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Original Communications.

TONSILLOTOMY AND ITS COMPLICATION BY HÆMORRHAGE.

DR. N. A. POWELL, EDGAR, ONT.

(Read at the Meeting of the Ontario Medical Association.)

A three-fold purpose has induced me to present, at this meeting, certain points regarding tonsillotomy and one of its occasional complications. To give you in brief a history of the case which first directed my attention to this subject, to bring out in discussion some of the experience at present stowed away in the gray matter of the cerebral convolutions of the members of this association, and with such help to reach sound conclusions as to what the treatment of the complication in question should be, have been the objects which I have had in view in the preparation of this paper.

At the last meeting of the American Laryngological Association, its secretary, Dr. George M. Lefferts, of New York, discussed "The Question of Hæmorrhage after Tonsillotomy," and classified its frequency and severity thus:—

- 1st. A fatal hæmorrhage is very rare.
- 2nd. A dangerous hæmorrhage may occur.
- 3rd. A serious one, serious as regards both possible, immediate, and remote results, is not very unusual, and
- 4th. A moderate one requiring direct pressure, and strong astringents to check it is commonly met with.

Of the first or fatal class, the reader had not been unfortunate enough to meet with an example.

Other surgeons have, however, placed on record a small number of cases fatal from

hæmorrhage following the excision of the pharyngeal tonsils, while a much larger number of deaths have been caused by the loss of blood succeeding operative procedures, other than amputations, in the tonsillar region.

Coming within the *second* class, two cases have occurred in the practice of Dr. Lefferts from a total of about 500 operations. Both are recorded in his paper. The history of the first I shall read to you since I am able from the standpoint of the patient to add to it somewhat.

In the fall of 1874, while attending at Demilt Dispensary, the throat-clinic, held on alternate days by Drs. Lefferts and McBurney, I requested the former to remove my tonsils, as they were subject to recurrent attacks of follicular inflammation.

I give you in his language what then occurred.

"I amputated both excessively hypertrophied tonsils with the tonsil bistoury. My incisions, I may say here, were made with care, and were such as I had made many times before, in other instances. A few moments after the operation, an inspection of the throat having shown no excessive bleeding, I left the dispensary where the operation had been performed, and my patient, who was using an ice-water gargle. I did not see him again for several hours, and then found him almost exsanguinated and pulseless. Profuse bleeding commenced almost immediately upon my departure, occurring very suddenly. The flow was so rapid that the patient could not clear his mouth of it. Blood passed into the stomach, giving rise to repeated attacks of vomiting, and into the larynx, causing strangulation. As described to me, his con-

dition was for a time a dangerous one. All the resources at hand at the moment that suggested themselves to the doctors present, except pressure, were tried without avail. The hæmorrhage persisted. I was sent for but not found, and finally my colleague, Dr. McBurney, fortunately reached the case some three hours after the commencement of the bleeding. He at once did what should have been done before, cleared all blood clot out of pharynx, differentiated the source of the hæmorrhage, and applied direct pressure over the spot on the right side from whence it was found to come. In a short time it had ceased. I arrived later, and found my patient stretched upon a bench, as I have said, white, bloodless, and almost pulseless. After an anxious night spent with him where he lay, he was carried in the morning to his home, and slowly convalesced during the following month. There was at no time a recurrence of the bleeding."

In the removal of the right tonsil, the one which gave rise to the trouble afterwards, Dr. Lefferts was assisted by a surgeon who happened to be present. This latter gentleman held the vulsellum forceps in order to free Dr. L's right hand for the use of the bistoury.

I noticed that as the section was made strong traction was also made upon the tonsil, and this must have placed on the stretch the tissue last divided, which was the lower part of the gland. In this part lay the artery—probably the tonsillar branch of the ascending pharyngeal—from which the subsequent bleeding occurred. Its mouth opened deeply in the sulcus, between the tongue and the stump of the tonsil, and it was so obliquely divided that the contraction and retraction by which natural hæmostasis is effected could not take place. Possibly this vessel was enlarged at the expense of the others supplying the gland, possibly also the indurated tissue through which it ran prevented its closure.

About half-an-hour after Dr. Lefferts' hurried departure to fill his next engagement, the bleeding became very free. I then asked some of the physicians from other departments of the dispensary to look at the wound. They did so and one prepared for me a tannic acid gargle as advised by Mackenzie, while another im-

mediately after its use applied to the part a solution of the persulphate of iron with a brush.

Between them they filled the fauces and pharynx with ink, manufactured on the spot, a third gentleman then began giving me 10 grain doses of quinine, while another spoke rather indefinitely of the hypodermic use of ergotine or the ligation of the carotid. The fifth could only offer his regrets that he had to leave at once, as he "wanted to wait and see Lefferts stop this." These gentlemen were all educated and skilled physicians in their own specialties, and all but the last seemed anxious to be of service, but none of them remembered the simple surgical fact that direct pressure on the mouth of any bleeding vessel will control the loss till other and more permanent means of checking it may be adopted. The flow being rapid, I became faint and exsanguinated in a short time, and in the opinion of those better able than myself just then to form a correct opinion, I could not have survived another hour without the help which Dr. McBurney afforded. It was estimated by several gentlemen present that the loss of blood amounted to between six and seven pints. If either my friends, the throat specialists, or a good practical surgeon had been present, when it began, it would not probably have reached as many ounces, nor would the general condition have become a dangerous one.

Since that time I have frequently had occasion to perform tonsillotomy, and have met with nothing more unsatisfactory afterwards than the loss of an occasional fee for so doing. I have knowledge, however, of nine cases besides my own in which a fatal result was all but reached. One of these occurred in the practice of an old fellow-student of mine who now fills a chair in a western college. In this case the doctor left a student to watch his patient and was recalled in haste two hours later. He found it necessary to apply pressure with a sponge on a holder for many hours, and has stated that without the recollection of my experience and treatment to guide him he would have been at a loss to know what to do.

From the statistics which I have at hand, based chiefly on the practices of leading sur-

geous, I am disposed to think that a dangerous degree of hæmorrhage occurs in about one per cent. of all tonsillotomies. If with proper after treatment it is thus frequent, may we not consider its risks to be greater in connection with that slap-dash and happy-go-lucky surgery with which even in Ontario we are not altogether unacquainted. We know how often some physicians meet with post-partum hæmorrhage and are apt to connect this frequency with a fault or careless treatment of the third stage of labor. That obstetrician will see least of it, probably, who has its dangers and its prevention most constantly in his mind. The same reasoning will apply to this form of hæmorrhage. With the conviction that the liability to hæmorrhage from the stump of an amputated tonsil will be lessened by the right performance of the operation that may cause it, I submit without argument the following conclusions for your approval or amendment:—

The surgeon who proposes to remove a tonsil should have at hand a strong and perfectly manageable light, such as is obtained from a student's lamp and a forehead protector of four inch diameter and short focus.

He should not be dependent upon the kitchen cupboard for a part of his armament, but should have a good tongue depressor, and this is almost the same as saying that he should have Turke's model, as for any operation on the back of the throat it is the only good one.

He should use the tonsillotome preferably for children, and especially if ether be not given. If the part to be removed be prominent he should use this instrument for adults also, and should prefer Mackenzie's or Hamilton's models, which cut by propulsion, to any of the forms in which a sickle-shaped knife makes the section as it is being retracted.

He should use the vulsellum forceps or double-hook and probe-pointed bistoury for all cases in which the gland is sessile, or in which a particular portion of it is to be excised. In operating he should stand before the patient, seize the left tonsil and cut from above downwards, so as to remove all that projects beyond the anterior pillar of the fauces. Then standing behind the patient he should remove to the

same degree the right gland by cutting from below upwards.

Bearing in mind the manifold risks of operating on even small inflamed parts, he should select a period of quiescence for the amputation, the exceptions to this rule being: first, that class of cases in which the gland is very small and flat between the catarrhal attacks upon its secreting surface; and second, the rare condition of actual danger to life from combined hypertrophy and inflammation.

The surgeon after a tonsillotomy should not lose sight of his patient for several hours but should make frequent and careful inspection of the throat. He should remember that, especially in children, blood may pass into the stomach and give no external sign till blanching of the face or faintness shows its loss. Should this examination reveal actual hæmorrhage in unsafe amount he should resort at once to direct pressure, either with the finger or a sponge on a firm holder. After this has been some time applied he should examine for bleeding points, and if found, they should be caught and twisted.

Cold, in the form of ice-water or ice in substance, may be made use of, but it is better to avoid the application of the styptic preparations of iron or other astringents. In the rare event of pressure, torsion, and cold being, when properly applied, insufficient, the ligating of the external carotid artery, and this also failing, of the common trunk may be taken into consideration.

CASE OF LOCOMOTOR ATAXIA, WHERE RIGHT SCIATIC WAS STRETCHED FOR RELIEF OF "LIGHTNING PAINS."

BY J. STEWART, M.D., BRUCEFIELD.

Read before the Ontario Medical Association, May, 1882.

M. Shea, aged 43, when first seen in Sept. of 1881, complained of shooting pains in his legs, thighs, and lower part of the abdomen. He also complained of an inability to walk in the dark, and giddiness. The pains made their first appearance twelve years ago, while he was engaged in working in the lumber woods of Wisconsin. His occupation was that of a driver, and he was compelled to sit for hours on

the cold logs, and it is to cold, contracted in this way, that he attributes his present trouble. For several years the pains only recurred at long intervals; but lately he is seldom—rarely more than 24 hours—free from them. They have also greatly increased in severity during the last two years, and especially during the last few months. He first noticed that he was apt to stumble in the dark, five years ago. The ataxia has steadily increased during this period. For several months it has been so pronounced that he has been unable to perform his usual work. With the exception of gonorrhoea, he never had any illness. He is certain that he never had syphilis.

Family history is good. He says he never ate or drank to excess.

State on the 1st of Oct., 1881, being two weeks prior to the stretching of the right sciatic nerve.

The lightning-like pains with which he is afflicted recur very frequently; the longest interval of freedom from them during the last year has been only five days. They generally affect the lower extremities. It is but seldom that he complains of pain elsewhere, and then only in the left arm. The pains are of extreme severity, but only of momentary duration. They generally last 24 hours, and during that time are nearly always confined to a small spot. A favourite situation for them is the dorsum of the right foot. When they last for twenty-four hours it is always noticed that the limb which has been their seat has atrophied. Repeated measurements have shown a diminution of half an inch in the circumference of the limb. He is very slow to appreciate painful sensations when applied to the two lower and left upper extremities. In the feet there is an interval of about six seconds before he is able to feel a severe pinch or the prod of a needle. In the legs this interval is five, and in the thigh eight seconds. He feels the simple rubbing of the hairs on his legs much more readily than a severe pinch of the skin. He is able to distinguish, although slowly, the difference between a hot and a cold application, when applied to his lower extremities. With his eyes shut he is unable to touch the point of his nose with either hand, nor is he able to point out the position of his feet. His sight is good, although there is

commencing atrophy of both discs. The pupils react slowly to light, but readily when the eyes are accommodating. There is no myosis or paralysis of any ocular muscle. He is able to distinguish colours. His hearing, taste, and smell are all normal.

He complains greatly of numbness of both lower extremities, and of a very disagreeable sensation, as if the skin were too tight for his legs. When walking he has to keep his eyes on his feet or he would fall, and he feels as if he were treading on some soft substance. There is loss of sensation in the thumb, index, and middle finger of the left hand. He is able to retain his urine without causing him the least inconvenience for over twenty-four hours. To empty his bladder he has to strain very much. He is troubled with obstinate constipation. He says he often feels as if a weight of one hundred pounds was compressing his waist. When standing or walking he complains of what he calls a cramp-like condition of the muscles of the lower part of the abdomen. The patellar tendon reflex is absent on each side. There is no ankle clonus or plantar reflex. The cremasteric and epigastric reflexes are absent. When walking, his knees often give away suddenly under him. He says that for this reason he avoids as much as possible walking on the streets. He has the characteristic gait of an ataxic. He is unable to walk or stand with his eyes shut. Intelligence and memory are not affected. Lately he has been at times melancholy, at other times he is in the best of spirits.

On the 14th of October the right sciatic was stretched. The right was chosen on account of the pain being generally more severe in that limb. The night following the operation the pains set in on the outer side of the right knee, and were severer than they ever had been. The following day they left, and did not reappear for three weeks. This was the longest interval of freedom from the pains since they first commenced, twelve years previously. It is now about eight months since the operation was performed, a period sufficiently long to judge what, if any, influence the stretching has exercised on the disease or its symptoms. The results may be summed up as follows:—

(1.) *On the pain.* The result on the whole has been very satisfactory. Previously he suffered nearly one-fourth of the whole time from the pains, which were of an agonizing character. Now he seldom has attacks oftener than once every three weeks, and he has been as long as six weeks free. Before the operation the pains set in suddenly, with great severity, and left just as suddenly. Since its performance they come on by degrees, increase up to a certain pitch, then decline slowly. During the wave of ascent the intervals become shorter and shorter, and during the wave of descent they become longer and longer, until finally they cease altogether.

(2.) *On the patellar reflex.* Previous to the stretching there was absolutely no response, but since there has been an appreciable jerk when the tendon is struck. It is, however, very late in making its appearance, there is often an interval of two seconds between the tap and the response. According to Eulenburg* the interval should only be the $\frac{1}{3}$ of a second. This he found to be the interval in the examination of 80 healthy male adults.

(3.) *On the delayed sensation.* Prior to the operation it took him from five to eight seconds to feel the stab of a needle in either lower extremity. He can readily appreciate now, and has since the stretching, a similar irritation in from one to two seconds.

(4.) *On the muscular sense.* Up to the time of operating, it was with the greatest difficulty, and then only after repeated trials that he could touch his nose or point to the position of his toes when his eyes were shut. He can readily perform these acts now.

(5.) *On the ataxia, etc.* The operation did not exercise the least beneficial influence over the ataxic symptoms. Neither was there any favourable change made over either the bladder or rectum symptoms. The ataxia has been steadily progressive. The sense of weight around the lower part of the abdomen is as great as ever.

A very interesting symptom occurred six

days after the stretching, viz.: a very extensive hæmorrhage from the wound and into the subcutaneous tissue of the limb operated on. The bleeding was copious enough to saturate all the antiseptic dressings, and even find its way through the bed.

This was likely the result of the pains which set in a few hours after the operation, and lasted with great severity for nearly twenty-four hours. This is a more probable explanation than that the result was from any injury sustained by the vessels from the stretching. Straus* reports several cases of extensive subcutaneous hæmorrhages following the pains of ataxia.

