffle is heard very intense throughout the thorax. As for the pulse, it is large, vibrating, and would rather resemble that of aortic insufficiency; œdema and ascites; no albumen with urine. In spite of blistering, matters do not change, and suddenly the child is seized with very severe convulsions. The application of the Marteau de Mayr recalled him to life; but the next day he had varioloid eruption which became hæmorrhagic, and to which he rapidly succumbed.

At the autopsy the following lesions were found: pericarditis slight, without effusion; heart enormously hypertrophied; nothing at the mitral orifice, but on the aortic side of the mitral valve, which forms the mitro-sigmoidal sinus, two small yellowish spots not elevated,—these were evidence of previous inflammation. The sigmoid valves red, thickened, and swollen; at the point of their union they grasped tightly a death-clot. Two or three centimetres above the origin of the aorta, on its inner surface, were small, irregular, yellowish patches from 2 to 5 mm. in dimension, forming projections scarcely perceptible.—*Progrès Médical.*

CURE OF PHYMOSIS BY SPONGE TENT has recently been practised with success by Dr. Gregorely, in a case of syphilitic origin.

SOME idea of medical fees in Austria and Bavaria may be gathered from the following translation of items which recently appeared in one of our Vienna exchanges:—A petition got up by the physicians of Upper Austria to raise the fees in legal cases states that a surgeon (*wundarzt*) for the legal examination of an individual, together with the report and attendance on court receives, 8 $\frac{3}{4}$ kreuzers (about 18 cents). It further enquires where the common labourer is to be found who will work for such wages. In Bavaria an order has been issued by royal command regulating the fees to be received by medical men in private practice. This regulation comes in force when no previous private arrangement has been made. Visits are divided into three classes—for the first 1 $\frac{1}{2}$ to 5 marks, (37 $\frac{1}{2}$ cts. to \$1.25) for each following visit, 1 to 3 marks, (25 to 75 cts.,) for night visits double. For advice in the doctor's office $\frac{1}{2}$ to 3 marks, (12 $\frac{1}{2}$ to 75 cts.)—*Medicinisches Chirurgicalische Rundschau.*

RUSSIAN CURE FOR DRUNKENNESS.—M. Haurowiz says that for some time past the *Herba serpyllia* (wild thyme) has been used with great success to effect a permanent cure of drunkenness; in case of a relapse (only after years), a short treatment will effect a cure again. The treatment consists in making an infusion of wild thyme (1 $\frac{1}{2}$ oz. to 1 $\frac{1}{2}$ pint), and giving the patient a teacupful every half hour. The next day it is given every two hours, and then four to six times a day until the cure is complete, which generally takes from two to three weeks. The effects are in the following order: vomiting, diarrhoea, increased urine, strong transpiration; then, generally, increased appetite and craving for acidulous beverages. Diet: easily digested food, and lemonade or other acidulous liquids.—*American Journal of Pharmacy.*

TREATMENT OF RABIES BY XANTHIUM SPINOSUM.—The *Paris Medical* says that Dr. Grzymala, of Podolia, has been using this plant in doses of gr. ix. of the powder, [it does not say of what part of the plant], three times a day for a period of three weeks. For children under twelve years half that dose is given.

Rabies is very common in Podolia, and in cases where Dr. Grzymala gave it before the attack showed itself it seemed to neutralize the virus, both in man and other animals, whereas other cases bitten by the same dogs, and subjected to other modes of treatment, succumbed with all the symptoms of rabies. *Xanthium Spinosum* acts either as a sudorific, sialogogue, or feeble diuretic; it rarely acts in all these methods at once.

SEARCHING FOR VESICAL CALCULI is one of the latest uses to which the aspirator has been put. We observe from the *Paris Medical* that M. Von Brandt had several times to withdraw the urine of an old man by means of a capillary trocar, and suspecting stone he explored with the canula. He recommends this plan of exploration when the more usual has left the operator in doubt. No part of the *bas-fond* can escape the search of the canula. He considers the one procedure no more injurious than the other.

TURPENTINE EXTERNALLY IN POISONING BY PHOSPHORUS.—Dr. Hicgret has reported to the *Société de Liège* two cases of poisoning by phosphorus, in both of which frictions of turpentine were employed. In one, a man aged 35 took about 13 grs. of phosphorus. The stomach could retain nothing. The frictions were used for eight days. He recovered perfectly. In the other a woman aged 53 took about 19 grs. The frictions were used every two hours, and bags soaked in turpentine were used to saturate the air of the room with it.

