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THE
Canadian Journal of Medical Science.

A MONTHLY JOURNAL OF BRITISH AND FOREIGN MEDICAL SCIENCE, CRITICISM, AND NEWS.

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171 Church Street Toronto, Corresponding Editor.

SUBSCRIPTION, \$3 PER ANNUM.

All Communications, Letters and Exchanges must be addressed to the Corresponding Editor.

TORONTO, NOVEMBER, 1878.

Selections: Medicine.

THROMBOSIS OF ONE OF THE CORONARY ARTERIES OF THE HEART DIAGNOSED DURING LIFE.

BY DR. A. HAMMER, St. Louis.

Translated from *Gazetta Medica Italiana* by JOSEPH WORKMAN, M.D., Toronto.

All the pathological alterations which are met with in the entire arterial system, as endocarditis, atheroma, aneurisms and stenoses, calcifications, ossifications, thromboses, whether arising spontaneously or from embolisms, with invariably consecutive formation of infarctions, abscesses, &c., &c., have been already often observed in necrosopies of the heart. Not, however, during life, has there yet been diagnosed or described a thrombosis of one or both of the coronary arteries.

As, then, I have made this diagnosis, I may venture to treat of the subject as an original fact, since I have never yet read of it or even heard it spoken of. Having, however, had doubts whether the affection was a newly discovered malady, I re-examined all the books within my reach in which diseases of the heart are treated of. In none did I find any description of such an affection. I consulted all the more recent periodic literature of medicine, so far as available, but without meeting with anything relating to the subject. I might therefore, without self-dissatisfaction, have ventured to publish the present case as one really new, but a certain disinclination to write (commonly called laziness) restrained me; and then again sprang up afresh the doubt that already similar cases might have been published,

so that I might be found in the rather unpleasant situation of augmenting the number of those illusionists who have believed that they have discovered new things, which were, nevertheless, already well known.

Because of the great interest with which I regarded the case, I made mention of it in the German Medical Society of New York, prior to my departure thence, in the spring of 1877. This intimation was quite unfruitful, and even the most-learned Dr. Jacobi, who might well be called a walking dictionary of medicine, knew nothing of the disease. On my arrival on this continent I conferred with various illustrious clinics, among whom were Kussmaul of Strasbourg and Bamberger of Vienna: none of them could afford me the information sought for. They all said they never had observed, nor ever had read of, a similar case. For these reasons, as well as because many of those to whom I had mentioned the case urged me to keep it no longer unpublished, I have written the following details:—

On the 4th of May, 1876, at nine in the morning, my young friend and colleague, Dr. Wichman, came to ask me to visit with him a patient on whose condition, he said, he was unable to come to any decision. Of the course and character of the disease he gave me the following relation:—

The patient, Jacob Schreier, a merchant, aged 34, married, of robust constitution, habitually a free beer-drinker, had suffered for a year past repeated attacks of articular rheumatism; no alterations in the valves of the heart could ever be detected. Four weeks ago he had an acute return, which invaded simul-

taneously various articulations. Improvement proceeded tardily, and in a few days convalescence set in: the pulse 60 per minute. Yesterday (3rd May) the patient would, regardless of admonition, get out of bed a little before mid-day. He sat on a settee, and an hour after rising he fell suddenly into a state of collapse. Half-an-hour afterwards Dr. Wichman arrived; he found the pulse feeble, 40 per minute, the lips livid, a little cyanotic, some dyspnoea, but no pain. At first Dr. Wichman believed the collapse had resulted from an instantaneous and copious effusion into the pericardium, but he subsequently abandoned this opinion. At six p.m., there was nothing new, but the pulse was less frequent, 23 per minute. At ten the same night the pulse had gone down to 16, otherwise there was no change.

Present state.—I found the patient as follows:—The body stretched horizontally on the bed with the trunk a little elevated, the hands on the coverlet, the pulse only 8 per minute (being only half of that noted at 10 last night); it was rhythmical, that is, it gave one beat every 8 seconds. The face and the skin of the whole body, pallid, cool, and covered with a viscous sweat; the eyes limpid, the pupils of half size, promptly reacting to light; over the lips, a lightly cyanotic colour; the tongue and the lining of the mouth and pharynx, pale and anæmic; no dyspnoea, no sputa, no cough, and no pain in any part of the body; the respiration counted 24 to the minute; the mind was perfectly free. The patient, whether by his posture, or by his aspect and conversation, gave us the impression that he had no just conception of the gravity of his condition.

Physical examination.—From percussion of the region of the heart no abnormal dulness was perceived: the circumference of the heart, and its size, could without difficulty be ascertained on the thorax, just as if its position was quite normal. Percussion of the lungs, in like manner, gave no dulness, in consideration of which I was constrained to exclude from the diagnosis pleural effusion, pulmonic, and every other infiltration. Auscultation of the lungs gave, over all, the normal respiratory murmur, mingled only here and there with rales and ittle bubblings, as we are wont to meet with

them when the lungs are in a state of pronounced hyperæmia. Auscultation of the heart, on the contrary, gave phenomena rather strange. To the systolic and diastolic valvular tones, weak indeed, but clearly distinguishable, there followed immediately a clonic spasm of the heart, which manifested to the ear placed over it a fremitus, which persisted for five seconds, with equal force, exactly, and then ceased completely.

The convulsive contractions of the muscle of the heart followed each other with such rapidity that they could not be better compared than to the tremors of the hand in a man labouring under *delirium tremens*. To the sudden cessation of the cardiac spasm, there followed two seconds of absolute rest, then a normal contraction (one second), a cardiac spasm (five seconds), a pause, and so on, in series. I continued the auscultation fully 20 minutes, and never succeeded in detecting the least deviation from the precision and regularity of the above-mentioned series of phenomena as already stated, neither systolic nor diastolic murmur was perceived. Examination of the intestines gave a negative result, and so did that of the neck. With this closed the physical exploration.

But from all these marvellous phenomena, what conclusion? What pathological process could I construct, or imagine, from such facts? How, finally, could they be explained? I confess that at the outset I found myself perplexed; but presently I sought to disembarass myself by a process of exclusive reasoning: I would not admit disturbance of innervation, consequently this datum was unavailable. The sensorium was completely free.—I might say unusually clear, so that I had no right to admit that in this there was any alteration capable of producing disturbance in the functionality of the nerves. Along the peripheral course of the nerves, in the region of the neck, I found nothing which could support this supposition. The symptoms of our case did not square with fatty or relaxed heart. The result of the physical examination was too evidently opposed to this belief to give validity to other reasons. Besides, the symptoms of these two affections of the heart are by no means constant, but vary so much that the

opinions of the majority of authors are very diverse, and some even deny altogether that any diagnostic reliance should be placed in them.

Infectious diseases must from the very outset be excluded, for all their respective constant symptoms were absent. Abnormal conditions from pressure could not be the object of my search, since they manifestly did not exist: the percussion and auscultation of the heart and thorax proved this fact.

Other affections of the heart, as, myocarditis, endocarditis, hypertrophy, atrophy, valvular alterations, must certainly be excluded, alike because of the negative auscultatory result, and the deficiency of other symptoms pathognomonic of such affections. What, then, remained to me? Absolutely nothing, or at least nothing as yet known. In this embarrassment I fortunately recalled that which happened to a certain preacher, whose better arguments came to him only after entering the pulpit.

Above all, the sudden and persistently increasing collapse surprised me. I reasoned thus:—What, unless a disturbance of nutrition of the heart, or, better yet, a cutting off of its sanguinous irrigation, with the consequent abstraction of its nutrient material, could explain the phenomena of the case, and must not such an impeded afflux have its origin in the occlusion of, at the least, one of the coronary arteries? At a loss for supports of any other adequate explanation, I assumed, I might say intuitively, this hypothesis:—

After a little reflection I judged that only one coronary artery was obstructed; corroborative of this belief was the fact that the collapse advanced progressively and relatively slowly. If, on the contrary, both arteries had been occluded, the action of the heart must have more speedily relaxed and its action must sooner have ceased. A still stronger proof of the unilaterality of the affection was the cardiac spasm, regularly recurrent and tumultuous, and lasting each time 5 seconds. If it be considered that one-half of the heart required 8 seconds of rest, to enable it to become innervated afresh, and to give a new contraction, whilst the other half was functioning normally, we may readily conceive that the sound half, intimately connected with the affected one, could not execute

rhythmical movements. We are forced to regard the affected part as an actually inert mass which, during the efforts of the other, became shaken and agitated, as a mere structural appendix.

These reflections confirmed in my mind the idea that the thrombus was seated solely in one coronary artery; but whether it was situate on the right or the left side, I was unable to decide.

I exposed immediately my opinion to my colleague, who, with a face expressive of bewildered compassion, thus broke out:—"Such a diagnosis I never in my life have heard;" to which I replied, "Neither have I," ("*e neppur io.*") He was at first unable to achieve tranquillity, and he made the impression on me that he believed that I had sought to conceal my embarrassment by the utterance of a frivolous witticism. I had something to do to persuade him that what I had said was spoken with entire seriousness. I then enumerated to him the preceding particulars in development of my diagnosis, and I assured him I not merely believed in its probability, but I was convinced of its actuality. I then said to him that the case was equally interesting to both of us, and that for my own part I desired nothing more ardently than to be undeceived if I had been in error; and as the patient could not live more than a few hours longer, we might arrive at the coveted certainty in the necropsy. Let the best be done to obtain this permission from the family (This requirement becomes necessary when it is considered that in America, even in this day, the greatest difficulty is encountered in obtaining permission for an autopsy. How many times have I bought this privilege by giving up my fees! In some cases, indeed, I had to supplement this by cash from my own pocket. This would seem to be the panacea for all tender scruples, the most subtle, and even sometimes those of the Church!)

The patient survived 19 hours, and died on the morning of 5th May. Dr. Wichman received permission to examine the body, but within narrow limits. He might only extract the heart, and all the other organs must be untouched. For our object this sufficed, and we thought ourselves very lucky in having secured so much.

On 6th May, 29 hours after death, at 11 a.m.,

whilst the body now lay clothed in the coffin, we proceeded with our partial necroscopy.

The sternum being elevated so far as to enable us to see and detach the heart, the anterior margins of both lungs came into view, emerging from their costal encasement towards the mediastinum, puffed, outstretched, and of a dark hue (undoubtedly because of the high degree of hyperæmia and œdema). The external surface of the pericardium showed nothing abnormal: in its cavity it had about half an ounce of limpid yellowish serum; its walls were smooth and lucid. The heart was normally situate, of normal size and form; on its surface, besides a copious layer of fat, in the coronary and longitudinal sulcus, nothing was observed,—not a trace of stain, of exuded deposit, or of interstitial exudation.

Having removed the heart we passed to its internal inspection. The right auricle and ventricle were filled with coagulated blood, dense and dark, holding copious fibrinous coagula and vegetations of globulous form, (most probably developed in the final agony). The capacity of the auricle and ventricle was of normal size; the tricuspid and semilunar valves were intact; the colour of the cut surface was pale, with a brownish yellow tint; the wall of the ventricle was of normal thickness, and the endocardium was unaltered.

The details given above as to the auricle and ventricle of the right side, are equally valid as to those of the left, but not as regards the semilunar valves of the aorta. In this we found most singular alterations, which could be readily seen by looking from above, through the canal of the aorta.

With the view of observing these more closely we divided the aorta, conducting the cut across the commissure of the right and left valves, a process which we afterwards found most suitable, since had we made the cut as usually defined across the posterior and right valves, we should have destroyed a great part of the anatomical marks, and thus to a certainty the evidence of the entire pathological process, and its origin and ulterior development, would have been obliterated.

That which more desirably resulted was the tension of the completely displayed right valve

in the midst of a mass which not only filled the right sinus of valsalva, but further overlaid one-half the themisphere. Extracting this, with all possible caution, and examining it very closely, I found that its superior strata as far down as the origin of the coronary artery, within the precinct of the sinus, consisted of recently coagulated fibrin, whitish yellow, mixed with blood. Descending into the base of the coronary artery, the nature of this fibrinous mass became changed, very much discoloured, more dry and interlaced, and a greyish-red colour. All these characteristics of thrombus were found still more fully expressed in the ultimate stratum over the base of the sinus of valsalva.

From this stratum, I detached a slender filament, about $2\frac{1}{2}$ centimetres in length, which was originally connected with a recent formation, presently to be described. The valves of the aorta, unenlarged, had a smooth lucid surface, but the posterior one had, over a small space, coalesced with the right and left valves, at the borders of the commissures (this space was in length about 4 millimetres). Corresponding to this coalescence, and to the underlying triangular portions of the aortic wall, from the posterior valve on one side, and the right and left ones on the other, there were, constructed of the recent (endocardic) excrescences, which were soft and whitish, resembling those situate at the connection of the valves with the deposit, small prismatic columns, clear and fine, adhering lightly to the orifice of the aorta.

At the apex of the column which filled the space of the commissure, from the posterior and the right valve, there arose a fine granular web, pointed and papillary, (excrescence,) of about $4\frac{1}{2}$ millimetres in height, and marvellously resembling an acuminate condyloma; it was not connected with the aortic wall, but floating free in the channel of the aorta. The detached filament, above mentioned, stood in direct organic connection with the point of this excrescence; in reality this filament was no other than the extirpated point of the excrescence.

In the right heart, as I have before said, no trace of endocarditis was found, with exception of the small spaces, intracommissurals from the posterior valve on one side, and the right and

left ones on the other. The walls of both coronary arteries were intact to their extreme ramifications.

This autopsy manifestly corroborates the diagnosis, and it also clearly explains the progressive development of the morbid phenomena. There can be no doubt that from the first formation of the thrombus in the sinus of valsalva, and so long as it had not reached to the precise height of the mouth of the coronary artery, the patient found himself comparatively ill, but that with the commencement of the occlusion of the coronary artery he fell into collapse,—the frequency of the pulse constantly diminishing, and this solely depending on the continuous increase of the thrombus up to complete obstruction. Furthermore, on the origin of the thrombus, and its mode of formation, the dissection furnished exact certainty. Undoubtedly the origin was mechanical. The pointed, papillary excrescence, erect and oscillating in the channel of the aorta, furnished the mechanical conditions. Upon its apex were deposited the first coagula, and then the first thrombus, from continual accumulation of coagula of fibrin, and from its too great weight, could no longer be upheld on the excrescence; therefore, obedient to gravitation, it fell down into the right sinus of valsalva, dragging down with it the flexile excrescence. The fine filament before described, in this manner represented in reality the abstracted apex of the excrescence, for which reason it could not be separated from it without force. Had the cut into the aorta fallen across the commissure, from the posterior and right valves, it is very probable that the papillary excrescence and its apex would have been destroyed, and we would not have been in a position to form a clear idea of the origin of the thrombus.