These ecchymoses are probably induced by direct irritation of the vaso-dilator fibres. It has been shown, both by Brown-Séquard, and Stricker, that the posterior roots contain vaso-dilating fibres. If this view is correct, then the ecchymoses and the lightning pains are caused by the same morbid process.

SOME POINTS OF GENERAL INTEREST IN OPHTHALMOLOGY.

(Paper read at Meeting of Toronto Medical Society,
May 18th, 1882.)

BY R. A. REEVE, B.A., M.D.,

Lecturer on Diseases of the Eye and Ear in Toronto
School of Medicine; Oculist and Aurist to
Toronto General Hospital.

(Concluded from page 221.)

CATARACT.

Idiopathic cataract is characterized by a gradual, painless failure of sight, the lens becoming opaque in a seemingly healthy eye. Some degree of irritability may be felt but the external signs of inflammation are wanting; and the pupil retains its normal size and activity, presenting, however, as the process advances, a more and more marked gray or milky background. There is a physiological haziness of the lens in old subjects, and also a gray pupillary reflex in some diseases of the fundus oculi and vitreous. A hasty diagnosis should, therefore, not be made, but a routine method followed, even in most of the cases which seem beyond doubt. The history should of course

* Ueber die Latenzdauer und den pseudoreflexorischen charakter der schenphenomene. Nemg. Centl. No. 1.

* Archives de Neurologie, No. 4, 1881.

be got, and the state of the eye as to tension,* sight, and visual field† learned; oblique illumination‡ should be practised; and the ophthalmoscope should be used, because one can sometimes get a view of the fundus through a lens which seems opaque, and upon the mirror we may have to depend in deciding that the dimness of vision is due, not to lenticular opacity, but to morbid changes in the vitreous, retina etc., which would invalidate an operation. In a small percentage of subjects beyond the prime there is a preliminary swelling of the lens, so that the eye becomes myopic and reading glasses can be dispensed with,—the so-called ‘second sight,’ which, however, in due course, gives place to the fogginess and gloom of confirmed cataract. Some seem to think a cataractous eye should be quite blind, but even when simple cataract is mature, one can discern the position of windows and of artificial lights, and the motion of fingers or other objects between the eye and the light, as the natural eye can through frosted glass. Inability to do this generally contra-indicates an operation. I have known a lens to be removed from a sightless ball and then the dread alternative presented of enucleation or possible loss of the second eye from sympathetic inflammation; and, again, a cataract to be extracted from a hopelessly diseased organ, and at the same sitting the clear lens of the fellow eye also taken out, the gray pupillary reflex in the latter case being really due to deep-seated changes.

Cataract often develops without apparent cause, and this is a common experience. It may be secondary to glaucoma, disease of choroid, diabetes, etc., or due to a jostling of the lens in its fossa or its luxation from concus-

* The tension is tested by gentle palpation with the tips of the index fingers placed upon the upper lid, the eye being closed and the patient looking downwards. The globe should dimple under very slight pressure.

† A lighted match or taper is moved to and fro, up and down etc., the eye looking straight forward, and should be seen over the normal field or area. Blank portions or marked contractions point to deep-seated disease.

‡ Light, generally artificial, is thrown obliquely into the pupil by means of a strong convex lens. The peripheral striæ, small opacities or central haziness of incipient cataract are thus revealed, and more marked lens changes well displayed.

sion of the eyeball. There is often an hereditary tendency to cataract, and in many cases it seems fairly attributable to excessive use of the eyes. The lens substance also becomes opaque when the aqueous humor has direct access to it through a puncture or rent of the capsule, as by a foreign body, instrument, or blow; and, again, where the iris is largely adherent to the lens capsule, owing to neglected iritis, secondary opacity of the lens is apt to supervene.

Idiopathic cataract is generally double, and formerly it was the practice not to operate for hard cataract until the second eye became blind. It is now held that the prolonged anxiety and enforced physical inactivity caused by such delay militate against the success of the operation, and, therefore, extraction of the cataract first mature is often done while the other is yet immature.*

Advanced age is no bar to the operation if there be a fair degree of vitality. Those who are inordinately fat or are prone to marasmus, and the victims of dyspepsia or alcoholism are not good subjects for extraction. The old “flap” operation, done with a broad triangular knife, is very largely supplanted by some modification of the “modified linear” or “peripheral linear” method, the characteristics of which are, the use of a narrow or linear knife, a curvilinear section across the summit (or bottom) of the cornea, and excision of a segment of iris. It has also the advantage of entailing a much shorter confinement to bed, thirty-six or forty-eight hours generally sufficing; and of a wider range of applicability, in regard to the maturity of the cataract and the age and degree of vitality of the patient. In the treatment of *soft* cataract, namely that ensuing up to the age of thirty or thirty-five, by the ordinary method of needling, dissection, or solution, advantage is taken of the fact that the aqueous humour will attack and dissolve the lens sub-

* Peripheral capsulotomy, the opening of the capsule near the margin of the lens, contiguous to the corneal section, enables us to operate with comparative impunity on immature cataracts, a practice which I have followed with advantage in some instances. The rule still holds, however, that it is better to wait until the cataract is ripe, *i.e.*, until the lens is opaque up to the plane of the iris, and the patient unable, or barely able, to count fingers.

stance when allowed direct access to it. The needle is entered through the cornea, not, as formerly, through the sclerotic; hence the term keratonyxis. Instead of resorting to repeated needling during the three or six months required to effect absorption of the lens, *linear* extraction is sometimes adopted as an expeditious and comparatively safe substitute, the lens substance, rendered flocculent and diffuent by maceration for a few days in the aqueous after a free needling, being gently extruded through a short corneal incision. Suction by means of careful aspiration through a tube or by the use of a syringe is sometimes practised, instead of evacuation by pressure and use of the curette. But it is better to make haste slowly in many of these cases, simple needling being the safest procedure. As already explained, lesion of the capsule or disturbance of nutrition by violence is followed by more or less diffuse opacity of the lens, and, therefore, *traumatic* cataract is a not uncommon condition. In such cases it is important to secure the maximum dilatation of the pupil at the earliest moment and keep it up by the use of a strong mydriatic, as sol. atropiæ sulph. gr 4-8 ad $\bar{3}$ aq. Cold or ice water dressings may be required, and they often do good service, during the first few days. In traumatic cataract an operation may be unnecessary, absorption of the lens quietly taking place, but in older subjects extraction may be required, and in younger linear extraction may be done. The latter or a paracentesis is imperative if the eye becomes hard (glaucomatous) or very irritable owing to rapid swelling of the lens, etc. Not unfrequently the posterior capsule becomes gauze-like or partly opaque after extraction, and more decidedly so after iritis,—so-called secondary cataract. Supplementary needling is then required, or a resort to iridotomy,—the division of pupillary membranes and iris by means of a delicate pair of scissors entered through an incision in the cornea. Very strong convex lenses have to be worn after extraction, and with these the final visual result is pretty satisfactory in about 85 per cent. of the cases; ability to read ordinary print being recovered in about 75 per cent.; and sight enough to go about alone in 90 per cent.

GLAUCOMA.

The chief characteristic of this interesting morbid condition is increased tension or plumpness of the eyeball, which, when in any marked degree, can be readily recognized by palpation. It is to be feared many eyes are allowed to become hopelessly spoiled for lack of this simple procedure, which is too little practised. Primary glaucoma may be of inflammatory or non-inflammatory form, and the glaucomatous state is also secondary to other diseases, as keratitis, staphyloma, dislocated lens, tumour, hæmorrhagic retinitis, &c. Idiopathically, it generally occurs in subjects over forty-five years, and mostly in females. Dyspepsia seems to predispose to it, and an inflammatory attack is sometimes lighted up by great fatigue, anxiety, or shock. Occasionally, it occurs in young subjects by virtue of heredity, and, now and then, the instillation of atropine acts as an exciting cause in older persons.*

Simple, chronic, or non-inflammatory glaucoma is insidious in its progress, and the globe may have become tense, the visual field contracted to a very small area, only central vision and that defective being retained, and the optic disc atrophied and sunken from pressure, the eye meanwhile looking healthy and the subject only aroused to the active condition by the second eye following suit,—a calamity that generally occurs: vision fails more and more, sometimes with, often without, intercurrent inflammation, the pupil is fixed and generally dilated, the lens possibly cataractous, the globe becomes distinctly hard, and, finally, the sight extinct. (G. absolutum.)

In the *acute, inflammatory* form the symptoms are indicative of actual mischief—intense pain, œdema of lids, turgescence and hardness of the globe, steamy cornea, dilated fixed pupil, and blindness. Often there is sympathetic vomiting, and sometimes the diagnosis of a "bilious attack" has been made. Spontaneous partial recovery may occur, but relapses ensue and the eye is lost, and ulti-

* For a number of years it has been the writer's practice not to use atropine for ophthalmoscopic cases. At any rate, strong solutions are unnecessary and needlessly unpleasant, a very weak solution, gr. $\frac{1}{2}$, $\frac{1}{4}$ ad. $\bar{3}$ j. aq. generally sufficing.

mately the other one too, unless there be timely interference. There is generally a "premonitory" stage of several months duration, a prominent subjective symptom being the observance of coloured rings as of rainbow hues when looking at an artificial light, associated with transient fogginess.

The etiology of glaucoma is engaging much attention, and the following are the main factors and features of this morbid process: Increased tension is, with hardly an exception, considered the essential fact of the disease, though in the G. simplex optic nerve atrophy plays an important rôle and the treatment directed to tension is sometimes only of partial benefit or useless; undue rigidity of the sclera; serous choroiditis and intraocular hypersecretion of possible neurotic origin; defective excretion or escape of fluids by virtue of narrowing of the space between the lens margin and the ciliary processes by swelling of one or other, and also contact or union of the peripheral part of the iris and sclero-corneal junction, impeding or closing the avenues to the important venous canal there; atrophy of the ciliary muscle, etc. A pathological condition of some interest is the recession of the face of the optic nerve towards the lamina cribrosa as the result of pressure, producing what is termed pressure-excavation or cupping, a characteristic feature of confirmed glaucoma readily recognizable with the ophthalmoscope. The field of vision is also affected after a manner sufficiently common to be considered characteristic, inability to see objects on the *nasal* side being first noticed, and then above and below, and so on until only a central sensitive point or islet remains.*

Iridectomy was for years the only radical treatment of glaucoma,—“curing” as if by magic the inflammatory form and arresting most of the simple chronic cases. Its record is a brilliant one: it has saved myriads of eyes and averted an incalculable amount of suffering. To be most effective it should be done promptly in the inflammatory variety, and before the

field of vision is very much curtailed in the non-inflammatory.

Sclerotomy, in which a carefully-executed incision by means of a narrow knife, is made in the sclero-corneal junction without removal of any iris, is now being practised in lieu of iridectomy proper for the relief of tension, notably in the later stages of non-inflammatory glaucoma; on the supposition that the escape of intra-ocular fluids by means of filtration through the cicatrix contiguous to the important venous and lymph channels of that region, is the real remedial process, and excision of iris largely superfluous. The place to be filled by it is not fully determined. *Eserin* is of great value in inflammatory glaucoma, repeated instillations (of eserin sulph. grs. iv.—vii. ad. ʒj. aq.) at short intervals causing generally marked reduction of tension and abatement of symptoms. In some instances acute attacks and also milder sub-acute seizures are tided over by its use alone, and in others the eye is saved from irretrievable damage until an iridectomy can be done. It is sometimes of service in chronic glaucoma, though occasionally injurious. Its value in arresting staphyloma and averting secondary glaucoma, &c., in extensive ulceration of cornea has been already noticed.

Simple chronic glaucoma is sometimes confounded with cataract because the lens seems hazy and the sight is somewhat impaired, the eye appearing healthy, and also because when it is fully confirmed the lens is often cataractous. But, as already noted, in idiopathic cataract the eye is of normal tension, the pupil active, and the visual field unaffected. Cataract with dilated pupil generally means glaucoma, and if the eye be not hard it is likely quite blind from some other disease. In very young subjects we sometimes find the pupil dilated and the eye more or less hard, and a creamy reflex from the depths of the eye, but the primal mischief is glioma of the retina, which is itself sometimes mistaken for cataract though the lens is generally clear. Inflammatory glaucoma is distinguished from iritis by the hardness of the globe, suddenness of onset, and of loss of sight, and dilatation of the pupil. In iritis, excepting the rare serous form, the eye is of normal tension and the pupil contracted.

* In testing, one eye should be closed and the other directed straight forward. One's hand or a white watch dial makes a good test object. If cataract be present an artificial light is needed.

INJURIES.

The eye has wonderful reparative powers, and will bear a deal of damage of a certain kind. There is one part of it, however, which is very intolerant of injury, namely, the ciliary region, corresponding to a circum-corneal zone of about 5 mm. in width; and a small, penetrating wound there may set up serious inflammation (cyclitis, irido-choroiditis, etc.), with loss of the eye, and, finally, of its fellow. Cases where the ciliary body is involved, which fully recover, may be considered exceptional. The entangling of the iris in corneal wounds or incisions, causing much traction upon its tissue or irritation of the ciliary nerves, is a source of danger not to be despised. Happily, we are now armed with a valuable remedy, eserine, the instillation of which done early in strong solutions (grs. 2—4 ad. ℥j. aq.), by virtue of its powerful myotic properties draws the iris out of the lips of peripheral wounds, or materially lessens its involvement. In cases of prolapse of the iris, if seen at once, the "hernia" can sometimes be reduced by means of a slender, blunt probe, carefully handled, and if this attempt or the vigorous use of eserine does not avail, it is advisable in many cases to excise the knuckle in the wound, or if a cystoid cicatrix should have formed, to split it open and attempt removal of the part involved, or do an iridectomy. In more or less central corneal wounds, especially with injury to the lens, atropine, not eserine, is indicated. Traumatic cataract has been already referred to, but it should be noted that in cases of violence to the eyeball without apparent damage, the prognosis should be somewhat guarded in view of the possible development of cataract, or of detachment of the retina, which is a not infrequent result. Rupture of the choroid may also occur. (I have seen one instance of the almost unique rupture of the retina without external lesion). Not infrequently a good recovery follows a moderate extravasation of blood from traumatism, either spontaneously or under treatment by rest, ice-water dressings, atropine, local depletion etc.; but a copious intra-ocular hæmorrhage puts the eye in a critical state because inflammatory and other changes are likely to supervene. A foreign body on the

iris should be removed without delay through a corneal incision, excision of the underlying iris tissue being often necessary, but if it be a metallic particle and capable of responding, the use of a magnet would likely suffice,—a large one being held close to the corneal wound or cut, or else a probe-point attachment passed within the anterior chamber. This expedient might also effect removal from the region of the lens as well as the anterior part of the vitreous. A foreign body in the vitreous chamber can not unfrequently be seen with the ophthalmoscope or its pathway traced; and even when the vitreous has become hazy and the lens more or less opaque, the presence and position of the intruder may sometimes be determined by testing the field of vision with a lighted taper; a blank or blind spot gives a fairly reliable indication. And again, the holding of a large magnet close to an eye containing a metallic substance capable of responding, will cause pain (by motion) in the globe if encapsulation by lymph etc., have not occurred. The lighting up of severe inflammation after a quiescent period or interval of some days following recovery from the immediate effects of injury, points strongly to the presence of a foreign body; and if a fair trial of the usual antiphlogistic treatment by rest, atropine, cold water dressings, local depletion etc., should fail, and the case go on from bad to worse, the enucleation of the eye is pretty clearly indicated. Some lesions condemn an eye at once to extirpation, e.g., extensive rupture involving the ciliary region even without the presence of a foreign body, and, sooner or later, this is generally its fate; also when a foreign body, even a tiny one, is lodged in the vitreous chamber; for successful removal or tolerance with preservation of a useful organ is the exception. The use of magnets for the extraction of metallic substances will increase the number of recoveries.

