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CANADA
MEDICAL RECORD

NOVEMBER, 1902.

Original Communications.

SEPTICEMIA AND THE CURETTE.

BY H. PLYMPTON, M. D.; BROOKLYN, N. Y.

To attempt to break up an old established custom in any line of life is at best a thankless job, and one likely to call down harsh criticism upon the head of the daring iconoclast.

To attempt to uproot old prejudices existing in favour of a certain line of practice in surgery, and diametrically oppose such practice, is to invite from some, adverse criticism of the harshest kind. The only recompense for this is a logical refutation of, or concurrence in the argument advanced, on the part of other members of the profession.

This latter is what I hope for, and if I provoke a discussion, or start a line of thought in the minds of half of the readers of this article, I shall have achieved all I started out to do.

Curetting the uterus to remove fragments of after-birth or other debris has been taught in our Medical Schools from time immemorial, and it is firmly fixed in the receptive and retentive mind of every Medical student that the first move following any such abnormal uterine condition is to cleanse the uterus by means of the curette.

That the organ should be thoroughly and aseptically cleansed admits of no argument, but that the work should be done with the curette I deny most emphatically.

The majority of cases of death following the decomposition of foetus or placenta in utero are caused by the use of the curette, and I hold that septicemia may be avoided if a more rational procedure be resorted to.

The condition of the uterus containing septic matter is one of great congestion, the thickened walls being coated internally and over the os with a thick, brown, tenacious mucus.

The congestion is active, and therefore the more dangerous in the event of the admission of septic matter into the circulation.

If the curette is used, denuding the walls of their protective covering, an immediate vaccination takes place with a septic virus, septicemia following in an incredibly short space of time (chemical metamorphosis is marvellously rapid in the circulatory system), and death quickly ensues.

If, without using the curette, we can remove the septic matter from the uterus without disturbing the mucus covering, and enable the uterus of itself to expel the coating, we shall have taken a long step forward in the treatment of this class of uterine cases.

The uterus by reason of its congestion may be made to perform a self-cleansing act by exciting the exudation of the serum of the blood into its cavity, thereby washing itself out, and expelling all septic matter instead of absorbing it.

This process of exosmosis is induced by a properly combined alkaline solution at a temperature above 100° and a strict avoidance of bi-chloride, carbolic acid, formaldehyde, or any antiseptic of an acid reaction or astringent nature, which would coagulate the fibrine and albumen of the blood.

My method of procedure is as follows:

First, the gentle removal of whatever fragments are lying in the uterine cavity, by means of forceps, care being taken not to tear from the walls any adherent piece.

Second, the gentle flushing of the uterine cavity with the alkaline solution (110°), the reservoir containing the fluid being not more than two feet above the level of the hips.

If the flushing could be continuously administered for a few hours (say two or three), the conditions would be more speedily reduced to normal, but the discomfort of the position of the patient (on a douche pan), prevents this, and a flushing once every two hours with one quart of solution is about the limit of treatment.

For flushing the uterus, I use a small dilating uterine douche, and as there is plenty of room for the escape of fluid and fragments, there is no danger of fallopian colic or salpingitis.

The first flushing is frequently followed by contractile pains and expulsion of any previously adherent pieces, together with much of the mucus.

A tablet of Ext. Cannabis Indica, gr. $\frac{1}{4}$.

“ Ext. Ergotin, “ gr. $\frac{1}{2}$.

every hour till desired effect is produced will contract uterus and alleviate pain.

The bowels should be moved freely, both by enema and catharsis.

During the interval between douches, the patient should be kept on her back with the hips sufficiently raised to permit the retention in the vagina of as much of the alkaline solution as it will hold.

The rapidity with which this treatment will reduce temperature, relieve pain, stop vomiting and remove offensive odor is marvellous to one who has not tried it. Sometimes two flushings are sufficient to cleanse the uterus thoroughly, vaginal douches being all that are needed subsequently to complete the work.

Uterine congestion is speedily relieved, and the uterine discharge changes from brown, thick, bad smelling mucus to a thin transparent one, accompanied or followed by more or less of a flow of blood.

A reduction in the frequency of the flushings is desirable as soon as a tendency to return to normal conditions begins to be observed, as it frequently will within twenty-four hours. Then simple vaginal douches every three hours with an occasional uterine flushing if symptoms indicate it.

The action of exosmosis (and endosmosis, for there is every reason to believe in the absorption of some of the fluid) is what is desired to relieve the existing congestion, as in bronchitis, pneumonia, congestion of kidney, congestion of any mucous membrane, etc., and is the most rational means of restoring to normal condition.

I do not wish to be understood as decrying the use of that most valuable instrument, the curette, but only the abuse of it, to wit: its employment under such conditions as make it practically a sharp weapon loaded with septic matter, dangerous beyond the poisoned arrow of the Malay, or the fang of cobra, and utterly opposed to our modern ideas of antiseptis.

PROCEDURE IN POST-MORTEM MEDICO-LEGAL EXAMINATIONS.

BY CHARLES A. HEBBERT, M.R.C.P., London,
Professor of Anatomy, Bishop's College, Montreal.

CASE 7.

This case is published for the purpose of bringing forward several points in the cases of presumed infanticide and to draw attention to the law on the subject, and further, to demonstrate some ill-defined or imperfectly understood conditions which a medical jurist may have to determine or elucidate, and probably lead by such methods to some clearance of the difficulties he may have to contend with. It may be stated that the inquiry was as to the death of an illegitimate child born in secrecy, the mother being alone and seated on the water closet at the time of

EXTERNAL APPEARANCES.

The body was that of a male infant, 19 inches in length, weight 8 lbs., the testicles were in the scrotum, the finger nails projected beyond the finger ends and the toe-nails were at the level of the toe ends. The umbilical cord was attached. The whole length of the cord was $3\frac{1}{2}$ inches, of which 1 inch showed an irregular obliquely torn margin. There was no sign of ecchymosis in this margin. There was an ecchymosis over the glabellum, and the upper lip was swollen and showed some marks of bruising. The lower lip and chin were free from bruising. The tongue was clenched between the gums. The surface of the body was pallid and *rigor mortis* was present.

INTERNAL EXAMINATION.

Head.—No fracture of skull. Brain normal. The tongue, with larynx, pharynx, trachea, œsophagus, lungs, heart and thymus gland, were removed *en masse*. The lungs floated in water and had been fully aerated. There were no ecchymoses visible on the pericardium or pleura. The larynx, trachea and bronchi down to the third and fourth division appeared healthy, and there was no reddening or softening of the mucous membrane in any part of the tract.

The Heart.—The right side was engorged with black fluid blood.

Abdomen.—The stomach was empty. The mucous membrane pale and no ecchymoses noticeable. Small intestines empty. Large intestine contained some meconium.

The liver and kidneys were apparently normal in structure, but somewhat dark in colour, and congested. The spleen was normal. Bladder empty. The verdict returned was that the child had been born alive at full term and that the cause of death was probably due to asphyxia.

COMMENT.

The first point of importance in this case was how far the mother was responsible for the death of the child, and

whether or not a charge of homicide should be brought against her? The child was expelled in the pan of a water-closet, the mother being alone and unattended; the child was born alive, but died before severance from the mother, as shewn by the absence of ecchymosis in the foetal end of the cord. The placenta was removed from the mother some hours later with some difficulty on account of firm adherence to the womb. This fact with the ragged appearance of the foetal end of the cord would indicate a forcible tearing of the structure, as might occur on a woman suddenly arising from the seat of a closet, the weight of the child on the one hand and the firm union of the placenta to the womb on the other hand causing a sudden fracture of the cord at the point of least resistance.

The bruising of the glabellum and the upper lip, the two most prominent parts of an extended head in delivery, would suggest the impact of those parts at the time of expulsion on the hard floor of the basin and the fact that the basin must have contained various fluids would account for the cause of death, partly from asphyxia, partly from shock, and it may be added from the fragility of a newborn child's life. Every practitioner knows how hard sometimes it is to preserve a child's existence on birth even under the most favourable surroundings, and how much harder it must be for a child to survive under the circumstances of non-attention, the complete ignorance of the situation and the terrified state of the suffering woman at such a time.

The verdict that the mother should not be incriminated was obviously just.

Now, the next point of importance is the law on the subject.

The law humanely assumes that the child has been born dead until the contrary is proved, and in this accepted proof the question is involved as to when does a child become a human being.

The Criminal Code, 1892, 55-56 Vict., c. 29, criminal offences, Part xvii., section 219, defines:—

A child becomes a human being within the meaning

of the Act when it has completely proceeded in a living state from the body of its mother, whether it has breathed or not, whether it has an independent circulation or not, and whether the navel string has been severed or not. The killing of such a child is homicide when it dies in consequence of injuries received before, during or after birth.

SECT. 271—KILLING UNBORN CHILDREN.

1. Every one is guilty of an indictable offence and liable to imprisonment for life who causes the death of any child which has not become a human being, in such a manner that she would have been found guilty if such child had been born.

Now, in this case it was clear that the child had legally become a human being, because it had fully breathed, but, at the same time, had died before it had an independent circulation from the mother, as shewn by the evidences of the umbilical cord.

The question is, under which section the woman could be indicted? It was clear that the cause of death was not the result of either wilful neglect or criminal interference, but rather due to the fright and lack of attention attending such a situation; and it would have been a grave mistake to have prosecuted the woman on the more serious charge. On the other hand, she could not be liable to the minor charge, as the child had been pronounced a human being. Separate existence ought to be more clearly defined. Should a child which has breathed, but has not had a separate circulation, be considered as the victim of homicide? The law says yes, but the foregoing is a case which might suggest some emendation of that clause.

I have thought this subject worth airing and considering, for the issues may be very important, involving the liberty or even the life of a person.

In the first section of the code quoted, a child is accepted as a human being if it has breathed, without a separate circulation, or has had a separate circulation without having breathed, or either the first or second condition

whether the cord is severed or not, and the charge is homicide if this being dies by interference. It might be reasonably argued that, biologically, a being is not a being until the functions of life, breathing, circulation separate from the mother have been completely established and the being is organically capable of maintaining its own existence.

This, then, is the dilemma; legally, a human child is a human being with a possible imperfect separate existence. Biologically, it is not until the separate life of the organism is complete and self-maintaining.

I have consulted several eminent lawyers on these points, and they fully appreciate the legal difficulties which may arise. I have brought forward this case as suggestive, and to invite some comment and argument on the subject.

Selected Articles.

THE DIFFERENTIAL DIAGNOSIS OF PLEURITIC EFFUSIONS.

BY DR. ALEX. VON KORANYI, PROFESSOR AT THE FACULTY OF
MEDICINE AT BUDAPEST.