CHLORAL IN PITYRIASIS.—Dr. Martineau asserts that a solution of forty grains of chloral to an ounce of water, applied to the scalp each morning by means of a sponge, using slight friction, and allowing it to dry, is very efficacious in pityriasis. If the disease is recent, and the lotion is uninterruptedly used for a month, he predicts a certain cure. In the chronic and more obstinate cases, he recommends the continuance of the application of the solution until the disease disappears, as its daily use produces no inconvenience, whilst it relieves the itching.—*Med. and Surg. Reporter.*

THE CANADIAN
Journal of Medical Science,

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

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

TORONTO, JUNE, 1876.

COMPULSORY ANNUAL EXAMINATIONS.

That a student in medicine should not be compelled to pass annually an examination on the work prescribed for him during the winter course of lectures, when in law, arts, and divinity such examinations must be completed, is an anomaly that requires very strong reasons for its justification and continuance. When the question was before the Medical Council last year, considerable hesitation, nay, even opposition, was evinced by certain members, with regard to a reform that carries conviction on the face of it. And why was this? Simply because from the present position of our medical schools, sectional feeling caused a division of opinion upon a subject of whose utility, apart from all other considerations, no one who has studied the matter can venture to doubt. And when men are delegated from the schools to watch over the interests of those schools as well as of the profession at large, no one can find fault with them for doing their duty and looking closely after those interests with whose care they have been entrusted. We merely think it very unfortunate that the general good should be in danger of being subordinated to sectional interests. We hope, however, that it was shown at the Council last year, that these two interests need not necessarily clash, and we trust that the approaching meeting will confirm the act of last year. Surely, too, our universities must soon see the necessity and wisdom of annually testing the knowledge of medical students. When we find that for five years

past the University of Toronto, the pride of all her graduates, has been behind her sister University of Harvard in this educational reform, we must think that the Senate as formerly constituted was indifferent alike to the best interests of the University, her students and her graduates. Now that we have working men in the Senate Chamber, and especially when the medical graduates are so largely and so ably represented, further delay in the matter certainly cannot take place. At Harvard, a medical student is compelled to pass annually an examination in certain branches before he can pass on to the next year, and before he can obtain a degree. We should be sorry to see the details of the plan adopted by Harvard, substituted for the present curriculum at the University of Toronto; still theirs is a move in the right direction, which has been followed by good results. Granted that a certain number of students require no compulsion to cause them to make the best use of their time; it is well known that many others waste six months or a year in the commencement of their course, and during their second year endeavour to cram up what they consider will suffice to pass them through their primary examination, and in many cases a third session is wasted in a similar manner, to be followed again by the cramming process in their fourth year. That so large a number as sixteen out of thirty-one should be wholly or in part rejected at primary examination, shows clearly that the ambition and determination of many are not sufficient, without some compulsion, to enable them to qualify themselves for useful practitioners. In England, where they are slow to reform, Mr. John Marshall has lately brought the question of annual examination before the Council of the Fellows of the Royal College of Surgeons, and strongly urged its adoption. Mr. Marshall made the suggestion on account of the large number rejected at the primary examinations, and the unsatisfactory knowledge of many candidates who do pass. The scheme was kindly received, and referred to a committee for consideration.

Last year, at the University of Toronto, six candidates competed for the three scholarships in medicine. This year there were thirteen,

and yet this latter number is far too small. If all had to enter for these examinations, the competition would be keener; many good men who at present either through indolence or indifference are content to make a good pass, would, when they knew that their names would be ranked in the yearly class lists, endeavour to place themselves high in honours, and others for very shame would strive not to be last. The University scholarships and medals, high as they are valued now, would hold a still higher place in the estimation of all, and would far better fulfil the objects for which which they were instituted. The status of University graduates would be raised higher still, the University would be still more honoured in her graduates, and the public at large would be still more benefitted. Had we any doubts as to this scheme of annual examinations being adopted by the University and by the Council, we would strongly advocate a regulation requiring all students appearing for their license or degree to produce certificates of having passed annually a creditable examination at the school at which they studied. We hope, too, that botany will either be removed from the curriculum, or placed among the subjects for matriculation. As at present studied, it is a nuisance and a waste of time to the student, and crowds out more important information. Part of chemistry, too, might be well added to the matriculation.

TO OUR SUBSCRIBERS.—We hope we need only mention the subject of our subscription to elicit a hearty and substantial response. The expenses of initiating a journal are heavy, and individual subscriptions will be gladly welcomed.

SEVEN SPRINGS IRON AND ALUM MASS.—In our advertising columns this medicine is highly praised by several Virginia physicians. The virtues claimed for it are Tonic, Diuretic, and Alterative. Its chemical composition will be found in the adv't.

THE ONTARIO MEDICAL COUNCIL will meet on June 6th. We hope the subject of annual examinations, the collection of the annual tax, and the prosecution of unlicensed practitioners will then be definitely settled.

TORONTO EYE AND EAR INFIRMARY.—We beg to call attention to the advertisement of the removal of the Eye and Ear Infirmary. This useful institution is now situated at 153 Church Street.