SYMPATHETIC OPHTHALMIA.

The subject of injuries naturally leads to that of sympathetic ophthalmia, though it should not be forgotten that the latter is not always due to traumatism. Although its exact etiology is not fully known, sympathetic ophthalmia is a dread reality, and its chapter is a painfully interesting one. There are two

broad classes of lesion which may entail mischief in the fellow eye, namely, A. wounds, especially those involving the ciliary region or "dangerous zone;" and the presence of foreign bodies; B. Inflammatory, degenerative and other changes, which may or may not be due to original injury. Even a neglected iritis with closed pupil and consecutive changes may excite it. It may develop as early as two weeks, (or even less) after the primary lesion, but even in young subjects, who are the most susceptible, not generally sooner than four to six weeks; and months or years frequently elapse, the offending member being possibly partly atrophied and in a state of chronic or recurrent inflammation (irido-choroiditis), with tenderness in some part of the ciliary region representing pressure and enforcing care in washing the face, &c. The sympathetic trouble may be confined to a group of symptoms termed sympathetic *irritation*, with more or less photophobia, lachrymation, asthenopia or "weakness," and transient foginess. This condition may persist for a good while without organic changes, but its occurrence should prove a warning to both patient and practitioner. S. *inflammation* is generally a plastic iritis or irido-choroiditis, insidious, and often painless in its onset, protracted and prone to relapses, almost intractable, and as a rule ending in closed pupil, with degenerated iris glued to lens capsule, hazy or cataractous lens, with also vitreous and retino-choroidal changes; truly, a rather hopeless state of things. It is superfluous to say that the great point is prevention, by a timely enucleation. Once established, the removal of the primarily affected eye, though that may be indicated, will not arrest it or undo the mischief. It is easier to remove an eye than sometimes to take the responsibility of sacrificing it, but the opinion of some, that when sympathetic inflammation has been actually set up it is useless, nay, may be positively injurious to extirpate, should not be unduly magnified, nor should it afford any ground for neglecting to advise enucleation as a prophylactic measure. Some authorities decline to extirpate an eye which is suppurating, fearing secondary meningitis, &c., but in my own experience, covering a number of cases, there has been no mishap, the only special precaution

being the free application of saturated solution of boracic acid by means of the sponges or absorbent cotton to the eye and parts during the operation and as a dressing (iced), with borated vaseline, for a few days afterwards.

LACHRYMAL AFFECTIONS.

By the very nature of the case derangement of the lachrymal apparatus may cause untold annoyance; and as epiphora is very common, it is well that there are few cases which cannot be materially relieved. Chronic conjunctivitis and coryza, which should be always looked for and attended to; inversion or eversion of the puncta; mucocele, which in turn depends on stricture of the nasal duct—these are the usual causes. The modern method of treating stricture by slitting the canaliculi and systematic probing, and, perhaps, the temporary wearing of a stylet, has proved a great advance upon the old line of treatment, though yet giving a smaller percentage of permanently satisfactory results than the surgery of cataract; one explanation being the fact that the lachrymal duct is a bony canal with muco-periosteal lining. Mucocele, or chronic inflammation of lachrymal sac (chronic dacryocystitis), is easily recognized by the touch if not by the eye, presenting a small doughy swelling at the inner canthus, pressure upon which causes regurgitation of glairy mucus or muco-pus into the conjunctival sac, or, rarely, forces it into the nose. Mucocele demands attention because, if neglected, slight exciting causes may light up acute inflammation, ending in fistula with its added annoyance and disfigurement. Merely opening the canaliculi into the sac, so that the latter can be emptied by pressure several times a day, instillations or injections of boracic acid and zinc being then used, will generally give marked relief and also prevent an acute attack; and the same course in cases of fistula will be followed by speedy healing of the sinus and contraction of the sac (unless there be bone disease), though radical treatment requires relief of the stricture. The most troublesome epiphora may arise without mucocele, stricture, or mal-position of the puncta, from a tightening or stricture of the tiny sphincter at the inner end of the canaliculi. Dilatation, or division by a fine probe-pointed knife gives marked,

if not perfect, relief, but is a little feat sometimes more difficult of execution than may seem. Acute inflammation of the lachrymalsac is sometimes diagnosed erysipelas, owing to the extensive inflammatory œdema of the surrounding parts, involving the cheek and even the lids of the opposite side; but the less rapid onset, and the history, generally to be had, of a previous epiphora and mucocele, and the fact that pressure on the sac gives acute pain and reveals a tense tumour-like swelling will make the differential diagnosis easy. A prompt opening of the canaliculi into the sac will generally abort the inflammation and give vent to the inflammatory products, and later on probing can be instituted. A number of cases of mucocele or fistula have occurred to me in infants, requiring operative treatment, and as a rule resulting well. It should be added that chronic conjunctivitis with slight eversion or atresia of the lower punctum will sometimes persist in spite of the ordinary treatment unless the canaliculus be slit, the cut being made well on the inner wall, and possibly a little bit of conjunctiva cut out in order to favor traction inwards by cicatrization.

A CASE OF PELVIC HÆMATOCELE (RETRO-UTERINE).

BY H. P. HENNING, M.C.P. AND S.O.

Mrs. R—, æt. 28. Health had always been good; a stout robust-looking woman. A day or two before I saw her, July 25, 1879, she had fallen or jumped down a distance of four or five feet in the barn, and now complained of a severe sharp pain low down in the pelvis. The fall occurred at the proper time for the recurrence of a menstrual period. There was a good deal of hæmorrhage from the uterus for a few days; was called again on July 31, six days afterwards, the hæmorrhage had nearly ceased, but the pains had continued to increase in severity and duration—one or two hours at a time—and occurring two or three times in the twenty-four hours. I now made a thorough examination, both digital and specular, and could find nothing wrong. There was no puffiness about the uterus.

Saw the patient Aug. 2. The paroxysms of very severe pain continued. There were no other symptoms, except slight exhaustion from the suffering. Did not make a vaginal examination; left opiates, and had the patient rest in bed.

Was called again Aug. 8. The only symptom yet was the pain, which was increasing in severity, and of longer duration. I now made another examination per vaginam, and discovered a large tumour behind and on each side of the uterus, pressing the latter forwards. Continued to treat the patient with rest, absorbents, and opiates until August 21, with the result of a large increase in the tumour, the pain continuing very severe. The os uteri was pushed forward and upward almost out of reach. I now called to my assistance Dr. McCollom, of Dunnville, and we decided to try the effect of further complete rest, with the before-mentioned medicines.

This course was pursued until Sept. 19. By this time the pain had mostly ceased. The enlargement had increased until the os uteri was completely out of reach, but for the last few days had appeared about the same. The tumour filled up the pelvis all but the lower part, and was so hard that no impression could be made upon its surface by the finger.

I now, Sept. 19, punctured the tumour near the centre with a large-sized trocar leaving the canula, after moving it about pretty freely to break up the clots, this being followed by considerable discharge of broken down blood clot. I afterwards introduced a probe-pointed bistoury and made an opening sufficiently large to admit the finger and turn out a good deal of the clot, but could not clear the cavity as it was so large. The clot continued to break down and come away, was very foetid in character, and the patient began to get chills and showed signs of septicæmia.

I now fitted a female catheter by India rubber tubing six inches in length to a common Davidson's syringe, and using a proper solution of glycerine and carbolic acid in water—nearly a quart—injecting and withdrawing the injection repeatedly until the cavity was completely washed out and the liquid returned clear (and here let me remark that there is danger unless

care is taken of drawing the wall of the cavity into the fenestra of the catheter).

Great relief followed at once, the chills ceased entirely. I continued to daily use the injections the same way for a week, and then every second day for another week, by which time the cavity was completely closed as also the opening made with the knife, and the patient soon, without further trouble than consequent weakness for a time, regained her usual health and is now not suffering from any consequence of the hæmatocele.

There seem to be certain peculiarities about this case which differ from most recorded cases. This was, no doubt, an extra-peritoneal hæmatocele. Bernutz says, "The intra-peritoneal is the more common, and the extra-peritoneal is very rare." Lawson Tait says, "That in his experience the latter is ten or twelve times more common." Most authors speak of the tumour as being "doughy-soft." Now the tumour I speak of was very hard, no impression could be made on it by the finger. The last named writer says he has seldom seen any evidence of repetitive hæmorrhage, and never experienced anything approaching to alarm from the immediate symptoms. There was in this case repetitive hæmorrhage for a good many days, for I had a splendid opportunity to watch the process of filling up and distension of the cavity by repeated attacks of the hæmorrhage, and the pain from the distension and the prostration were quite alarming. Most cases were said to surround the uterus. In this case there was no tumour in front of the uterus, which was pushed up out of reach.

The last named author says: "The majority of cases of hæmatocele should be left alone, for they will become *absorbed in greater part though they do not seem ever to disappear entirely*," and goes on to say, "I attended a case with Mr. Brown, of Bath Row, Birmingham, in which there were no urgent symptoms, and which we did not interfere with in any way, *in about four months it had nearly disappeared, leaving only the uterus fixed on the sacrum*; this seeming to be a very common result of hæmatocele." And to quote a little further, "Occasionally we get cases of old neglected hæmatocele which have suppurated and burst

into the rectum, the point of election for their natural opening, and they will go on *discharging quantities of pus for years, exhausting the patient* till a counter-opening is made in the vagina."

The case I described above could not be left alone, as the patient was in a state of extreme pain and exhaustion. Then next, the woman was cured in less than three weeks after operation. There is no fixation of the uterus to the sacrum, and nothing to indicate that the woman once had a hæmatocele. Would it not be better to operate in such cases after the attacks of hæmorrhage have ceased than to leave a chance for discharging quantities of pus for years, or the more harmless but still unwelcome fixation of uterus to the sacrum with long months of illness and lying on a hard bed?

CASE OF HYDATID DISEASE OF LIVER —SPONTANEOUS CURE OWING TO CALCAREOUS DEGENERATION OF THE CYST.

Reported by W. G. ANGLIN, Medical Student.

The following case is reported as one rarely seen in general practice, and will no doubt be of pathological interest to our readers:—

On the 23rd May, 1881, S. C., aged 62 years, a patient in the Asylum for the Insane, Kingston, Ont., died suddenly, and seven hours after death a post-mortem examination was made to ascertain, if possible, the cause of death. The patient was a native of England, and belonged to the poorer classes. When young he was addicted to the use of alcoholic liquors in excess, and the continued intemperance had much to do with the cause of his insanity. He was admitted to the Asylum in March, 1865, suffering from an attack of acute mania, which gradually became chronic in its character, and continued without remission until the patient's death. For some time before this event he had not been feeling well, but did not complain of any particular pain, and refrained from joining the working party on the Asylum farm, an unusual thing for him to do, as he was an exceptionally well-developed muscular man, and always an active worker.

This illness was so slight that he was not prescribed for, and after a few days' rest he re-

sumed work, and the day before his death was in remarkably good spirits.

Next morning, after partaking of an unusually hearty breakfast, he went down to the basement for a smoke, and not more than five minutes afterwards was found in a dying condition at the door. The Assistant Medical Officer was immediately summoned, but upon reaching the spot found the patient dead. The facial expression was placid; there was no discolouration of the skin from capillary congestion; no frothing at the mouth or any other evidence of epileptic seizure; no wounds or bruises, with the exception of a very slight scalp wound, supposed to have been caused by falling from his seat as he became unconscious.

The autopsy was very minuté, and yet no apparent cause of death could be made out, a result which, while it proved extremely unsatisfactory, is not of exceedingly rare occurrence in cases of sudden death.*

Without entering into details of the entire autopsy, the most important object of pathological interest which presented itself will be described. This was found in the liver. Upon passing the hand beneath the base of the left lung a hard, nodular mass was distinctly felt through the diaphragm. This at once drew attention to the liver, which organ when "in situ" presented a healthy appearance and was not abnormally large—the left lobe, however, projected further than usual to the left side.

On attempting to raise the left lobe it was found to be firmly attached to the diaphragm through the intervention of this hard, globular mass which could now be distinctly made out. In order to raise the liver the adhesions were not broken, but the adherent mass of liver and diaphragm was removed.

When placed upon the scales, the whole organ, with a small piece of attached diaphragm, was found to weigh fifty-five ounces. The general appearance was healthy, but the discovery of the morbid growth before mentioned, as well as two calcareous bodies, each about the size of a pea, made the examination one of great interest.

The cystic tumour found in the left lobe was nearly round, very hard, of a dirty-white color,

and looked like an ordinary billiard ball. It was one and three-quarter ($1\frac{3}{4}$) inches in diameter, attached firmly by its upper surface to the diaphragm and free on its lower side, being partly encircled by the substance of the liver and projecting slightly from the left extremity.

At the time of the post-mortem examination it was impossible to determine the nature of the tumour, but minute investigation of the foreign body revealed the following facts, viz:—

First,—That the tumour was cystic in its character.

Secondly,—That it was of parasitic origin.

Thirdly,—That the parasites had perished and undergone a process of degeneration.

The wall of the cyst was calcareous, hard, and brittle, being of variable thickness, from one-sixteenth to one-eighth of an inch thick. The contents were of a putty-like consistence, having evidently undergone transformation and become atheromatous—deeply stained with bile, and had an offensive odor. Small fragments of calcareous matter were also present.