It is well known to clinicians that many cases of pleuritic effusion are difficult, if not impossible, to delimit by percussion owing to one or more of the solid organs, such as the liver, lying in the immediate neighbourhood of the effused liquid. These cases, rare though they be, are sufficient to prove the existence of certain defects in our means of clinical investigation. The importance of Traube's space in the diagnosis of left-sided effusion is also a factor in the diagnosis of all such cases, one, too, that should not be overlooked in the delimitation of the chest. This is a space which is often filled by increase in size of the liver, the heart, or the spleen, and these conditions require to be differentiated from pleuritic effusion. The space is in the lower part of the thorax lying between the liver and spleen. This, the so-called Traube space, is often the most difficult to percuss owing to the frequency of its being filled with fluid, while above it may be found the consolidated lung, fluids always gravitating to the low-

est level. In this case the crescentic outline of the lung will still be observed whether the dulness be present or not. The same difficulty prevails posteriorly in defining the limits of the lung and spinal column. It is with this object in view, and to elucidate the utility of transsonant percussion, that the author has approached the subject.

If the stethoscope be placed over a solid organ of the body at a point where it approaches the parietes, and the part percussed at the same time, a peculiar sound of a shrill ringing character will be heard. This sound continues as long as the percussion is within the parietal contact limits of the auscultated organ, but ceases immediately the limit is passed. By this means the surface contact of a parietal organ can be accurately delineated on the surface of the body. The author has marked out the boundaries in many obscure cases by this topographical percussion, which could not have otherwise been accomplished. The author uses a simple binaural stethoscope with two india-rubber tubes fitted with olive-shaped vulcanite ends for the ears. The point of the left index finger is pressed well down into the surface of the body and then struck with the firmly extended finger of the right hand. This form of percussion is a slight modification of Reichmann's, who employed a rod to press into the surface, which he struck with the finger in percussing. Either method may be employed in this form of auscultation, and the results obtained will be in proportion to the operator's experience of the particular method, as the principle is the same, though reduced to its simplest form in the striking of the finger.

The method adopted by the author is to press the point of the left index finger well into the thorax, and then strike it with a finger of the right hand; either method gives a similar tone by the stethoscope. Long and careful observation is absolutely necessary to prevent mistakes. One point might be noted for the benefit of those who have not practiced this form of auscultation, viz., that the distance between the finger and the stethoscope must not be too great, or the sound may be so altered as to lead to error; it is therefore necessary that the finger should slowly and methodically follow the stethoscope in percussing the organ. Again, the ribs are good conductors of sound, and may lead to error if the finger be not well pressed down between them, more particularly in the neighbourhood of the sternum. In the event of one's not being able to get between the ribs, an assistant may be directed to place his hands on the chest on either side of the point which is under examination; for instance, one on the sternum and

the other on the lateral wall of the thorax. By this device the author has been able to percuss the most complicated cases with excellent results.

This form of auscultatory percussion enables one to analyse the dulness of a number of organs lying in very close proximity to each other, which can be done with perfect accuracy and ease, when the heart, liver, and stomach are clearly defined.

This method of diagnosis is particularly valuable in left-sided pleuritic effusion. If the stethoscope be placed on the outside of the cardiac area it will be found to have extended far into the effusion if followed to its outer border. In percussing the exudation itself it must be borne in mind that the upper part of the dulness does not accurately define the limit of the effusion, as more accuracy will be required to define the line of demarcation between the compressed lung and the fluid. If the thorax be percussed behind, it will be difficult to limit the effusion externally, as the lung will gradually sink; but if percussed towards the spinal column it will be found to go across the medial line, towards the right or healthy side.

The lower margin of the fluid is another important feature in the diagnosis, which practically should extend from the twelfth rib posteriorly along the margin of the thorax to the front, but in practice it will be found to be far below the marginal vault of the thorax, as the exudation by its own weight tends to push the diaphragm down, and thus distend the pleural sac in that direction. On the other hand, the empty lung will be found, not in the complementary space made by this depression of fluid, but highly placed in the posterior part of the thorax about on a level with the ninth rib in the scapular region. It will be seen that the defining of an effusion is a long and tedious process, and entails what in many cases is unnecessary labour; but questions do sometimes arise that tax our ingenuity to the utmost to delimitate effusions from some other morbid change that may lead us astray in operating—for instance, if it be doubtful whether the case is pleural effusion or pneumonia or whether there is effusion with pneumonia. This can easily be differentiated by placing the stethoscope within the scapular line and slowly percussing outwardly. If a pleural effusion exist the dulness will follow the costal curve, but if it be pneumonia without effusion the alteration in sound will be two inches higher than the curve. By the same process of examination both sides may be high and reveal double pneumonia, while an effusion in both sides would be two inches lower than the normal.

The author urges that no one should be without this knowledge in the diagnosis of disease, which can only be made practical by long experience and careful observation. Its value is not confined to the delimitation of Traube's space, as he has already shown, but may be extended to many obscure cases constantly presenting themselves to the clinician.

In conclusion, it should be noted that the thick muscular masses on both sides of the spinal column are good conductors of sound, and may lead to an erroneous conclusion when percussed by the resonant method; but if the scapular line be taken as a guide there is less risk of error.—*Dublin Medical Press.*

THE EMPLOYMENT OF DIGITALIS AND ACONITE IN THE TREATMENT OF CARDIAC DISEASE.

By H. A. Hare, M. D., Professor of Therapeutics in the Jefferson Medical College,
of Philadelphia.

Among all the difficulties which have beset the subject of the proper use of drugs in disease, and there have been many, as we all know, it cannot be doubted that the factor of greatest importance has been the employment of remedies by physicians without their having a correct conception, and sometimes no conception at all, of the pathological process underlying the condition which is to be relieved. This depends upon the fact that many practitioners lack preliminary training, not only in morbid anatomy and morbid physiology or pathology, but also fail to study the possible effect of well-known drugs in abnormal states. The employment of certain remedies in disease has cast discredit upon therapeutics by their abuse, while many physicians who have carefully studied diseased organs become so saturated, so to speak, with the seriousness of the lesions which they find, that they scoff at the thought that drugs can be of service, forgetting that the vital powers are eliminated at the autopsy, and that the conditions present represent a state so grave that death has taken place—that is, the worst possible state of affairs is seen. I have made these opening remarks because I do not wish to be considered a therapeutic optimist or nihilist, and because I so often emphasize the fault of using drugs when they cannot do good that I fear I may be called a therapeutic unbeliever. In no class of cases

does what I have said hold true with greater force than in those of cardiac disease. Some physicians are content to diagnose valvular disease, prescribe digitalis, and ignore the state of the heart muscle, the state of the blood vessels and that of the kidneys, liver, and even the dose of the drug, so long as it is within bounds not poisonous.

It has always seemed to me that it is the duty of the physician to study the condition of the heart muscle, and almost entirely exclude any suppositions as to the condition of the valves of the heart. While this may be an exaggerated way of making the statement which I wish to emphasize, it is resorted to because in the majority of instances we are apt to endeavour to decide which segment is diseased without a correspondingly careful study of the condition of the ventricular wall.

Again, it is by no means an uncommon practice of physicians, after determining more or less carefully the condition of the heart, to fail to make a careful study of arterial tension, pulse force, and, equally important, to attempt to discover whether there is arteriocalillary fibrosis. Upon the condition of the heart muscle, and upon the development of arteriocalillary fibrosis, much more depends in the diagnosis, prognosis and treatment of a case of so-called cardiac disease than is usually thought. It is also not permissible to reach correct conclusions in regard to these important factors in the case unless at the same time the renal condition is adequately investigated. And, again, it is not sufficient in many of these cases to be content with one or two examinations of the urine, which may fail to reveal albumin, unless at the same time estimations of urea are also made, and a careful record of the quantity of urine and of its specific gravity is kept. Not only do these renal conditions aid us in getting information concerning the probable conditions of the heart muscle and of the blood vessels, but they also give us an insight into the ability of the kidneys to eliminate poisonous materials and the drugs themselves, both of which, if retained to an abnormal degree, produce results which are disadvantageous.

I have within the last few years devoted a great deal of attention, not only to these factors in these cases, but as to the question of the proper administration of the various cardiac stimulants, and, equally important, as to the dose which each individual patient needs from day to day.

Digitalis, like iron, has proved itself so valuable, doing good in so many instances which seemed grave, that we are

wont to forget that, like most things which do good, it can also do harm, and judging from my previous habit, and from the habit of other practitioners, I am convinced that in the great majority of instances digitalis is administered in doses which are much too large, and often continued over a period which is far too long. It is by no means an uncommon thing to find physicians administering as much as 10 or even 20 minims of tincture of digitalis three or four times a day in cases of marked rupture of compensation. There can be no doubt that in some cases such doses are necessary at the beginning of the treatment to meet the crisis which exists, and in much the same way that we are wont to give large doses of mercury in early syphilis, afterward cutting the doses down one half, so it may be necessary at times to give massive doses of digitalis which, after a period, should be rapidly and considerably diminished. I have been surprised to find what excellent results I could produce by the use of such small amounts as one or two minims of an active, physiologically tested tincture of digitalis given three or four times a day, the patient being, of course, required to rest and so give his heart that most needed therapeutic aid when its compensation is ruptured.

Apropos of this, I may add that in my belief we often fail to get results from doses and from drugs upon which we rely, more because we are careless as to the physiological activity of the product than because we have made an error in judgment as to the remedy which is needed, or the dose which is required. With the important subject of the employment of drugs closely related to digitalis in the treatment of various cardiac conditions, there is not space to deal in this paper. In deciding what cardiac stimulant is required in a given case, we must not only consider the condition of the valves and the myocardium as already indicated, but we must, if possible, reach some conclusion in regard to the state of the coronary arteries. Digitalis, which improves the nutrition of the heart, largely by improving the circulation in these arteries, can manifestly do more harm than good, if these nutritive vessels are so nearly closed that it is impossible for the heart to pump blood through them in increased quantity. And again, the myocardium may have undergone such advanced degeneration that it is impossible for the digitalis to improve the nutrition of the heart, although at the same time it may be driving the remaining healthy fibers to an endeavour far in excess of their ability.

I am also quite sure that in a certain number of cases of valvular disease the patient does not require digitalis or any other cardiac stimulant for the relief of his cardiac symptoms; but, on the other hand, in addition to rest, will often be greatly benefited by the administration of aconite, which has the same steadying effect upon the heart through its influence on the vagi as has digitalis, while by its sedative influence on the heart muscle in cases of excessive compensation, and by its relaxing effect upon the blood vessels, it diminishes the overaction of hypertrophy which is sometimes confused with the tumultuous overaction of ruptured compensation. It is much easier for us to conclude, in the case of valvular disease, with dyspnea and disturbed heart action, that these symptoms are due to a failing heart than that they are due to a hypertrophy and an excessive activity. Such cases I have frequently seen in men who are well developed, in the muscular sense, and whose occupation has caused them to do heavy manual work, or to take part actively in some of the severe athletic games. And not infrequently have I seen other cases in which the use of well-balanced doses of aconite and digitalis have produced results which neither drug could produce by itself, although at first glance they are physiological antagonists.