The case yet presents many interesting features, deserving of diligent examination and discussion. But our narrative has already overpassed the limits of a periodic article; on the other hand it appears to me that the proper time for such discussions will not have come until we have command of a number of similar cases, which may not be very remote if clinical observers will give special attention to the subject, and if experimental pathology, as we

believe, will promptly assume possession of the argument.

To the acute and potent intelligence of Conheim this case will be of special interest. In his "*Lectures on General Pathology*," published in the end of 1877, page 24, we find the following,—“And in truth Bezold succeeded, by occluding the coronary arteries with ‘*the pinzette a morsa*,’ and Panum, by creating in the same vessels an artificial embolism, by injections of a weak emulsion of wax, in causing cessation of the heart’s action; that a similar fact should come to be observed in human pathology seems to me a very probable occurrence.”

When he wrote these words he was not aware that this very fact had, eighteen months before, been actually observed.

The preparation may be found in the hands of my friend, Dr. Wichman.

METHODS OF REDUCING PYREXIA OF FEVER.

—Dr. T. G. Thomas has employed the effusion of cold water with great benefit, by means of Kibbee’s fever bed. The bed consists of a frame like a common cot, having a bottom of coarse-meshed cloth, made of material similar to that used by the sugar refiners for straining, only not so fine; and under this is an Indiarubber cloth to catch the water as it passes through, which is conducted to a tub at the foot of the bed. A blanket folded double is laid across the middle of the cot, in order to prevent the meshed cloth cutting the patient, and over this is a sheet folded in several thicknesses and hanging over the sides long enough to be brought over and cover the patient’s body as he lies upon it. The patient is put upon the bed with his or her night dress well drawn up under the arms, and the lower extremities covered with blankets, and hot bottles placed at the feet. The sheet upon which the water is to be poured is brought up, the two ends lapping over the trunk of the patient, and in this he may be allowed to remain as long as necessary—even three or four weeks. The idea is to keep the animal heat below 100°F., and water at a temperature of from 50° to 80° is poured slowly from a pitcher upon the sheet. The affusions may be made several times an hour if necessary, but in many cases, once in every twelve or twenty-four hours is sufficient, a pitcherful or more being used each time.—*North Carolina Med. Jour.*

ON THE TREATMENT OF ACNE BY THE INTERNAL ADMINISTRATION OF SULPHIDE OF CALCIUM.

BY HOWARD CANE, M.D., L.R.C.P. LOND.

From the great frequency of occurrence of acne, and from its manifesting itself on the faces of individuals of both sexes, about and for some years subsequent to the period of puberty, when any disfigurement is much thought of, especially, though not alone, by the female sex, any therapeutic agent which promises success in this often intractable skin disease will be welcomed by most practitioners as a real gain. It is for this reason that I have been induced to publish the following cases, that the remedy there prescribed may have a more extended trial than I think it has as yet received. I do not bring the sulphide of calcium forward as a new remedy in the treatment of this disease, for it was recommended some years ago by Dr. S. Ringer, but I wish to bring it more prominently into notice as a drug which will often prove of signal service in acne when almost all other means have failed. When I first tried it, I cannot say that I had much faith in its efficacy, and in fact only used it as a *dernier ressort*, because I knew that probably most, if not all, of the remedies commonly recommended for this troublesome affection must have been tried. The success which I attained in my first case, which was of a most obstinate nature, led me to try it in others, and with an eminently satisfactory result. I may here mention that the patient should be cautioned not to wear metallic ornaments during the treatment, as the sulphuretted hydrogen given off from the lungs and skin forms with the metals a sulphide, and this greatly tarnishes any ornaments about the person. I have in all cases employed the sulphide of calcium (in preference to the other sulphides), and it may be combined with a few grains of powdered loaf sugar, which I have found to be better than the sugar of milk usually recommended. I have always exhibited it in the form of a powder, and have given directions that the powder should be kept in some nearly air-tight receptacle, such as a wide-mouthed stoppered bottle or a wooden pill-box with a tightly fitting lid, as left exposed to the

air the sulphide rapidly deteriorates. This direction is especially necessary to patients living some distance in the country, where it is inconvenient to be constantly sending to the chemist to have the prescription freshly prepared, for to derive permanent benefit from the use of this drug it is necessary that it should be taken perseveringly for some length of time.

CASE I.—G. R——, a young lady, aged nineteen, has been troubled for the last five years with acne of the most severe kind. When she first came to me her face, especially the forehead, was thickly covered with acne spots in all stages of development, the inflamed and suppurating papules being very numerous. She stated that ever since its first occurrence she had been more or less constantly under treatment, but with the result of the disease becoming worse instead of better; though at times it had seemed to improve, it had invariably relapsed after a few weeks, and become as bad as ever. She stated that she had been to three physicians in London, two of whom are eminent skin physicians. Upon making inquiries into the state of her general health, I found it was excellent in every respect, nor was there any derangement of the menstrual functions, as is so often the case in this affection. The eruption was so thick that she was obliged, when out of doors, always to wear a veil, and it precluded her from entering into society to any extent. She spoke in a very desponding way about it, saying it had been there so long, and she had tried so many different drugs for it, that she was afraid she would never be cured. I encouraged her to hope on still, and, though with but faint hope of success, prescribed the sulphide of calcium, of which I gave at first one-tenth of a grain four times daily, with four grains of powdered loaf sugar. At the same time I directed her to hold her face over a vessel of very hot water night and morning for some ten minutes or more, and then to rub the parts where the little black-topped comedones were very thick with a towel, after which she was to use as a face powder some precipitated sulphur, which I directed to be coloured with Armenian bole. At the same time I gave minute and careful directions as to diet, &c., forbidding pastry and flour puddings of all kinds, all salt meats,

together with pork and veal, and all stimulants, and likewise enjoined the frequent use of all green vegetables, especially cabbage, watercress, and salad generally, together with regular outdoor walking exercise. At the end of a fortnight I saw her again, and I found there was a slight improvement, but not very marked; there were not many more inflamed papules, and the black-topped comedones were considerably fewer in number. I determined to persevere, and my patient, fancying she was somewhat better, was quite ready to carry out my directions to the letter, as she was most anxious to get rid of her disfigurement. I now ordered one powder to be taken six times daily, and to see me again in a fortnight; otherwise to continue as before. At the end of that time I again saw her, and, though there was no very great improvement that I could see, still the patient declared she was better, and that there were not nearly so many fresh spots. I now increased the dose of the sulphide to one-tenth of a grain, six times daily; continue everything else as before, and see me again in a fortnight. This she did, and I could now plainly see that there was a marked improvement. The patient was in excellent spirits about it, and had been most zealous in taking her powders and carrying out my directions. I now further increased the dose to one-fourth of a grain six times daily, with a very excellent result; in another fortnight to half a grain six times daily; and at the end of another fortnight not only but few new spots appeared, but they were much less inflamed than usual, and the others were rapidly disappearing, and the complexion was much clearer. To take one grain six times daily for another fourteen days. I then saw her again. She had now been taking the sulphide for three months with the very best possible result. From this time the progress was uninterruptedly good. No fresh spots appeared, and she continued to take the sulphide for another two months, gradually decreasing the dose until from taking six grains daily she took only one. When no fresh spots appeared, the black-topped comedones were all gone and the complexion was very much improved, the slight scars left, which were at first red, becoming pink. I need not say that both mother and daughter were delighted, especially the latter,

while the former expressed her gratitude in a very substantial form. I saw the patient eight months after, and no fresh spots had appeared, the scars were rapidly fading in colour, and she now never wore a veil, and was able to enter into society with ease and comfort to herself, which hitherto had been impossible.

CASE 2.—C——, a young lady twenty years of age, came to me for an eruption of acne on the face which she had had for a year, and which had gradually become worse. There were some very large inflamed papules, and numbers of black-topped comedones. She had had acute rheumatism some years previously, and a somewhat loud mitral systolic murmur was heard at the apex, but from the general state of her health I judged that, though the murmur was loud, the regurgitation of blood was not very great. I prescribed the same diet and face powder, and gave the same directions as in Case 1, but gave, to begin with, one-fourth of a grain of the sulphide daily, gradually increasing the dose to one grain six times daily. At the end of six weeks she was nearly well, and in another month I saw her again, when she was quite cured. She had taken the sulphide in all two months, gradually diminishing the dose during the last fortnight. This was not so severe a case as the first, but the result was equally good. I may here say that this patient also had been taking various drugs for some months previously, but without any appreciable result.

I have before me notes of fourteen other cases treated in exactly the same way, but which I need not detail, as they are merely repetitions of the two given above. The result in eleven out of these fourteen were perfect, whilst in the remaining three, though great benefit was derived, the cure was not complete. I now always begin with a quarter of a grain four times daily, gradually increasing the dose to one grain six times daily, or according to the progress and severity of the case.—*London Lancet.*

Dr. Fano has put forward a theory of visual accommodation, that the notion of variable distances of objects is due to the formation of more or less distinct images on the different regions of the retina.

FATTY DEGENERATION OF THE DIAPHRAGM.

The diaphragm is a muscle the functions of which are of such importance that it is a matter of some surprise that so little attention has been paid to its diseases. With the single exception of the heart, no muscular structure of the body is in such constant action, and no muscle has so great influence on the functions of important viscera. And yet until now very few observations have been made upon its morbid states, and the student will search in vain for any important facts regarding its diseases, with the exception of a few valuable and suggestive observations recorded in our columns some ten years ago by Mr. Callender. In the last number of Virchow's *Archiv*, however, is an account of some observations by Professor Zahn, of Genth, which show how frequently it is found diseased, how various are the morbid changes it presents, and which suggest very strongly that their influence may often be in a high degree prejudicial. It was, indeed, the observation of some cases in which slight bronchitis and emphysema, with congestion of organs, and simple, moderate dilatation of the right ventricle, seemed insufficient to account for death, but in which marked degeneration of the diaphragm coexisted, which led Zahn to study the condition of the diaphragm in other cases.

The result was the discovery that a degenerated state of the muscular fibres is by no means infrequent. The changes observed were of several kinds—simple brown atrophy, with proliferation of cells and nuclei, and granular clouding, with fatty and vitreous degeneration of the fibres. The former appears to be the more frequent, although the least important. It is not easily recognised with the naked eye, the muscular tissue appearing merely thinner than normal, and somewhat pale. The peritoneum covering it, when stripped off, has a brown colour, and between the muscular fasciculi collections of fat exist. The microscope reveals greatly degenerated fibres, lying among others nearly normal. The former have lost their striation, and contain many granules and spherules, much less numerous than those which characterise fatty degeneration, and the smaller disappearing under acids. About the nuclei are

accumulations of yellowish granular pigment, sometimes separating proliferated nuclei. A peculiar protoplasm-like substance sometimes surrounds the nuclei, or lies in the muscular fibres, giving them a peculiar appearance, and in places occupying peculiar lateral bulgings of the wall, and these containing numerous nuclei. These bulgings may be so numerous as to be in contact. The proper tissue of the fibres so affected is always more or less degenerated. During two months Zahn met with no less than twenty cases in which this brown atrophy of the diaphragm was more or less marked. Almost all of the individuals presenting it were over fifty years of age; all were considerably emaciated: in most, other organs presented also simple atrophy; and in all the muscular substance of the heart presented distinct brown atrophy. The cause of death in most was senile emphysema and bronchitis, catarrhal pneumonia or some tubercular disease of the intestine; in one cancer of the œsophagus. In all some causes had produced a state of chronic marasmus. Zahn conjectures that the condition of the fibres may have arisen from a degeneration of the contractile element and an imperfect attempt at restorative growth in the cells of the muscle.

The granular and fatty degeneration of the diaphragm gives, as seen through the peritoneum, a pale and somewhat opaque appearance, and when intense, minute yellowish spots may be seen among the muscular bundles. Microscopical examination shows that the degeneration affects all the fibres, and presents its usual appearance, the change in different fibres being, however, far from uniform. In some, the granules are very fine and closely set. The muscle-cells present no proliferation in young persons, but in the old the fatty degeneration may be accompanied by cell-proliferation, with or without a deposit of pigment. Protoplasm surrounding the nuclei is, however, in this case crammed with fat-globules. This change Zahn found twice in nine cases, each individual being over eighty years of age. Callender recorded six cases of fatty degeneration found in subjects of various ages. In all it was associated with marked fatty degeneration of the heart, while the other voluntary muscles were healthy. To

these cases Zahn adds nine others, five over fifty, and four under forty. All presented the traces of more or less bronchitis and emphysema, and some, croupous pneumonia. In the latter cases there was no fatty degeneration of the heart, but in all the others the heart and the diaphragm presented the same change. Putting together Callender's and Zahn's cases, we have ten men and five women, and thus the affection appears to be more frequent in the male sex.

The third form of change—the waxy or vitreous degeneration of the fibres—Zahn has found in one case only, a middle-aged man who suffered from chronic alcoholism, and died of pneumonia. To the naked eye, the diaphragm was normal, but under the microscope many fibres presented the change in its most characteristic form, while others were in a state of commencing fatty degeneration. No similar degenerations could be found in the heart or other muscles, but the liver was fatty.

The correlation of these changes with clinical symptoms has yet, in a great measure, to be made. One of the most important clinical facts is the great frequency with which degenerations of the diaphragm and of the heart coincide. The changes in the two muscles are similar in character, and occur for the most part at a time when muscular tissue elsewhere in the body is normal. The two structures have certain common physiological conditions. From birth to death they are in almost uninterrupted work, and each appears to suffer at the same time from the same general cause; and it may well be that the increased work which chronic bronchitis and emphysema throw upon the diaphragm and heart may lead, in some cases, to the occurrence of the simultaneous degeneration of the two structures, since in the heart the change is found most intense in that portion of the heart on which the greatest work falls—the right side. An explanation of the origin of the degeneration in acute lung diseases, in which commonly the heart is unaffected, is less obvious. All the conditions of muscular overaction tend, however, to produce hypertrophy, as well as, and even more than, degeneration. Whether in these cases the muscular tissue of the diaphragm is increased in quantity is a

question that must be left for the present uncertain. The symptoms and consequences to which the degenerations give rise must also be ascertained by further observation. In many of the cases intense dyspnoea had existed during life, but there were in all other conditions to which this symptom might be, in part at least, ascribed. Virchow long ago pointed out that atrophy of the diaphragm increases greatly the effect of asphyxiating causes, and may determine the fatality of the least bronchial catarrh. Whether, however, we may suggest, this is true in cases in which the diaphragm alone is affected, the intercostals being normal, is a point on which further observation is necessary, and on which the phenomena of some cases of paralysis of the diaphragm throw some doubt. The point suggests, however, the desirability of a more careful examination than hitherto has been made into the condition of the intercostal muscles in other cases. This is always important as regards the question of pathogenesis, since, if overwork plays a potent part in the production of the change, the intercostals should suffer in due proportion in the same cases.—*The Lancet.*

MENSURATION OF THE HEART.—At the meeting of the *Association Française pour l'Avancement des Sciences* in August last M. Constantin Paul read a communication upon a new method of mensuration of the heart. The principal objection to former works on the subject is that they take percussion alone as a guide, a method which may lead to mistakes, because the absolute dulness of the heart is confounded with that of the liver. But to come to his process, M. Paul at first sought to determine what were the exact relations of the heart to the anterior wall of the chest; he found that the fixed points were the vena cava inferior, immobilised by the diaphragm (as has been nowhere remarked) and the vena cava superior: the apex corresponds to the fifth rib or to the sixth intercostal space, at eight centimetres ($3\frac{1}{2}$ inches) from the median line; as for the nipple, it is the worst landmark that can be imagined. In cases of cardiac hypertrophy the right edge of the heart always remains in the same place; it is the apex which is carried to the left, and settles down a little on account of the weight of the heart.