A microscopical examination of the contents was made with the following result:—Large numbers of crystals of cholesterine and hæmatoidine were to be seen under a $\frac{1}{4}$ th objective, and hooklets of the "echinococcus" were distinctly visible, both separately and in groups of three or four.

The hooklets were not numerous, but to be seen in sufficient quantity to establish beyond a doubt the origin of the tumour.

This form of tumour is of very rare occurrence in this country, and the spontaneous cure effected by the calcareous degeneration of the coats of the cyst proved a fortunate thing for the patient.

*Frerichs remarks that he has seen a hydatid cyst of the size of a goose-egg, completely surrounded on all sides by a calcareous shell from 2 to 3 lines thick.

It may be mentioned that in the examination of the brain, the coats of the majority of the vessels were filled with an atheromatous deposit and atheroma of the basilar artery was particularly noticeable.

Also, as hydatid disease of the liver and lungs, and more especially of the liver and

*Delafield on Post-Mortems

*Reynolds' System of Medicine. Vol. III., p. 393.

spleen, are said frequently to co-exist, it may be well to state that both these organs were thoroughly examined and found to be in an apparently healthy condition, no trace of disease being observable.

TREATMENT OF PERITONITIS.

BY A. M'PHEDRAN, M.B.,
Physician to the Toronto Dispensary.

(Read before the Medical Society.)

Quinine has the power of arresting inflammation if given before migration of the white corpuscles, or proliferation of the cellular elements of the inflamed tissue has taken place, but is powerless to prevent the further progress of the disease after the occurrence of these processes as it cannot cause the disintegration and absorption of inflammatory products. The addition of morphia greatly increases the utility of quinine in this direction. Therefore, in a case of threatening peritonitis, or one in the initial stage, an effort should be made to arrest the disease by the administration of two or three large doses of quinine, about twenty grains each.

Opium is the most important of all remedies in inflammation, and is of special utility when the serous membranes are affected. It relieves pain, allays excitement, quiets restlessness, and gives sleep, thus lessening the depression of the vital forces. By adding to the tone of the blood-vessels it aids in maintaining the blood current and hindering the migration of the white corpuscles. Bartholow says there is good reason to believe that the early administration of opium will cut short an attack of inflammation of the serous membranes; if the disease is too far advanced to effect that purpose, it will modify materially its course and duration. It is in peritonitis that the curative powers of opium are specially evident. Besides its constitutional effect it stops all peristalsis of the bowels, thus securing complete rest, the most essential element in the treatment of all acute inflammations. To obtain this desired result, the opiate must be given in such doses, irrespective of the amount, as are needed to keep the patient in a state bordering on narcotism, as shown by the absence of pain, the slow respira-

tion, and the somnolency from which, however, he should always be easily roused, lest the effect of the opiate be carried too far. This condition is to be maintained till the last trace of the disease has disappeared, as relapse is liable to follow too early suspension of the opiate. Fordyce Barker, in his admirable treatise on Puerperal Diseases says, he has often had to continue the opiate for a week or two after the abdominal pain, tenderness and tympanites had disappeared, because the appetite did not return, and the pulse continued quick and temperature high. Morphia is the best form in which to give the opiate, and is best administered by the stomach, as the hypodermic injection usually causes considerable excitement, and this should, if possible, be avoided. If the stomach reject the medicine then it may be given hypodermically till quiet is restored. There is often remarkable tolerance of opium in peritonitis. In a case recorded in Barker's work, above referred to, over 80 grs. of sulphate of morphia were administered in 24 hours, and other cases are reported, in which quantities almost as large were borne.

It is of great importance to allay the vascular excitement in peritonitis as it tends to rapid depression of the vital powers. In vigorous patients, with a full strong pulse, the most effectual means for attaining this end is venesection. In the *Lancet* (1859), a case is recorded by Erichsen of acute peritonitis and pleuritis from injury that yielded at once to venesection, twenty-four ounces of blood being drawn. All evidence of inflammation had disappeared in less than six days. But in the great majority of cases the patients are not sufficiently vigorous to render recourse to the lancet advisable; in these cases the vascular excitement must be quieted without loss to the vital powers. Two remedies meet the requirements very efficiently—aconite and veratrum viride. Both act as depressants to the vaso-motor centres. Aconite dilates the arterioles, doubling their capacity, and thus relieves the congestion of the inflamed part or organ—"bleeds the patients into himself" (Fothergill.) It appears to be more effectual in small inflammations as tonsillitis. It must be given in small doses (1 to 2 gtt.) and repeated frequently—in most cases hourly, and

sometimes it may be given every fifteen minutes for a few doses with advantage. *Veratrum viride* causes contraction of the arterioles unless given in lethal doses, and would, therefore, probably, have no local effect on the inflamed part, similar to aconite. It should be given in 3-5 m. doses, and repeated hourly till the pulse is reduced to 80 in the minute, and continued in such quantities as are necessary to maintain about this rate of pulse. Either medicine requires careful and intelligent administration to be of much service; given in a haphazard fashion it would be useless, if not dangerous.

If the rapid pulse is due to exhaustion, instead of these depressants, stimulants, especially the alcoholic, are indicated to slow and strengthen the pulse and maintain the powers of the patient past the critical period. They should not be delayed too long, nor given too sparingly, as the tendency in peritonitis is to rapid asthenia. Alcohol increases the supply of blood to the brain, promotes digestion and assimilation, and diminishes the waste of tissue (Beale); it is, therefore, of the greatest utility in all acute diseases in which waste greatly exceeds assimilation.

Vomiting is frequently a troublesome complication; it indicates inflammation of the serous coat of the stomach, as frequent painful micturition does that of the serous coat of the bladder. It should be treated by morphia hypodermically and ice, hydrocyanic acid, bismuth, etc., by the mouth. If the vomiting persists, and is frequent and bilious, Fordyce Barker advises giving 10 grains of calomel, well rubbed up with 20 grains of bicarbonate of sodium. This will cause two or three free watery, usually painless, evacuations from the bowels; they usually relieve the vomiting. The peristalsis of the bowels, caused by the calomel, cannot do as much injury to the inflamed structures, as the movement of the stomach in the persistent vomiting. Purgatives are advisable under no other conditions. As much nourishment as possible should be taken, chiefly fluid, and in small quantities at short intervals, especially if there is a tendency to vomiting.

Turpentine applied to the abdomen is of great service in relieving the pain and tympanites.

It is best applied sprinkled on two or three layers of flannel promptly wrung out of hot water. It seldom can be borne longer than twenty minutes; on removing the flannel the abdomen should be covered with cotton wool, over which laudanum may be freely sprinkled to allay the burning pain caused by the turpentine. The application should be repeated as often as it can be borne. The effect is usually to lessen the tympanites and improve the general condition of the patient as shown by moistening of the tongue and skin, fuller pulse, and less anxious countenance. This may be due simply to the counter-irritant effect, or possibly to absorption of some of the turpentine. For the typhoid state turpentine is an excellent stimulant. From five to fifteen drops may be given on lump sugar or in emulsion. The existence of tympanites is an additional indication for its administration in peritonitis.

The utmost quiet should be enjoined on the patient. No unnecessary movement, active or passive, should be permitted. If much straining is needed to empty the bladder a catheter should be used.

In the discussion that followed the President referred to several cases of peritonitis he had had in his practice, and pointed out the great benefit derived from the administration of turpentine and carbonate of ammonia, when there was much prostration.

Dr. Oldright had given *veratrum viride* and found it the most effective remedy in allaying vascular excitement.

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GELSEMIUM IN RIIUS POISONING.—Dr. Benjamin Edson, of Brooklyn, recommends (*New York Medical Journal*) the following wash for the rapid relief of symptoms produced by poison ivy:—℞. Acid carbol. ʒss; ext. gelsem. fluidi ʒii; glycerini ʒss; aquae. ad. ʒiv ℥. With this cloths are to be kept moistened and applied to the parts affected. Internally the fluid extract of gelsemium in two minimum doses every three hours. Thirty-six hours sufficed to control the symptoms.

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The idea that iron is an analeptic has come to an end. Alimentation is more than sufficient to furnish the two or three grams of iron which are contained in the totality of an adult's blood.—Dr. Luton, in *L'Union Médicale*.

Selections: *Medicine.*

AN ABSTRACT OF REMARKS ON THE PRACTICAL SIGNIFICANCE OF CRYSTALLINE AND OTHER URINARY SEDIMENTS, EXCEPT TUBECASTS.

Read before the Clinical Section of the Philadelphia County Medical Society, January 31, 1882.

BY JAMES TYSON, M.D.

In the first place, no crystalline or other urinary sediments are of any significance unless they are present in urine at the time it is passed or immediately thereafter. Nor can the occasional appearance of these sediments have any significance. They should occur continuously, or at least for several days in succession.

Secondly, of the urinary sediments referred to, I will consider only the following:

1. *Uric acid and urates.*—They indicate insufficient ingestion of fluids, imperfect oxidation of the proximate principles which go to make up food, or excessive acidity of the urine as the result of which they are precipitated. Such conditions may result in the undue accumulation of these substances in the blood, or their deposit as sediments in certain parts of the urinary passages, as the pelvis of the kidney, ureters and bladder, in such quantities as to form calculous aggregations with the symptoms which usually attach to them.

The former—that is, undue accumulation in the blood—gives rise to gout or the condition to which the name lithæmia has been applied, and of which the symptoms have been well described by Da Costa in a recent paper.*

Uric acid is very easily recognized by the rhombic shape or some one of its variations; if there is any doubt about any of these forms, it may be removed if it be remembered that uric-acid crystals are invariably stained yellow, which is true of no other crystalline sediment of the urine except the urate of ammonium, which exists only in spherules similarly coloured, but by their shape easily distinguished. Amorphous urates of sodium and potassium, which frequently accompany uric acid, may be recognized by their pink, fawn, or brick-dust

hue, and their solubility by warmth. In form they are not distinguishable from any other amorphous matter.

A good method of dissolving amorphous urates—which often fall in cold weather during the transit of a specimen from the patient's house to the doctor's office, and make the detection of other more important sediments difficult—is to place the bottle for a few minutes in a pitcher of hot water.

The *treatment* of uric-acid and uratic sediments is by diluents of an alkaline or even neutral reaction. The citrates, acetates, and carbonates of the alkalies, *freely* diluted, in most instances speedily dissipate these sediments. Even the use of a quart of plain water in addition to that ordinarily ingested in the twenty-four hours will have the desired effect. And I am certain that the effect of the chemically-indifferent mineral waters which are so much advertised and consumed in this country is due to the dilution they afford.

With regard to the solution of uric-acid calculi in the urinary passages, the experimental researches of Roberts, of Manchester, England, have shown that by the administration of alkalies, it is at least possible to prevent them from growing larger. Elimination by aperients, especially by the natural aperient mineral waters, as Hunyadi and Friedrichshalle, is efficient in relieving the kidneys of a part of their work.

2. *Sediments of oxalate of lime*, which are readily recognized by their octahedral and dumb-bell forms, are also the result of mal-assimilation, indigestion, or the ingestion with the food of substances containing large amounts of oxalic acid, as the pie-plant, sorrel, and tomatoes. Their significance also depends upon their permanence. If permanent or sufficiently abundant, they may cause irritation of the urinary passages similar to that resulting from uric-acid accretions.

The treatment of oxalate-of-lime sediments is that of the mal-assimilation and indigestion of which they are the symptoms. A solvent treatment of oxalate-of-lime calculi in the body is admitted to be impossible; but the same method of treatment which tends to prevent the *formation* of uric-acid sediments will pre-

* American Journal of the Medical Sciences, October, 1881.

vent the formation of oxalates, as they are both the result of the same conditions.

3. *Phosphatic sediments*.—These include the crystalline triple phosphate, phosphate of lime, and amorphous phosphates. They occur only in alkaline urine, and if present when the urine is passed or soon thereafter—when alone they are of any significance—they indicate that the urine is alkaline at such time. The result of a constant condition of this kind, which, it is important to remember, may occur from the excessive administration of alkaline remedies, may be phosphatic accretions in the urinary passages. These may occasion the same symptoms of irritation as those of uric-acid and oxalates.

As to *treatment*, it is acknowledged to be impossible to produce by medication such a degree of acidity of the urine as will dissolve phosphatic accretions of any size; but here, again, the natural acid reaction of the urine may be restored and kept up by the administration of benzoic acid, which is, in my experience, the only remedy to be relied upon for this purpose. Phosphatic sediments often accompany the pus and mucus which are the result of inflammation of the bladder, but it is questionable whether they as sediments add to the inconvenience of these affections. This is chiefly due to the viscid, glairy product of the action of alkalies on pus, which is the principal cause of the difficult and painful micturition which attends this condition.

Serious errors in practice are often made by the administration of alkaline mineral waters in these conditions of phosphatic sediments, these waters being indiscriminately resorted to in all bladder affections, without regard to accurate diagnosis.

4. *Urate of ammonium* appears in the shape of yellow spheres in urine of alkaline reaction, under the same circumstances as those under which the phosphates are found.—*Philadelphia Medical Times*.

RÖTHELN.—Dr. Block (*Hospitals Tidende*, February 8, 1882), attaches great diagnostic importance to the swelling and tenderness of the lymphatic glands, especially of the post-cervical glands. This may occur during the prodromal stage, and will then, Block is inclined to think, furnish a valuable means of differential diagnosis between rubeola and rötheln.—*Chicago Medical Review*.

VARIOLA AND THE ANTISEPTIC OF M. PENNÈS.

BY P. H. BRYCE, M.A., M.D., TORONTO.

Journal D'Hygiene, Paris.

In the review of the *Exposition of Sciences Applied to Industry*, we have noticed that the judges awarded a *diploma* to M. Pennès for the great variety of zoological preparations preserved by his *vinegar*, composed of salicylic acid and eucalyptus as the principal bases.

The successes which this new product has met with, in some twenty hospitals in Paris, under the control of the most prominent medical men, have already awarded it a worthy recompense.

Now, we recognize with pleasure that this antiseptic of Pennès has realized a real advance in the treatment of variola, which continues to make ravages, both in private abodes and in the hospitals of Paris.

In the words of one of the most distinguished physicians of the St. Louis:—"The *Vinaigre de Pennès* has realized, in our hands, the most brilliant expectations that its chemical composition has allowed us to conceive of. For nearly six months we have had recourse to this powerful therapeutic agent in our *service* of small-pox at the hospital of St. Louis, and we cannot sufficiently praise the brilliant results which it has given us in its various methods of application.