BOOK NOTICES.

Medical and Surgical Memoirs. By Joseph Jones, M.D., New Orleans.

On some Practical Points in the Treatment of those forms of Eye Disease of most frequent occurrence in General Practice. By A. M. Rosebrugh, M.D., Toronto: Dudley & Burns, Toronto.

On the Wire Ligature in the Treatment of Ununited Fractures, and in Resections of Bones for Deformity. By William A. Byrd, M.D., Quincy, Ill. New York: D. Appleton & Co.

GRATUITOUS ATTENDANCE ON THE CLERGY IN THE UNITED STATES.—It seems that it is a custom among many practitioners in the States to render their services gratuitously to the clergy, even when they may be quite able to afford payment. An anecdote related by a correspondent of the *New York Medical Record* (March 11) shows that the recipients of such services attach about the same value to them as the donors. Having attended a clergyman's child through a long illness, on being asked for his bill he declared there was "nothing" to pay. Some time after he learned that another practitioner was in attendance on the family, who always made it a rule to be paid for what he did. He expressed his surprise to a friend. The latter replied that he had learned from the clergyman's wife that as Dr. — did not charge anything for his services, they concluded that they could not be worth much, and determined, on the occurrence of a serious case in the family, to resort to another practitioner.

The *Allgemeine Medicinische Central Zeitung* states that in one district several foxes, which were shot, were found to contain in their muscles a large number of free and encapsuled trichinae.

Meetings of Medical Societies.

WESTERN AND ST. CLAIR MEDICAL ASSOCIATION.

The sixth regular meeting of the Western and St. Clair Medical Association was held at the Crawford House, Windsor, on Wednesday, the 3rd of May, at 10.30 a.m. Dr. Bray, President, in the Chair. There were present, Drs. Andrews, Casgrain, Lambert, Carney, Coventry, Aikman and Martin, of Windsor; Nesbit, of Sandwich; Allworth, of Leamington; Gaboury, of Belle River; Tye, of Thamesville; Vanvelsor and Samson, of Blenheim; Holmes, Abbott, Murphy, Fleming and Roe, of Chatham; Fraser and Maclean, of Sarnia; Edwards and Stephenson, of Strathroy; and Ross, of Birkhall. And by invitation, Drs. Jenks, Noyes, Brodie, McGraw, Shirley, Eugene Smith, Sinclair, and H. Smith, of Detroit; and Leonard, of New York.

The minutes of last meeting were read and adopted.

A communication from the Centennial Medical Commission of Philadelphia, inviting the appointment and attendance of delegates to the International Medical Congress, was read. A letter from Dr. L. Harvey, regarding the meeting of the American Medical Association, was also read.

Moved by Dr. Carney, seconded by Dr. Casgrain, that Dr. Andrews, of Windsor, be elected an honorary member of the Association. Carried.

Moved by Dr. Abbott, seconded by Dr. Gaboury, that a Committee, consisting of Drs. Holmes, Tye, Casgrain, Fraser, and the mover, be appointed to recommend delegates to the Dominion Medical Association, and International Medical Congress. Carried.

Dr. Fraser, Chairman of the Printing Committee, presented his report.

Moved by Dr. Carney, seconded by Dr. Lambert, that the transactions in future be printed at the end of the year instead of quarterly as at present. Carried.

Dr. Samson then read his paper on a number of cases of great practical interest which had occurred in his practice; and Dr. Bray read a

paper upon post-partum hæmorrhage introductory to the discussion upon that subject. Both gentlemen received the thanks of the meeting for their excellent papers.

The meeting then adjourned to enjoy the generous hospitality of the Medical fraternity of Windsor at the Crawford House, and by their kind arrangement the members from a distance were enabled to visit the museum of the Detroit Scientific Society, the House of Correction, Harper's Hospital, the chemical works of Messrs. Parkes and Davis, and other places of interest in the city.

On re-assembling at 4 p.m., the committee appointed to nominate delegates, recommended that Drs. Edwards, Coventry, Holmes, Murphy, Tye, and Maclean be delegates to the International Medical Congress; and Drs. Bray, Carney, Hoare and Fraser, delegates to the Dominion Medical Association.

On motion the report was adopted.

Dr. Andrews returned thanks to the Association for having elected him an honorary member, and announced in a few parting words his retirement from the active practice of the profession in which he had been engaged for over fifty years.

Dr. Brodie of Detroit thanked the Society for the invitation to be present at the meeting, and expressed his good wishes for the Society, and for the profession in Canada; and extended a reciprocal invitation to meet the State of Michigan Medical Society at Ann Arbor on the 10th of May, and the American Medical Association in June.