Finally, the utter uselessness of expecting good results from either of these drugs in the treatment of certain cases of myocardium disease which persistently take severe exercise "for their health" needs to be emphasized. I have repeatedly seen cases of men of advanced years with somewhat fibroid blood vessels who have mistaken the heaviness of advancing years for the heaviness of lack of exercise, and who on the golf field, on the bicycle, or by rowing or walking, have tried to drive away the symptoms from which they suffer, with a result that sooner or later the condition from which they are suffering becomes greatly aggravated, and they become more or less invalids if they are so fortunate as to escape sudden or nearly immediate death from their ill-judged efforts. It seems to me, too, that when we are attempting to treat such cases, and are endeavouring to administer doses and remedies as accurately as possible, we should insist upon quiet and a careful mode of life until we are able to determine that the remedies suit the case, for otherwise the change of exercise or change in diet may not only prevent the remedies from doing good, but also warp our judgment as to our own plan of treatment, and prevent us from instituting it in another case, when in

reality, had proper precautions of this kind been taken, we would have increased confidence and been able to do much good to a large class of patients, for it is not to be forgotten that every one in this room sooner or later, according to his years, his inheritance, and his mode of life, develops more or less arteriocalillary fibrosis, degeneration of his myocardium, and sclerotic changes in his kidneys.

I may close by saying that curiously enough a very large proportion of the patients to which I have recently referred are physicians who, after a long life of intense nervous strain, not infrequently find themselves at a comparatively early age suffering from disorders of the heart, which they fail to recognize, either because on examining this organ they fail to discover murmurs, or because they do not recognize the fact that a physician's life seems to be peculiarly apt, as is that of the banker and large business manager, to develop degenerative cardiac change. The employment of strychnine, belladonna and other drugs, in connection with digitalis and aconite, might be discussed if time permitted, but they are not included in the title of this paper, and, therefore cannot be considered. — *The Therapeutic Gazette*.

Progress of Medical Science.

MEDICINE AND NEUROLOGY

IN CHARGE OF

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TREATMENT OF ECLAMPSIA.

In the *Therapeutische Monatshefte* for April, 1902, Veit asserts that we do not yet possess a rational treatment of eclampsia, because the exact nature of the disease is still unknown. The treatment, therefore, must be such as is found to be the best from experience. The main object is to check the attacks and obtain the spontaneous labour. Some say that expectant therapy is the best, and as soon as the child is born spontaneously the disease is at an end; others,

on the contrary, say that we must terminate the pregnancy, for only then will the attacks cease. In Veit's opinion both are wrong. Neither is a good treatment. Morphia is advised by G. V. Veit, and Cæsarian section is advised by Halbertsma. None of these means can be applied to every case of eclampsia.

In treating any given case, first of all the strictest anti-septic rules must be observed during labour, because eclamptic patients are particularly predisposed to puerperal infection. Secondly, the quantity of food and remedies per os must be limited, as the somnolent patients are threatened with aspiration pneumonia. Thirdly, each vaginal exploration should be made under narcosis in order to avoid irritation. These are the prophylactic measures which the author usually follows. The treatment itself depends upon the general and local conditions of the patient, and especially upon the dilatation of the cervix. When the os is totally dilated and the presenting part of the fetus is high up in the pelvis, in spite of the good general condition of the patient at the onset of the first attack of eclampsia, the extraction of the child should be done under narcosis. When the external os is not completely dilated, our conduct will depend upon the state of the cervical canal. If the last is totally soft above the external orifice there is no danger in dilating the cervix; this can be done with two fingers or with a slight cut in the sharp pendulated border of the cervix. At the first eclamptic attack delivery should be done at once. When the cervix lets in only one finger and the canal is yet intact, our conduct should depend upon the patient's condition.

At the beginning of eclampsia every effort should be made to tear the membranes in order to diminish the tension of the uterus and allow the pain to become stronger. If in spite of these measures more attacks follow, it is recommended to apply a dilator. As soon as the canal is dilated, extraction should be made at the first convulsion. In this case administration of morphia is indicated, not with the expectation of complete removal of the attacks, but to render them less severe. Some obstetrician reported aggravations of symptoms after injections of morphia. Although it is difficult to form a definite opinion, it is, nevertheless, certain that it renders the attacks less severe; it is, therefore, only a symptomatic remedy. If we have recourse to it occasionally, it should be used as early as possible. Among other nar-

cotics we may mention chloral hydrate (per rectum), which can be administered in 15-grain doses repeatedly. Little benefit can be obtained from the bromides, veratrum viride, or amyl nitrite. Venesection has been recently recommended. A rapid cure cannot be promised, but amelioration of symptoms, and especially lessening of cyanosis, can thus be readily obtained. Some follow up the venesection by saline infusions, as the disease is supposed to be of toxic nature. The practical importance of this treatment is still slight. Next to this treatment are hot baths, which gained the utmost confidence; their effect is produced by diaphoresis. If hot baths cannot be employed, Jacket advises the use of wet sheets.

In spite of their favourable influence, the means mentioned cannot cure eclampsia, no matter how correct the theoretical considerations are; the complete practical result has not been obtained of any of them. Cæsarian section and *accouchment forcé* are advised by some, but in the author's opinion they cannot be applied to uncomplicated cases of eclampsia. For the last eleven years, among 11,000 confinements, he observed fourteen cases of eclampsia, and only one died; it makes a percentage of 15.8. Among operated cases the mortality is very high. However, in the hands of skilful operators Cæsarian section and *accouchment forcé* are not always fatal.

The conditions are different when with a narrow cervical canal the convulsions increase in intensity and frequency, the labour does not advance, and the patient's condition becomes aggravated. The choice of the method will depend upon the patient's surroundings. The author was called to the country to see a patient; Cæsarian section would imperil her life because of surroundings unfavourable to an operation. With one finger in the cervix he took hold of one foot and extracted the child. Combined version in such cases is recommended. Dürrssen obtained good results with cervical incisions and vaginal Cæsarian section; others, on the contrary, obtained less favourable results. In case the cervix is entirely closed, a question arises whether eclampsia has anything to do with the pregnancy. Narcotics should be given then and patients kept under observation. Should the attacks repeat themselves in a threatening manner and the patient's condition become aggravated, while the cervix is still closed, pregnancy is at fault. Then the classical Cæsarian section is indicated in preference to the vaginal route. Here Cæsarian section is easier and less

complicated than a confinement through the vagina with a closed cervix.

These various ways of treatment are in accord with the most modern views on the subject. It certainly does not follow that they are perfect and complete. Our efforts should be directed toward the pathogenesis of the affection, as well as to a better study of the normal anatomy and physiology of pregnancy. The method of study of cytotoxins is particularly worth mentioning, because we find in normal pregnancy, and especially in eclampsia, certain cells in the circulation of the mother, under the influence of which anti-toxins are formed. From researches the author made in conjunction with R. Sholten, they were astonished to find albumin in the urine after the placenta was transplanted in the abdomen. When it will be possible to show that the albuminuria of pregnancy is analogous to the cytotoxic albuminuria produced experimentally, we will have in our power the foundation for a new therapy which may lead to a proper understanding of the affection; but, unfortunately, the time has not yet arrived for a definite opinion on the subject.—*Therapeutic Gazette.*

DYSMENORRHEA.

The *British Medical Journal* of May 17, 1902, contains an article by Herman, in which he gives the following advice:—

Spasmodic dysmenorrhea has no tendency to spontaneous cure. A patient has been known to suffer from it throughout the whole of her menstrual life. In cases of exceptional severity it may grow worse. About twenty-five years ago the writer saw a patient, then aged about forty-five, who had suffered ever since her catamenia began from pain every month so severe as to make her vomit. In her early youth she consulted Sir James Clarke, who was at that time physician to the Queen, and was by him advised not to have any local treatment. As she got older the monthly attack of vomiting came to last longer and longer, till at length she was almost continuously sick. In some cases in which pain has lasted long and been severe it has seemed that the body of the uterus was larger than in most nulliparæ, as if some hypertrophy had taken place. But it is so difficult to be sure of a slight increase in size that this is only a conjecture.

The natural cure of spasmodic dysmenorrhea is

pregnancy. But the disease is often accompanied by sterility, which may be cured by the dilatation. In about one-third of the writer's patients who were married and sterile, the cure of the dysmenorrhœa was followed by pregnancy.

The best drugs for the relief of uterine colic are anti-pyrin and phenacetine. In slight cases these give adequate relief, and as we know, not of any harmful results from their occasional use, if these drugs relieve there is no need for further treatment. If these drugs fail, powerful narcotics, such as morphine or chloroform, will, if given in sufficient doses, quiet the pain, and cases have been known so bad that the pain could not be otherwise controlled. But it is a bad thing for a young woman to use these drugs every month, and, if this is necessary, local treatment which will remove the pain is preferable.

In a few cases the writer has found that guaiacum removed the pain. He gives ten grains of guaiacum resin in a tablespoonful of malt extract, twice or three times a day, beginning a week before menstruation is expected. He does not know how this drug acts, nor how to pick out the cases that it will cure; but he knows that it sometimes will cure.

The local treatment of spasmodic dysmenorrhœa is to dilate the cervix. This is best done by the passage of bougies. In most cases the cervical canal will admit a No. 6 bougie easily. A little resistance is usually met with when about No. 9 is reached. When a bougie has been passed which entered with difficulty and fits tightly, after it has remained two or three minutes in the canal, it will be loosely held and a size larger can be passed. The writer has generally continued the dilatation until the bougie met with considerable resistance. This usually begins with the passage of No. 12 or thereabouts. He knows not what is the minimum dilatation that is sufficient to cure. He has known the passage of a No. 8 bougie, in a case of spasmodic dysmenorrhœa and sterility, to be followed by pregnancy. Before the introduction of dilatation as a means of treatment it was known that occasionally menstruation could be prevented from being painful by the passage of the uterine sound shortly before its occurrence. Hence extensive dilatation is not always necessary. The enlargement of the canal that dilatation produces lasts for some months, and one would suppose that the larger the dilatation the longer will the effect last, but the author has few facts with which to support this opinion.

The cervix does not always yield to the dilating agent

with the same readiness. In about one-sixth of his cases the author has it recorded that unusual resistance was met with. The fact of such unusual resistance does not in his experience modify the prognosis.