1st. Employed in the form of pulverization with the aid of Lister's apparatus, and following the same methods as for the carbolic spray, the *Vinaigre de Pennès*, reduced by five times its weight of water, has served us as a means of disinfection in our small-pox wards.

2nd. The jet of antiseptic spray, directed upon the face and the skin, facilitates, in a remarkable degree, the detachment of the crusts which the varioloid pustules leave after them, and masks the smell, sometimes so repulsive, which is exhaled from the bodies of such patients. It is, especially in the after-stages of small-pox, and principally in those of desiccation, that this spray renders the greatest service. To the action produced by the vapour upon the crusts is added, in effect, the action which is exerted upon the subjacent surfaces,

the cicatrization of which is manifestly hastened. The patients are fond of the spray and ask for it. The odour of this antiseptic is agreeable and pleasant.

The spray begun early, from the tenth to twelfth day of a coherent variola, and directed specially upon the face of the patient, is repeated four or five times during the day; it thus prevents patients from scratching by allaying the uneasiness, and effaces, by favouring cicatrization, the hideous marks which the disease so often leaves after it.

These antizymotic vapours have, moreover, the merit of preventing, when frequently renewed, those *saillies verruqueuses*, true post-varioid condylomata, so frequent upon the face, and so slow in disappearing.

3rd. It often happens that patients are taken to the hospital in a carriage, this vehicle thus becoming one of the surest means of contagion. Hence, should there not be an immediate application of this prophylactic vapour to it? We have been accustomed to spray the carriage with it.

4th. The *vinaigre de Pennès* has equally rendered service as a lotion in baths for cleansing the ulcerated surfaces so frequently following the opening of abscesses—frequent in the later stages of small-pox.

In a word, this new agent appears, to us, to realize a true progress in the prophylactic treatment of contagious diseases, parasitic or zymotic, and we are happy to be able to denote here the principal indications for its employment, and the benefits following its use.—*Dr. Labadie-Lagrave, Médecin des Hôpitaux de Paris.*

ADMINISTRATION OF OIL OF TURPENTINE.—

Ordinary sulphuric ether has the property of modifying the persistently unpleasant flavour of oil of turpentine. The following mixture has been found very beneficial in vesical catarrh, neuralgia, and sciatica :—

R. Ol. terebinth ʒij.

Æther sulphur ʒj.

Mix by shaking violently, and add :

Syr. aurant. flor. ʒj.

Aquæ ʒiv.

M. S.—Teaspoonful every 2 hours.—*Druggists' Circular.*

KOCH AND THE INFECTIVE ELEMENT IN TUBERCULOSIS.

Ever since Villemin, more than fifteen years ago, claimed, as the result of his experiments on the lower animals, that tubercle was a specific disease, due to a special virus, almost endless experiments have been made in different parts of the world to test the validity of his statements. The outcome of their conjoined labors has placed the matter in a somewhat new light, for while it has been determined with great accuracy that the miliary granulum is a product of inflammation, it has also been shown, with about as much certainty, that various organic substances may produce it, and, therefore, to a certain extent it may be classed among the infective diseases. These results have been derived from the studies of Fox, Sanderson, Clarke, Cohnheim, Salomonsen, and Buhl. Those, however, who, like Cohnheim, Klebs, and Koch, maintain that the tubercle granulum is due solely to the interposition of a specific virus, have naturally hunted for it with their microscopes, but thus far when one has proclaimed a discovery he has obtained little credence, because these alleged discoveries have almost invariably proved premature. The latest announcement comes from Robert Koch, who has recently received an appointment as advisory councillor in the Sanitary Department in Berlin. He claimed by using aniline dyes to have been able to colour certain minute bacterial organisms found in tuberculosis, and he is prepared to affirm that they are the essential elements that cause infection.

The dyes in question are methyl-blue and vesuvin, which cause peculiar staining, differentiating them from the ordinary bacteria of decomposition that take a purple colour with hæmatoxylin. His method is as follows: A methyl-blue fluid is made, which consists of 1 c.c. of a concentrated alcoholic solution of methyl-blue in 200 c.c. of distilled water, to which 0.2 c.c. of a 10 per cent. caustic soda solution has been added. The preparations remain in this mixture from twenty to twenty-four hours, or, if they are kept at a temperature of 104° F. in the water-bath, the time may be reduced to a half-hour. Then the same pre-

parations are flooded with a concentrated watery solution of vesuvin, and two minutes later are washed with distilled water. All animal tissues and ordinary bacteria are now said to be stained brown (lepra bacilli excepted), but the tubercular parasite is coloured blue.

He further announces that he has been able to isolate these bacteria from the others with which they are found, by successive cultures in the well-known sterilized fluids. He regards these bacteria as different from those that have been described by Klebs, Schuller, or Aufrecht. His experiments have been very numerous.—*Cincinnati Medical News.*

AMYLOID KIDNEY WITHOUT ALBUMINURIA.

J. Straus concludes a paper on amyloid kidney without albuminuria, as follows:—

1. In certain cases of amyloid degeneration of the kidneys, albuminuria may be constantly absent until death.

2. The absence of albuminuria is due on the one hand to the absence of a deep lesion (interstitial or epithelial) of the kidney, and on the other hand to a special localisation of the amyloid degeneration. This, in such cases, bears chiefly upon the *vasa recta* of the medullary substance and implicates in a minor degree the glomerular vessels.

3. From a clinical point of view, if in a phthisic, or an inveterate syphilitic, or a subject of chronic osseous suppuration, etc., we find enlargement of the spleen and of the liver, but without albuminuria, we are not justified on this account in rejecting the idea of amyloid degeneration of the viscera, nor even in absolutely denying amyloid degeneration of the kidneys.

4. Those authors who date the beginning of amyloid degeneration in the economy from the moment at which they observe the presence of albumen in the urine, commit a double error, (a) because amyloid degeneration is far from beginning always by invading the kidneys. On the contrary, the spleen and the liver are habitually the first to be attacked, (b) because the kidney itself may be suffering from amyloid

degeneration without albuminuria being present. It is then necessary to mistrust calculations by which it has been sought to fix the possible duration of life in subjects afflicted with amyloid cachexy, by making this date from the first appearance of albuminuria.—*L'Union Médical.*

FORCED FEEDING IN PHTHISIS.

We recently called attention to the proposal of M. Debove to treat cases of phthisis attended with vomiting, &c., by forced feeding with the stomach pump, and the subject was again brought before the Société Médicale des Hôpitaux, on April 14th by M. Dujardin-Beaumez, who had at first met with little success, in consequence, he believed, of having employed raw meat and eggs. M. Debove, on the other hand, transforms the food into impalpable powder before administering it to his patients. This M. Beaumez has given in a daily quantity of 200 grammes, which correspond to 600 grammes of raw meat, and he has obtained by this means the same results as M. Debove—progressive fattening and general amelioration, especially in hysterical patients with almost intractable vomiting, which ceased completely under the new method of treatment, although if ordinary feeding by the mouth were attempted the vomiting reappeared at once, as if excited by a pharyngeal spasm, the result of the passage of the food down the throat. M. Debove stated that all the phthisical patients treated by this method were doing admirably, fattening in a remarkable manner, some having gained twelve kilogrammes in a month, and most of them seemed in a fair way towards recovery. One of the patients, however, having obtained permission to go out for a couple of hours, under the promise of taking no alcohol, had employed the time in such pleasures of another kind that he returned with absolute retention of urine, and the necessary surgical treatment resulted in his death. The subsequent post-mortem examination showed that the large cavities in the lungs were lined with granulations, and in full process of healing.—*London Lancet.*

TREATMENT OF ACUTE DYSENTERY WITH ACONITE.

Dr. Wm. Owens reports 151 cases of acute dysentery occurring in the Convict Hospital, Port Blair, India, which were treated with tincture of aconite; all the cases were typical examples of acute dysentery, and all, with one exception, recovered. He states that he was led to give aconite a trial, as the remedy most likely to be successful, from the following considerations:—

(1) From its beneficial action in other acute inflammations.

(2) From its effect on the capillaries of the skin, which it dilates, thus relieving internal congestion.

(3) From its antipyretic action in febrile cases.

(4) From its sedative action on the mucous membrane of the stomach and intestines, and its beneficial action in some forms of dyspepsia. In the first case in which he tried this remedy he was somewhat diffident, and he had ten cases in which a combined treatment of ipecac and aconite was used. However, he soon discontinued the ipecac entirely, finding there was no occasion for its use.

Dr. Owen gives one minim every quarter of an hour for the first two hours, and a minim every subsequent hour, or thirty minims in twenty-four hours; this method he finds to be followed by the best results, inasmuch as the action of the medicine is more rapidly established, and an effect on the disease was more quickly produced than by other methods.—*Medical News.*

Dr. Koch in one of the demonstrations accompanying a discourse to the Physiological Society of Vienna, fully showed that miliary tuberculosis is a bacteria-disease.

1. By a definite method of colouring with methyl violet, and then vesuvin he could regularly discern the very characteristic and motionless projections of the bacillus distinctly on the stage.

2. It occurred to Koch to rear this bacillus out of the animal body and free from all extraneous animal matter, from a specially pre-

pared blood serum—gelatine. The bacillus grew very slowly, thrived only at a temperature of 30 to 42 C., and was substantially changed from the distinctly pathological bacillus to the coccus.

3. With these, outside of the organism, for a period of 200 days, from glass to glass, there was obtained a cultivated bacillus, in a constant and characteristic way, similar to those found in tubercle.

4. When this 'crop, raised from the coccus, was injected into the blood of an animal, acute tuberculosis was produced in a short time.

MINIMUM DOSES OF IODIDE OF POTASSIUM IN FRONTAL HEADACHES.—Dr. Haley draws attention to the powerful anti-cephalalgic properties of this drug when used in small doses. As a rule, a heavy, dull headache situated over the brows, and accompanied by languor, chilliness, and a feeling of general discomfort, with distaste for food which sometimes approaches to nausea, can be entirely removed in about ten minutes by a two-grain dose of iodide of potassium dissolved in about half a wineglassful of water, this being quietly sipped so that the whole quantity is consumed in about ten minutes. This class of headache seems to have no particular or definite cause, belonging apparently to the class of sympathetic headaches. In many cases the effect of these small doses is simply wonderful, and their great advantage is the rapidity with which they act.—*Australian Medical Journal.*

A bill has been introduced into the New York Assembly, ordering all persons selling poisons of any nature to put up the same in a corrugated bottle or box, with a printed label giving the antidote in English and German. In case of failure to comply, the wholesale or retail dealer is declared guilty of a misdemeanor.—*American Medical Weekly.*

MENTAL STATUS OF GUILTEAU.—Dr. W. A. F. Browde, Royal Commissioner in Lunacy for Scotland, (*Journal of Psychological Medicine*, Volume VIII, Part I.) after a careful analysis of the expert and other testimony given in the Guiteau case comes to the conclusion that Guiteau was insane.—*Chicago Medical Review.*

Surgery.

JUXTA-EPIPHYSEAL SPRAIN, ITS IMMEDIATE AND REMOTE CONSEQUENCES IN REGARD TO INFLAMMATION OF THE BONES.

BY OLLIER.

In his work the author gives extensive conclusions which suffice to convey a just idea of it.

1. Juxta-epiphyseal sprain is the totality of the lesions produced in the juxta-epiphyseal regions of the diaphysis of the long bones by forced movements of the articulations.

2. In young children, especially under the age of 3 years, forced movements of the articulations do not produce appreciable articular disorders; they give rise chiefly to disturbances in the osseous tissue of the juxta-epiphyseal regions.

3. These disorders of the osseous tissue consist, sometimes, in the first degree of diaphyseal separation, sometimes in an incomplete fracture of the juxta-epiphyseal region. They are the more easily produced according as the consistence of the bone has been more altered, either by rachitism or by any other acute or chronic affection, which may have disturbed the nutrition of the osseous system.

4. As these lesions occur in the depth of the bone beneath the periosteum, they often pass unperceived, not only by the clinician whose eyes are solely preoccupied by the search for articular lesions, but also by the experimentalists, who have not recognised them, although they must necessarily have produced them in all their experiments upon the so-called separation of the epiphyses.

5. These disorders consist in the following lesions: crushing depression, trabecular fractures of the spongy tissue, inflexion, torsion, infraction of the thin compact peripheral layer, and as a consequence of these ruptures, expression of the medullary juice, blood effusions into the spongy tissue, and beneath the more or less separated periosteum.

6. If the effort continues, permanent depression of the compact peripheral layer on the side of flexion, (juxta-epiphyseal notch) fracture by dragging-tension and tearing of the periosteum on the side of extension. This is the moment

at which are prepared and soon effected fracture or separation of the diaphysis and its luxation without the periosteal sheath.

7. Juxta-epiphyseal sprain is generally without gravity, and is reduced to a painful torpor which soon disappears of itself. But if the child is not taken care of, and if it is scrofulous or hereditarily predisposed to tubercle, the juxta-epiphyseal sprain will be the frequent origin of osteomyelites, early or late, which are explained by the depression and the trabecular fractures of the spongy tissue. All the forms of osteomyelitis may be consequent upon the lesions of juxta-epiphyseal sprain.

8. Juxta-epiphyseal sprain gives rise to a tumefaction more or less painful, but very clear, of the juxta-epiphyseal region, the neighbouring articulations remaining free. *This is the characteristic symptom of this lesion.* It is due to the tumefaction of the separated periosteum, and the hyperplasia of its osteogenic layer.

9. What has been called *painful forced pronation, painful torpor* of young children is explained by juxta-epiphyseal sprain.

10. To prevent the dangers of juxta-epiphyseal sprain, there is only immobilisation of the limbs for a sufficient time. It is necessary then to carefully examine in children limbs which have been the seat of a forced movement, or which have suffered in a fall, and if we find a juxta-epiphyseal swelling, painful or not, to care for these children until the bone has regained its normal volume.—(*Revue de Chir.*)—*L'Union Medical.*

ORCHITIS.—I know of no remedy that will allay the pain, and subdue the inflammation of a swelled testicle so effectually, as a tobacco and flaxseed meal poultice. The application was used by some New York surgeons long before it became much known, and Van Buren and Keyes have probably done more than any others to spread the knowledge of its use. A hot flaxseed meal poultice to which has been added previously, about half a paper of fine cut chewing tobacco, should be applied fresh two or three times a day, until the swelling and pain subside. A piece of oil silk should be placed outside the poultice to prevent evaporation. This poultice gives relief quickly, and in the course of a few days, the swelling is so reduced that an ordinary suspensory bandage may be worn with comfort.—*Phila. Medical Times.*

SUBBOTIN ON TREATMENT OF HÆMORRHOIDS BY FORCIBLE DILATATION OF THE ANUS.