"EXPERIMENTS ON THE BILIARY SECRETION, WITH REFERENCE TO THE ACTION OF CHOLAGOGUES."

Seventeen substances have been investigated since the last experiments were published. All the experiments were made upon the dog whilst under the influence of curare, artificial respiration being kept up. Observations were made at periods of fifteen minutes, each experiment lasting eight or ten hours. All the substances were injected into the duodenum as near to the orifice of the bile-duct as possible, and the following is a summary of the results obtained.

—Dilute nitric acid stimulates the action of the liver. Physostigma is a powerful stimulant of the secretory action, and its effect is strongly antagonized by atropia, which has a negative influence on the secretion when injected alone. Menispermine, an impure resin derived from the yellow merilla of America, and administered in seven-grain doses in some forms of dyspepsia, did not effect the liver, but acted as a stimulant of the intestinal glands. Baktisin, derived from the baptisma tinctoria, and used in America in the treatment of scarlet fever, typhoid fever, and gangrene, stimulates both liver and intestine. Phytolaccin, like the two foregoing, an American eclectic medicine, is derived from the *Phytolacca decandra*, and is given in quarter to one-grain doses in chronic rheumatism, and in larger doses as a purgative. It acts upon the liver, its action continuing for two hours; it is antagonised by atropia. Benzoic acid has but little action, sodic benzoate a decided effect, and ammonia benzoate a powerful action on the liver, but not on the intestinal glands. Ammonium phosphate excites the liver briskly, and its effect persists for about three hours. Sodium salicylate powerfully stimulates the liver, but has no action on the intestinal glands. Morphia does not prevent its action, if injected during or before the experiment. Tannic acid has no effect. Hyoscyamus causes a slight fall in the amount of the flow of bile. Acetate of lead diminishes, and potassium iodide neither increases nor depresses the action of the liver. Veratrum acts as a stimulant of the intestinal glands but not of the liver. The action of the cholagogues is not by increasing the secretions of the whole alimentary tract,

for some, as gamboge, which stimulate the whole mucous tract, do not excite the liver. Nor is it by increasing the blood flow, for substances stimulating the intestines, and thus causing portal congestion, do not increase the flow of bile. But they act either by stimulating the hepatic cells or the nerves which preside over them. If a purgative agent only stimulates the intestinal canal, it diminishes the secretion of bile by draining the portal vein, and by carrying off the bile-forming substances in the intestine, thus depriving the liver of its supplies in a double manner.—*London Lancet*.

MOLLITIES OSSIUM.—Dr. Bennett exhibited specimens procured from a subject in the Anatomical School—the wasted body of an old woman. Along the right side of the thorax ran a projection, which looked as if a cart-wheel had passed over the body shortly before death. The long bones contained a red marrow. There was a fracture of the left clavicle and scapula, which had united by bulky, soft, recent callus. Plates 1, 2, and 3 in Sandifort's *Museum Anatomicum* were almost identical with the specimen. Dr. Bennett counted fifty-five fractures in the ribs, and many of these had united with callus. The pelvis was compressed in the direction of the two oblique diameters. There was a triangular fracture in the ilium, and the sacrum was incurved. The history of the case was important. The woman had been several years an inmate of the North Dublin Union Workhouse. She was over ninety years of age, and had been bedridden for many years. She was never known to have any fracture, nor had she ever complained of any pain; therefore, a senile change, almost unnoticed, was what had occurred. This was important from a medico-legal point of view. Ranvier described three forms of this disease—1. True osteo-malacie, occurring in the young subject, and as a sequence of pregnancy (of this form a case was exhibited to the Society by the late Dr. R. W. Smith); 2. Senile osteoporosis; 3. Fatty osteoporosis. On examining the decalcified bone under a low power, a great number of vessels obstructed by what were not mere coagula were observed. Dr. Bennett could not yet state certainly whether this obstruction of the vessels was caused by embola or not. The callus was composed of cartilage passing on into ossification in the ordinary way.—*British Med. Journal*.

Surgery.

ON "LITHOTRITY BY A SINGLE OPERATION," WITH CASES.

BY W. H. VAN BUREN, M.D.,

Professor of Surgery, Bellevue Hospital Medical College.

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Personally, I feel much confidence that Prof. Bigelow's novel proposition, that lithotrity may be safely accomplished at one sitting, will be successfully demonstrated, and that his discovery of the hitherto unrecognized tolerance of the bladder—for it is certainly to be regarded as a discovery, in the full sense of the term—will, by its great practical value, modify the future of lithotrity.

As a contribution towards a final judgment on this interesting question, I append some cases, which, although less serious in character than those of Drs. Bigelow and Curtis, may, nevertheless, serve as evidence.

In March, 1876, I felt justified in attempting to empty the bladder of a calculous patient at one operation—a lady of sixty-six, partially hemiplegic and exceedingly hyperæsthetic, whose sufferings were constant and excessive. Her heart was also weak and dilated, but the ether was, nevertheless, borne well. The stone was phosphatic, and not large. The operation, which was not timed, lasted more than half an hour. The evacuating apparatus was by no means efficient. The urethral orifice was nicked on either side and the finger introduced for exploration, pressure upon the hypogastrium and from the section being employed to bring all parts of the surface of the bladder, as far as possible, in contact with it. The fragments were thoroughly removed, and the operation was followed by no vesical reaction, and by no bad symptoms. A week later there was temporary suppression of urine, and a mild convulsion, which passed off quietly. The patient died six months later, exhausted by the midsummer heats, having experienced much relief from the operation on her bladder.

I have, in several instances, greatly exceeded the conventional limit of five minutes for a lithotrity crushing, and never had cause to regret the infringement of the law, the propriety

of which I considered, nevertheless, as based upon too much experience and too high authority to be questioned. In fact, I had taught it myself for years, and regarded its transgression as a risk of doubtful propriety; but the perusal of Prof. Bigelow's paper at once recalled incidents in past experience which accorded with his statements, and so far confirmed the reasonableness of his novel practice, as to determine Dr. Keyes and myself to test it in the following case, which was at that time in our hands:

Mr. I. L., 60, an over-sensitive and timorous person, a sufferer from bleeding piles since early life, has had for ten years occasional irritability with difficulty in emptying his bladder, which led him to habitually use a catheter. Within two months his pain has increased, the urine showing a considerable deposit, for which he came to the city for advice in January last. I found some atony of the bladder and a soft stone of moderate size, and lithotrity was commenced in the usual way. The first crushing, however, was more painful than he had anticipated; he voided very few fragments, and became demoralized, and his bladder symptoms also were aggravated. Under precisely similar circumstances I have been compelled to resort to lithotomy, but now decided to try rapid evacuation. On the 29th he was etherized, his stone reduced to small fragments, and, as far as we could judge, the bladder was entirely cleared. Time, about half an hour; quantity of calculous matter obtained not weighed. There was no reaction whatever on the part of the bladder, and the relief that followed was so prompt and decided that Mr. L. went home within ten days, with instructions to wash out his bladder daily with the "fountain-syringe," and return in a month for a final examination. For this operation neither Bigelow's lithotrite nor evacuating catheter could be had; only his new washing-bottle was used, with one of Nélaton's evacuating-tubes, and a lithotrite, which became impacted. When Mr. L. returned in March, fragments could still be detected by the searcher, and some had passed. He was again etherized, the fragments caught and crushed, and the bladder thoroughly washed out, this time with the new evacuating-catheter. Time, twenty-

five minutes. No reaction whatever on the part of the bladder. In a week he returned home, considering himself well. I saw this gentleman again in July as he passed through the city; he was in improved health, free from vesical pain or irritability, washing out his bladder daily with the fountain-syringe. The latter precaution was required by the persisting atony, which, as far as I could judge, had not been aggravated by the prolonged sittings. His urine had nearly regained its normal appearance.

G. P., aged 63, merchant, a spare, gouty nervous person, was brought to me by Dr. Ceccarini, March 19, 1878, complaining of great vesical irritability, which had been gradually increasing for four months. I found two small, hard, moveable stones, a rigid urethra, a somewhat enlarged prostate, and moderately clear urine. On the 25th Mr. P. was etherized, and 123 grains of uric acid calculus obtained by means of the new pumping-bottle, in about an hour. There was no inflammatory reaction on the part of the bladder, and the temperature did not exceed 101° until the third day, when it suddenly went up to 105°, coincidently with a severe chill, which was followed by profuse sweating and some mental cloudiness. There was no recurrence of the chill; complete inability to pass water followed the operation, and it was regularly drawn, and the bladder washed out with a weak quinine solution. This remedy was also given freely internally, together with acetate and citrate of potass. The atony gradually passed off, and, by the end of the second week, Mr. P. was able to void his urine without pain, at normal intervals, and it was quite clear. Within the month he was entirely well, and has remained so, suffering only a little from a slightly enlarged prostate, and so much of atony only as prevented him from voiding the last drachm of residual urine. We had not yet been able to obtain the Bigelow evacuating-tubes, nor one of the lithotrites in working order. The instruments used for this case were: the Nélaton tube, the new washing-bottle, and one of our ordinary lithotrites of the Weiss-Thompson pattern, which Dr. Keyes had succeeded in having so modified in the blades that it worked absolutely without impaction.

This he used in this case, at my request, and the entire freedom from clogging, after a half-hour's steady work, and the uniform size of the hard uric acid fragments subsequently brought away, was exceedingly satisfactory.

I attribute the chill on the third day, in this case, to mechanical irritation of the rigid urethra by the frequent introduction of the catheter, which was rendered necessary by the atony. There was no increase of pus in the urine, nor hypogastric pain, nor other evidence of cystitis.

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In this, as well as in the preceding case, both of which were operated upon on the same day, all the Bigelow instruments were used, except the lithotrite, which was substituted by Dr. Keyes modified Weiss instrument, the working of which has thus far proved entirely satisfactory. The curved evacuating-tubes worked admirably. In the last case it was necessary to incise the meatus freely in order to receive the largest size. As their inventor suggests, care is required in managing the curved beak in the bladder, and the dimple in the bottle must be watched to detect obstruction promptly; but when the tube is rightly placed, the rapidity with which the fragments pour into the glass bulb is exceedingly satisfactory.

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If the safety of Prof. Bigelow's proposition as regards rapid lithotripsy be finally demonstrated by adequate proof of the tolerance of the bladder, certain corollaries will necessarily follow: 1. That the cystitis which so often occurs after first crushings—regarded by Thompson and Cadge, in the discussion already quoted, as one of the "serious defects" of lithotripsy—is due to the increased mechanical irritation of sharp fragments, and *not* to "continued instrumentation." 2. That the more thorough evacuation of the bladder attainable by the Bigelow method lessens materially the danger of leaving undiscovered fragments after lithotripsy.

It remains to be seen whether the protracted manipulations of "lithotripsy by a single operation" are more likely to cause atony than the shorter and more frequent sittings of ordinary lithotripsy; and whether this disability will not be sooner removed by the prompt restoration to health likely to follow evacuation of the bladder.

at one sitting. It may become evident on further experience that atony, like cystitis, is caused and kept up by the presence of irritating fragments in the bladder, rather than by repeated or even prolonged instrumentation.

I have found that the use of cooler water in the daily washing of the bladder by means of the fountain-syringe, and the gentle and effectual fomentation of the surface of the irritated organ thus accomplished, is the best local remedy for atony; and I believe strongly that the regular use of tepid water, in this way, for a time, after lithotripsy, by lessening pus-formation and consequent phosphatic precipitation, will diminish the tendency to recurrence, or perpetuation, of calculous disease. In fact, the thorough washing which constitutes so prominent a feature in rapid lithotripsy has seemed to me to have a large share in securing for this proceeding the remarkable degree of tolerance of its manipulation which the bladder exhibits.

It may be within the knowledge of the reader that I have advocated for some years fomentation of the interior of the bladder by tepid or medicated waters—a proceeding greatly facilitated by the improved apparatus contrived by Dr. Keyes—as the most efficient remedy in many of its morbid conditions; and it is proper to add here that my confidence in this remedy has been strengthened by recent experience.—*N. Y. Med. Record.*

PERMEABILITY OF THE ENTIRE ALIMENTARY CANAL BY ENEMATA.—Dr. Robert Battey, of Rome, Georgia, U.S., in a paper read before the Surgical Section of the American Medical Association at Buffalo, in June, 1878, discussed the question of the permeability of the entire alimentary canal by enemata. He is convinced, both by experiments in the post-mortem room, and by cases occurring in the practice of himself and others, that the ileo-cæcal valve does not prevent the passage of fluids from the colon into the cæcum, if sufficient pressure be used. A number of cases are cited in which treatment based upon these views was very successful.

APPOINTMENT.—Dr. Kennedy, of Dundas, has been appointed Surgeon to the North-west Mounted Police, *vice* Dr. R. B. Nevitt resigned.

ON THE DIAGNOSIS OF URINARY ABSCESES.

Hôpital de la Charité.—(M. Gosselin.)

A propos of a patient occupying bed No. 47, Saint Vierge Ward, I have to direct your attention to a case of great practical importance. The man is affected with an enormous perineal abscess, in all probability urinous, that is to say, caused by the passage of urine into the subcutaneous cellular tissue.

I say that we have in this case an abscess probably urinous, because up to the present moment the direct confirmation of my supposition has not been afforded us, that is to say, we have not yet seen the urine reach the light of day through a perineal fistula; nevertheless, I do not doubt that eight or ten days from now this phenomenon would occur.

It is my opinion, therefore, that this abscess has been caused by the passage of a certain quantity of urine into the cellular tissue, and that it is consecutive to an intense, suppurative, phlegmonous inflammation arising from the contact of this fluid.