Dilatation does not invariably cure. The author has gone through some records of cases to find out what proportion of cases are cured. He found that in at least two-thirds of cases benefit follows. That no relief followed in one-third of the cases dilated does not imply that one-third of cases of spasmodic dysmenorrhea are incurable; it is partly accounted for by some cases having been dilated in which the dysmenorrhea was not of the spasmodic kind. In some of these cases the patients' statements may have been misleading; in others, diagnosis was known to be doubtful, and the dilatation was done either because nothing else offered any prospect of benefit, or for some reason other than the cure of the dysmenorrhea. But allowing for the inclusion of these cases, it must be admitted that some cases of spasmodic dysmenorrhea are not cured by dilatation. Some cases are not cured even by pregnancy. The author believes that he is within the truth when he states that cure follows in three-fourths of the cases. Among his cases in which the disease was primary (that is, dated from the beginning of menstruation), the proportion of cures was larger than among those in which the pain began to be felt at a later age. How long does the benefit last? It is so difficult, for reasons that need not be gone into, to keep such patients in communication with their physician, that nothing very exact can be said about this. The cure may last throughout the patient's whole menstrual life. One patient, whose cervix the author dilated in 1878, she then being aged twenty-seven, he saw in 1900. She had menstruated with little or no pain ever since the dilatation, and the irregularity of the menopause had begun. This justifies the assertion made. In some cases the cure is temporary only; the pain returns, and is again removed by further dilatation.—
Therapeutic Gazette,

VARIETIES OF ENEMATA AND METHODS OF PREPARING SAME.

Of much practical value is a knowledge of not only the indications for the employment of rectal injections, but the different varieties thereof and their immediate method of preparation. A physician's resources are oftentimes abundantly

enlarged by a practical adjustment to circumstances in this direction. For instance, purgative enemata may be necessary in patients who cannot well bear, or who respond feebly to cathartics by the mouth. After abdominal operations a purgative enema may be called for, and also in cases of intestinal obstruction and in many varieties of abdominal pain. Then, again, to supplement aperients given by the mouth cathartic enemata may be resorted to, likewise in almost all cases preceding operative work in the abdomen. An aperient enema should also be given before rectal and vaginal examinations, and before the administration of an anesthetic.

The simplest form of an enema for unloading the bowels is a mixture of soft soap and warm water, the activity of which may be increased by adding about half an ounce of turpentine, a handful of salt or a little molasses. In lieu of a watery enema (sometimes objectionable on account of the quantity necessary—one to three pints), four to six ounces of warm olive oil, two to four ounces of castor oil, or one ounce of glycerine, may be used. A little turpentine will aid any of these. Turpentine has always seemed especially valuable when there is much intestinal flatus.

Nutrient enemata become highly valuable in quite a number of conditions, among which may be mentioned persistent vomiting of pregnancy, gastric neuroses of other types, gastric ulcer, and other gastric diseased states, various intestinal conditions and operations upon the stomach and bowels, and sometimes in diseased conditions of the mouth, throat and esophagus. Nutrient enema usually are made up with peptonized milk, to which is added beef tea or extract, beaten eggs, various gruels and brandy as may be desired.

A cleansing enema should always precede one containing nourishment. A disregard of this rule has caused many a failure.

Normal salt solution, consisting of one dram of salt to one pint of water at a temperature of 100° F., is now very commonly employed to overcome collapse after operations and general shock from hemorrhage or other cause.

In cases of heart failure, opium poisoning and other forms of depression, stimulating enemata are many times of value. These may consist of brandy and hot water, strong hot coffee, aromatic spirits of ammonia with hot water. While the water should be hot, care should be exercised that it is not at such temperature as to damage the mucous lining of the bowel.

Medicines may sometimes require administrations per rectum. Chloral, the bromides, strychnia, opiates, etc., in proper solutions and dilution undoubtedly can be made effectual in this manner. In order to be certain of the use of the full portion of the drug, when used in this way, it is best to make a separate and smaller mixture of the medicament which may be injected and followed by such quantity of diluent as can readily be retained. In this manner one can be certain of the administration of all of the drug intended.

The old "starch and laudanum" enema, so often mentioned in text-books in relation to the treatment of diarrhea, has frequently been misapplied or not used at all because of ignorance in its preparation, and thus a means almost always readily at hand is lost. The starch and opium enema is made up as follows: a tablespoonful of ordinary starch is rubbed up first with cold water, a thin paste resulting. Boiling water is then added to the consistency of thick gruel. When the preparation is cool, such quantity of the tincture of opium as desired is thoroughly incorporated. A high injection with a soft tube is always best.

If a patient can for a time maintain the knee-chest position after an enema, so much the better; but if not, it is more desirable to lie prone upon the abdomen or upon the left side.

Only gentle force should be exerted in giving a rectal injection.

In the experience of some, cold solutions for purgative effects have appeared better, and not without reason is it argued that cold enemata, and not warm, are indicated in those conditions where they are employed almost constantly.
—*The Clinical Review.*

EUCALYPTUS IN THE TREATMENT OF DIABETES.

In the *Glasgow Medical Journal* for May, 1902, Faulds details his investigations as to the value of eucalyptus in diabetes mellitus.

What seems very interesting is the fact that, when the patient gets a fresh warm infusion, the sugar at once drops in quantity, and in some cases from 60 grains to half a grain per ounce. It is evident, then, that there is not any one of the substances contained in this infusion that arrests the excretion of sugar, but, evidently, a combination of them have this effect—*i.e.*, there seems no alkaloid in it which, when given alone, has the power of influencing the amount

of glucose in diabetic urine. Then how and why does the fresh infusion act so promptly? The writer thinks that, just as a newly infused cup of tea is an enjoyable beverage, not on account of the action of its alkaloid theine alone, but because it contains, in addition, a mixture of a volatile oil and tannin, so does tea from eucalyptus (which we know has antiseptic properties) act in checking tissue metamorphosis, which is so active in this disease.

The causation of glycosuria is still wrapped in mystery, but it is probably produced by a variety of causes, such as gout, cold, nervous exhaustion and over-indulgence in food and drink. In fact, any condition that tends to limit or prevent the appropriation of sugar must lead to an excess of sugar in the blood, and thus to glycosuria. In these cases it seems that in the earlier stage the eucalyptus treatment will prove beneficial; but where the disease has been inherited, or where the patient's antecedents or immediate relatives are neurotic (in which case the probable cause is a progressive degeneration of the vasomotor centers of system which will disturb the equilibrium of the blood-supply to the hepatic cells), this treatment, like others, will be of no avail. And such has been the author's experience; for, in forty-one cases treated with eucalyptus, eleven came from talented families, or were neurotics; seven were hard brain-workers, and four inherited the actual disease. In these twenty-two the eucalyptus treatment had no effect. Add to these four cases in which the disease had gone to the stage of approaching coma before this treatment had been commenced, and we get the total number of unsuccessful cases. The remaining fifteen showed a total disappearance of the disease, and so far as can be judged are completely cured.—*Therapeutic Gazette.*

NIGHT SWEATS IN PHTHISIS.

All physicians know the difficulty of keeping the night sweat of phthisis in control. Almost every known remedy has been tried since the Greeks used agaricin down to the present. Graves and Stokes used Dover's powder, which in time gave place to mineral acids, zinc and belladonna, atropine, and a host of other specifics. To the long list Nolda adds tannoform, the external use of which he recommends. In seven out of eight cases in which he had the front and back of the thorax dusted with powdered tannoform, it checked the sweating (*Berl. Klin. Woch.*). This

method of treating the symptom has the advantage of not interfering with the digestive function, which is usually so imperfectly performed in such cases; neither does it in any way preclude the use of any of the other antisudorifics. The powder of itself should prove an agreeable application to the skin, and promote the comfort which is such an essential factor in producing sleep in such cases.—*Dublin Medical Press and Circular.*

HOW TO SLEEP SOUNDLY.

The "sure cures" for insomnia are almost innumerable. One of the latest is that of a German, Prof. Fischer (*Doctor's Magazine*), who claims that it will not only bring about profound and refreshing sleep, but also increased mental strength. The discovery consists essentially in putting the pillow or pillows under the feet instead of the head. The advantages claimed for the innovation are that the venous circulation is favoured and the heart needs to work less during sleep, hence the tired feeling on waking is prevented. The professor claims to be in receipt of a great many communications from ladies all over the German Empire who are profuse in their praises of his epochal discovery.—*Denver Medical Times.*

LEUCOCYTES AND DIAGNOSIS.

The importance of a microscopic examination of the blood in the estimation of both red corpuscles and white is coming to be more and more recognized, not only in diseases of the blood, but in those of a general nature. In many undefined cases it is found that the point of diagnosis is immediately cleared by a blood examination. Thus, in typhoid fever lymphocytosis is the rule, while leucocytosis is stated never to occur unless there is some complication. As the latter is the rule in most infectious diseases and inflammatory conditions, the value of the distinction is obvious, more especially as the lymphocytosis in typhoid occurs early, along with a leucopenia, some time before the Widal reaction is established. An examination of the blood is stated to distinguish at once a case of early typhoid from one of pneumonia or influenza. Again, a marked leucocytosis occurs in such conditions as appendicitis, pyosalpinx

and suppurating ovarian cysts, thereby distinguishing them, not only from typhoid, but from malaria, in which leucopenia is the rule. And not only in the early stages of disease is the condition of the leucocytes of assistance, but during its progress any marked increase or diminution in their number points to some change of importance in the patient's system. Thus, a sudden leucocytosis in typhoid very frequently points to a perforation. The whole subject is very well summarized in a recent paper by Dr. Brown of Baltimore (*Medical News*, July 26), who quotes two cases in which a sudden increase in the number of leucocytes from about seventeen to thirty-four thousand per cmm. synchronised with a perforation of the appendix. *The Medical Press*.

THE MEDICINAL TREATMENT OF TUBERCULOSIS.

While not denying the importance of the hygienic treatment of tuberculosis, especially as conducted in sanatoria, the writer believes that the medicinal treatment should not be neglected.

The writer has used ichthyol in his clinic in great variety of cases, many of them advanced. The most noticeable and most constant effect was the diminution of the bronchial catarrh. This diminution showed itself in the lessened amount of sputum and the partial disappearance of the rales. Secondly, an increase of weight and an improvement in the general condition was noted. One advantage of ichthyol is the fact that it can be used for long periods of time without unpleasant secondary effects. It may be used with advantage in cases of actual or threatening hemoptysis, on account of its vaso-constrictor effects. In short, the writer believes that it should be given a trial in all cases not too far advanced.