V. IDELSON, M.D.

Having referred to the dangers accompanying the usual methods of radical treatment of hæmorrhoids, *i.e.*, excision, ligature, and cauterisation, Professor Subbotin (*Mejdunarodnaia Clinica*, No. 1, 1882) advocates a fourth method, which is alleged to be entirely free of such dangers as subsequent pyæmia, stricture of the anus, secondary hæmorrhage, general peritonitis, etc. This operation is forcible dilatation of the anus and lower part of the rectum, recommended, about thirty years ago, by Maisonneuve, and after many years of oblivion, in 1876-77, again introduced into practice by Verneuil and Fontan, and later by Guyon, Trélat, and other French surgeons. The author, from his own experience, draws attention to the simplicity, safety, rapidity of curative action, and efficiency of this method, which is described by him as follows: On the day before the operation the bowels are thoroughly opened by a purgative; and immediately before the dilatation, the rectum is washed out by an enema. The patient being brought under the influence of chloroform, and placed on his left side, with his thighs fully flexed, the operator stands behind the patient and introduces a bivalved Recamier's anal speculum, then he gradually and cautiously opens the speculum (introduced down to its handle); and, when all the rugæ of the anorectal mucous membrane have been effaced by stretching, he leaves the instrument opened to its widest extent *in situ* for two or three minutes, and then removes it. With this action the treatment comes to an end, no after-treatment being required. The operation lasts about six to eight minutes. The immediate effects of the dilatation consist: 1. in a parietic state of both rectal sphincters, which exists three or four days, and then is followed by normal contraction of the parts; and 2, in complete relaxation or disappearance of the hæmorrhoid varices. Small piles usually disappear at once, never to return; large ones remain visible for some time after the operation as soft, lax,

and empty capsules. These are gradually diminished, and, as a rule, finally disappear, or remain in the shape of simple polypi, causing no discomfort to the patient. According to the author, the action of dilatation in the treatment of hæmorrhoids is two-fold. First, by relaxing the sphincters, it removes the cause of stagnation of the blood in the beginnings of the hæmorrhoidal veins; and, secondly, it expels the contents of the varices and compresses their walls in such a way as to cause their adhesion and obliteration of the cavity. Professor Subbotin points out only two contra-indications to forcible dilatation. They are, suppuration and incipient gangrene of the piles. In cases of highly tense and irreducible hæmorrhoids, he advises that the operation should be done in two stages: first, dilating by means of the fingers alone, and, some days later, proceeding with instrumental dilatation.—*London Medical Record*.

THE REDUCTION OF OLD HERNIÆ.

Ordinarily an old and large hernia is left pretty much to itself. Palliative measures alone are attempted. Yet the positive and continuous inconveniences remain, sufficient in many cases to render life a burden, and should be a constant incentive to renewed efforts. M. Thiry, in the *Bulletin de l'Académie Royale de Belgique*, has lately shown us what may be justly called a new method of dealing with such tumours, by frequently repeated attempts at the taxis with compression during the intervals.

The patient was a man of forty-two, whose hernia measured sixty-seven centimetres in circumference. The intestines had "*perdu droit de domicile*" in the abdomen and were all in the scrotum, and produced a considerable dysuria. Undismayed by the size and age of the hernia, M. Thiry repeated the taxis twenty-four times, at unequal intervals extending over nearly three months. At each sitting more or less of the hernia was reduced, and, once reduced, was retained in place by an elastic bandage. After complete reduction, a truss with a very convex pad penetrating into the ring was applied. At the end of some months,

the reduction was still effectual, the abdomen had resumed its usual rotundity, and urination was readily accomplished. Life had again become desirable.

We commend so happy a success to our readers. Old herniæ are so frequent and so annoying that he who opens a new path to their successful treatment confers a great boon on multitudes of sufferers.

Of course, in very many cases the adhesions are such as to forbid the hope of success. But no such hernia should be abandoned without at least patient and repeated trials.—*Medical News*.

TREATMENT OF STRUMOUS GLANDS.

The treatment of chronic caseating strumous glands has undoubtedly been improved in quite recent times. In the earlier stages the external application of iodoform, in the form of its colloidion, is frequently of marked service, and when suppuration has taken place the thorough local application of powdered iodoform, and the enucleation of the glands are of great value in cutting short the affection and producing a quick recovery. In a paper in the *Central. f. Chirurg.*, Dr. Von Lesser points out that the disease in the glands often assumes the form of small caseous foci, which may become encapsuled and possibly calcareous, but are more likely to lead to suppuration, during which they are extruded, or to general tubercular infection. In view of these events he has, while the glands are still only indurated, attempted to enucleate these caseating portions of the glands. His operation is thus performed. Fixing the gland and pushing it forward under the skin with the finger and thumb of the left hand, he makes a small puncture through the skin and into the gland with a narrow knife. Through this wound he passes a small sharp spoon and scrapes the interior of the gland. The soft cheesy portions readily yield and come away, while the more healthy parts of the gland prove more resistant. If several glands lying close together are enlarged, he operates on them all, or on several through one skin wound, the spoon being pushed into one after another. By this means the disease is cut short, ulterior dangers are avoided, and unsightly scars prevented. Lesser recom-

mends that the operation should be done with strict antiseptic precautions, and that care should be taken not to wound any large vessel, nor to leave behind in the wound any of the cheesy débris.—*London Lancet*.

EXPERIMENTS WITH CATGUT LIGATURES ON ANIMALS.—MM. GROSS and ROHMER (*Revue de Chir.*, 1881, p. 961) having made numerous experiments on animals, arrive at the following conclusions: 1. The immediate effect of catgut ligature in the continuity of an artery is the same as that of an ordinary ligature. The outer coat resists the constriction and is reinforced by the new tissue formed under the influence of the irritation produced by the ligature. The vessel is never divided. The fear of secondary hæmorrhage is, therefore, abolished, and the ligature of the arteries in their continuity has become less serious than heretofore. 2. An ordinary double knot only produced temporary obliteration of the artery; the ligature becomes prematurely loose, perhaps, before any clot is formed; or the thrombus, if formed, disappears, the ruptured coats heal, and the calibre of the vessel is restored in eight or nine days. Before the fifteenth day, the obliteration cannot be considered as final. 3. In order to obtain final closure of the vessel, the ligature must be secured by a surgical knot upon which is added a simple knot, as recommended by G. and J. Boeckel, of Strasburg.—*Birmingham Medical Review*.

ABSORPTION OF SEQUESTRA.—M. VIGNAL has lately made a series of experiments on this subject. He has determined that a sequestrum covered with pus will not be absorbed, whilst one enveloped with granulations will be. A fragment of bone (bone peg) being driven into the tibia of a rabbit was almost entirely absorbed.—*Gaz. des Hôp.*—*St. Louis Med. and Surg. Journal*—*Cincinnati Lancet and Clinic*.

TREATMENT OF ECZEMA WITH ANIMAL CHARCOAL.—ONOCOOL CHUNDER CHATTERJEE claims to have found a specific for eczema in freshly-prepared animal charcoal made into an ointment and applied to the affected part. He finds it particularly efficacious in vesicular eczema confined to the extremities.—*Indian Med. Gazette*.

Midwifery.

VIENNA GENERAL HOSPITAL.

(Service of PROF. SPAETH.)

VIABILITY OF PREMATURE CHILDREN.

A pair of male twins was recently brought into the lecture-room of Prof. Spaeth, and formed the text of some remarks upon this subject. One of the children presented several malformations, such as hydrocephalus, harelip, cleft palate, club feet, umbilical hernia, etc.

The other was born alive, normally formed, and weighed 900 grammes. If the weight of a fully-developed, new-born child is taken at 3,000 grammes, 1,500 grammes will be the weight of a child at the end of the seventh lunar month. A weight of 900 grammes corresponds to a fœtus in the second half of the sixth lunar month, and, according to the generally received opinion, the child was not viable, since the end of the seventh lunar month is the accepted time of viability.

Prof. Spaeth, however, supported by his rich experience, affirmed that children even in the sixth lunar month could be kept alive, if special care was taken in their treatment. The slight amount of bodily heat which these children produce renders it necessary, in the first place, to guard against the dissipation of that agent. For this purpose, careful wrapping in cotton-wool is excellent.

The delicacy of the digestive organs must be noted, and only such milk selected for nutriment as contains a small amount of casein, the constituent of milk most difficult of digestion. Experience teaches that the longer a nurse suckles, so much richer in casein does her milk become.

It is, therefore, necessary to select for a wet-nurse a young woman who has been very recently delivered. Another requisite is that the wet-nurse must have long nipples; since the child itself is too weak to suck and to swallow, the nipple must extend deep into the mouth, so that the milk runs, so to speak, directly into the stomach.

That it is possible to raise a child so poorly developed, Prof. Spaeth proves by the relation of a case in his own private practice. The child was born in the sixth month. The

parents were wealthy and every detail of the costly experiment was scrupulously carried out. The child, a boy, is now five years old, in perfect health and bodily vigour. Indeed, in this respect, he surpasses his brothers and sisters, who came into the world at the end of the usual period. Moreover, that the mortality among premature children is very great is easily comprehensible when the great mortality of children, generally, during the first year of life, is taken into consideration.—*Medical News.*

Correspondence.

To the Editor of the CANADIAN JOURNAL OF MEDICAL SCIENCE.

CLINICAL EXAMINATIONS.

SIR,—In reading your report of the proceedings of the Medical Council at its last session, I observe that you have published one of the motions as it appeared in the columns of the daily press. I refer to that one in reference to "clinical lectures" at the Toronto General Hospital. If you had substituted the word *examinations* for "lectures" you would have been exactly right.

The Council has no direct power to establish a course of clinical lectures at the Hospital; but by carrying into effect the motion for examinations it will in a very great measure assist the Hospital authorities, and those medical gentlemen engaged in clinical teaching there, to secure a thorough course of clinical lectures.

At the suggestion of some of our most active teachers, and with this object especially in view I was led to bring in the resolution. It is not a matter of disappointment that immediate action was not taken by the Council, for this is a subject requiring more than passing consideration. The members generally were strongly in favour of the scheme and deferred it until next session in order to enquire more closely into the practicability; and the readiness with which the motion was accepted leads me to believe that suggestions from members of the profession as to how these examinations may be held will receive attentive consideration.

Yours truly,

J. H. BURNS.

Toronto, July, 1882.

To the Editor of the CANADIAN JOURNAL OF MEDICAL SCIENCE.

DEAR SIR,—Leipsic, a city of about 225,000 inhabitants, is celebrated, as a fellow-traveller expressed it, in these particulars: as a place of business, as a place for the study of science, and on account of its presenting great facilities for the cultivation of art, especially music, the Conservatory being the most renowned in Europe. To the medical world it is of special importance on account of the pathological laboratory. The latter is a large building which affords every facility for making *post-mortem* examinations, and for microscopical work. In the histological room there is an immense amount of material arranged and classified, so that the student can easily find what he requires for section. Cohnheim's microtome is very much used here. It is especially good for cutting fresh specimens, as they can be easily frozen, and beautiful sections made. Medicine is well taught by Professor Wagner, who is now, perhaps, the best clinical lecturer in Germany. He was for years Professor of Pathology, a course which has eminently fitted him for the position he now occupies. One is struck with the very thorough manner in which *post-mortems* are made. They are done according to a certain system, and every organ is thoroughly examined.

I shall, however, leave Leipsic and hurry on to Vienna. The latter city presents many features peculiar to itself as a place for medical study. The vast amount of material afforded by the hospital, and the large staff of teachers, render it an easy matter for a medical practitioner, who has only a few weeks at his disposal, to spend his whole time in the study of one or two subjects. One can, for instance, spend ten hours a day at gross pathology and pathological histology, or at dermatology, or surgery, &c.

In gross pathology I might give a short list of some of the rare specimens presented during the last three weeks. 1. A case of peritonitis produced by collection of hardened feces in the form of nodules in diverticula of the intestine. These, by their presence, excited inflammation and ulceration. 2. A heart with stenosis of both mitral and tricuspid valves. 3. Cholesteatoma at the base of the brain,

which, although of considerable size, did not produce any marked symptoms during life. 4. A dermoid cyst of the ovary, somewhat larger than a child's head, the walls of which had undergone carcinomatous change and ulcerated through into the duodenum. The interior of the cyst was partly filled with matter which had passed out of the intestine, and partly with hair and other epidermic growths. 6. Uterus unicornuus with narrowing of the internal os. 7. A case of suppurative hepatitis, produced by the pressure of an *ascaris lumbricoides* in the common bile duct. The latter had been distended by the passage of gall stones, and the worm had found its way into the liver from the duodenum. The great advantage they have here in teaching pathological anatomy is the way in which they can often group specimens. For instance, they presented on the same day three different forms of ovarian tumours, and on another three different kinds of ulceration of the bowels.

In the medical department, a case of hydronephrosis in a floating kidney was shown and lectured on by Dr. Bamberger. In the skin clinic there were no less than three cases of scleroderma at one time. This is remarkable considering the rarity of the disease. The more one sees of this obscure affection, the more one is convinced that we know little of its true pathology. The cases here presented very remarkable pigmentary changes. A case of multiple sarcoma of the skin, of the fungoid character, was also shown. Primary disease of the skin of this form is very rare, and most of the cases have been of the pigmentary or melanotic kind. Only four or five cases of the fungoid variety have yet been reported. A case of pityriasis rubra has also been under observation, which presented, on the lower extremities, small gangrenous patches.

One of the most interesting features of the Vienna Hospital is Prof. Billroth's clinics. He operates every morning, usually, from two to three hours, and during the time that the patients are being anaesthetized gives short lectures on the abundant material always at hand. He has ten assistants, each of whom appears to have his own special duty, so that, although they are always busy, there is no

confusion. Operations of great magnitude seem to be performed with the same coolness as the removal of trifling tumours. Opening the peritoneal cavity is a matter of frequent occurrence. The spray is not used, but the parts to be operated on are first thoroughly washed with a solution of carbolic acid, and the instruments are placed in trays containing the same solution. A modification of the antiseptic dressing is used.