Dr. Jenks of Detroit, President of the Michigan State Medical Society, said he was authorized by the Michigan, Ohio, and Indiana State Medical Societies to bring before this Association the matter of forming a sort of limited International Medical Society for purely scientific purposes and discussion, to embrace the States above named, and a portion of Western Ontario. After some discussion as to the desirability and best means of bringing this about, it was moved by Dr. Tye and seconded by Dr. Carney,—That the President and Secretary of this Society, together with Drs. Edwards, Casgrain, Coventry and Carney, be a committee to meet with a committee from the Societies

above named; the joint committee to meet at the call of Dr. Jenks. Carried.

A discussion now took place on the paper read by Dr. Bray on post-partem hæmorrhage, in which Drs. Jenks, Holmes, Roe, Noyes, Smith, Edwards and Coventry, in the main agreed with the opinions advanced in the paper, some however taking exceptions to the treatment by injection of perchloride of iron.

Dr. Noyes, of Detroit, kindly consented to read a paper before the Association at its next meeting, and Dr. Fraser promised to introduce a subject for discussion.

The Association then adjourned to meet at Sarnia in August next.

At the half-yearly Meeting of the Medical Association of King's and Queen's, held at Port Perry, on May 16th, resolutions were adopted condemning the contemplated change in the system of prosecuting unlicensed practitioners, and condemning the principle of appointing the Examining Board from among the members of the Council. The officiousness, alleged drunkenness, and arbitrary conduct of some examiners were censured, as also the practice of furnishing the public press with notices and reports of operations. The following names are to be submitted to the Council as fit examiners: Dr. Sangster, Chemistry and Physiology; Dr. Bascom, Medicine; Dr. Hillary, Materia Medica; Dr. Coburn, Midwifery; Dr. McGill, Surgery; Dr. Eastwood, Medical Jurisprudence. The publishing, in the public press, of a candidate's standing at the late examinations was characterized as a gross violation of confidence. Those examiners whose conduct at the late examination was calculated to cause insubordination were censured.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

At the meeting of the Council in April last, Dr. Sleveking was appointed Examiner in Medicine. With regard to the admission of women to the examination for the degree of L.M., it was agreed that Mesdames Jex Blake, Thorne, and Peachey should be informed that the members of the Board of Examiners in Midwifery having resigned their offices, the Council are obliged to postpone the holding of examinations for certi-

ficates of qualifications in midwifery. It appears that Dr. Graily Hewitt has withdrawn his name as a candidate for the vacant Examinership in Midwifery, and the Council are not inclined to offer the appointment to the younger class of obstetricians. The Council, finding that the number of Fellows is yearly growing less, or in other words, that the number who take the fellowship by examination is insufficient to maintain the numerical strength of the present body of Fellows, has determined upon altering that examination in such a manner that it shall in future be less difficult for a member of the College engaged in practice to prepare himself for and to pass the examination for the fellowship.

TORONTO UNIVERSITY ANNUAL EXAMINATIONS IN THE FACULTY OF MEDICINE.—The following gentlemen passed their final examination for the degree of M.D.:

Britton, W.; Cameron, K. H.; Leslie, R. B. Degree of M.B.: Bentley, R. H.*; Bowerman, A.; Jessop, E.; Knowles, W. R.; Lackner, H. S.; Mackie,—; McDonagh, G. R.; McPhedran, A.; Smith, J. W.; Strangways, W. F.; Tyrrell, R. S.; Wilson, W. Primary: Ashby, T. H.; Barkwell, R. H.; *Burton, W. H.; Davidson, A.; *Esmond, J. J.; *Field, B.; *Grant, A.; Kennedy, G.; *Langstaff, G. A.; Langstaff, J. E.; Macklin, M.; McKeough, G. F.; McKinnon, A.; Munro, W. A.; Park, W. T.; *Robson, W. F.; Sinclair, J. A.; Smith, J. B.; Sutton, M.; Wilkinson, F. B.; *Winskell, W. E.; Young, O.

University Gold Medal,	McPhedran, A.
“ Silver “	1. Lackner, H. S.
“ “ “	2. Bowerman, A.
“ “ “	3. Wilson.
Starr Gold Medal, - -	Lackner, H. S.
“ Silver “ - -	1. McPhedran, A.
“ “ “ - -	2. Bowerman, A.
3rd Year Scholarship, -	Stuart, W.
2nd “ “ -	Griffin, H. G.
1st “ “ -	Adair, J.

Sixteen candidates entered for the degree of M.B., and thirty-one for the primary examination. In the third year, two; in the second, six; in the first, five.

* To take one subject over again.

Miscellaneous.