If we expect to derive benefit from ichthyol it must be given in large doses and for long periods of time. The following formula is convenient:

R	Ichthyol.	10
	Aq. menth. pip.	80
	Syr. simpl.	20
	Mix.	

During the first week one teaspoonful in a glass of water is given daily, half being drunk in the morning, half in the evening. During the second week two teaspoonfuls in two glasses of water are given daily, to be taken at

four times. The dose is slowly increased in this manner until eight grammes are taken daily. In comparatively robust cases the dose may be increased as above, but daily instead of weekly.

Ichthoform is given in powders of ten to thirty centigrammes (grs. *iss* to *ivss*), ten powders being given daily. Its action resembles that of ichthyol, but it seems to have a particularly favourable effect upon the bowel disturbances accompanying tuberculosis. The meteorism, colic and diarrhea are effectively combated and a greater ingestion and assimilation of food made possible.

Sodium salicylate was given as an antipyretic. With few exceptions its use caused a drop in the maximum temperature from 102° or 104° to 99° , and of the average temperature from 100° to 98° . During the use of this drug tuberculin injections produced little or no rise of temperature, and cannot therefore be used as a diagnostic aid. Sodium salicylate must be used steadily for months if we desire to cure the fever, as the temperature promptly returns to its former height if its administration is interrupted. The drug is best administered in powders of one gramme (gr. *xv*) each, followed by a glass of water. Of such doses, four to six are taken daily; when the fever is unusually high, eight to ten. The former number produce no effect on the blood pressure, while the latter do cause a fall (10 to 12 mm. Hg.) of the same.—*Interstate Medical Journal*.—ERRICO OF RENZI (*Berl. Klin. Wochenschr.*, 1902, No. 18).

TREATMENT OF TUBERCULOUS PERITONITIS IN CHILDREN.

Rotch summarizes the treatment of tuberculous peritonitis from a study of sixty-nine cases treated at the Boston Children's Hospital.

The most common age of incidence in childhood is one and a half to four years. In the first year of life it is very rare and almost universally fatal, as at this time it is almost invariably part of a general tuberculosis. Pathologically, the cases may be divided into primary and secondary cases. The secondary cases are most often those infected from lungs, intestines and mesenteric lymph nodes. Where the lungs or the intestines are the primary cause, the prognosis is that of general tuberculosis, so that laparotomy is seldom of avail. Where the tuberculosis is primary in the mesenteric lymph nodes, laparotomy is often of value and should be tried. And

where the tuberculosis is *primary in the peritoneum*, laparotomy is directly indicated and often results in complete cure.

In the primary cases the prognosis is better where the tuberculosis is represented by miliary tubercles of the peritoneum with ascites than in the cases with thick adhesions, without much fluid.

Taking into consideration the fact that in competent hands exploratory laparotomy is a safe procedure in comparison with non-operative treatment, and the further fact that spontaneous recovery without laparotomy occurs only in a small minority of the cases, the author believes that the laparotomy should be done whenever it is possible.—*Archives of Pediatrics*, September, 1902.

EMPHYEMA IN INFANTS AND CHILDREN.

It is not possible in infants and children to differentiate the symptoms of pleurisy with effusions from those of empyema. In most children, before the age of five, the effusion is likely to be purulent. In children empyema follows some acute affection of the lung in 95 per cent. of the cases. Naturally, this affection is most often a pneumonia, though bacteriological examination of the fluid shows that a mixed infection is not infrequently present. The tuberculous forms of empyema are relatively infrequent in childhood. Empyema may follow the acute exanthemata, also typhoid, tonsillitis, appendicitis, sepsis of the newly born, etc. It sometimes happens that the effusion is at first serous, later becoming purulent, without extraneous infection.

In a few cases, not necessarily tuberculous, the effusion is hemorrhagic.

The symptoms are usually masked by those of the causal affection. The temperature is usually elevated; there is more or less cough, pain and dyspnea. Exhausting night-sweats are common. The diagnosis must rest on physical signs and exploratory puncture.

The prognosis in the post-pneumonic form is not bad, except if there be complicating secondary broncho-pneumonia, or where the pneumonia persists. The prognosis of the tuberculous forms rest upon the age of the patient and the extent of the lung involved in the pleuritic affection; but, on the whole, it is better even in this class of case than it is in adult life.—KOPLIK (*Medical News*, September 13, 1902).

CONSTIPATION—ITS TREATMENT WITHOUT DRUGS.

First, *correct all the bad habits.* Nothing can take the place of this injunction. * * * Take time for every meal, or don't eat it. * * *

Bending the body at the middle backward and forward, sidewise, twisting, gyrating, stooping, swinging and thrusting the arms upward, backward, forward, round and round, reaching, striking, pulling and pushing—all these motions are of value. Rapid walking, horseback riding—if the horse is not too easy in gait!—kicking, swinging the legs, squatting and rising rapidly many times repeated. Any motions or exercises that act upon the abdominal muscles, that stimulate the diaphragm, accelerate the breathing function and favour the peristaltic movement of the bowels will aid in banishing the demons and hobgoblins that dance and devastate in the wake of this national if not cosmopolitan malady, constipation.—*The Dietetic and Hygienic Gazette.*

AN IMPROVED METHOD OF PERCUSSION.

The limitations of percussion in thoracic and abdominal disease are quite well understood. In the majority of instances, percussion is carried out by tapping with the fingers of the right hand upon the back of the fingers of the left hand laid flat upon the part. There are certain limitations to percussion when performed in this manner that do not obtain when some substance other than the fingers is brought between the wall of the cavity to be percussed. The fingers may not fit the part accurately. They inevitably cover a considerable surface, and, consequently, the vibrations are conducted over a considerable area. Various substitutes for the finger, made of rubber and celluloid, have been devised, which have for their general purpose the limitation of the area which is to be percussed. The disadvantage of these, as compared with the finger, is that the sense of resistance, which is of such value in diagnosis, is left out.

A method devised by J. Plesch, of Budapest, combines both methods to advantage. He uses the middle finger of the left hand, but instead of laying it flat upon the chest, only the tips of the fingers are brought in contact with the part to be percussed. The finger is bent at a right angle at the second joint and the percussion is made over the first phalanx. In this way the vibrations are limited to a small area, and are accurately brought out; at the same time the vibrations are conducted to a considerable

depth into the tissues because of the limitation of the surface application. More precise data are furnished by this method of percussion than by the usual means. The value of the method has been proven by Plesch, who has confirmed the results by radiosopic examination.—*Medicine*.

In stab wounds of the abdomen in which intestines escape, they should be immediately reduced after careful cleansing with saline solution. If there is any difficulty owing to tightening of the abdominal wall around the gut, the parietal wound should be enlarged. In some cases it is proper to let out the gas with an aspirating needle, after which a stitch should be taken at the site of puncture.—*International Journal of Surgery*.

SURGERY.

IN CHARGE OF

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WHEN IS ACUTE NEPHRITIS, EXCEPTING THE TUBERCULOUS FORM, PROPERLY THE SUBJECT OF SURGICAL TREATMENT ?

The most important of the diseases here considered is acute nephritis with miliary abscesses. The danger of urogenic infection of the kidney commences as soon as the outflow is in the least obstructed, and after the abscesses have formed in one kidney it is altogether possible that the same may occur in the healthy organ as a consequence of embolism. Thus it may come about, and probably does in most cases, that the two methods of infection combine to account for the condition. Where the transmission is through blood current, it is by far the greater number of cases which originate from the intestinal tract. However, the greater number of slight infections of this nature never lead to abscess formation, and are easily cured by internal treatment, which consists in great part in the drinking of immense quantities of water. The first and

principal symptom of suppurative nephritis is pain in the vicinity of the affected organ. The disease is most frequent in men, because they are more subject to obstruction than are women, and is, in consequence, almost always bilateral. In the lighter forms of the disease the best preventive treatment is free and careful drainage of the bladder. It must be kept constantly empty. Where suppuration has once occurred within the kidney, it is very likely also to affect the tissues immediately surrounding the organ, either by lymphatic transmission or by breaking down of the kidney capsule under influence of the pus. On account of the many blood vessels in the kidney and the tension which this capsule causes, these rapidly lead to general sepsis. The chief danger at first is for the second or healthy kidney. Hence the first indication is to thoroughly drain the diseased organ; but, however, it has been demonstrated that if the kidney is already slightly affected, still the patient may regain perfect health after an operation on the organ which is primarily most diseased. Of course, the exact diagnosis is highly difficult; hence every operation for this infection is primarily in the nature of an exploration. If the diagnosis has been correct, one finds edema of the fatty capsule; the kidney very dark in colour and hard; then the little abscesses shining through the capsule or else felt as circumscribed nodes covered with fibrin; then the organ is split either in the ordinary post-mortem plane or else through the most diseased portion, after which it is good practice to exercise everything which seems bound to undergo softening. A rubber drain is now placed in the pelvis of the organ and the incision stuffed with gauze, the same material being packed around the kidney. By this means the tension is relieved, the circulation resumes its normal course and free exit of pus and urine is allowed. It is, further, good practice to completely remove the fibrous capsule of the organ. If it is found that the greater part of the kidney has undergone pus formation, it is well to completely remove the organ. If then there be obstruction of the bladder by clot formation, it is well to make suprapubic section at once. The principal symptoms for which operation is necessary are local pain and sensitiveness to pressure; these, of course, being reinforced by the usual chemical and microscopical examination. Such an operation as described is especially to be undertaken where a sudden oliguria or anuria occurs in a patient whose general condition is good and who manifests symptoms just detailed above.

The author gives histories of several cases upon which

he has operated with results which must be characterized as brilliant.—LENNANDER (*Mitteilungen aus den Granzgebieten der Medizin und Chirurgie*, Band x, Hft. 1 und 2).—*Interstate Medical Journal*.

THE SURGICAL TREATMENT OF TUBERCULOUS CERVICAL ADENITIS.

J. F. Mitchell (*Bulletin Johns Hopkins Hospital*) says :

1. Tuberculous cervical adenitis is primarily a local disease of very frequent occurrence, more often in young persons ; in itself not extremely serious, and rarely, if ever, proving fatal.

2. It bears, however, a certain definite relation to tuberculosis of the lungs, and serves as the starting-point from which tuberculosis may spread.

3. The tuberculin test, as an aid to diagnosis, is positive and harmless.

4. While recovery may often take place under good hygienic conditions, surgical interference is clearly demanded in most cases.

5. When surgical treatment is resorted to, the operation should be radical in all cases.

6. Recovery may be predicted in 70 or 80 per cent. of cases so treated. Tuberculosis of the lungs, after complete removal of the glands, is comparatively rare.