This view of the case would be evident if, some time from now, we should see, as I have said, the urine issue from the wound. But it might also happen, even although my diagnosis be absolutely correct, that this phenomenon may be absent. And this is why: When, in certain subjects, there is developed in the canal of the urethra an inflammation behind any obstacle, which most commonly is a stricture, the first effect of this is to produce an ulceration of the mucous membrane, and afterwards a perforation of the canal, through which some drops of urine escape, during micturition, into the subjacent cellular tissue. If the stricture be not very tight, and if micturition occur only at long intervals, it is not impossible that the solution of continuity should cicatrize over and that a certain quantity of urine should thus find itself shut up in the perineum, where it would soon determine an extremely intense suppurative inflammation, notwithstanding that the communication between the purulent focus and the urethral canal had ceased to exist. Ordinarily this cicatrization of the urethral wound is only transient; at the end of some time a new perforation occurs, the urine accumulates anew

in the meshes of the perineal cellular tissue, and consecutively produces a new abscess, and afterwards the formation of a perineal fistula; but it happens that in certain cases things remain in a stationary condition for a rather long time, during which the urine does not find its way out externally. But, you say to me, that one can only affirm the existence of an urinary abscess when the urine flows by the wound. What then are the reasons which authorize you to diagnose in this patient an abscess of that kind, instead of saying that he is simply affected with a phlegmonous abscess of the perineum?

My reasons are these: In the first place, this man appears to have had a stricture. True, I have not established this fact for myself, but he was catheterised on the day of his admission on account of his inability to urinate, either because the pus accumulated in the perineal meshes by compressing the canal of the urethra presented a mechanical obstacle to the passage of the urine, or the pains produced by this abscess provoked a reflex contraction of the neck of the bladder, or perhaps an inertia or complete paralysis of this organ. Whatever may have been the cause, the man micturated by overflow, and the bladder, hyperdistended, mounted up over the symphysis pubis, and it was therefore right to fear that, if it were not promptly emptied, there might result dilatation of the ureters, pelvis, and calices, and consequent compression of the cones, and of the malpighian corpuscles, in a word, of all the constituent elements of the renal filter.

When, therefore, you catheterize a patient whose bladder does not empty itself, you render him the service of avoiding the chances of a grave nephritis; although unhappily in certain of these individuals the introduction of the catheter has the effect of itself provoking a re-inflamatory condition of the bladder, which, too, may be propagated along the upper excretory passages and reach the kidneys.

Nevertheless, on considering the results furnished by the totality of the facts, we are justified in saying that, speaking generally, there are less chances of seeing grave nephritis occur from emptying the bladder than from allowing the urine to accumulate.

The first reason, then, in favour of an urinary abscess in our patient is the existence of a urethral stricture, manifestly evidenced by the circumstance that it was necessary to catheterize him in order to secure the exit of urine, and that to attain this result it was necessary to use a very fine instrument, No. 9.

If I have not deemed it necessary to verify for myself, as I have already told you, the existence of this constriction, it is, in the first place, because this man now empties his bladder perfectly, and, in the second place, because I do not wish to run the risk of aggravating his condition by again introducing the catheter.

But, you will say to me, there may exist peri-urethral phlegmons without any communication with the canal of the urethra. Who then has told you that in this patient you have not to do with one of these abscesses? I do not think so, because this abscess was formed very rapidly, and because when these tumours are developed in so short a time they are more likely to result from the passage of the urine into the subcutaneous cellular tissue through some tear or fissure of the urethral walls than from a propagation outwards of an inflammation of which the mucous membrane is the seat. I do not mean by that to say that all urinary abscesses are formed rapidly, far from it: I know, on the contrary, that there are urinary swellings which have a slow, chronic, cold course, a fact the more important to be aware of because under these circumstances one is liable to mistake the nature of these abscesses and to see the phenomena of urinary infiltration supervene on account of having neglected to open them in time. But although certain forms of retention of urine give rise to these phlegmons of slow course, it is none the less true that when an abscess is seen to develop very rapidly, it is always due to the fact that the urethra, torn or ruptured, has allowed a certain quantity of urine to penetrate into the perineal cellular tissue. Another circumstance which also goes to support my diagnosis is that the patient at the time of his admission to the wards presented a swelling of the scrotum with redness and heat, notable and extensive enough to spread up over the pubis. This swelling might be considered, it is true, as due to a dif-

fuse phlegmon ; but, as a rule, when a perineal abscess of rapid formation is accompanied by these phlegmons we have ordinarily to do with a case of urinary infiltration.

Thus you should most frequently, if not always, regard this swelling of the scrotum as announcing the beginning of urinary infiltration, seeing that this interpretation will lead you to practise numerous and large incisions, which, if it actually turns out to be retention of urine in the subcutaneous cellular tissue, will enable you to save the life of your patients, and which, should the diagnosis turn out to be ill-founded, will not be attended with any kind of inconvenience.

A fourth consideration in favour of urinary abscess, which is of considerable importance, is that the pus accumulated in the pouch of the abscess was, as the fluctuation indicated, very abundant, and moreover very liquid, both characters which are not observed in cases of periphlegmons. Yesterday, in fact, when we opened the abscess we gave issue to a considerable quantity of pus and so liquid that in place of flowing *en nappe* it was projected with very considerable force.

Well then, it is this establishment of an abundant fluctuation in a man suffering from retention of urine, and this coincidence of an abscess with a diffuse phlegmon, and lastly, the presence of a very liquid pus, which have established me in the opinion that we have to do with a urinary perineal abscess, and have led me to treat it as such.—*Gazette des Hôpitaux.*

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OPIUM POISONING RELIEVED BY THE APPLICATION OF BOILING WATER.—Dr. William Seldon, of Norfolk, Virginia, in a communication to the *Virginia Medical Monthly* for October, relates several cases of opium poisoning in which the patients could only be roused by immersing their feet and legs in water scalding hot. He uses water hot enough to cause severe pain, but tries to stop short of vesication, though in most cases in which he has used it blistering has occurred. He also advocates the plunging of the feet in water scalding hot, or nearly so, in cases of coma or torpor of the brain from various causes.

REUNION AND RESTORATION OF DIVIDED NERVES.

BY C. G. WHEELHOUSE, F.R.C.S.

In the *Lancet* of June the 1st of the present year, a series of experiments are recorded as in progress in Germany, the object of which is to ascertain whether the nerves, like other structures, are not amenable to surgical treatment for their restoration after division and complete loss of function ; but, whilst the Germans are patiently experimenting to determine the point, it is my good fortune to be able to answer this question distinctly in the affirmative, as the following case will show.

On May 5th, 1875, a patient named Adam Smith, a labourer, aged 22, entered the Infirmary at Leeds, under my care. He limped into the ward on crutches, his left lower limb being completely paralysed and useless, and stated that he had come to request us to remove it, as an incumbrance. The story he told me concerning it was this. Nine months previously, as he was returning home one evening, at the close of his day's labour, carrying his scythe over his shoulder, being anxious to make a short cut to his cottage, he attempted to climb over a fence ; in doing this, the point of his scythe caught in the hedge behind him ; he was jerked suddenly backward, and fell with the back of his thigh upon the sharp edge of the implement. The result of this was a ghastly wound, the contracted cicatrix of which measured nine inches in length when I first saw it nine months afterwards. He lay, bleeding profusely, where he fell for many hours before he was found and carried home ; there the hæmorrhage was staunched, the wound was dressed, and, in process of time, it slowly healed ; but he noticed, during the whole time so occupied, that the limb was slowly wasting and withering away, and that it manifested no sign whatever of any returning sensibility.

Eventually, when he was able to leave his bed, he found to his horror that, although the wound was healed and the limb was apparently saved, it had become wholly useless to him. So far as the distribution of the sciatic nerve was concerned, the power of sensation was entirely lost ; of voluntary muscular power he had none, and the joints were relaxed and flaccid.

I need not detail to you all the efforts, vain efforts indeed, that he made to recover the lost powers of the limb; suffice it to say that, receiving no benefit from anything he did or tried, he finally came to the hospital to ask for its removal.

The whole cause of the mischief was, of course, clear at a glance. The sciatic nerve had been divided, and, in the healing of the wound, the separated ends had never reunited. Here, if ever, was a fair opportunity to test the question, Are nerves which have been divided, and have for long remained disunited, capable of restoration?

I called my colleagues to my assistance in forming an opinion on the matter. Dr. Clifford Allbutt was good enough most patiently and carefully to test electrically the condition of the disused and wasted muscles, and he reported that, though not wholly destroyed, their irritability was well-nigh exhausted. My surgical colleagues agreed with me that whereas, should the attempt to restore the lost nerve-power altogether fail, I could still, as a last resource, remove the limb, I should be justified in making an attempt to reunite the ends of the divided nerve. After fully explaining to the patient the position of affairs, and obtaining his assent, I determined to do so.

Having laid open the back of the thigh, and, by a careful and deliberate dissection of the parts, exposed the wounded nerve, I found it completely cut across; the two ends were firmly felted in cicatricial tissue two inches apart. On the upper one was a large bulbous swelling, the lower appeared atrophied and somewhat wasted. Both were carefully loosened and detached; the bulb was removed from the upper one, and each was then pared obliquely until apparently fresh nerve tissue was exposed. When I then attempted to bring them together, the nerve was found to be so much shortened that I could not do so until I flexed the knee fully. This enabled me to make the ends of the nerve meet without strain; they were then carefully stitched together with very fine carbolic catgut thread, the wound was closed, the ankle was firmly lashed to the buttock, and in this position the patient was put to bed.

I will not weary you with details. Suffice it

to say that little by little, and in very wandering fashion, day by day, and week after week, sensation was found to be returning in the limb. At the end of five weeks, I began slowly to relax the position and let down the leg inch by inch, until at length it became straight again, and then, to my intense satisfaction, I found that the restored sensibility remained. By very slow degrees, the power of voluntary motion also returned, and, on August 7th, he was discharged from the hospital so far cured that, with the help of two sticks, he was able to support himself on the limb and could walk. From that time to this, he has gone on improving. During the whole of the past winter, he has worked in the fields as he was wont to do before his accident, requiring neither stick nor support nor help of any kind; and, though the limb remains greatly inferior in size and nutrition to the opposite one, it is, to all intent and purposes, a useful member again.

Since the performance of that operation, my colleague Mr. Atkinson has in similar manner successfully reunited a divided median, and Mr. Jessop has reminded me that, long prior to my case, he also had been equally happy in thus dealing with an ulnar nerve.—*British Med. Jour.*

CONTRACTION OF THE FINGERS.—Mr. William Adams thus describes the operation and treatment which he now practises in cases of Dupuytren's contraction:

1. The subcutaneous division of all the contracted bands of fascia which can be felt; the bands to be divided by several punctures, with the smallest tenotomy-knife passed under the skin and cutting from above downwards, a pledget of lint being at once placed over each puncture and retained in position by a strip of plaster.

2. Immediate extension to the full extent required for the complete straightening of the fingers, where this is possible, and the application of a retentive well-padded metal splint from the wrist along the palm of the hand and the fingers; the fingers and hand to be bandaged to the splint.

3. The bandage not to be removed until the fourth day, when the lint and plaster may also

be taken off, as the cutaneous punctures are always found to be healed by the fourth day. The retentive metal splint to be reapplied and the hand and fingers bandaged to it.

4. Extension to be kept up by the splint worn continuously night and day for two or three weeks; but the splint and bandage to be changed every two or three days. After this the extension splint is to be worn at night only for an additional three or four weeks, free motion being encouraged during the day.

COMPOUND COMMINUTED FRACTURE OF GREAT WING OF SPHENOID BONE ON LEFT SIDE.—Dr. E. W. Collins detailed the case of a boy aged 14, who was struck by a bolt propelled with force from some machinery to which he was attending in a saw-mill. Profuse hæmorrhage took place at the time of the accident, from an extensive lacerated wound in the left temporal fossa. Symptoms of cerebral concussion and syncope were present, and profuse reactionary hæmorrhage occurred at 5 a.m. the next day, which was restrained with difficulty. When the wound was opened up a few hours later, the finger passed downwards between the zygoma and sphenoid into the zygomatic fossa. The finger could be passed into a fissure in the base of the great wing of the sphenoid, where it was extensively fractured. The profuse hæmorrhage was found to come from the zygomatic fossa, indicating laceration of either the internal maxillary artery or its middle meningeal branch. Owing to the depth of the wound, the bleeding could be checked only by direct pressure within the wound by plugs of lint. This was effectual, the plugs separating without further hæmorrhage. No intracranial complications ensued, probably in consequence of the large amount of blood lost. Necrosis took place, and two months afterwards many pieces of bone were removed from time to time. The boy perfectly recovered. Dr. Collins showed the necrosed fragments of bone.—*British Med. Journal.*

PREVENTION OF THREATENED MAMMARY ABSCESS.—A mixture of chloroform and glycerine, well shaken and quickly applied, and covered with oiled silk is highly recommended.

Midwifery.

ON CERTAIN FORMS OF NON-PUERPERAL UTERINE HÆMORRHAGE.

BY A. E. AUST LAWRENCE, M.D.,

Physician-Accoucheur to the Bristol General Hospital.

With a view of bringing prominently before you the causes which produce uterine hæmorrhage in non-puerperal women, in order that suitable treatment may be adopted, I have analysed my hospital cases with special reference to this symptom; and I find that, out of a total of nearly seven hundred patients seen by me during the last three years, ninety came complaining of hæmorrhage, and it was only that symptom upon which they laid stress when detailing their troubles. The hæmorrhage in these ninety cases was found to be due to eleven different pathological conditions.

The following are the eleven causes, and the number of cases they each furnished:—

1. Malignant disease	25 cases.
2. Fibroid tumours of the uterus	8 “
3. Mucous and fibrinous polypi growing from the cervix uteri	9 “
4. Subinvolution of the uterus	10 “
5. Retroflexion	5 “
6. Antelexion	3 “
7. Parametric inflammation	5 “
8. Hæmatocele (pelvic)	4 “
9. Ulceration (so-called) of os and cervix uteri	10 “
10. Stenosis of cervix and os uteri	6 “
11. Anæmia	4 “

I will now mention briefly the main points in the diagnosis and treatment of each of the conditions above enumerated.

1. *Malignant Disease.*—It is certainly a terrible thing to contemplate that one out of twenty-eight patients applying, for different uterine diseases, should be affected with so terrible a disease; and of those applying for the relief of hæmorrhage, nearly one-fourth were malignant cases. Before passing to consider the points in diagnosis, I wish to refer to the very advanced condition in which most of the cases were before they came to the hospital; this I attribute to the fact that, in a good many cases, pain was not a prominent symptom in the early stages, nor was hæmorrhage, until the mass began to break down. The forms of malignant disease have been epithelioma in one-third and medullary cancer in

two-thirds of the cases. The age has varied from twenty-seven to sixty-nine; so you see that age does not enable us to negative the existence of malignant disease. Fifteen cases were over fifty years of age. The chief points in the history were, that the catamenia had ceased for periods varying from one to ten years; and that they had again, to use their expression, become unwell; some of them with pain, and others without. This cessation and recurrence of hæmorrhage at this epoch of life is a most suspicious circumstance, and always demands a most careful examination; there may be no pain, and yet advanced cancer may exist. I have notes of several cases where the pain was so slight as not to draw the patients' particular attention to it. When pain is present, it is in some cases excruciating, being felt in the lower part of the abdomen, back, hips, and thighs. The pain is often lessened by the hæmorrhage, I believe, by relieving the general congested condition of the uterus; and were it not that the anæmia is so soon induced by the repeated discharges of blood, one would regard the hæmorrhage to a certain extent as beneficial.