The great event of the past week was the address and torch-light procession given in honour of Billroth. During the past month the latter was offered Langenbeck's position in Berlin, and very great efforts were made by the Berlin University to induce the celebrated Vienna surgeon to return to his native land. Billroth, however, declined, preferring to remain here where his greatest triumphs have been achieved. In recognition of his abilities and high standing as a surgeon, and of the fact of his refusing so tempting an offer as the Berliners had made, the students determined to present an address and give him a torch-light procession. The programme was carried out last Thursday. The address was presented at noon in the aula of the old University, and the torch-light procession took place in the evening. The latter was in every way a most brilliant affair. The streets were lined by tens of thousands of people, and the procession was at least a mile long. It was formed on the opposite side of the city, and marched through to Dr. Billroth's residence. After a serenade by the Students' Choral Society, the Dr. made a short address. While witnessing the procession one naturally wondered if it would ever happen on our side of the Atlantic, that a city of nearly a million inhabitants should be moved to its very centre, as Vienna was, to do honour to a man purely for his scientific work. It is not difficult to get up such an excitement for a politician or a champion oarsman, but I am afraid it will be a long time before so much spontaneous enthusiasm is shown in honour of a physician or surgeon, no matter how great his attainments in those departments.

According to the public press, this was the most brilliant affair of the kind since the time of Rokpitanisky.

J. E. G.

THE CANADIAN

Journal of Medical Science,

A Monthly Journal of 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 forwarding reports of the proceedings of their Associations*

TORONTO, AUGUST, 1882.

HOSPITAL OUT-PATIENT DEPARTMENTS.

The out-patient departments of general hospitals, their use and abuse, have long formed the theme of interesting and animated discussions, both lay and professional. The unquestionable question of their abuse is not however our present topic, regard being merely had to the best mode of use, and the highest proficiency of our own out-door department. And first with regard to the mode of use. As at present conducted, during the six months of the session of the schools, the schoolmen on the staff are told off to take day about in rotation; and during the other six months in the year, the non-schoolmen discharge the duty in like manner. There is, in our opinion, great room for doubt if the out-door department can be as thoroughly and profitably worked by the in-door staff, as it could be by a separate and less busy body. The fact cannot be gainsaid that the labour of seeing out-patients is both time consuming and arduous, and it is scarcely to be expected that those whose available time is pretty fully occupied with in-door cases, will be likely to manifest that same zeal and attention in out-patient work, which might reasonably be looked for from an active, intelligent, and ambitious assistant staff. We should, therefore, rejoice to see a staff of assistant physicians appointed for out-patient duty. Six might be elected to serve one day a week each, or three appointed to go on duty twice a week. This might readily be accomplished by amalgamation with the Toronto Dispensary, or by a judicious selection from the many accomplished

and highly-qualified younger practitioners in the city. We are aware that objections have been expressed to the multiplication of the number of practitioners already connected with the hospital, but we certainly must confess that we do not understand the objections, and, therefore, cannot sympathize therewith. The whole field,—in-door and out-door,—constitutes a rich mine of information, a wide sphere for charity, utility, and humanity, yielding greater results as worked by the greater number.

Apart from the consideration of having the work more carefully and, therefore, better done, teachers should be anxious for the full development of the out-patient department, as capable of securing more material for clinical lectures, and of replenishing the wards with instructive cases. Properly conducted, too, it would serve to relieve the wards of many unsuitable cases without entailing an uncharitable neglect of minor, though distressing, ailments, in cases which require supervision and occasional attention, though not constant treatment. Facilities for gynecological out-patient practice are greatly wanting in this city, and this lacuna in our eleemosynary institutions the out-door department of our hospital might properly be made to fill, two days a week at different hours from the ordinary out-patient visits being set apart therefor. The out-patients' department should be a grand school for the practitioners engaged therein, as well as for the students, and both directly and indirectly of immense advantage to the public. It is with the hope that something of importance may yet be accomplished in this direction that we have ventured, at this juncture, to direct attention to the subject.

OVARIOTOMISTS, ATTENTION!—Dr. J. E. Janvrin, of 191 Madison Avenue, New York City, has been selected to prepare the chapter on the History and Statistics of Ovariectomy in the System of Gynecology by American Authors which is to appear at the end of the year. He is desirous that all who wish their cases published should forward to him before the 1st Sept. next answers to a printed list of questions which will be forwarded to any address on application.

CLINICAL EXAMINATIONS.

We have much pleasure in publishing in this issue a letter from Dr. Burns with reference to his motion in the Medical Council respecting Clinical Examinations. We have often commented on the great importance of practical examinations, and have cheerfully given the Council due credit for the important steps it has taken in improving the character of the examinations year after year. It requires a peculiar aptitude to render a man a good practical examiner, and it was somewhat discouraging to see the Council, at its last session, leave one of the best clinical examiners off the Board, after a term of only two years. An examiner is much better fitted for his work his third year than his first; why should he be dismissed just when his fitness has been thoroughly established, in order to provide a place for a new, untried man who may, as sometimes in times past, prove to be a disastrous failure?

After the appointment of a suitable Board the most important consideration is the adoption of a suitable system, which will enable the examiners to give the candidates an opportunity to show their practical knowledge in the diagnosis and treatment of disease, as well as their practical skill in note-taking, bandaging, surgical dressing, etc. This can only be done by taking the students to the Hospital, or by bringing patients to the Council Hall while the examination is going on, or by both plans. We shall be glad to give space in our columns to any suggestions from medical men who take an interest in this very important subject.

NEW REGISTER.

As before announced, a new Medical Register for Ontario is being prepared, and is expected to be in the printers' hands in a short time. All who have changed their place of residence, or who wish to register new degrees, etc., should at once communicate with the registrar, Dr. Pyne, as requested by him in advertisement which appears in this issue.

The British Medical Association will hold its Jubilee Meeting at Worcester—its birth-place—on the 8th, 9th, 10th, and 11th instant.

MEETING OF THE CANADA MEDICAL ASSOCIATION.

The members of the Profession in Toronto are taking an unusual interest in the next meeting of the Canada Medical Association, to be held in this city on the 6th, 7th, and 8th of September. The Committee of Arrangements appointed at the Halifax meeting, has made large additions to its numbers, and all are uniting in the effort to extend a cordial and hearty welcome to those who come from a distance.

Dr. Daniel Clark, Superintendent of the Toronto Asylum for Insane, has kindly signified to the Committee his intention of inviting the members of the Association to a luncheon in the Asylum.

It has been decided by the Committee that the reception by members of the Profession in Toronto shall take the form of a *conversazione* to be held in the Normal School buildings, which have been kindly placed at their disposal by the Government. We will give further particulars in our next issue.

From the reports which have reached us from a distance, we have no doubt that there will be a large attendance, and we have strong reasons to hope that the meeting will be in every sense a most interesting one. The General Secretary, Dr. Osler, of Montreal, with the assistance of the local Secretary for Ontario, is making arrangements with the railroad, and steamboat companies for reduced fares. The City Council has kindly promised the use of the Council Chamber for the meeting, and it is intended, if possible, to set aside one room for the reception of interesting specimens, pathological or otherwise, exhibited by the members

AN ANNUAL MUSEUM.

It has become a custom much honoured in the observance, in the last few years, to have at all large Medical gatherings facilities afforded for the exhibition of interesting and instructive pathological and physiological specimens, gross and microscopic. Sanitary and surgical appliances may be included. We sincerely trust that all members likely to be present at the Canada Medical Association Meeting next month will spare no effort to make the initiative in this department a grand success. *Ce n'est que le premier pas qui coûte.*

MEDICAL DEPARTMENT OF THE WESTERN UNIVERSITY.

All arrangements have been completed for the opening of this new Medical School in London, on the first of October next. A Faculty has been organized with Dr. Charles G. Moore, as Dean and Lecturer in Surgery. The other subjects are distributed as follows:— Practice of Medicine, Dr. John M. Fraser; Nervous and Mental Diseases, Dr. Bucke; Materia Medica and Pharmacy, William Saunders, F. R. S. C.; Therapeutics and Toxicology, Dr. J. A. Stevenson; Chemistry, James Bowman; Obstetrics, Dr. C. S. Moore; Physiology, Dr. Eccles; Anatomy, Dr. Waugh; Clinical Medicine, Dr. Arnott; Clinical Surgery, Dr. Niven; Histology and Dermatology, Dr. Moorhouse; Sanitary Science, Dr. Jones; Medical Jurisprudence, Dr. Fenwick; Demonstrator of Anatomy, Dr. Wishart; Secretary, Dr. Stevenson.

PERSONALS.

Dr. Sheard has returned from Europe. Drs. Aikins, Covernton, and Graham are still in Europe.

Dr. R. A. Reeve will spend the month of August in the North-West.

Dr. A. M. Rosebrugh of Toronto, is spending his holidays in Manitoba and the North-West. Nothnagal has succeeded the late Prof. Duchek in the Chair of Medicine in Vienna.

Dr. J. E. Graham (Toronto School of Medicine) has been appointed Pathologist to the Toronto General Hospital.

Dr. George Wright and Dr. A. H. Wright, (both of the Toronto School) have been placed on the active staff of the Toronto General Hospital.

Vogt has been called to the Chair of Surgery in Greifswald, as successor to the late Prof. Hueter.

Chiari, of Vienna, has been called to the Chair of Pathological Anatomy at Prague, in succession to Klebs.

Dr. Robert J. B. Howard, of the McGill School, passed the primary examination of the Royal College of Surgeons of England on the 1st ult.

Dr. E. C. Spitzka has been elected Professor of Medical Jurisprudence and State Medicine in the New York Post-graduate School of Medicine. Dr. T. V. Clevenger, Professor of Artistic Anatomy in the Chicago Academy of Fine Arts. Dr. D. W. Cheever, Professor of Surgery in the Harvard Medical School.

JUNE EXAMINATION.—TORONTO UNIVERSITY.
—*Matriculants in Medicine*:—Haultain, C. S.; Johnston, D. R.; Noecker, C. F.; Patterson, C. J.; Reid, J. B.; Farrish, McJ. *Scholarships*:—1. Johnston, D. R., Collingwood Collegiate Institute; 2. Noecker, C. F., Berlin High School.

The death of Dr. Treiber is announced by cable from Athens. He was the physician who attended Byron in his last illness at Missolonghi in April, 1824. By his death Athens loses the last foreign resident who was engaged in the struggle for Greek independence.—*American Medical Weekly*.

Book Notices.

The Announcement of the Woman's Medical College of Baltimore.

Johns Hopkins University Circulars—Biology, work of the past year, 1881-2.

Michigan College of Medicine, Detroit. Announcement for Session 1882-83.

The Detroit Medical College. Announcement and Catalogue, 1882-83.

Toronto School of Medicine. 40th Annual Announcement, 1882-83.

Twenty-Second Annual Announcement of the Bellevue Hospital College, 1882-83.

Electricity in Medicine and Surgery. By I. J. CALDWELL, M.D.

Thirty-Ninth Annual Report of the Managers of the State Lunatic Asylum, Utica, N.Y., 1881.

McGill University, Montreal, 50th Annual Announcement of the Faculty of Medicine. Session 1882-83.

Plastic Splints in Surgery. By SAMUEL N. NELSON, A.B., M.D., Boston. (Reprint from *Annals of Anatomy and Surgery*, April.)

Genius Resistless. An Ode: A Tribute to Jenner and Pasteur. By J. J. CALDWELL, M.D., Neurologist, Baltimore, Md.

Static Electricity as a Therapeutic Agent. A paper read before the New York Academy of Medicine. By JAMES KNIGHT, M.D.

University of Bishop's College. 15th Annual Announcement of the Faculty of Medicine, Montreal, Session 1882-3.

A Contribution to the Subject of Nerve Stretching. By WM. J. NORTON, M.D., New York. (Reprint from *Journal of Nervous and Mental Diseases*.)

The Voice in Diagnosis and Prognosis. By T. WESLEY MILLS, A.M., M.D., L.R.C.P., London. (Reprint from *Canadian Medical and Surgical Journal*.)

Excerpts from Opinions of Distinguished Medical Men in this and other Countries, justifying the treatment of the late President Garfield. By D. W. BLISS, M.D.

Report on Ophthalmology to the Medical Chirurgical Faculty of Maryland, at its 84th Session, April, 1882. By JULIEN J. CHISHOLM, M.D.

Combined Intra-uterine and Extra-uterine Twin Pregnancy, with an analysis of twenty-four cases, and full Extracts from the most important cases. By B. B. BROWNE, M.D., Baltimore, M.D. (Reprint from *Gynecological Transactions*.)

Double Irrigation and Drainage Tubes. Uterine Dilatation by Elastic Force. The Cure of Hernia by the Antiseptic use of Animal Ligature. By HENRY O'MARCY, A.M., M. D.,

Boston. (Reprint from *Transactions International Medical Congress for 1881.*)

Fourteenth Annual Report of the Inebriates' Home, Fort Hamilton, N.Y., for the year 1881. Also a Statistical Report of Six Hundred Cases of Alcoholic Inebriety treated there from Nov. 1, 1879 to Jan. 1, 1881. By LEWIS D. MASON, M.D., Consulting Physician.

Eighth Annual Report of the Secretary of the State Board of Health of the State of Michigan for the Fiscal Year, Ending Sept. 30, 1880.

We are much indebted to the State Board of Michigan, and to its most indefatigable and efficient secretary, Dr. Henry B. Baker, for a copy of this very valuable report, containing as it does many excellent papers and a mass of most interesting and instructive statistical information.

Second Annual Report of the Astronomer in charge of the Horological and Thermometric Bureaus in the Observatory of Yale College, 1881-2. By LEONARD WALDO.

We are pleased to learn from this Report that the number of Physicians' Thermometers examined has more than doubled in the past year, and that a considerable improvement in the manufacture of Thermometers has been noted. The amount of breakage for which the department has been found responsible, is about one-tenth of 1 per cent. There can no longer be found any excuse for a physician employing an uncertain or unreliable thermometer.

A Treatise on the Physiological and Therapeutic Action of the Sulphate of Quinine. By OTIS F. MANSON, M.D., Prof. of Physiology and Pathology, Medical College, Virginia. Philadelphia: J. B. Lippincott & Co. 1882.

This little *brochure*, of some 160 pages, contains an entertaining account derived from a variety of sources of the physiological and therapeutic action of the sulphate of quinine. This remedy has grown to be regarded almost as a panacea, and like all medicines of that class is oftentimes employed irrationally, empirically, injudiciously, and injuriously. It is well, therefore, that its extravagant use should be curtailed by a due appraisalment of its virtues

and capabilities. If in the attempt we can learn something of its proper use, and mode, and time of use, so much the better. As an honest contribution to this end we commend the book.

Minutes of the Proceedings at the Sixth Annual Meeting of the American Gynecological Society.