THE CONTRACTILITY OF THE SPLEEN.—From the benefit observed to arise in certain cases of splenic leukæmia from repeated electrization, Prof. Botkin of St. Petersburg was led to the conclusion that the nutritive disturbances in leukæmia can be explained by the increase of white blood corpuscles. Prof. Biesiadecki, of Cracow, lately propounded a similar view; but from other reasons (*vide Med. Times and Gazette*, page 552, vol. ii. 1875.) The relation of swelling of the liver to the contraction of the spleen has been lately made the subject of experimental investigation by Dr. Drosdoff and Dr. Botschetschkaroff, of St. Petersburg, with the following confirmatory results. They found (*Centralblatt*, Jan. 29, 1826) that in dogs (1) the spleen enlarges in all its diameters several centimetres, when the nerves of the splenic plexus are divided, and that it contracts again when the peripheral ends of these nerves are electrically excited; (2) that when the contraction of the spleen is produced by electrical stimulation the liver enlarges, its outlines become more definite, its color brighter, and its consistence firmer, and when the spleen again enlarges these signs disappear; (3) that if a prick be made in the liver when the spleen is swollen, scarcely any blood flows, but as soon as the spleen contracts it issues in abundance; (4) that with each contraction of the spleen there is a discharge of white blood-cells into the hepatic blood, as proved by counting the proportion of white to red corpuscles in blood drawn before and during the contraction. It seems probable that the spleen thus rids itself, so to speak, of the white corpuscles, which were stored up in it; (5) if a manometer is attached to the splenic vein, and the splenic nerves are stimulated, the pressure rises in the instrument in proportion to the extent to which the spleen contracts, and it again falls to its former level when the stimulus is intermitted. It does not immediately begin to enlarge on the withdrawal of the stimulus, but takes some minutes before it alters perceptibly in shape. Thus the contraction and enlargement depend not solely on vaso motor influences, but also on the presence of muscular

elements in its tissue, such as Müller and others have described; (6) the contractile power of the spleen is not completely destroyed by ligaturing all its vessels, but only considerably diminished. If the arteries alone are ligatured, the enlargement and diminution on stimulation are much less than in the normal state; if the veins alone are tied the organ swells up more, and contracts less powerfully.—*Med. Times and Gazette*.

THE PROFESSION AND THE DRINK QUESTION.—The President of the College of Physicians, we are glad to say, presided, on March 30th, at a conference of medical men and clergymen as to the medical aspects of intemperance, at which many very sensible suggestions were made by various members of the profession. We rejoice in every moderate and consistent protest against drunkenness from men who can lay any claim to representing the profession. We know that some of the best medical practitioners are fearful of taking any part in such a movement lest they should compromise their professional independence, or sanction fanatical or sensational views of this question. We share this feeling to a great extent, but we see very urgent reasons for not giving it too much weight. As medical men we know more than any other persons in the community of the physical evil that is being wrought by the large quantities of alcohol which, partly under mistaken notions, are being consumed by all classes of the people. We feel strongly, as we have said before, that a scientific statement of this evil ought to be made by the profession to the Government authoritatively. The very precision which recent labours in physiology and pathology have given to our knowledge will only be an additional guarantee of moderateness and accuracy, and therefore of force, in any statement of the kind we advocate. This is no question of rabid teetotalism, nor of dispute between the pathologist who thinks alcohol does its deadly business through the liver and another who thinks it does it through the kidney. Both these pathologists could agree in a statement that would impress both the public and public men. It is an urgent question both of pathology and of patriotism that needs to be taken out of the

region of fanaticism, and faced soberly if any check is to be given to the demoralizing vice of drinking. Whence is this statement to emanate? Clearly from the College of Physicians. The question is perfectly cognate with that of the homes of the working classes, on which the College so happily made a representation to the Government, the value of which as a stimulus to legislation was gratefully acknowledged by the Home Secretary. The College of Physicians represents all branches of medicine. But it represents them too timidly. It will die of dignity and reticence if it cannot identify itself with some of the urgent problems of society and legislation. The President has seen his way to preside over a conference of medical men in Shoreditch on the subject of drinking. All honour to him. Let us hope that his successor will soon see his way clear to calling the Fellows of the College together in Pall Mall to give out a statement on this question.—*London Lancet.*

DORSAL DISLOCATION OF THE HEAD OF THE FEMUR, WITH EVERSION OF THE LIMB (*The Lancet*, February 5, 1876).—Mr. Annandale reports the case of a sailor, æt. 29, who six months before coming under observation received an injury of the hip from a bale of goods falling upon him. When examined, the injured limb was found to be shortened three-quarters of an inch and *everted* to its full extent. The whole limb was fixed in this everted condition. The great trochanter was displaced upwards and backwards, and the head of the bone could be felt over the situation of the sciatic notch. In addition to these symptoms, Mr. Syme's characteristic sign of sciatic dislocation was present,—namely, that the injured limb could not be straightened without an arching of the spine. If the spine was straightened the thigh became flexed, and if the thigh was straightened the spine became arched. No crepitation could be detected. Having from all these symptoms diagnosed a sciatic or dorsal dislocation, the patient was put under chloroform, and the manipulative method of reduction practised. The bone was readily reduced by flexing and adducting the limb and then making it take a sweep outwards, but it also readily slipped out

of the acetabulum again when the limb was moved; and in order to prevent its displacement a long thigh-splint was applied and retained for a month. At the end of this time the patient was allowed to rise from bed and use crutches, and two weeks afterwards he was dismissed, being able to bear considerable weight on the limb. When the limb was examined before his dismissal it was found to be natural in length and position, and it admitted of free flexion, extension, adduction, and abduction at the hip. The only symptom complained of was some weakness of the whole limb; but this was gradually passing off.