7. Tuberculosis of the lungs, unless far advanced, is not a contraindication to operation, the removal of the glands apparently exerting a beneficial influence on condition of the lungs.

EXAMINATION OF THE BLOOD IN SUPPURATIVE CASES TREATED SURGICALLY.

Curschmann has pointed out that leucocyte counts afford definite information as to the proper time to interfere in cases of appendicitis. Kuttner and Brunn have verified this statement in 161 cases, and have at the same time tested the value of Ehrlich's reaction, which depends on the presence of glycogen in the white corpuscles. It is necessary in these investigations to guard against various errors, to make two counts a day, to remember the normal variations in children, in adults, during digestion, etc.

Leucocytosis and Ehrlich's reaction have been of value in acute infections; but not in tumours or in inflammation, chronic or specific.

Even in acute infections the results obtained are

demonstrable only where the condition develops rapidly. When the process becomes localized and an abscess is formed the leucocytosis diminishes or disappears; the iodine reaction is less definite.

Thus the leucocyte count can only serve to differentiate between an abscess or a tumour if with a normal temperature one finds at different times an increase in the white cells.

Abscesses uncomplicated by mixed infection never show a leucocytosis.

(1) In appendicitis the results obtained by Küttner accord closely with those obtained by Curschmann and Cabot. When, at the onset of appendicitis, uncomplicated by pneumonia, the number of leucocytes increases rapidly and remains high, after the first few days one can state definitely the existence of pus, and one should operate at once; the temperature matters little. In the same way one meets with a high leucocyte count in those cases which clinically give the impression of a general peritonitis, but in which some parts of the peritoneum will be found healthy. In cases of this kind Ehrlich's reaction is, perhaps, of more value than leucocyte count, because it disappears more quickly than the leucocytosis if, after interference, the patient goes on to recovery.

(2) What is true in appendicitis is true also in rapidly spreading phlegmonous suppuration. Here a leucocytosis indicates a rapidly-extending process. On the other hand, a rapid diminution in number of the white corpuscles justifies one in making a favourable prognosis, even when clinically the condition appears very grave. But in cases of rapidly fatal general septicemia, as in general suppurative peritonitis, leucocyte count fails.

(3) The examination of the blood is also important after operations in aiding prognosis. If all goes well and there is no infection, the leucocytes progressively diminish. Occasionally it is best after an operation to make the first dressing as late as possible, for example, after a resection of the knee. In cases of this kind, even though the temperature may remain at 40° C. for the first few days, the leucocytes may drop to normal and healing take place by first intention.—Küttner. *Abstract from Revue de Chirurgie, Maryland Med. Jour.*

DULNESS IN APPENDICITIS.

H. T. Miller, Springfield, O., believes that in the symptom dulness, we have an infallible means of differentiating in appendicitis between cases that are operative and non-operative. When we have a case of appendicitis without the formation of an inflammatory exudate we can afford to wait, but with the occurrence of dulness it is jeopardizing the life of the patient to defer operative interference. In an acute attack of appendicitis with dulness, persisting from twenty-four to forty-eight hours, and after the bowels have moved, one should operate, and the chances are that pus will be found. In a recurrent attack with dulness, even if the temperature and pulse are normal and the patient is able to be up and around, one should operate, and one will most likely find an indurated appendix with adhesions around the appendix and caecum. In the former case an immediate operation is the only recourse, in the latter the surgeon will by operating anticipate an outbreak with pus formation. In acute attacks of appendicitis without dulness, the case should be treated conservatively; should dulness make its appearance and remain, surgical intervention should be at once advised. Pain in the region of the appendix does not always mean appendicitis, but localized dulness with the associated symptoms of appendicitis always does. While it is true that in every case of appendicitis with dulness we do not find pus, in all of these cases the conditions are such that no mistake is made by surgical interference.—*N. Y. Med. Record.*

UNDER WHAT CIRCUMSTANCES IS IT ADVISABLE TO REMOVE THE VERMIFORM APPENDIX WHEN OPENED FOR OTHER REASONS.

Howard A. Kelly, Baltimore, having written to eighty well-known American surgeons upon this subject received replies from seventy-four. His questions were as follows :

1. When the abdomen is opened for other causes, and the perfectly normal appendix is easily accessible, is it your rule to remove it ?

2. When the appendix is slightly adherent to neighbouring structures, as peritoneum, ovarian or fibroid tumours, do you then remove it ?

His conclusions are embodied in the following :

1. The appendix should always be examined and its

condition noted whenever the abdominal cavity is opened for any reason, provided no additional risk is involved.

2. The opinion of the majority of surgeons in this country is against the removal of a perfectly healthy appendix, forty-four to twenty-six being the proportion shown in my investigation.

3. The opinion of a large majority of surgeons is in favour of removing an appendix which is even slightly adherent to other structures, sixty to seven being the proportion shown in my investigation.

4. The fact that the appendix is normal in appearance does not prove that it contains no fecal concretions, for I have found them in a number of instances. Their presence is sufficient reason for the removal of an apparently healthy appendix.

5. After removal of the right ovary the stump should always be covered with peritoneum in order to prevent the risk of adhesion to the appendix. A long and free appendix should invariably be removed.—*Jour. A. M. A., St. Louis Med. Rev.*

APPENDICITIS FROM A PHYSICIAN'S STANDPOINT.

James Tyson, Philadelphia, after relating a number of cases in which operation did not seem indicated, says:

It is such experiences as these which have brought me to the conclusion that every case of appendicitis whose diagnosis is thoroughly established should be operated on, always, if possible, in the interval between attacks. Of the diagnosis, however, we should be reasonably certain. In view of the occasional difficulties of diagnosis, it may happen now and then that a normal appendix is removed; but I have come to the conclusion, too, that it is better to have a few normal appendices removed than that one which ought to have come out should remain and cause death of its owner. The appendix is not an organ of which we need be especially proud. It is useless and exceedingly vulnerable and without powers of resistance when attacked.—*Jour. A. M. A.*

THE PRIMARY TREATMENT OF RAILWAY INJURIES.

J. N. Baker, Montgomery, Ala., lays especial stress on the importance of recognizing shock, which he states may be defined as a state of general depression, reflexly

produced by damage done the peripheral nerves and with symptoms referable, in the main, to vasomotor paralysis. A distinction should be made between surgical shock and collapse, restricting the latter to cases in which serious loss of blood is the causative factor; for it is the exception rather than the rule in railway accidents to have serious primary hemorrhage. The symptoms of shock are given as a depressed and enfeebled circulation, a lowering of body temperature, a pinched and expressionless countenance, pupils varying, though usually dilated; mental apathy, a cold and sweaty skin, and in the graver forms a relaxation of the anal-sphincter. Should the head be involved, instead of mental apathy we may have profound unconsciousness or mental excitability. Treatment should be directed toward arousing the nervous system, both centrally and peripherally. Centrally this may be done by the administration of the usual agents, strychnine, nitroglycerin, whisky, morphine or atrophine, etc., all of which should be given hypodermically. Morphine, combined with atrophine, is usually the drug of most service. Peripherally, stimulation is induced by heat, the free use of blankets and hot water bags and by having the temperature of the room more than comfortably warm. In addition to these measures, saline infusion is of the greatest service. After a brief report of a few cases, to illustrate the measures to be adopted in various forms of injury, the following points are especially emphasized: The importance of an understanding and an appreciation of the nervous phenomena of shock. The value of the saline infusion, intravenously administered, for the relief of this condition in its graver forms. The importance of prompt surgical interference immediately upon the establishment of reaction. The importance of a plantar flap where the foot is involved, or of a palmar flap where the hand is involved. Never uselessly sacrifice tissue; never sacrifice a joint; and always strive to leave the patient with a smooth, painless, non-contracted, non-cicatrized stump.—*N. Y. Med. Rev., St. Louis Med. Rev.*

A NEW PROTECTIVE DRESSING.

Karl Springer describes a new protective dressing, which is intended especially for use in plastic operations, skin-grafting, etc., where it is important to keep the dressing from adhering to the surface of the wound. The various materials, such as rubber tissue, oiled silk, oiled gauze, etc., which are in general use for this purpose are

open to the objection that they stand sterilization by heat but once, after which they must be preserved in some antiseptic solution, which often impairs their strength or pliability, and always requires washing off in sterile water to remove before use. The substance which the author employs as a substitute is paraffin of a melting point of 45° to 47° C. If a small piece of this is thrown on the surface of boiling water it is first melted, and then, on cooling, forms a thin, floating pellicle, which may be handled with forceps and cut to the proper shape with scissors. The technique of its practical application is simple. A flat vessel provided with a cover is partially filled with water and brought to a boiling point. A piece of paraffin is then thrown in and the boiling continued for ten minutes. The vessel is then placed in another dish of cold water, causing the paraffin to harden as a thin pellicle on the surface. As soon as this occurs the vessel is placed in water at a little above body temperature, which keeps pellicle soft and pliable. Holes for drainage may then be punctured through it with a sterile needle, and after cutting to shape it is lifted with forceps and applied to the wound with the water side down. The thickness may easily be controlled as experience dictates by the size of the lump of paraffin used.—*Centralblatt f. Chir. St. Louis. Med. Rev.*

Jottings.

Dr. Bartholow states that the loss of voice from fatigue or simple laryngitis is relieved by small doses of nitric acid well diluted and given every two hours.

A blister applied to a felon in its early stages will often prevent its further progress. The blister need not be more than one and a quarter inches square, but should be kept on perhaps eighteen hours, when dark serous accumulation can be let out. Paint the locality with comp. tinct. of iodine every hour or two until the pain ceases or inflammation is removed. The application of fresh grated Indian turnip moistened with turpentine is most highly extolled.—*Med. Summary.*

Abram Meyer (*Med. Record*, March 8, 1902), reports a

recovery from diabetic coma following the administration of several twenty-grain doses of urotropin. He explains its beneficial effect on the theory, that being a chemical combination of ammonia and formaldehyde, in the presence of acid in the blood it is split into its component parts, the ammonia serving to neutralize the acid in the blood.

The best remedy for bleeding at the nose is in the vigorous motion of the jaws, as if in the act of chewing. In the case of a child, a wad of paper should be inserted, to chew it hard. It is the motion of the jaws that stops the flow of blood. The remedy is so very simple that many will feel inclined to laugh at it, but it has never been known to fail in a single instance, even in the severest cases.

Brieger has reported excellent results from the treatment of sciatica by means of hot water baths or packs and massage.

Dumesnil says that the most unsightly scars can be removed or greatly lessened by means of electrolysis.

Derby obtains better results in the treatment of progressive atrophy of the optic nerve from the use of subcutaneous injections of strychnin in the temples, in increasing doses. He begins with grain 1-25, and increases this dose daily by 1-100 of a grain, until constitutional effects are noticed, usually about the tenth day. The drug is then discontinued for about ten days and then repeated.