One point very suspicious of malignant disease is the way in which the hæmorrhage begins. Thus a woman may have ceased menstruating for, say, two years, when she suddenly loses a great quantity of blood; probably this discharge goes on for twenty-four or forty-eight hours, and then ceases, to recur again, at an interval varying from a few days or weeks to even months, until it eventually becomes more or less continuous. I say this mode of bleeding is suspicious, but not absolutely characteristic of malignant disease, as I have seen it occur in two cases of fibroids of the uterus. In these cases, the women had both ceased menstruating about two years, when, in each case, a severe fit of pain (referred to the uterine region) and hæmorrhage set in suddenly and lasted for some weeks, when, upon examining them, I detected a fibroid polypus coming down through the cervix uteri.

In the other nine cases of malignant disease, the patients had not ceased menstruating. They all complained of excessive menstruation; in most of them the period lasted from ten

to fifteen days out of each month; some of them had bleeding for about two days each week. The main point was that there existed an excess of blood-discharge, both too much and too frequent. Some had pain, others had none. There was nothing characteristic about the discharge of blood to enable one to say definitely, without an examination, what its cause might be. The suspicious point in some of them was that exertion or coitus would often produce a sudden flow of blood.

The only definite opinion is derived from a digital examination. In the advanced cases, it is soon learnt by the finger that the absence of the natural os and cervix uteri, a rugged cavity being recognised instead, a hard feeling in the roof of the vagina, and fixation of the uterus, tell only too surely the tale of malignancy. In early cases, the enlarged lip of the cervix uteri, with one or two prominences and a hardness about the cervix, is often quite enough to raise one's suspicions. The finger is all that is requisite for the diagnosis of malignant diseases; but the microscope is required, in some cases, before we can say whether it is medullary or epithelial. Now, as the finger is so important, I often wonder that it is not more used in the diagnosis of the various uterine diseases to the partial exclusion of the speculum.

I am often asked by gentlemen how I know by the feel that it is a malignant diseased condition of the cervix; why is it not something else. Possibly, they suggest simple ulceration, but at the same time admit they only know simple ulceration by the look and not the feel; and I trust that I may be excused for saying that no man has a right to use the speculum before his finger has told him that it is required, and, I am sure, for the purpose of diagnosis, the speculum is not often wanted.

The diagnosis of malignant disease by the finger is done by exclusion, to a certain extent, until one becomes accustomed to the feel of cancer in its various stages and phases. Let the finger become accustomed to the feel of the different diseased conditions of the uterus, and then the diagnosis of cancer will be an easy matter. The eye can be deceived more easily than the finger. Take, as an example,

fibroid polypus hanging in the vagina ; for some time, nothing looks so much like a mass of medullary cancer ; it has a nasty sodden look, and bleeds when touched by the speculum ; but as soon as the finger touches it, and sweeps round it and feels the cervix, all anxiety is at an end, as you have a case you can cure straight off.

The question of treatment is, I am sorry to say, not satisfactory ; but a great deal may be done that is often left undone. Disinfectant and astringent injections give comfort, to say the least of it. Destruction of the sprouting mass with the actual cautery, although a temporary measure, yet is often beneficial for the time ; as also is the plan of scraping the surface where the growth presents numerous small points. One plan, lately advocated by Dr. Marion Sims, is also a good one, and enables the surgeon to follow up the malignant disease higher in the uterus than can be done with the *écraseur*. His plan is to cut away, with knife and scissors, bit by bit, every portion of diseased tissue, restraining the hæmorrhage after with firm plugs of cotton-wool, soaked in a saturated solution of persulphate of iron. He maintains that the disease is kept in abeyance more by this plan than by any other of the operative proceedings.

In reference to the use of the *écraseur* in the various forms of malignant disease of the cervix, where it is desirable to remove portions of the uterus affected with cancer, my experience is that it is far inferior to the knife and scissors, unless the portion is very pedunculated. In cases where the cervix is in broad flattish lobes of medullary cancer or epithelioma, it is almost impossible to get above the growth into healthy tissue. I believe the best plan is to cut away as much as possible, and use the actual cautery ; but even this is not free from danger, as plugging of the pelvic veins has been occasioned by the application of escharotics and caustics to the diseased tissues.

With reference to medicinal treatment, the main point is to keep up the general health as much as possible, by giving cod-liver oil and mild non-astringent preparations of iron. To relieve pain, the various preparations of opium, chloral, etc., would at once suggest themselves

to you ; but there is one drug I have found very useful in relieving pain in these cases, and that is ergot. I believe it acts by lessening the blood-flow into the uterus, and therefore keeping it freer from congestion. I was led to try it by noticing that the pain was frequently much lessened by hæmorrhage ; and therefore I considered that, if it were possible to check the blood somewhat from passing into the uterus, then one might gain the same object. It has answered very well in several cases. As an injection in these cases, I prefer iodine, and, if much pain be present, I add carbolic acid and opium.

The prognosis in these cases is, unfortunately, bad ; but I have been struck with the time that they go on without destroying life. One sees cases where the whole of the cervix is destroyed, with ulceration into the bladder and rectum, and yet they live for months. Other cases are more rapid, and seem to die without anything like the amount of local disease with which some patients live months.

2. *Fibroid Tumours*.—I now allude to the second class in my table, viz., those cases where the hæmorrhage was due to fibroid tumours in the uterus. There have been eight cases where the patients have come complaining of hæmorrhage, and, upon examination, a fibroid condition of the uterus was diagnosed. The age in five cases was under forty ; in the remaining three, it varied from fifty to sixty. It is impossible here to enter fully into the diagnosis and treatment of fibroid uterine tumours. I only wish to draw attention to a few main points, so that one's suspicions might be aroused, and one's attention directed to a possible cause of hæmorrhage. One main point is in the cases of those women under forty years of age—excessive menstruation, the discharge lasting ten days or a fortnight, and recurring at the end of a similar period. Another point noticed is that the blood most frequently contains clots, and the period is often accompanied with great pain. The sound often shows displaced conditions of the uterus and an elongated state, the cavity often measuring four or six inches. The diagnosis, in some cases, rests entirely upon the history of hæmorrhage and the enlarged condition of

the uterus, as it is not always possible to detect a fibroid tumour of the uterus as a distinct mass, growing either into the cavity of the uterus, or out from its walls towards the cavity of the abdomen; in this last form, hæmorrhage is not such a troublesome complication, although the pain is often greater. One case came before me, eighteen months ago, with a history of excessive menstruation, passing clots, and great pain. The cavity of the uterus measured three inches and a half. There was no external source for the hæmorrhage, and upon examining the cavity of the uterus, after dilating the cervix, there was not found any growth; however, from her history and the absence of any other cause, I entered it in my case-book as one of fibroid tumour of the uterus, most probably lying in the walls of the uterus, immediately beneath the mucous membrane. This patient took ergot for the last eighteen months, and gradually a fibroid tumour was expelled into the cavity of the uterus, and, dilating the cervix, presented at the external os. At this stage, I saw her again, and removed the growth with the *écraseur*. I relate this case as being typical of a large number of others, where the fibroid tumour lies in the wall of the uterus, between its muscular layers, and gradually grows towards the cavity, or is pushed in that direction by the fact that, in the case assumed, there is a thicker layer of muscular fibre on the peritoneal side of the tumour than upon the mucous; this gradually converts an interstitial fibroid into a sub-mucous, and eventually into an intra-uterine tumour; and even it may be dislodged entirely from the body. In the cases where the age varied from fifty to sixty, the diagnosis of malignant disease had been made in two of them before they were sent to the hospital, simply on account of the hæmorrhage and pain; and, I am sure, anyone looking at them would have drawn the same conclusion. In fact, I would not give an opinion to my obstetrical clerk before I made a vaginal examination, as their history was like that of malignant disease. A vaginal examination revealed in all three cases a fibroid tumour coming through the cervix uteri, and in one case reaching nearly to the vulva. In each case, removal

of the growth by the *écraseur* entirely relieved both the hæmorrhage and pain. To sum up, the diagnosis must be made partly by excluding all other known sources of hæmorrhage, and partly by direct evidence of the existence of a fibroid growth, either as an enlargement in the wall of the uterus or growing out from it. Several of my cases were diagnosed at an early stage to be fibroid cases, mainly by exclusion, with the assistance of two positive factors, viz., uterine enlargement and excessive uterine hæmorrhage.

The question of treatment I must dismiss in as few words as possible. In some of the worst cases, where the tumour is large and embedded in the uterus, nothing can be done with a view of curing the disease, unless we subject our patient to the ordeal of gastrotomy and remove the uterus. These cases, however, can have two symptoms relieved to a certain extent, viz., hæmorrhage and pain: the former by ergot and the latter by opium. In some cases, where the cervix is narrow and allows the blood to become pent up in the uterus, and so act as an exciting cause of more hæmorrhage, and pain is produced, these symptoms are relieved to a great extent by dividing the cervix. Where the growth is pedunculated, the proper course to adopt is removal by the *écraseur* or knife. Where no operative measures are admissible, much can be done by maintaining the uterus in a good position, keeping up the general health, and lessening the hæmorrhage by ergot, turpentine, etc.

(To be Continued.)

PEMPHIGUS VAGINÆ.—Kleinwächter (*Obst. f. Chir.*, 1878, p. 392; from *Präger Med. Wochens.*) gives the following case. The patient had suffered from pemphigus, especially of the leg, for three years, in spite of every kind of treatment. The mucous membrane of the vagina was laid bare of its epithelium in numerous small patches, and bled easily upon contact; on many of the patches a thin, sometimes crumpled skin could be observed. The intact portions of the mucous membrane were reddened, and poured out a catarrhal secretion. The upper third of the vagina was particularly affected. About the vulva six or eight distinct bullæ could be seen. Astringent injections were ordered, but the patient, who suffered no discomfort from the eruption, disappeared.

Therapeutic Notes.

FOR DYSENTERY.—Injections of chloral grs. v to x to \mathfrak{z} ii of starch are highly recommended.

CONSTIPATION.—Injections of chloral (gr. x to \mathfrak{z} i) are recommended for habitual constipation also glycerine \mathfrak{z} i to \mathfrak{z} i of warm water.

PERFUMED CARBOLIC ACID.—Carbolic acid one part, oil of lemon three parts, alcohol at 36° 100 parts. M. The odour of the oil is alone appreciable.

Dr. Busey, (*American Practitioner*) recommends the combination of oxalate of cerium with opium to obviate nausea, &c. He also gives strong coffee or the citrate of caffeine.

KELOID.—Dr. J. E. Kempf reports, in the *Louisville Medical News*, a case of keloid cured by injecting two or three times a week, for several weeks, extract of ergot dissolved in alcohol.

INFLAMMATIONS OF THE NASO-PHARYNX.—Mr. Lennox Browne commends iodoform as superior to all topical applications. Apply an ethereal solution (one in ten) by means of a brush, or mix with vaseline (5 to 8 grs. to \mathfrak{z} l.)

LARYNGISMUS STRIDULUS.—Mr. Wm. Stewart (*Lancet*, May 25) has found chloral the remedy *par excellence* in laryngismus stridulus. He gives two grains to a child six months old, two and a half at twelve months, and three grains at three years.

VAGINITIS.—Dr. Parvin, in an obstinate case of membranous vaginitis, after failing with nitrate of silver, carbolic acid, sulphate of zinc, tannin, and glycerine lotions, and mucilaginous injections, used tampons of lint smeared with oxide of zinc ointment, and in a week great improvement followed.

KOUMISS.—Take a quart champagne bottle, put in two ounces of fresh yeast and half an ounce of powdered sugar, and fill with fresh unskimmed milk, cork tightly and tie. Let it stand in a warm place until the liquid begins to

thicken, then lay on the side in the cellar for about a week, and you will have a splendid article of fresh koumiss.

IRRITABLE TESTIS.—Dr. Reuben A. Vance, of Gallipolis, Ohio, reports a case of obstinate neuralgia of the testis which he cured by the application by means of a speculum, of vesicating collodion to the rectum over the prostate and vesiculæ seminales, allowing the collodion to dry before removing the speculum, and then inserting a wad of cotton saturated with glycerine.

DIABETES.—After all other remedies had failed, Dr. Balfour, of Edinburgh, gave diluted nitric acid in 20 minim doses four times a day to a patient with diabetes: the diet was restricted. A year previous he was passing 400 oz. of urine daily, containing 16 oz. of sugar, and three months before he weighed seven stone. The daily quantity of urine was reduced to 50 oz., with 1 oz. of sugar, and the body weight had risen to nine stone.

CHOREA.—Dr. John Van Bibber, of Baltimore, in the *Transactions of the Medical and Chirurgical Faculty of Maryland* for 1878, has a paper on the treatment of chorea by prolonged rest in bed, and cites eight cases in which the element of rest was the main factor of treatment, which was singularly successful: the average duration was two weeks. The patient should be free from interruption or irritation in a darkened room. Massage or passive exercise was ordered twice daily, and nourishment liberally given.

CHROMIC ACID CATGUT.—Take a few yards of thin, common, unprepared, dry catgut, and place it in a wide-mouthed vial, containing glycerine and carbolic acid, (one part of acid to seven of glycerine), and after steeping for a week or longer, transfer the catgut to a vessel containing chromic acid one part, acetic acid twenty-five parts, water seventy-four parts. At the end of seven hours take the catgut out and dry it, while made tense, by winding round two nails driven into a piece of wood. In the course of a few hours it is fit for use. It is brownish-black, smooth and strong.

TREATMENT OF ACUTE INTESTINAL CATARRH OF INFANTS BY MERCURIC CHLORIDE.—Dr. Rudolph Ravenburg, (*Med. Rec.*, July 6, 1878,) calls attention to this use of corrosive sublimate which Ringer so earnestly advocates. To avoid the errors of drops Dr. Ravenburg prescribes one grain of the bichloride to 12 oz. dist. water; a teaspoonful to be mixed with an ordinary teacupful of milk previously subjected to a heat of 150° for five minutes, the milk should never be brought to the boiling point. Of the milk as prepared, the judgment of the physician is required as to the quantity to be given. In ordinary cases the fecal discharges will, without any other remedy, gradually lessen and be restored to their normal condition. In severer cases it may be necessary to use as an enema a cupful of boiled and cooled water, plus starch or laudanum, as the physician may deem proper.