The occurrence of eversion of the limb in cases of dorsal dislocation of the head of the femur is quite exceptional.—*Philadelphia Med. Times.*

HOMŒOPATHIC CREDULITY.—Gouty and rheumatic readers may take warning of the dangers of lithia from a story in one of the journals, reproduced from an American source. It is the case of Dr. Denham, who "was compelled for a time to relinquish practice in consequence of severe cardiac rheumatism," but who has been so effectually cured as to be chosen as president of a convention to be held in Philadelphia this summer. He consulted Dr. Hering; who at the third interview told him that if "Lith. carb." was not the remedy, he did not know what was. Thereupon Dr. Denham "returned to his home, and not being able to find the desired potency of the *lithium* he procured the third trituration, and attempted himself to triturate to a higher degree. The medicine having been placed in a mortar with the requisite sugar of milk, he began the trituration. It was not long, however, before the exhalations from the triturating drug began to manifest themselves, and the patient succumbed to their influence, lying for some time in a semi-unconscious state. The recovery from this latter seeming complication was slow, but resulted in most complete recovery from his cardiac disease, without further medical aid, thus illustrating the wonderful efficacy of the truly homœopathic remedy, and the care requisite in its selection." If such fearful effects follow the "exhalation" from triturated infinitesimals of lithium, what will happen to the imbibers of Blake's lithia-water.—*The Doctor.*

DIFFERENTIAL DIAGNOSIS OF CROUP AND DIPHTHERIA.—Dr. J. Solis-Cohen, Medical Record, presents the following differences between croup and diphtheria:

CROUP.	DIPHTHERIA.
Non-specific in origin.	Specific in origin.
Never contagious.	Often contagious.
Not inoculable.	Inoculable.
Not of adynamic type.	Of adynamic type.
Usually sporadic.	Usually endemic or epidemic.
Rarely attacks adults.	Often attack adults.
Always accompanied by exudation.	Sometimes unaccompanied by exudation.
Fatal only by physical obstruction to respiration, whether directly or indirectly.	Often fatal without any physical obstruction to respiration whatever.
No depression of heart.	Marked depression of heart.
Pulse often strong and hard.	Pulse never strong and hard, even though quick and full.
Respiration more accelerated in proportion to the pulse; ratio rarely, if ever, less than one to four.	Respiration not accelerated in proportion to the pulse; ratio usually less than one to four.
Albumen rarely in urine.	Albumen often in urine.
Not followed by paralysis.	Often followed by paralysis.
Would bear antiphlogistics.	Would not bear antiphlogistics.
Rarely attacks more than once.	Often attacks more than once.

In addition to this, it may be mentioned that diphtheria, unlike croup, has never been thought due to excessive plasticity of the blood.—*American Practitioner.*

RESEARCHES ON THE MILK OF WOMEN TREATED BY MERCURIAL INUNCTION.—Dr. O. Kahler ('Prag. Viertelj.' vol. iii., p. 39, 1875), has published three observations made on syphilitic women who were suckling, and who had been submitted to mercurial inunction. He could find no trace of mercury in the milk of any of them. He thinks that mercury does not escape with the milk until it is given in quantities sufficient to produce symptoms of poisoning; and he thus explains the positive results obtained by some writers who have experimented on animals. He therefore rejects the views of those who would give mercury to the nurse to cure syphilis in the child.—*British and Foreign Medico-Chirurgical Review.*

SUCCESSFUL CASE OF TRANSFUSION.—At a meeting of the Royal Academy of Medicine of Belgium (reported in the *Gazette Hebdom.*, February 11, 1876), a paper was presented, reporting successful transfusion of a patient comatose from carbonic-oxide poisoning. The man, aged twenty-five, was in a severe state of collapse, the result of sleeping near a charcoal-brazier; heartsounds, imperceptible; pulse 130; temperature, 37.6°. Two hours later, respiration became slower, and tetanic convulsions set in. Microscopical examination of the blood showed that the red globules had lost their tendency to form rouleaux. Sixty-seven grammes of blood (no mention of the kind of blood used or the method) were transfused; the patient's heart became more active, a chill followed, and the convulsions ceased. In six hours the improvement was well established, and in eight days the patient left the Hospital.—*N. Y. Med. Journal.*