For the removal of vegetations from the external genitals salicylic acid is an excellent remedy. Half a drachm should be dissolved in an ounce of acetic acid and applied to parts with a camel's hair brush.

Hare says that the atonic stomach of drunkards is much improved by a pill made up as follows :

Oleoresinae capsici.....	m x.
Olei caryophylli.....	m x.
Hydrargyri chloridi mitis.....	gr. xx.
Aloes socotrinae.....	gr. xl.
Ft. pil, xx. S.: One t. i. d.	

In ingrowing toenail, with granulations, a piece of twisted absorbent cotton soaked in a strong alum solution and inserted under the edge of the nail is a valuable remedy.

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Editorial.

A LESSON TO THE WORLD. A LESSON TO THE WORLD.

To us it seems an extraordinary matter that to-day we find even a few, who, being possessed of average intelligence and fair reasoning powers, yet enroll themselves among those who delight to style themselves "Anti-Vaccinationists." In our opinion, if there is a fact which is beyond the pale of doubt, it is that vaccination and revaccination has saved countless lives from smallpox. Twenty years ago vaccination was almost totally neglected in the parishes of the Province of Quebec and very largely neglected and imperfectly performed in its cities. Of the latter fact the writer is perfectly cognizant, for he was then, and for many years before, a public vaccinator in the City of Montreal. At a meeting of the Health Committee about that time, he expressed the opinion after having examined the arms of many thousands among the French Canadian population, that 90 per cent. of that nationality were not protected, the marks found not being "good vaccine marks." That he was correct is proved by the terrible visitation which Montreal received from smallpox in 1885, when the epidemic was very largely among French Canadians. We frequently, at

our clinic in the Montreal General Hospital, with a view of enforcing in the Montreal General Hospital, with a view of enforcing on students our strong views on the benefits of vaccination, relate what we have written above, at the same time, to prove our assertion, have kept a record of the nationality of those who are badly marked from the disease. We have repeatedly recorded one hundred French Canadians under this head, without a single English speaking person. Occasionally, of course, they are found, but they are rare, and their safety has been due to proper vaccination. Thanks, however, to the intelligence and the zeal of our French Canadian physicians during the past two decades, their leading spirits being Dr. Laberge, Montreal Health Officer, Dr. E. P. Lachapelle, president, and Dr. Pelletier, secretary of the Provincial Board of Health. All this is changed. Vaccination is to-day perhaps as well performed among French Canadians as it is among the English speaking portion of our population. Since 1885 there have been, on a large scale, many instances where smallpox has been vaccinated out of existence. An illustration of this has occurred within the last three or four years in Porto Rico. Major Ames, brigade surgeon United States Army, has published in the *Pacific Medical Journal*, for September last, a most valuable report on vaccination in Porto Rico, of which he was director. He summarizes the work and its results in the following words: "In October, 1898, smallpox was endemic in Porto Rico; in December it was epidemic; in January, 1899, it had "honey-combed" the island; by February there were over 3,000 recent cases and the disease was spreading at a gallop.

"In February, systematic compulsory vaccination, carefully and scientifically conducted and recorded, was begun simultaneously and with pretty equal efficiency in all parts of the island. It was vigorously prosecuted for four months only, till 1st July, when 800,000 vaccinations had been made in a population of about 600,000. Of these 87½ per cent. were successful. The work then ceased, because completed; the disease had, practically, disappeared; the fuel for it to feed

upon had been consumed by the "head-fire" of vaccination. In the two and a half years that have since passed, instead of the former annual average death-rate of 621, the mortality from smallpox has been but two per annum in a population of nearly a million. Can any *honest*, intelligent person doubt in face of these indisputable and easily verified facts, *what* it was that in *four* short months drove smallpox from its wide and long-time reign on the Island, and has since kept it out? *Vaccination alone did it, and will do it effectively wherever compulsory legislation, properly enforced, secures its benefits to all!*"

URETER-CATHETERISM: ITS PURPOSE AND PRACTICABILITY.

At the meeting of the Mississippi Valley Medical Association, at Kansas city, October 15, 1902, Dr. Bransford Lewis, of St. Louis, read a paper under the above title, and presented his perfected model of catheterising cystoscope for male and female, which permits of catheterization of both ureters at the same sitting because of the new double-barrel arrangement of the ureter tubes. After the reading of the paper, a demonstration of double ureter-catheterism was made by Dr. Lewis before a number of members of the Association, the time required for getting both catheters into the ureters, after the introduction of the cystoscope into the bladder, being three or four seconds for each ureter; local (cocaine) anesthesia was used; and very little discomfort was complained of by the patient during the procedure.

The essayist claimed for ureter-catheterism great advantages in respect to both diagnosis and treatment, and under these two divisions presented a schedule of the purpose of the procedure.

A number of cases were reported, in which the clinical aspects of the subject appeared. Case I. referred to a patient who had been advised to undergo an operation for

removal of three stones that were supposed to be lodged in the ureter, the diagnosis being based on an X-ray photograph. Ureter catheterism showed the ureter to be absolutely void of any foreign material, and drainage gave perfectly clear and healthy urine from that side. Case II. was one of persistent cystitis and infection of the urinary tract that was rebellious to various treatments applied for several months, and only responded satisfactorily after regular periodic irrigations of the infected left kidney-pelvis had been carried out. These removed all foci of infection and restored the tract to health. It was mentioned that two other cases of urinary infections with prolonged history had behaved similarly and had proved equally as amenable to the boric acid irrigations of the kidney-pelvis. Cases of unilateral and of bilateral renal tuberculosis, in both male and female subjects, were mentioned, the definite diagnosis being made in each case without serious disturbance to the patients and without subsequent increase of irrigation, etc. On the contrary, there was improvement in each case, following the washings with antiseptics that were also given. The question as to whether the air used for distending the bladder had any beneficial effects had come to Dr. Lewis' mind. Several cases were mentioned in which there had been so much bleeding from the urinary tract that successful cystoscopy or ureter catheterism with the older, instruments by which the manipulations would have to be made through clear fluid in the bladder, would manifestly have been impossible; the fluid would have become clouded with blood so quickly that no view of the bladder or of the ureter openings could have been obtained. But this did not deter the writer from accomplishing both objects, as the blood flowed along the walls of the bladder, collecting in small pool at the fundus, out of the way of the manipulations, the patient being in the elevated pelvic posture on his back. Catheterism of both ureters had been accomplished in each case of this kind in which it had been undertaken; and a means of appropriate medication, with-

out operation, had been supplied, also. The bearing of this method on pyo-nephrosis and peri-renal abscess, with respect to both diagnosis and treatment, was shown by illustrative cases. A description of the instrument and the technique of its use was given. General anesthesia had been abandoned and had been satisfactorily replaced by cocaine anesthesia, best secured by means of the writer's urethral tablet depositor and cocaine tablets made by Searle and Hereth Co. The ureter-cystoscope was being made by the Surgical Appliance Mfg. Co., Rochester, N. Y. It was mentioned that a table for the purpose of expediting and facilitating the procedure was being developed under the author's supervision by the Willbrant Surgical Mfg. Co., of St. Louis. This table was intended to be adapted to other genito-urinary operative and office work also.

UNIVERSITY OF BISHOP'S COLLEGE
FACULTY OF MEDICINE.

The session of this Faculty opened early last month, and we are glad to learn that it promises to be the most successful in its history—nearly, if not quite, thirty Freshmen having so far registered. An unusually large number of Second, Third and Fourth Year men have also registered, many being new men who have come from distant schools on account of the reputation of the Faculty for its practical teaching. This session will be one of nine months, the first in its history. We are informed that in view of concluding work before the "dog days" arrive, the courses will open next fall, early in September.

The Annual Dinner of the graduates and undergraduates in medicine and dentistry of Bishop's took place at the Place Viger Hotel, on the 6th November; one hundred and eleven sat down, among the guests being the Hon. J. Israel Tarte. The speeches were much above the average of such occasions. We hope in our next issue to give a more extended report.

Book Reviews.

A Text-Book of Pathology and Pathological Anatomy.—By Dr. Hans Schmaus, Professor in the Pathological Institute at Munich. Translated from the sixth German edition by A. E. Thayer, M.D., Instructor in Pathology, and edited, with additions, by James Ewing, M.D., Professor of Pathology in Cornell University Medical College, New York. In one octavo volume of 597 pages, with 351 illustrations, including 35 coloured inset plates. Cloth, \$4.00, *net.* Lea Brothers & Co., Publishers, Philadelphia and New York.

Professor Schmaus is a Pathologist of high authority in his own country. Dr. Ewing has won reputation in this, by his work on the blood and his studies on inflammation. Messrs. Lea are known everywhere for the excellence of their publications. When these three forces were known to be working together in one direction, toward the production of a text-book on Pathology, an unusually good result was to have been expected. The book has appeared; and on account of this high hope it demands careful examination and particular notice.

The publishers have left nothing to be desired. The book as it leaves their hands is substantial, handsome and even dainty; the illustrations are fresh, clear and artistic. In a word, the make-up of the work is admirable, pleasing to the hand and eye.

The best text-book is one that is most useful, a statement not so obvious as it would appear. This usefulness depends on a large number of qualities. It must contain the common information upon a subject, brought together for common use; it must be full and accurate. The present book is full to repletion, it is accurate in its statement of fact. But there is something more. The information must be well classified, and easily accessible. In the present case it is not well classified, it is not easily accessible, and English-speaking students have not the industry of their German confrères to dig into the text for isolated facts and correlate them in their own minds. One example will serve. The introduction is burdened with an account of the signs of death, full and excellent, but no one would think of looking for it there. It is quite true this foreign material is found in the German, but there is nothing profane in a free handling of the original, for the comfort of the student is the supreme law in the making of text-books. That is the editor's business.

There is still something more. A text-book does not imply originality on the part of the maker, editor or translator; it does imply good sense in selection, in leaving out as well as putting in. There must be a correct and nice use of words, a logical sequence of sentences, in short, it must have style. The text-books that endure are those that have this quality, in addition to those already

named. They are the great books—Erichson's Surgery, Quain's Anatomy, Osler's Medicine. No German professional book ever has style; at least, it is not apparent to the Gentile mind. It is the business of the translator and editor to supply it, unless the book is to remain merely a translation, and so stated in the outset.