CHRONIC PHARYNGITIS.—The following treatment of Pippingsköld for chronic pharyngitis will at least commend itself for its simplicity. In case of pharyngeal catarrh, with extension to the mucous membrane of the general air-passage, he recommends methodical and thorough gargling, morning and evening, with water at a temperature—of 15° to 20° C. This to be continued for months, or, under certain circumstances, for a whole year; at least to be recommenced as soon as the symptoms of the catarrh shall begin again to annoy the patient. Two glasses full of water at the above temperature—used at each gargling—relieve hyperæmia, and restore tone to the relaxed vessels of the soft palate. Ice-cold water, in less quantity, will reduce the temperature of the parts more quickly, but causes a powerful reaction, with increased hyperæmia, and can easily therefore do more harm than good. The writer recommends this remedy likewise in granular pharyngitis.—*N. Y. Med. Journal*, July, 1878.

DIVISION OF THE ABDOMINAL AORTA BY A PISTOL BULLET.—Survival for one hour and ten minutes after the abdominal aorta was divided in three-fourths of its circumference by a pistol bullet, which also cut the right renal vein, is reported to have occurred in Detroit.

Original Communications.

A FATAL CASE OF CHRONIC GASTRIC CATARRH.

Specimen presented by Dr. Graham before the Toronto Medical Society.

George Hastie, aged twenty-four, clerk, single, was admitted into the Toronto General Hospital. He had one sister, who died of phthisis: family history otherwise good. He never drank to excess, but used tobacco very freely until two years ago: since then he has smoked occasionally. He commenced the habit of masturbation when he was ten years of age, and continued it until two years ago. Most of his life he has spent in the smoky part of Glasgow: came here about a year ago. He has always had delicate health; had small-pox when young: is always of a costive habit: never had any venereal disease, has had emissions twice a week for the last two years. I learned from the nurse that before he left Scotland he kept a cigar and tobacco store. Present disease: patient has complained of trouble with the stomach for the last eight years. The principal symptoms have been pain in the epigastrium and in region of the heart an hour or so after eating, with constipation and headache. He was laid up three years ago with what the doctor called chronic dyspepsia and inflammation of the stomach. He had another attack sixteen months ago. During both attacks the treatment was a light dry farinaceous diet, and medicine to relieve the constipation. The present attack began nine months ago. He has not had as much pain in the stomach as in previous attacks. He thinks it was brought on by eating canned peaches three times a day. His bowels are obstinately constipated, and if not relieved by medicine, a week or more will pass without an evacuation. He is of melancholy disposition; dreams very much during sleep, and is excessively irritable and hard to deal with when awake. He had eaten nothing for two days; has severe headache; takes nothing but milk and water and a part of a soda biscuit occasionally. He never vomits, but immediately or soon after taking food he is seized with a severe dull pain in the stomach; sometimes a burning sensation, together with pain or palp-

tation of the heart. He is very thin, and his countenance has a pinched, anxious, discontented look. The temperature is normal. Pulse, 48 or 50.

Treatment.—A mixture of bismuth with chiretta and pills of ferri sulph., ext. nux. vom., aloes socot. One to be taken twice a day.

January 19th.—Patient somewhat better, he can take a little more milk than formerly, cannot take beeftea or any kind of beef essence without causing unbearable pain. No kind of pills or medicine seems to have any effect on the bowels, which are only moved on the administration of an enema.

June 26th.—Patient is worse again: ordered him lactopeptine to be taken in sherry wine.

July 2nd.—He is gradually becoming more emaciated;—is very much more so than when he came in. The lactopeptine seems to have had no effect. He sometimes takes only a biscuit in two days without milk or even water, the latter almost causing as much pain as the milk. He is greatly troubled with thirst. Tongue dry and coated. Had to put him on a water bed to avoid bed sores.

July 9th.—Ordered rectal alimentation. He is much troubled with eructations and difficulty of breathing and severe cramping pains in the stomach.

July 16th.—The rectal alimentation has not been successful, as the nurse had been using too large an amount at a time. Ordered smaller quantities.

July 23rd.—The patient is becoming weaker, and is occasionally feverish. Pulse more rapid. Dr. Wright, who saw the case with me, spoke of a similar case in which the post-mortem revealed a very much contracted stomach. We examined the lungs and heart and found them healthy. There appeared to be a swelling a little to the left and below the umbilicus. No other abnormal condition of the abdomen could be found. He complains of pain in the region of the heart, with palpitation.

August 5th.—Patient died this morning, apparently from starvation. Had severe pain in the region of the heart.

Post-mortem appearances.—Body extremely emaciated; weight, about sixty pounds; height, five feet eight. On opening the abdomen

found the liver slightly congested: weight, two pounds three ounces. It was a matter of difficulty to find the stomach. It did not appear nearly so large as the transverse colon. Its weight, with the contents as removed, four ounces. The lower margin appeared thickened. On opening it, found it to contain a mucous substance. The mucous membrane had a peculiar granulated appearance and the rugæ were very prominent. In some parts it was of a dark red colour and in others greyish. It did not anywhere present the pink colour ordinarily seen. It was thickened and indurated in some places, and in others, it appeared thinner than normal. There was no special thickening towards the pyloric orifice. The organ would not hold more than twelve ounces of fluid.

Kidney appeared normal, but very small: weight, three ounces. Heart weighed four ounces: no valvular lesions; pancreas, two ounces; spleen, two ounces. Lungs were healthy. I am sorry that, for want of time we were not able to examine the mesentery and *receptaculum chyli* as well as we might have done. We found no tumour of any kind.

From the observations I have made of the patient, and from my reading, I would call the case one of chronic gastric catarrh. This disease is described very fully by Niemeyer in his "Practice of Medicine." Catarrh of the stomach is common in Germany, caused, I think, by too great consumption of lager. In Reynolds' "Practice of Medicine" there is also an excellent article on this subject. The principal symptoms given by these authors are feeling of weight in the stomach after eating, together with fulness, rifting, vomiting, the latter not a constant symptom. The food sometimes undergoes decomposition in the stomach, causing an accumulation of gases. Hunger and thirst annoy the patient. There is generally obstinate constipation. Emaciation, anxious, discontented face, and contraction of the skin are given by Reynolds.

Causes.—Venous obstruction, constant use of food which disagrees, medicinal substances and constant use of alcoholic beverages. There is very frequently some other disease present: phthisis, heart-disease, or Bright's

disease. The cause in this case may have been the excessive use of tobacco.

Pathological appearances.—Local congestions and extravasation: mucous membrane is indurated, and presents an ash-grey colour with small spots of pigment. The membrane is also thickened in places, generally near the pylorus.

On microscopical examination a degeneration of the tubules is found. They are often less in number and the contents have undergone degeneration, &c. Wilks and Moxon, Habershon Handfield Jones and Wilson Fox all speak of this degeneration of the lining membrane. The great diminution in size might, in great extent, be due to its almost entire emptiness for the last two or three months. Delafield gives as causes for small stomach (1) New growths; (2) Hypertrophy of the muscular coat; (3) Cicatrization of ulcers; and (4) Habitual emptiness.

Diphtheria everywhere prevails inversely to typhoid fever, with which disease it is closely allied, although an attack of typhoid fever affords no protection from a subsequent attack of diphtheria, nor *vice versa*; when introduced into a town diphtheria may become epidemic, and be disseminated by precisely the same channels as typhoid fever; the infection may be conveyed into any house by sewer gas or otherwise, altogether irrespective of dampness of structure; but its endemic breeding grounds are to be found in certain well-defined spots in rural districts, where it is constantly liable to break out as if *de novo*, and the constant condition of these localities is structural dampness of habitation.

TRACHEOTOMY IN CROUP.—At the Children's Hospital in Paris up to 1848, forty-nine operations were followed by forty-eight deaths. In 1858 only three escaped out of forty-two operated upon. Oppitz, in a tabulated series of ninety-six cases of tracheotomy for the extraction of foreign bodies, found seventy-three cases of recovery. Bouchut has collected 388 cases of tracheotomy for croup, of which 346 were fatal and forty-two recoveries.

UNCOMMON SYMPTOMS IN A CASE OF BRIGHT'S DISEASE.

[Read before the Toronto Medical Society.]

BY DR. A. ALT.

Lecturer to Trinity Medical School, and Ophthalmic and Aural Surgeon to the Andrew Mercer Eye and Ear Infirmary.

As a rule, neuroretinitis is one of the later symptoms in Bright's disease. However, every now and then the oculist has occasion to see a case of pronounced neuroretinitis of an albuminuric character, when there is no other symptom of the disease of the kidneys present, and the latter sometimes develop many months after the disease of the eyes has first been observed. The following case, which has lately come under my observation, is an example of these rare forms; however, it shows some further symptoms, which make it, it seems to me, especially interesting.

On April the 12th, 1878, Miss J. W. B., æt. 30, presented herself at my office on account of failure of sight. For several months she had been treated for neuralgia and general debility and loss of appetite, and for four months her eyes had been gradually getting weaker. A prominent symptom in the general disease was attacks of violent headache, localized above the eyes. These attacks would last sometimes for several days, and leave behind a marked numbness, which was mostly confined to the left side, sometimes also involved the right. During the attacks, the patient lost control of her tongue for some time, so as to be unable to speak.

The following was the *status præsens*: Patient is a rather frail and anæmic individual. Sight in the right eye, $\frac{2}{6}$; in the left, $\frac{2}{6}$, with difficulty. Jaeger No. 8. On ophthalmoscopic examination, I found that in both eyes the outlines of the optic disc and the origin of the retinal vessels were invisible, being hidden by a whitish infiltration of the papilla and a small area of the surrounding retina. The arteries were thin and anæmic, the veins broad and tortuous, overfilled. There were no hæmorrhages and no fatty patches.—This, then, was the picture of optic neuritis in both eyes; and the ophthalmoscopic appearance gave no clue as to its origin. The visual field was, perhaps, a little contracted; perception of colours and tension

of the globes were normal. There was no organic disease of the heart, no symptom of kidney disease (especially no albumen in the urine), nor did the ophthalmoscopic condition remind one of Bright's disease, since the characteristic hæmorrhages and fatty patches, etc., were wanting totally. There was no history of syphilis, injury, or lead-poisoning.

From the symptoms above related I came to the conclusion that, with the greatest probability, I had to deal with a case of tumour of the base of the brain; and hearing afterwards that the patient's father had died from a tumour of the brain, I was the more convinced of the correctness of this diagnosis. I then treated the patient symptomatically; gave her iodide and bromide of potassium and iron, and advised rest for the eyes, some out-door exercise after the sun had gone down. Later on, I applied a weak constant current for some time, and, finally, gave tannate of iron. Under this treatment the general health and the sight improved gradually. The patient had only two more slight attacks of headache, and sight was, at the end of two months' treatment, $\frac{3}{8}$ in both eyes. All the time, however, the ophthalmoscopic condition remained perfectly unchanged, until the beginning of July, when, one day, there appeared a small hæmorrhage in the left eye, and when I then examined the urine there was some albumen in it. I thus was forced to change my diagnosis, at least so far as to allow the co-existence of a kidney-disease and tumour of the brain. That with regard to the kidney-disease I was not mistaken, was proven by the further changes. In the course of a few weeks, the characteristic hæmorrhages and patches appeared in the retina of both eyes, and when I examined the patient last, I found the urine to contain albumen to nearly a third of its volume. Of course, I then gave back the patient to her former physician, as being beyond my area of practice.

The strangest points in this case are certainly the attacks of localized headache, with loss of power over the tongue and numbness of the limbs. Had the kidney disease been farther advanced, and had general œdema been present, these symptoms might have been easily explained by uræmia. As this was, however, not the case, I am yet inclined to believe that we have here to deal with a co-existence of a disease of the brain and of the kidneys; at least, I am at a loss for another explanation.

(To the Editor of the CANADIAN JOURNAL OF MEDICAL SCIENCE.)

CEPHALIC LOCK OF TWINS.

DEAR SIR,—I enclose the following rare case, never having seen or heard of a case of the kind, I have taken the liberty to name it myself. I copy from my midwifery case-book almost *verbatim*.

At six a.m., June 17th, 1874, I was sent for in great haste to a Mrs. Brown, living on the rear of lot 66, 1st con. King, on the road leading from Yonge Street to King Station. My brother, Dr. Lewis Langstaff, of Springhill, was in attendance. The patient, a stout woman, in her first confinement, had become delivered of one child, all but the head, which could be distinctly felt above the symphysis pubes, while the head of the second child had descended into the pelvis. I had the patient placed upon her back with the body of the child, already born, held forward over the abdomen, and applied the forceps to the head of the second child, which was easily delivered alive, after which, the head of the first child was brought away. Both children were large for twins.

The above treatment, it appears to me, would be the proper one in all cases of this kind, for the following reasons:—

1st. I had no hesitation on examining the case in adopting the course I did, although the head was not yet pressing forward the perineum.

2nd. There is almost always difficulty in putting anything back that comes down during labour.

3rd. Such a case would never occur, except when there is a large pelvis.

4th. The bony outlet of the pelvis is almost invariably larger than the brim, consequently, what passes the brim will pass the outlet.

5th. The perineum had already been distended.

6th. The labour terminated quickly.

We kept the patient under opium for a time and she did well.

Mr. Editor, I earnestly desire any information from yourself, or readers, on any case like the above, or a reference to where such a case is recorded.

Yours truly,

JAMES LANGSTAFF, M.D.

Translations.

From *Le Progrès Médical*.

ABORTIVE TYPHOID.

We extract from a review by A. Laveran, in the above journal, of a work by Prof. P. Lorrain, entitled "*Etudes de Médecine Clinique*," the following passage:—

"The existence of abortive typhoid fever can no longer be doubted. The evolution of the fever, the slow defervescence by descending oscillations, the diarrhoea, the pain on pressure in the right iliac fossa, the presence of rose spots, all together seem to prove that these slight fevers which were formerly described under the names of *mucous fevers* or of *synochas*, and the duration of which did not exceed eight or ten days, should be annexed, in great part at least, to the history of typhoid fever. When a patient, who has just got over one of the slight fevers, succumbs by chance, we can assure ourselves that lesions of Peyer's patches exist, as we have recently had occasion to do. A knowledge of these abortive forms of typhoid fever is very important. Thus may be explained the immunity from typhoid fever enjoyed by many of the inhabitants of our large towns, who affirm that they have never had typhoid fever, (to the public, and to a large number of physicians, typhoid fever is always a long and serious affection,) but who have had mucous fever, or so-called *synochas*, to which they have attributed no importance. The introduction of these light cases into statistics enables us, moreover, to understand the discrepancies which exist between the figures of mortality furnished by different authors. The mortality of typhoid fever which in the time of Louis was about 36 per 100 is now-a-days, according to the statistics of a large number of observers, no more than 7 or 8 per 100. Has typhoid fever become less grave, or is the credit of the change due to new therapeutic measures? The principal cause of these differences appears to us to reside in this fact, that a large number of physicians now-a-days include in their statistics the abortive typhoid fevers, (or *typhoidette*), which were excluded in the time of Louis.

From *Gazette des Hôpitaux*.

TWO FORMULÆ OF LA CHARITÉ.