THE AUSTRIAN PHARMACOPŒIA.—The Metric system has been introduced into Pharmaceutical use throughout Austria, since January 1, 1876, and for the future all physicians will be expected to prescribe according to it, and all druggists to dispense by it. Tables have been issued for reducing the old grain and ounce weights (the same as we still adopt in Great Britain) into that of the gramme and its fractions; and old prescriptions written prior to the new system, will, if redispensed, have to be so reduced. An excellent feature of the Austrian system seems to us to be, that for poisonous drugs there is not only a maximum single dose defined, but also a maximum collective dose for the day of twenty-four hours, which the chemist is forbidden to exceed, unless the prescriber has appended a note of admiration to show that he purposely ordered an unusual dose. We might with advantage take a hint from the Austrian regulations.—*Med. Times and Gazette.*

CANADIANS IN ENGLAND.—George Herbert Buchanan of the ——— School, and Donald B. Fraser, M.B., Trinity College and Toronto University, have passed the final examination for membership of the Royal College of Surgeons, London, England.

OIL OF SANDAL-WOOD IN THE TREATMENT OF GONORRHEA.—*By S. B. Merkel.*—I am fully persuaded that the oil of sandal-wood possesses a much greater power in restoring to a healthy state the mucous membrane of the urethra than does either cubeb or copaiba. In no case have I ever known it to produce sickness. There are objections, I admit, to the use of the oil of sandal-wood, on account of the persistent and disagreeable sensation it leaves in the throat, the irritating action it has on the stomach, and the difficulty of obtaining the pure oil, much of it being adulterated and of inferior quality. The first difficulty is overcome when it is given in the form of a capsule; the second, when it is mixed with a tenth part of the common oil of cinnamon; and the third is to be met by selecting a brand of established purity.

IN the *United States Medical Investigator* (Hom.) of March 1st, 1876, the Registrar of the Hahnemann Medical College, Chicago, publishes the questions submitted to the candidates for graduation, and concludes his letter to the editor with the following sentence: "*No better index of progress can be given than this, the annual publication of examinations and results.*" The average per cent. required to pass a candidate was 70. From the 22 questions on *Materia Medica* and *Therapeutics* we select the following: What remedies have the following characteristics. 1. Desires Death rather than fears it; 2. Stools dry and hard as if burnt; 3. Profuse, transparent, acrid leucorrhœa, *running down to the heels*; 4. Trembling carotids; 5. Scanty, slimy menses appear too late; 6. Pointed objects seem to have a double point; 7. Sour sweat on the neck. Average standing of graduating class 91.53 per cent. (Our readers who cannot answer the above questions can look them up.—*Ed. United States Medical Investigator.*)

PROLONGED GESTATION.—Dr. Frank Wells (Boston *Med. and Surg. Jour.*, Dec. 2, '75) records a case in which delivery took place three hundred and four days from the date of sexual congress. The birth was tedious, forceps necessary; almost entire absence of liquor amnii. Child weighed eight and one-half pounds, vigorous and healthy.—*Med. News and Library.*

MILK AS AN ABSORBENT.—A correspondent of a morning contemporary, on the 14th inst., draws attention to one circumstance respecting the peculiar properties of milk—that of its power of attracting and absorbing impure matter,—which is worthy of notice, namely: "To the practice of placing a saucer of new milk in a larder in order to preserve meat or game from approaching taint. It is said that not only does it answer that purpose, but that the milk, after a few hours, becomes so bad that no animal will touch it." The correspondent adds: "I think that this little homely fact may, perhaps, interest those who are studying the causes of the Eagle epidemic."—*Med. Times and Gazette.*

WE notice that Mr. Stiles, writing in the *Monthly Microscopical Journal*, recommends for wood sections one grain of the finest cake or crystal magenta dissolved in two ounces of spirit, or half a grain of pure aniline soluble blue in one dram of distilled water, to which he adds ten minims of dilute nitric acid, and enough spirit to make the quantity up to two ounces. After staining he washes with spirit, soaks for an hour in cajeput oil, and afterwards in turpentine, finally mounting in balsam or dammar. The cellular tissue takes the blue more readily than the red, the vascular tissue to a great extent retaining the red when subsequently treated for a short time with blue.—*The Academy*, 1876.

CERTIFICATE OF LUNACY.—"He? Broadway
"A Potcarey of Gillingham Certefy that Mr.
"James Burt Misfortin hapened by a Plow in
"the Hed which is the Ocaisim of his Ellness
"& By the Rising and Falling of the Blood
"And I think A Blister and Bleeding and
"meddeson Will be A Very Great thing But
"Mr. Jame Burt wold not A Gree to be Don
"at Home
"March 21, 1809. "H^{vy}. Broadway."