Dr. Thayer, the translator, writes English excellently well,—for a German; but, apparently, he had not much assistance from the editor, for Dr. Ewing, in his preface, considers the text has been rendered into "clear English." The rendering is neither clear nor correct. It is doubtful if there is a page which will not yield proof of this, and there are nearly six hundred pages in the book. The meaning of such a sentence as the following, on page 18: "these cellular elements, the very bricks of the edifice, are the actual carriers of life functions," is not clear, unless the cellular elements of the blood be thought of as bricks and the life functions carried by them as a roof to the edifice. In the same paragraph three subjects are named, and the last is referred to as "which latter." Upon the same page a "purpose" is referred to first as a "pathway" and again as a "foundation."

There is a straining after scientific exactness of definition common also in American books not confessedly translations, which destroys all fluidity and freedom of expression. The terms, "marantic edema" "universal and inclusive view," "expression of life," "concepts," "spontaneous injury," "signification of tuberculosis," "suggillation" are not essentially more correct than simpler expressions, and they give to the text a foreign sound, look and feeling.

Again, whole sentences, excellent in themselves, are interjected into passages where they only serve as obstructions. There is a good example of this on page 212 where the following occurs: "Baumgarten and Walz do not admit the existence of such alexins. *Natural immunity means that an animal is not a favourable medium for the bacteria invading it.* They rest their argument on the fact," etc.

The free use of "latter" and "former," "first" and "last" "the same," "the previous" is obstructive to the flow of thought, Adjectives are continually used in a substantival sense as "colloid," "amyloid." The sentence; "the arterio-sclerotic kidney is distinguished from atrophy with stasis by the over filled veins of the latter, even when very much decreased in size," is not "clear" in its meaning nor agreeable in its form. When one comes upon such terms as "regressive," and finds upon reflection that they are strictly justifiable, he is inclined to think that terms like "arrosion," on page 485, are also so, but that is an unwarrantable inference.

If it be considered that these are mere subtleties, one may mention more obvious departures from normal writing, in sentences without subjects, in a lack of agreement between nouns and their verbs, in a wrong use of adverbial expressions and prepositions. One or two random examples of each will serve: "Occurs in the

blood in septic diseases," page 217; "inflammation is but a pathological exaltation of processes which *serve*," page 105; "*there appear* to be grains," page 66; "there *are* found a number," page 239; "islands of tissue which *is* little affected or in fatty degeneration," page 425; "the cause of the cyanotic induration is the distention of the veins and the hyperplasia of the stroma which *leads* to," page 423; "similar as," page 216. These are little matters compared with the use of "and which." There is a trace of humour in the expression "the majority of the protozoa found (in carcinomata) are degenerative products of cells."

The merits as well as the defects of the original have been faithfully reproduced. There is often a variation in definition which is sure to confuse, as in the case of fatty infiltration and fatty degeneration, or rather a definition is made absolutely and later is qualified to the point of destruction. Very little attempt is made even in matters of controversy to state to compare and decide between opposing views. In the consideration of tumours the statement is made: "We know now that true epithelium, and hence its tumours may develop from the middle layer"; it may be so, but one would like to have some evidence of it. The handling of what is called inflammation, the real test of a writer on pathology, is not clever, and the result is disorderly and uninteresting.

Most of these things concern the work of the editor and translator; the fact still remains that the original is of great value to German students, and that a translation would be of great value to American students—if it were done by other hands.

Professor Schmaus' work is of so high an authority, the labour of rendering it more accessible to the American student has been so great, the enterprise of the publisher has been so marked, that the result challenges criticism, and it is permissible to speak thus freely of it here.

A. M.

Butler's Materia Medica. A Text-Book of Materia Medica, Therapeutics, and Pharmacology. By George F. Butler, Ph. G., M.D., Professor of Materia Medica and of Clinical Medicine, College of Physicians and Surgeons, Chicago. Fourth Edition, revised and enlarged. Octavo, 896 pages, illustrated. W. B. Saunders & Co., Philadelphia and London, 1902. Cloth, \$4.00 net.

This is essentially a student's book. The fourth and revised edition now before me is a marked advance on the first three editions. It has, practically, been rewritten, with a resulting improvement in the method of presentation of its subject matter. The portion dealing with Materia Medica as ordinarily understood is full and concise. The section on serum therapy (which by the way is placed under the "Alteratives," instead of the "Specific Medications," as one would expect) is somewhat sketchy. Under Organotherapy, seven pages suffice to dismiss a most important

subject, and personally I should prefer the word "secretions" in the opening sentence: "The striking fact that various *excretions* and tissues of the organism, when administered under certain conditions, possess a peculiar therapeutic value is now well ascertained."

The chapter on prescriptions embrace a sort of condensed Latin grammar. This part of it is (perhaps unconsciously) a caustic commentary on the standing of American medical students or standard of the matriculation of American Medical Colleges. This "how-to-learn-Latin-at-a-glance" method seems strangely out of place in a volume intended for medical students and for whom the standard of preliminary requirements should be so sufficiently high to obviate the necessity for such elementary notes, with its corollary confession of insufficient educational foundation. The best chapter in the book is written by Martin H. Fisher, M.D., Associate in Physiology in the University of Chicago, on "The Relation of Physical Chemistry to Pharmacology and Therapeutics," although but eight pages are devoted to it, and that it would be more at home in a "quiz-compend" than a text-book—altogether the volume lacks the extended physiological experimental work of words—the bio-chemical work of a Cushing, the practical therapeutical applications of a Shoemaker, and has been written for the United States, and its pharmacopœa. The paper is excellent and of dull finish, the type clear, and the binding above reproach.

R. W.

Lindsay and Blakiston's Visiting List for 1893.—P. Blakiston's Son & Co., 1012 Walnut Street, Philadelphia.

This is the fifty-second year of this annual, and no better visiting list is published; we have used it for over forty years, and have found that it answers perfectly every need. In addition to the numerous other valuable features for which this little work is noted we specially wish to draw our readers' attention to two new features—namely, the pages on incompatibility, chemic, pharmacologic and therapeutic; also the page on the immediate treatment of poisoning. We believe these additions will enhance considerably the value of this Physicians' Visiting List, as an ever-handly reference guide for the medical practitioner.

F. W. C.

A Text-Book on Diseases of Infancy and Childhood.—

For the use of Students and Practitioners. By Henry Koplik, M.D., Attending Pediatricist to Mt. Sinai Hospital, New York; ex-President of American Pediatric Society, etc. Octavo, 675 pages, 169 engravings and 30 plates in colours and monochrome. Cloth, \$5.00, net; leather, \$6.00, net. Lea Brothers & Co., Philadelphia, 1902.

This is a new work on pediatrics. The author aims at giving, as well as his own views, those of the best writers on this subject.

both in Europe and America. In this he has succeeded well, and the arrangement of the work is excellent, giving the author's name in brackets when quoted, and at the end of each chapter a list is given of the leading authorities referred to in the chapter. There is also an author's index. By this arrangement the views of an author on any particular subject may be easily referred to. The work, as a whole, deals with about all the diseases of infancy and childhood, but not minutely. The main features of the disease are given, and the author keeps the clinical aspects well to the front. Thus the work is not voluminous, which makes it better adapted for the use of general practitioners and students. Special attention is given to methods of examination and physical diagnosis. The work is well illustrated and the publishers have shown their usual skill and good workmanship in the general make-up of the book.

I. C. S.

Bacteriologic Technique. A Laboratory Guide for the Medical and Dental Student, by Dr. J. W. H. Eyre, Lecturer on Bacteriology, Charing Cross Hospital Medical School, London. W. B. Saunders & Co., Canadian agents: J. A. Carveth & Co., Toronto. Price, \$2.50.

No guide could be more useful than this one. It is complete, systematic and reliable. It is the outcome of the experience of a man who has wrought with his own hands and knows the difficult places in the course. Every method and operation employed in the laboratory is clearly described and could be performed by a student of average skill without any further instruction. The work is what it purports to be—a guide through the laboratory, not a text-book, not even a manual of bacteriology. It is intended for workers, not for readers.

The illustrations really do illustrate; the descriptions are clear and adequate, and given in good style. The range of work covered is very large and includes almost everything that can be done in a laboratory of bacteriology.

A. M.

The Medical News Visiting List for 1903.—Weekly (dated, for 30 patients); Monthly (undated, for 120 patients per month); Perpetual (undated, for 30 patients weekly per year); and Perpetual (undated, for 60 patients weekly per year). The first three styles contain 32 pages of data and 160 pages of blanks. The 60 patient Perpetual consists of 256 pages of blanks. Each style in one wallet-shaped book, with pocket, pencil and rubber. Seal Grain Leather, \$1.25. Thumb-letter Index, 25 cents extra. Lea Brothers & Co., Publishers, Philadelphia and New York.

A visiting list is an indispensable convenience for the active practitioner. Its carefully adapted blanks enable him at once to note clinical details of every day work, as well as charges and receipts, and to unburden his memory of that which can better be

carried on paper. It also furnishes him with a legal record necessary for the collection of delinquent bills. Among the most convenient of the many publications of this nature is the *Medical News Visiting List*. Its blank pages are arranged to classify and record memoranda and engagements of every description occurring in the practice of the physician, surgeon or obstetrician. The work opens with printed data of the most useful sort, including an alphabetical Table of Diseases with Approved Remedies, a Table of Doses, Sections on Examinations of Urine, Artificial Respiration, Incompatibles, Poisons and Antidotes, a Diagnostic Table of Eruptive Fevers, and a full page plate showing at a glance the incisions for ligation of the various arteries, an invaluable guide in such emergencies.

It is printed on fine, tough paper, suitable for pen or pencil, and durably and handsomely bound in the size of a wallet for the pocket. When desired a Thumb-letter Index is furnished, which is an economizer of time. We have used this little book in the past, and can honestly testify to having had perfect satisfaction, it being quite a *Multum in Parvo*.

R. C.

Physical Diagnosis.—Diseases of the Thoracic and Abdominal Organs. By Egbert Lefevre, M.D. Lea Brothers & Co., publishers, Philadelphia, 1902.

This is one of the most up-to-date and concise works on this important subject.

It is useful alike to student and practitioner. The work reflects credit on the author and the publishers. The subject matter of the book is excellent, and the printing, paper and engravings could not be improved upon.

The work is divided into five parts.

Part I. takes up the important subject of Regional Anatomy in a very thorough and clear manner.

Part II. deals with the methods of diagnosis of diseases of the Respiratory System. The principal diseases of the chest are discussed, and the important points in the diagnosis.

Part III. goes fully into the methods of diagnosing cardiac diseases.

Part IV.—In this section the principal elements in the detection of disease in the abdominal organs are dwelt upon. The principal diseases are mentioned with their special diagnostic points.

The book ends with Part V., in which there is an excellent dissertation on X-Ray work. Its technique and the uses to which it is applied in medicine from a diagnostic point of view. The plates in this section are particularly good.

We commend the book to all those interested in this department of medicine.

W. G. S.