This meeting was held in New York, in September 1881, and we are pleased to find the minutes of the proceedings, included with the reading of papers and the discussions thereon, recorded in the present volume. Although much of the subject matter is not new at the present time, having been already published in the Journals, still we are glad to see the continued publication, year after year, of the proceedings of a society which is second to none in the world in this important branch of medicine. We have in this Province very few gynecologists proper, but our general practitioners are taking much more interest in the subject now than formerly, and in their treatment are guided chiefly by the American specialists. We are, therefore, unusually interested in everything done by this society and proportionately pleased to have the opportunity of obtaining these "reports" which are got up in such a way as to be a credit to the publishers, and to the indefatigable and genial secretary, Dr. Chadwick.

Atlas of Gynecology and Obstetrics. By Dr. E. MARTIN, Professor of Gynecology at the University of Berlin, and Dr. J. P. MAYGRIER, Membre de l'Académie Royale de Médecine, Professeur de Accouchements, containing 475 plain and 35 coloured illustrations. A. E. Wilde & Co., Cincinnati, publishers.

These drawings are from the original designs of the master names in English, French, and German obstetrics and gynecology and pathology. The explanatory text is translated and edited with additions by Wm. A. Rothacker, M.D., Pathologist to the Cincinnati Hospital. The Atlas is designed as a hand-book supplementary to the text books and treatises in general use, and is issued in 15 parts for the moderate sum of \$1 per part. We are just in receipt of Parts VI. to XV. inclusive, and having regard to the way in which the work

has been completed have no reason to modify the high encomiums we passed upon the first four numbers. It would be impossible in our limited space to give an account of the work in detail, but, speaking in a general way, we have no hesitation in saying that it is the best work of its kind we have yet seen. Doubtless, in some instances, there is room for improvement both in the selection of the subject illustrated and the illustration itself; but until something better is produced we must award the palm where the highest excellence is to be found.

Clinical Lectures on Diseases of the Urinary Organs. By SIR HENRY THOMPSON. Sixth London edition. Illustrated with 73 wood engravings. London: J. & A. Churchill. Philadelphia: P. Blakiston, Son & Co. Toronto: N. Ure & Co., 5 King Street West.

This well-known text book which has been translated into five languages, and is universally recognised as the best treatise on the subject in six, needs no further commendation than the announcement of a sixth edition. The general superiority and other special merits of this edition may be stated in the author's words: "Among several important additions, the modern operation of Lithotomy at a single sitting, is fully considered and illustrated, and is regarded as superseding the old operation, and to a great extent the operation of Lithotomy. * * * * I venture to believe that my intention has been more fully realized in this volume than in any of its predecessors. I have also thought it desirable to follow a course which has been recently pursued with manifest advantage to the public, in works of general literature, and have issued this edition, which is more comprehensive and complete than any previous one, at less than a fourth of the former price, so as to bring it within the reach of all students." The modest sum demanded for this volume is 85 cents—a price at which no student or practitioner in however straitened circumstances can afford to be without it. We trust that other wealthy medical writers will not be slow to imitate the good example thus set by the most eminent lithotomist of the age. *Longum iter est per praecepta, breve et efficax per exempla.*

Meetings of Medical Societies.

MEETING OF THE BATHURST AND RIDEAU MEDICAL ASSOCIATION.

The Bathurst and Rideau Medical Association held their annual meeting at Smith's Falls on Wednesday, June 28th, in the Town Hall.

There were present Dr. J. G. Cranston, of Arnprior, President, Drs. Hill, Grant, Sweetland, H. P. Wright, Horsey, H. B. Small, Secretary, and Powell, of Ottawa. Dr. Baird, Pakenham, Drs. Burns and Lynch, Almonte, Dr. Preston, of Carleton Place, Drs. Atcheson and McCollum, of Smith's Falls. Dr. A. Malloch, of Hamilton, who happened to be in Smith's Falls on a visit, also attended the meeting.

The President gave a short and interesting address, alluding feelingly to the deaths of Dr. Blackwood, of Pakenham, and Dr. Weir, of Merrickville. He then gave an account of the late meeting of the Medical Council, and concluded by asking all present to revive the Association which, during the past three years, has gradually been dwindling in size and importance.

The election of officers was then proceeded with and resulted as follows:

Dr. J. G. Cranston, President elect.

Dr. Horsey, of Ottawa, and Dr. Burns, Almonte, Vice-Presidents.

Dr. Hill, Ottawa, Treasurer.

Dr. Small, Ottawa, Secretary.

Drs. Grant, Sweetland, and H. P. Wright, of Ottawa, and Dr. Dickson, Pembroke, Dr. Lynch, Almonte, Dr. McCollum, Smith's Falls, Dr. Baird, Pakenham, were elected as the Council.

The only prepared paper was one by Dr. R. Powell, of Ottawa, entitled "The Significance of Cardiac Murmurs." He dealt chiefly with the pathology, physical signs, and relative importance of murmurs.

A few questions on the paper were put by Drs. Small and Hill, and replied to by Dr. Powell. The usual vote of thanks was moved by Dr. Hill, and seconded by Dr. Grant, and tendered by the Chairman to Dr. Powell.

Dr. Grant then addressed the meeting, advocating a system, too much neglected, of the family physician being allowed to examine his

regular patients thoroughly, at least once in two years, so as to enable him to detect, and if possible, check approaching disease. This process he termed "keel-hauling."

Dr. H. P. Wright then related an interesting case of phantom tumour which occurred recently in his practice. This case will no doubt be submitted to the profession in a more prominent way shortly.

Dr. J. G. Cranston then gave a short account of a case of elongation and hypertrophy of the cervix uteri of remarkable interest, which he has at present under observation. The case is probably unique, and will deserve publication whether operated on or not. We will look for an early report.

The Society then adjourned to meet in Ottawa in January, 1883. Five of the members were requested to prepare papers.

Dr. Atchison then entertained the members at a convenient resort, when the customary "you scratch my back and I'll scratch yours" was gone through, accompanied by happy speeches and felicitous responses. The detention of the C.P.R. train for two hours was in this case a happy accident.

MEETING OF THE PROVINCIAL BOARD OF HEALTH.

A Meeting of the Provincial Board of Health was held in the Parliament Buildings, 27th June. Present—Dr. Oldright, in the chair, Drs. Cassidy, Rae, and Hall, and Dr. Bryce, Secretary.

Several communications were read, amongst them being one from Dr. Baker, Michigan Board of Health, as to the time required for the compilation of weekly health reports; one from Mr. Henry Hughes, Sanitary Inspector, Lindsay, as to various nuisances existing in that town, and another from Mr. Milroy, as to an epidemic of low fever and ague in Coboconk.

CONSIDERATION OF REPORTS.

Dr. Rae read a report containing certain recommendations to the Government on the subject of inspection of immigrants, which was considered in Committee of the Whole, and adopted with slight amendments.

The Chairman read an exhaustive report on

the sewerage and water supply of this city, particularly referring to the necessity of constructing a covered drain at the Garrison creek, the draining of University creek, and the reconstruction of Sherbourne-street sewer. The report embraces certain recommendations on these and other subjects, so as to strengthen the hands of the City Engineer in carrying out these improvements on sanitary grounds.

RESOLUTIONS PASSED.

It was moved by Dr. Cassidy, seconded by Dr. Hall, and carried, "That, whereas, it is the opinion of this board that contagious diseases frequently originate on shipboard solely from impure air, be it, therefore, resolved that it is a matter of great moment for the prevention of such diseases that ships should be constructed with a view to thorough ventilation, that in no case should hatches be closed without means being provided for the circulation of pure air in the meantime, and that the Government should insist on measures to secure such an end."

It was moved by Dr. Rae, seconded by Dr. Cassidy, and carried, "That Dr. Covernton be commissioned to attend the Congress of Hygiene to be held at Geneva from the 4th to 9th September next."

On motion, the Secretary was commissioned to visit Boston, Albany, and New York for the purpose of procuring information on sanitary matters, and as to the introduction of a vaccine farm. The subject of the introduction of the teaching of Hygiene in schools, as recommended by the Ontario Medical Association, was introduced by Dr. Oldright, but action thereon was deferred till a subsequent meeting.

Several other routine matters were considered, and the board adjourned.

INSECTICIDE LOTION.—F. BENVENUTI.—Dried flowers of the larkspur, 3 grammes, water 100. Macerate for 36 hours and strain. The inodorous and highly-coloured liquid thus obtained is employed as a lotion to destroy the pediculi pubis. Vinegar may be substituted for the water. Two lotions have constantly sufficed to destroy the lice and their eggs, without giving rise to either burning or itching.—*L'Union Méd.*

MEETING OF NOVA SCOTIA MEDICAL SOCIETY.

The Thirteenth Annual Meeting of this Society was held at Kentville, N.S., June 28th and 29th, the Vice-President, Dr. McPherson, of North Sydney, being in the Chair. The meeting was an interesting one and some of the discussions were quite animated.

On the second day the profession of Kings County gave them a luncheon, after a drive to North Mountain. The officers appointed for next year were: President, Dr. W. B. Slayter, of Halifax; 1st Vice-President, Dr. H. B. McPherson, North Sydney; 2nd Vice-President, Dr. H. Shaw, Kentville; Secretary-Treasurer, Dr. J. Somers, Halifax. It was decided to hold the next meeting at Truro on the third Wednesday in June, 1883.

TORONTO MEDICAL SOCIETY.

May 18th, 1882.—The Society met at 8.20, the President, Dr. Geo. Wright, in the chair. After reading of minutes of last meeting the President delivered his inaugural address, in which he reviewed the history of the Society from its inception four years ago, dwelling on the advantages afforded by such an association, for the discussion of all matters of scientific importance to the profession. He deprecated the diffidence sometimes shown by the members in furnishing papers, and expressed the hope that the current year may be one of gratifying prosperity.

Dr. Reeve then read an exhaustive and practical paper on "Diseases of the Eye," a full report of which has appeared in the JOURNAL.

Dr. Cameron exhibited a case of squamous pustular syphilide on the forearm of a washer-woman.

Dr. Oldright related a case of paracentesis thoracis, in which there were alarming symptoms, owing to a too rapid exhaustion of the fluid in the pleural cavity.

After some miscellaneous business the Society adjourned.

June 1st, 1882.—The Society met at 8.25, the President in the chair.

Drs. Sweetnam, Stark, and Riordan, were elected members of the Society.

Dr. McPhedran read a paper on acute peritonitis, treating of the etiology and treatment. —(Vide p. 262.)

Dr. Macdonald exhibited an instrument devised for twisting wire sutures in places difficult of access.

Dr. Oldright presented to the Society the photograph and notes of a pathological specimen, shown at the Ontario Medical Association, June, 1881.

After miscellaneous business, the Society adjourned.

Miscellaneous.

SMALLPOX IN BIRDS AND POULTRY.—The *Pittsburgh Medical Journal* states that Dr. Hewson, of Philadelphia, has traced the source of cases of smallpox to the English sparrow, in whose houses he has invariably found evidences of the disease. Also the Editor of that journal saw, in 1849, smallpox in poultry, covering the head and combs of the fowls, and quotes an extract from the *British Medical Journal*, in which it is stated that variola in India is prevalent amongst the pigeons and poultry.

THERAPEUTIC MEMORANDA. — Dr. John Meredith, in the *Birmingham Medical Review*, extols oil of peppermint as an external application in herpes zoster, both for the neuralgic pains often so piteously complained of after the eruption has disappeared, and as an application over the eruption in its fresh florid condition. Dr. Cambillard (*Courrier Medical*) recommends for chorde an injection 4ter die and repeated just before going to bed, composed of pot. brom. gr. 80; glycerin ʒi ss laudanum ʒi water ʒivss. Dr. Nowatschek reports favourably of the use of atropine either internally or hypodermically (into the perineum) in spermatorrhœa.

ÆSTHETICS IN CATHARTICS.—Bunthorne, the "fleshy poet," in the new opera "Patience," gives the following as "a wild, weird, fleshy thing, yet very yearning, very precious. To

understand it, cling passionately to one another and think of faint lilies :”

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

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

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

—*Michigan Medical News.*

DR. HOLMES ON HOMŒOPATHY. — In a late address, Dr. Holmes gives the following estimate of homœopathy, the careful study of which we commend to the supporters of the New York Code : “ Homœopathy has no *status* among the biological sciences, and has nothing of any practical value, so far as I know, to offer the medical profession. It began by promising to prevent scarlet fever, which it miserably fails to do, and from that day to this it has been a romance of idle promises slipping through the fingers like quicksilver, evaporating without residue like ether from the palm of the hand. If any one of these promises had been fulfilled, if any single remedy brought forward by homœopathy had proved trustworthy and efficacious, it would have been thankfully accepted by the medical profession, which welcomes every method of help unless it shows itself with false pretences, and even then will appropriate any fraction of truth which underlies the deception or delusion. . .

“ So far as I can take account of the stock, the present assets of homœopathy consists of a pleasing and sonorous designation, a nomenclature of symptoms, with sets of little phials, containing globules, which are the prettiest and most fascinating of amulets, arranged to correspond with the nomenclature, a collection of

“ provings ” which prove more about the prover than about the questions to be proved, and a doctrine which slips on and off like a kid glove, according to the company in which the practitioner finds himself.”—*Medical News.*

THE MAN SNAKE.

In the village of Cuantla, Mexico, says a recent number of *La Independencia America*, belonging to the Canton of Antlan, lives an individual whose scaly skin is in every way like that of the rattlesnake, even to the greenish colour; possessing, besides, the property of changing his skin every autumn; such phenomenon being accomplished all at once, and not by parts, so that the entire body is left like what is vulgarly called *Trown*, (a smooth leather bag, flesh side out), and not even a single hair is left. A sister of this individual, who died a short time ago, manifested the same phenomena and became gradually blind, for the new skin went on covering the eye-lids together in a circular form, until the eyes themselves were covered. The same thing is happening to the man who is living, who has already some small circles, that only permit him with difficulty to see and distinguish surrounding objects. Thus he presents the repugnant figure of the head of a rattlesnake. In Cuantla, these unfortunate people are known by the name of “ the rattlesnake man and woman,” and their appearance is attributed to the fact that their mother had eaten too much rattlesnake to cure herself of a disease of the blood. [Rupia, most likely, *Translator.*] Whatever the phenomenon may be, it is worthy of study. Would that the man could be induced to come to this capital (the city of Mexico), in order that his disease might be studied by the members of the profession !

A. A. R.

Births, Marriages, and Deaths.

MARRIED.

At “ Hillside,” Brantford Township, at the residence of the bride's father, by Rev. S. Sellery, B.D., on the 29th of May, J. Willmot, M.D., of Charlotte, Mich., to Martha V., third daughter of N. Lee, Esq.

DEATH.

At Simcoe, on the 28th July, John Salmon, M.D., aged 52 years.