For that kind of vomiting called nervous, because it does not correspond to any organic lesion, there are already many formulæ; but how often do they fail! It cannot therefore be said that one more is too many, especially when it has been approved in the hands of so distinguished a practitioner as M. Empis. He directs the following mixture to be boiled for some minutes; strychnine, 1 centigramme ($\frac{1}{20}$ ths of a grain); alcohol, 1 gramme; water, 99 grammes; then to throw the whole on a filter of paper, which retains the undissolved strychnine. Chemists pretend that this alkaloid is completely insoluble in water thus alcoholised; one of them even defies M. Empis ever to find the least change in weight in what he collects upon the filter. However, the liquid which passes through possesses a very great bitterness, which is proof enough that it has dissolved something. M. Empis usually gives this liquid in the dose of three tablespoonfuls in the day. It is not unusual to see the vomiting stop after the first. Another means not less relieving and also very efficacious is a method recommended by M. Laboulbène for destroying the oxyures or small thread-like worms infesting the anal folds, causing such insupportable itching, and which are so difficult to get rid of. This means consists in injections of syrup (or molasses) or glycerine. Every oxyuris touched by these liquids soon disappears, and as there is nothing irritant about them, they can be repeated often enough to exterminate every adult, and consequently destroy the race as soon as the eggs previously deposited shall have been destroyed.

ANTI-DIARRHOIC POTION.—(ARCHAMBAULT)

Tincture rhubarb.	ʒiiss.
Sulphate of magnesia.	ʒiiss.
Anise water.	ʒiiss.
Syrup of acacia.	ʒss. M.

A teaspoonful three times a day for a child of one year to control the obstinate diarrhoea sometimes observed after the weaning. Starch enemata.—*L'Union Médicale*.

A POINT IN THE PATHOGENY OF CARDIAC AFFECTIONS.—(POTAIN.)

At the meeting of the *Association Française pour l'Avancement des Sciences*, in August last, M. Potain read a paper upon "A Point in the Pathogeny of Cardiac Affections," and especially of the right heart. In this connection he cited those facts, some of which have been recorded in a thesis by one of his students, Dr. Mahot, upon pulsations of the liver in tricuspid insufficiency. He pointed out the influence of affections of the gastrohepatic apparatus, and particularly of acute affections of the biliary passages, upon the heart, and quoted M. Gangolphe's work upon the transient cardiac lesions which are met with in jaundice. Acute affections of the biliary passages produce transient dilatation of the right heart; chronic lesions give rise to a permanent dilatation. M. Potain pointed out the analogy which appears to exist between the mechanism of cardiac dilatations of gastrohepatic origin and that of hypertrophy in Bright's disease. These lesions (except in the case of tricuspid insufficiency) do not give rise to real *bruits de souffle*; but extra-cardiac bruits are often met with. Digitalis in such cases gives bad results. M. Potain concludes that certain dilatations of the right heart are due to gastric and hepatic affections.

M. Gubler said that his experience in this respect enabled him to confirm these views.

From *Le Progrès Médical*.

TREATMENT OF SCROFULOUS ULCERS BY THE SULPHIDE OF CARBON.

Dr. Obissier dresses scrofulous ulcers with a mixture of 16 grammes (240 grains) of sulphide of carbon; 40 grammes (600 grains) of iodine, and 4 drops of essence of peppermint. The addition of the iodine and of the essence of mint to the sulphide of carbon has the advantage of masking the odour, which would render its employment as a dressing impossible. Under the action of the sulphide of carbon, the ulcers heal very rapidly, and Dr. Obissier has already published a large number of observations favourable to this mode of treatment which may be applied to all scrofulides.—*Gaz. Med. Ital.*

From *Le Progrès Médical*.

ON A PERIOD OF ARREST IN THE COURSE OF NASOPHARYNGEAL POLYPI.

BY DR. LOUIS SAMONDÉS.

A discussion, which occurred in 1865 at the *Société de Chirurgie*, attracted the attention of the surgeons to an important peculiarity in the history of nasopharyngeal polypi, viz.: that these tumours, which constitute a disease of adolescence, often present an arrest in their growth when the persons affected by them approach adult age. It is this interesting point that Dr. Samondés, under the inspiration of Prof. Verneuil, has chosen as the subject of his inaugural thesis. He has gathered together a number of observations, which go to prove:—

1st. That if the patient is near adult age there is reason to hope for a period of arrest in the growth of the tumour.

2nd. That an operation practised at this age has large chances of being followed by a definitive success, either from the tumour not being reproduced after a radical ablation, or, the extirpation being only partial, from the remainder of the morbid mass persisting subsequently in a stationary condition and without repullulation.

3rd. That at 18 years the chances of cure are already numerous, and that they increase with the age.

EMPLOYMENT OF PHENICATED COLLODION.

Dr. Karl Frank very highly recommends phenicated collodion (collodion to which 10 p.c. of a solution of carbolic acid has been added), the employment of which has given him excellent results, in wounds, crushings, erysipelas, and burns. He has also successfully employed it in uniting by first intention the 3rd phalanx of the right index finger, which had been torn off by the bite of a horse, and which was suspended from the rest of the finger by a single strip of skin about one millimetre in breadth. In this case the wound was washed with cold carbolized water, the fragments accurately brought together, the finger covered with phenicated collodion, and the whole enveloped in cotton paper. At the end of four days union was complete, but the sensibility of the integuments of the finger only returned little by little.

From *Le Progrès Médical*.

At a meeting of the *Société Médicale des Hôpitaux*, M. Gérin Rose read a note on a work of M. Duhomme, relative to the *differential diagnosis between diabetes and glycosuria*, of which these are the conclusions:—

1st. However efficacious the treatment by privation of feculent and saccharine substances may be in glycosuria, it is altogether powerless in true diabetes, which is, moreover, very rare.

2nd. In diabetics the quantity of sugar undergoes, from day to day, but very slight variations, whilst in glycosuria it may vary *toto caelo*. Such is, according to the author, the pathognomonic sign of glycosuria.

3rd. In diabetes, the volumetric analysis by Fehling's solution is easy and without obscurity, whilst in glycosuria, on the other hand, the reactions are often obscure and difficult to observe. These difficulties in the reactions appear to be due to the presence in larger quantities of creatinic principles in the urine of glycosurics.

M. Gérin-Rose reported, in support of these conclusions, two which he had occasion to observe, and which represented these two opposite types.

From *Le Progrès Médical*.

DERMO-EPIDERMIC GRAFTS.

At the *Soc. de Biol.* on 22nd June, M. Maurel stated that he had had occasion at Guyane to try dermo-epidermic grafts upon the white, yellow, and black races of men. In all this operation had been successful; but on account of the thickness of the dermis it is rather difficult to take a graft in the black. Hetero-grafts (grafts made from one race to another) had given interesting results. Their efficacy for the cure of wounds and ulcers is constant. The pigment disappeared when a graft taken from a black was implanted on a white; the same does not hold for the negro and Hindoo. When both subjects are deeply pigmented the graft remains coloured; and even, by a sort of effect of contiguity, the pigment is reproduced over the wound in a very narrow zone around the graft, beyond that the cicatrix is white, as in fact is always the case in negroes when there has been a large loss of substance.

CAPILLARY TRANSFUSION.—(HEUROT.)

M. Heurot read a communication upon this subject. He uses a Pravaz syringe and a very small quantity of blood. M. Onimus said that almost as good results would be obtained by the injection of water: it is not the quantity of blood injected which is operative, but the circulatory stimulation induced by the injection of a liquid. M. Verneuil thought that transfusion was useless; the blood acted neither by its quality nor quantity; but, as M. Onimus had said, by its stimulant effect as so much liquid, and the injection of a few drops of ether would give as good results. This point, moreover, would be found developed in a thesis recently sustained at the Faculty by a Russian lady (Me. Okounkoff.) M. Cartez, while agreeing with these observations, believes that the effects of ether injections are less durable: he stated that Gaillard Thomas, who has done many transfusions in America, usually employs milk. M. Féréol was astonished at the considerable elevation of the number of globules in one of the cases narrated by M. Heurot (2,080,000 to 2,800,000) and at the rapidity of this increase.—*Le Progrès Médical*.

From *L'Union Médicale*.

A. GLYCEROLE FOR IMPETIGINOUS ECZEMA.

White precipitate	3ss.
Oxide of zinc	ʒj.
Glycerole of starch	ʒviiij.

M.

A mixture designed for the treatment of impetiginous eczema of infants at the breast. Emollient baths. In cases where the eruption is seated on the hairy scalp, the hair should be cut and an india-rubber cap applied during the night, and in the morning the fall of the crusts is easily provoked by bathing with tepid water.—*Archambault*.

From *L'Union Médicale*.

HÆMOSTATIC COLLODION.

Official collodion	100 grammes, (circ ʒiiij.)
Carbolic acid	10 " (ʒijss.)
Tannic acid	5 " gr. lxxv.
Benzoic acid	3 " gr. xlv.

M.

For external use.

From *Lyon Médical*.

WHY IS THE GREAT TOE A PLACE OF ELECTION
IN FIRST ATTACKS OF GOUT?

After meeting the explanation of this fact given by Sydenham Boerhaave and Van Sevieten, viz., the slight vascularity and the exposure to cold and traumatism of this part, the author (Paul Pouzet) narrates the researches of Mr. Barchard. The latter, in the course of the year 1876, having examined the metatarsophalangeal articulation of the great toe in almost all the autopsies at the Bicêtre Asylum, has remarked that a condition of integrity of this articulation is the exception, and that erosion or softening of the cartilage is the rule. This result is besides conformable to Garrod's experience, who, amongst twenty individuals, found only six having the toes in a state of perfect integrity.

From *L'Union Médicale*.

PRURITUS VULVÆ.

Lotions of glycerole of cade are employed by M. Marius Rey in vulvar pruritus: 4 grammes (3i) of oil of cade to 16 of glycerole of starch is the formula he recommends. He makes use at the same time of a tonic treatment, of hipbaths, and of strongly laudanumised emollient injections.

From *Gazette Médicale de Strasbourg*.

GAUTIER (OF GENEVA) ON MEMBRANOUS
DYSMENORRŒA.

1. Dysmenorrhœa is not primitively an endometritis.
2. Dysmenorrhœa is in its nature comparable with ichthyosis of the skin, or of the lingual mucous membrane.
3. The treatment which appears to be indicated in the first place is dilatation or incision of the cervical canal: the success of remedies applied directly to the uterine mucous membrane is dependent upon the permanent enlargement of the orifices of the neck of the uterus.

INFLAMMATION OF THE NASO-PHARYNX.—Iodoform in ethereal solution, applied with a brush, sponge, &c., or mixed with vaseline 5 to 8 grs. to 3i, is said by Mr. Lennox Browne to be the best application.

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 reports of the proceedings of their Associations to the corresponding editor.*

TORONTO, NOVEMBER, 1878.

TO SUBSCRIBERS.

PAY UP!—ACCOUNTS HAVE BEEN
MAILED TO ALL IN ARREARS. WE
HOPE THEY WILL RECEIVE PROMPT
ATTENTION.

THE LATE DR. WORKMAN.

Our obituary column last month contained the announcement of the death of Benjamin Workman, Esq., M.D., which took place at his daughter's residence in Uxbridge, Ont., on the 26th ult.

Dr. Workman, the eldest of a large family whose names stand high on the roll of Canada's honoured ones, was born at Lisburn, Ireland, 4th Nov., 1793. In the spring of 1819 he emigrated to Canada and settled in Montreal, at that time a very small town. Here he opened a school, where he educated many of those who subsequently have taken a very active part in building up the prosperity of our country, among whom may be mentioned Hon. Luther H. Holton and Hon. L. Wallbridge. In 1830 he became a teetotaller and so remained during the remainder of his life, publishing a newspaper for some time advocating the then unpopular doctrine of total abstinence. He was in business as a druggist for many years, took his degree as M.D. in 1852, and practised largely among those whose only pay could be their gratitude. Many a poor, suffering brother and sister have been lifted out of pain and penury by his self-sacrificing exertions. In 1856 he left Montreal and became Assistant Medical Superintendent

to his brother Joseph in the Lunatic Asylum in Toronto, where he remained till 1875, when his increasing infirmities rendered it necessary that he should retire to perfect rest of body and mind.

One of the first Unitarians who visited this country, he remained firm in his theological convictions to the end. He was connected with the Church of the Messiah in this city from its beginning; and the Unitarian congregation of Toronto owes much of its usefulness to his wisdom, earnestness, and untiring energy.

His life, simple and unostentatious, has yet had an influence for good that is beyond our computing; and he goes, full of years and honours, to reap the reward which awaits those who are faithful unto death.—*Montreal paper.*

TRANSACTIONS OF THE CANADA MEDICAL ASSOCIATION, 1878.

The Publication Committee of the Canada Medical Association are anxious to issue immediately a volume of Transactions containing the papers read at the Hamilton meeting. To cover expenses, at least, three hundred subscribers at \$1.50 are required. The Committee earnestly hopes that the profession throughout the country will give their cordial support to this undertaking, believing it to be one deserving the co-operation of every intelligent practitioner.

Intending subscribers will please forward their names at once to the undersigned, as the publication cannot be proceeded with until the requisite number have been obtained.

(Signed,) WILLIAM OSLER, M.D.,
1351 St. Catharine Street, *Chairman.*
Montreal, Oct. 10th.

W. H. Aikins, M.A., son of Dr. W. T. Aikins, was, on October 11th, waited upon by about a hundred of his friends at his father's residence and presented with a suitable address on the occasion of his accepting a position in the Civil Service of the Dominion. Mr. Aikins has pursued the study of medicine for some years, and his popularity amongst his fellow-students is attested by the fact that a very large proportion of the assembly was made up of students of the Toronto Medical School. The party dispersed at a late hour after spending a pleasant evening.

INFANTS' FOOD.

We have received the following letter, in reference to a statement made in the paper on infants' food, which appeared in our October issue. We shall be glad to receive the opinions of the profession on the point in dispute. Dr. J. Lewis Smith of New York, in his work on "Diseases of Infancy and Childhood," says:—

"The shops contain various preparations of food for infants, and most of them have been employed in the institutions of this city, sufficiently to ascertain their effects. The one which has given most satisfaction is known as Nestle's Lacteous Farina, prepared by Henry Nestle, a Swiss chemist. * * * *"

Nestle's food is, however, expensive, and although infants thrive well on it in the cooler months, I am of opinion, from my own observations, that in the hottest weather, when diarrhoeal affections are so prevalent and fatal, it has too laxative an effect."—*J. Lewis Smith*, pages 59 and 60, Edition 1872.

(To the Corresponding Editor of the Canadian Journal of Medical Science.)