WE are glad to notice that Mr. Simon was, on the 31st of March last, elected an honorary member of the Society of Physicians of Vienna. Professor Rokitansky was in the chair.

A CASE OF ACONITE POISONING.—Under the care of *Dr. G. F. Schreiber*, West Brooklyn.—I was called in haste, June 18th, 1874, to see *E. B.*, a labourer, aged 36 years, who had taken two teaspoonfuls of tr. aconite root an hour before, 9 a.m. He had taken it, he said, to overcome the nervousness and insomnia consequent upon a drunken spree. He was having convulsive attacks, coming on at short intervals; had vomited some, and complained of dryness of the throat, coldness and tingling of the extremities, and muscular weakness. The pulse was almost imperceptible, countenance pale and pinched, and skin shriveled and covered with cold, clammy perspiration. I ordered a draught of warm water and mustard, which produced emesis; the matter vomited had the odour of aconite quite strong. I sent for *Dr. R. M. Lackey*, and asked him to bring with him a Kidder's battery. I had hot bricks applied to the extremities, and body as well, and directed the occasional use of friction with dry warm flannel. While awaiting the arrival of counsel and the battery, he had another vomiting spell, after which he fell back in a state of muscular rigidity, eyes staring, respiration suspended, and to all appearance about to expire. Just then the doctor arrived with the battery, which was hastily set going, and one pole applied to the nape of the neck and the other over the region of the heart. He was at once relieved of the spasm, respiration became more regular, and he complained of pain from the current. He begged to be allowed to sleep, which was denied him, and he was kept well roused up by the frequent use of the current,

interrupted in such a way as to produce considerable shocks. At 12 o'clock m. the pulse was slightly perceptible, and he was more sensitive to the current. An enema of warm water and salt was administered, and a copious fluid evacuation was produced, having the odour of aconite. In making another attempt to raise up he again fell back and seemed about to expire, when a good, lively shock from the battery started him breathing again. Improvement from this time was decided, so that by 3 p.m. he was regarded as out of danger. He slept well the following night and was up the next day, but complained of tenderness over the stomach. No after-treatment was required, as his nervousness had disappeared, and he recuperated rapidly. The treatment in this case, as will be seen, was mainly by the faradic current, which seemed to counteract the tendency of the poison to produce paralysis of the heart. The point of greatest interest in the case is the fact that the patient has never tasted a drop of intoxicating drink since, and from being a confirmed drunkard and generally worthless fellow, has become a sober, industrious man; and this is the greatest and most decided curative effect I have yet observed from the internal use of aconite.—*Medical Press.*

Births, Marriages, and Deaths.

BIRTHS.

On the 17th inst., the wife of *W. T. Aikins, M.D.*, of a daughter.

At 206 Simcoe Street, on the 25th inst., the wife of *Dr. Temple*, of a son.

MARRIAGE.

On Thursday, May 25th, at Christ Church, R.E., by the *Rev. B. B. Ussher*, *Albert Angus Macdonald, M.D.*, of Guelph, to *Frances Elizabeth*, eldest daughter of *George L. Beardmore*, of Toronto.

VIRGINIA MEDICAL MONTHLY.

LANDON B. EDWARDS, M.D., - - Editor and Proprietor.

Member of Virginia State Board of Health; Lecturer Materia Medica, Medical College of Virginia; Secretary of Medical Society of Virginia, etc.

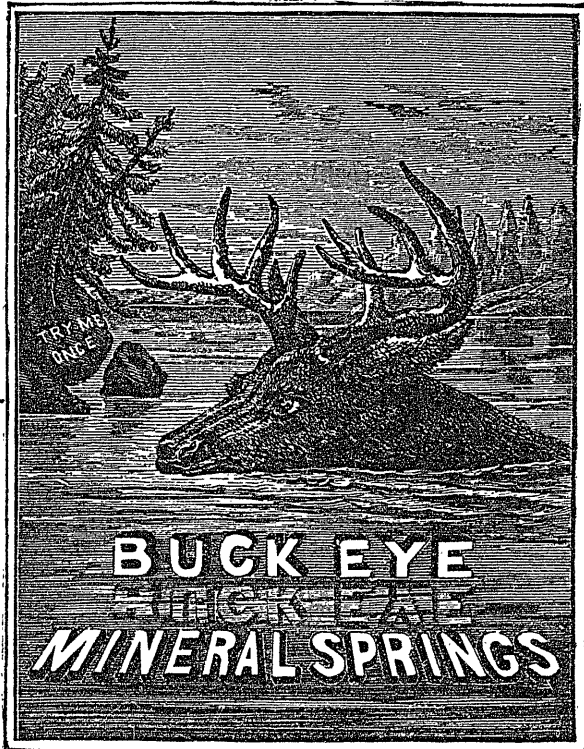
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