DEAR SIR,—We are obliged to you for the copy of the CANADIAN JOURNAL OF MEDICAL SCIENCE, and have read with interest the valuable paper by Dr. A. H. Wright. The reference to Nestle's Food as slightly laxative and not being suitable where there is a tendency to diarrhoea is singularly incorrect, as far as practical experience in this country and Europe is concerned. We send you a pamphlet by Prof. H. Lebert; also, a paper containing testimony of men whose reputation is, we have no doubt, well known to you, and is in direct contradiction to the opinion of Dr. Wright. If you would refer to Vol. 7 of Ziemssen's Cyclopædia of the Practice of Medicine, translated from the German, you will find strong testimony in behalf of Nestle's Food in cases of Sporadic Cholera. We mention these facts, believing you have no other object in view than the furtherance of the truth in reference to this important question of food for infants, and will be glad if you will correct the erroneous impression Dr. Wright may have given in connection with Nestle's Food.

Yours truly,
THOS. LEEING & Co.,
Montreal.

Book Notices.

Annuaire de l'Université Laval pour l'Année Académique 1878-79, Quebec.

Tenth Annual Report of the Toronto Eye and Ear Infirmary, 108 Shuter Street, 1878.

Ecole de Médecine et de Chirurgie de Montreal. Session 1878-79.

Annual Address delivered before the Canada Medical Association, Hamilton, Sept., 1878.
By JOSEPH WORKMAN, M.D., President.

Contributions to the Pathological Anatomy of the Eye. By Dr. ADOLPH ALT, of Toronto. Reprinted from the *Archives of Ophthalmology and Otology*, Vol. VI., Nos. 3 and 4.

Annual Reports of the Supervising Surgeon-General of the Marine Hospital Service of the United States for the fiscal years 1876 and 1877.
JOHN M. WOODWORTH, M.D., Washington, Government Printing Office, 1878.

Playfair's System of Midwifery. Second American, from the second revised London edition. 8vo., pages 639. Philadelphia: Henry C. Lea; Toronto: Hart & Rawlinson.

Of making many books there is no end, and the issue of new editions is a weariness to the pocket, but if all books issuing from the medical press were of the character and value of Playfair's midwifery, we are bound to say the old axiom would lose much of its force. This work bears the same relation to the obstetric literature of to-day, that Tyler Smith's lectures did to that of his time being the best work on the subject now published in the English language. It is written in a clear, pleasant style, without that verbosity which characterizes some modern and highly pretentious works. The author is quite up with the times, both in practice and theory. He adopts exfoliation of the mucous membrane in menstruation, as taught formerly by Tyler Smith, and more recently by John Williams. He approves of the early use of the forceps in delayed labours, and strongly advises the administration of chloral in 15 gr. doses every fifteen minutes till three doses are

given, for the relief of the cutting pains of the first stage. It is the best text-book we have for students, and sufficiently full of detail to supply all the wants of the practitioner. We would gladly see it in the hands of all who practise midwifery.

We notice very few typographical errors, the most important being that in connexion with wood-cut 98, page 264. from Hodge, which represents the head coming through the pelvis in the second position, but erroneously calls it the third.

We have to take exception to the author's account of the expulsion of the placenta when he says "that if it be allowed to come away without traction on the cord, the uterine surface is generally expelled first." We have carefully observed this point since it was noticed by Leishman and Matthews Duncan, and have satisfied ourselves that while it does often come away thus, it also comes away with the fetal surface first in by no means a small proportion of cases, even when no traction whatever has been made on the cord; and we believe that the manner of its expulsion depends quite as much upon the site of its attachment to the uterus as upon the application of force.

We believe, that if the placenta be attached to the uterine surface, in what may be called its central zone, or below it, the mass will be expelled either with the uterine surface in advance, or folded laterally, presenting its edge first, as described by the authors named, but if it be attached to the fundus or above the middle of the uterine wall, it is more apt to come away with the foetal surface first just as if traction had been exerted through the cord; and moreover, we think the adhesion or separation of the membranes on the shortest side between the placental site and the os uteri, as the placenta comes down, determines whether the foetal or uterine surface shall come first.

We fully endorse what the author says in regard to the removal of the ovum in protracted abortion, when he recommends the administration of chloroform and the introduction of the whole hand into the vagina, and the fingers into the uterus. "In this way," he says, "the complete detachment of the ovum can be far more safely and readily effected than by using any of the many ovum forceps which have been invented for the purpose."

Barnes on the Medical and Surgical Diseases of Women. Second American, from the second enlarged and revised London Edition. In one handsome octavo volume of 784 pages. Philadelphia: Henry C. Lea; Toronto: Hart & Rawlinson.

The reputation of the author is such as to warrant the expectation of a work of very high order, and there is no doubt but the volume before us amply sustains the high estimate we have formed of its author. Unlike many other works on the subject, it is useful both to the lecturer and practitioner. The style is pleasing and the typography good. The writer is emphatic in regard to the dangers of intra-uterine injections, and we think he is right. His chapter on gynecological instruments and their use will be found very useful to the young practitioner, but where all is so good it is needless to specify parts.

Dr. Barnes stands at the head of his profession in the old country, and it requires but scant scrutiny of his book to show that it has been sketched by a master. It is plain, practical common sense; shows very deep research without being pedantic; is eminently calculated to inspire enthusiasm without inculcating rashness; points out the dangers to be avoided as well as the success to be achieved in the various operations connected with this branch of medicine; and will do much to smooth the rugged path of the young gynecologist and relieve the perplexity of the man of mature years.

NEW BOOKS IN PRESS.—Mr. Henry C. Lea, of Philadelphia, has in preparation for early publication:—A National Dispensatory, by Stillé & Maisch; Clinical Manual for the Study of Medical Cases, by James Finlayson, M.D., of Glasgow; Principles and Practice of Surgery, by Ashurst, (Second Edition); Principles and Practice of Gynecology, by Emmet; Practice of Surgery, by Bryant, (Second Edition); A System of Human Anatomy, by Harrison Allen and E. O. Shakespeare, of Philadelphia; and a translation of Cornil & Ranvier's Manual of Human Histology, by E. O. Shakespeare, M.D., of Philadelphia.

OBITUARY.—Mr. John Hilton, F.R.S., died last month, aged 74.

Miscellaneous.

TO DESTROY MOTHS IN CARPETS.—Lay a wet sheet or other cloth upon the carpet, and then pass a hot flat iron over it, so as to convert the water into steam, which permeates the carpet beneath and destroys the life of the grub.

PERSONAL.—Dr. Rolph Lesslie, of Toronto, who acted as Surgeon in the Turkish army during the late war, paid a short visit to his friends in Toronto last month. He has returned to Vienna to devote the winter to study. The Sultan of Turkey has conferred the Order of Mejidîé on Dr. Lesslie.

DIAGNOSIS OF DOUBTFUL DISLOCATIONS.—Middeldorpf employs a long slender needle to diagnose doubtful luxations of the shoulder. It is pushed below the acromion towards the glenoid cavity. If dislocation exist it will enter easily and meet with no obstruction till it reaches the glenoid cavity. If there is no luxation it will strike the head or neck of the bone.

REMOVAL OF LOWER PORTION OF LEFT LUNG.—An Indian boy was shot by an arrow between the fifth and sixth ribs, just to the left of the median line. The barbed arrow-head, when withdrawn, carried with it through the orifice quite a large portion of the lung. This (four and a-half inches long, two and three-quarters broad) was ligatured and removed, the stump washed and returned, and the wound sutured. Complete recovery followed.—*Cincinnati Lancet and Clinic.*

LACTOPEPTINE.—Our readers may remember that last winter we published the experience of several physicians quite favourable to the above-named preparation, (Vol. xxxvi. p. 245). Since then we have employed it in several cases of obstinate dyspepsia, and have been gratified, even surprised, at the very excellent results obtained in the great majority of cases. We think it decidedly superior to any form of pepsin, "pure and simple," we have yet exhibited.—*Medical and Surgical Reporter, Philadelphia.*

OPERATION FOR THE CURE OF IRREDUCIBLE LUXATION OF THE SHOULDER.—H. Burckhardt, in a case of dislocation of seven months' standing, made an incision down to the joint, cut the various adhesions, and reduced the luxation. Three months later, the hand could be placed on the opposite shoulder, and behind on the crest of the left ilium. The patient eats and arranges her hair with this hand. Only rotation outwards is minimal.—*Cbl. f. Chir.*, 1878, p. 376.

A NOVEL URINAL.—Dr. Packard, of Philadelphia, has lately attended a lady suffering with a large abscess, where the use of the bed pan for micturition was impossible, and catheterism annoying, when the patient herself suggested the following expedient: She had a large coarse sponge enclosed in an oiled silk bag, and applied to the parts; it absorbed the urine perfectly, kept the bed dry, and contributed greatly to the comfort of the patient. He has since used the plan in other cases, with much satisfaction.

TREATMENT OF COLLES' FRACTURE.—Dr. Pilcher, of Brooklyn, has treated forty-nine cases of Colles' fracture without splints. He bends the hand and wrist sufficiently backward to free the fragments and relax the tense periosteum, then makes slight extension with pressure on the dorsum, concluding with placing the forearm in the normal position. A strip of adhesive plaster is then wound round the wrist as a support—massage and motion of the hand were begun after the third day.—*N. Y. Med. Jour.*

DIALYZED IRON.—Prof. Gowers (*London Practitioner*, July, 1878, p. 1) has, with the aid of the hæmacytometer, counted the red corpuscles of patients before, and at various periods after, taking this preparation. In the first case, an anæmic woman, the red corpuscles rose from 46 to 102 per cent. of the normal, in 34 days. In the second case, an extremely anæmic girl, the red corpuscles, before treatment, amounted to 26 per cent. of the normal, and after taking iron for 63 days to 92 per cent. Under the influence of the catamenia the number fell to 60 per cent., then rose to 70 per cent. The iron

was now discontinued for 28 days, and at the end of that time the number of corpuscles had fallen to 56 per cent. The iron was resumed, and 7 days after the corpuscles amounted to 70 per cent. of the normal.

TREATMENT OF DETACHED RETINA.—Cohnheim has employed the method of drainage by a loup of gold thread passed through the sclerotic and under the retina, in four cases of detached retina, with excellent results. As soon as the retina has become reapplied to the choroid, it becomes capable of perception even after the lapse of three years. But only the sense of space returns, not that of colour. In no case was any inflammation of the eye or impairment of the preexisting amount of vision observed.

VESICAL EPITHELIUM.—M. Livon made, in his own name and in that of M. Cazeneuve, a communication upon the physiology of vesical epithelium. He recalled the theory of Küss and the experiments of Susini, and indicated the experimental processes employed by him and M. Cazeneuve. The experiments were very numerous (more than sixty), and the two experimenters have reached the conclusion that the vesical epithelium absorbs nothing in its normal condition but that absorption may occur when the mucous membrane has been injured.

M. Gubler said he was pleased to observe that the results of experiment coincided with those of clinical observation, and recalled the analogous conclusions of Alling's thesis.

M. Aubert (*de Lyon*), who has been, and is still, engaged upon the subject of absorption by epitheliums, believes that the glandular orifices are the true passages for this absorption, which is consequently absent in permanent epitheliums without glands.—*Le Progrès Médical*.

FATTY EFFUSION INTO THE PLEURA.—Dr. Boegehold, of Berlin, reports a case of pleural effusion in which when tapped the fluid was found to be alkaline, opaque, dark yellow, and inodorous: sp. gr. 1023. On standing for about half an hour there formed on the surface, a thin, yellowish, creamy layer, consisting of fatty granules intermixed with larger fat globules. The patient died. On post-mortem examination

the pleural surface was found to be dotted with gray or yellow prominences of various sizes from a pea to a shilling, their apices flat and ulcerated. The stomach and pancreas were cancerous. In several places near the pleura and lymphatic glands the large cells contained oil globules, and in the gastric tumour the cells had almost wholly undergone fatty degeneration. The pleural ulcerations consisted mainly of granular matter and large cells containing fatty globules, and the fatty granules collected on the pleural fluid must therefore be regarded as the *débris* of broken-down cancer cells.

DO BACTERIA EXIST IN LIVING ANIMALS?

In the able lectures on the Infective Processes of Disease, delivered this year by Dr. Burdon Sanderson as Brown Professor, and published in January in the columns of the *British Medical Journal*, he quoted and appeared to confirm the experiments of Dr. Tiegel, of which he accepted the conclusion, that bacterial germs exist in the interior of the glandular organs of healthy animals during life. The question is one of the highest scientific interest, and of direct application to the principles and practice of antiseptic surgery; since, if wounds are liable to bacterial contamination from within, the basis of antiseptic precautions addressed *ad externam* is very sensibly weakened. Mr. Chiene of Edinburgh and Dr. Ewart of University College have, therefore, repeated Tiegel and Sanderson's experiments *under antiseptic* precautions of a simple kind; the result is to show, both by negative results and by severe test experiments, that in the organs of healthy rabbits, removed immediately after death with antiseptic precautions, no bacteria are found, and that it may fairly be concluded that neither bacteria nor their germs exist in the healthy organs of these animals during life. By way of indicating the relation of their researches to the germ-theory, the authors of the research point out that if neither bacteria nor their germs are contained in the healthy blood, milk, or other secretions (as Professor Lister has proved in his address, published in the *British Medical Journal* of October 6th, 1877); nor in the healthy liver, spleen, kidneys, pancreas, lymphatic and other glands, as the present

researches seem to prove—then there is no possible channel left through which bacteria can reach a wound from within; so that, in order to prevent putrefaction and the evils which follow it, it is only necessary to adopt an antiseptic method which will prevent living bacteria or their germs from entering the wound from without.

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ANTIDOTE TO ARSENIC.—It has been noted by Rouyer that freshly precipitated sesquihydrate of iron, although an antidote for arsenious acid (arsenic of the shops), fails entirely to counteract the action of arseniate of soda or arsenite of potassa (Fowler's solution), but that a mixture of a solution of the sesquichloride of iron and the oxide of magnesium will counteract the effect of these salts, as well as the arsenious acid itself, and hence this mixture is always to be preferred to hydrate in cases of poisoning by arsenic. The officinal solution of the sesquichloride of iron should first be administered, and afterwards the magnesia. In one hour after the administration of the antidote, a cathartic should be given. In all cases acid drinks (such as lemonade) are to be avoided, since the compounds they form are soluble.—*New Remedies.*

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 In the *Maryland Medical Journal* for June, 1878, Dr. Chisholm relates a case of a man who had taken two drachms of morphia at once without any bad effect. A child of eight months regularly took two fluid ounces of Magendie's solution of morphia in the twenty-four hours. These are very remarkable instances of the tolerance of opium following its continued use.

Births, Marriages, and Deaths.

MARRIAGES.

At Walkerton, on Oct. 3rd, J. J. Cassidy, M.D. Toronto, to Appie A., daughter of Anthony Mesner of Walkerton, Ont.

At Trinity Church, Gouverner, N. Y., on September 19th, Edgar H. Merrick, M.D., of Gananoque, to Sarah Elizabeth, daughter of the late Thomas Carpenter.

DEATH.

At Uxbridge, on October 15, Katharine Penelope, wife of Dr. Nation.