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INSANITY AND ITS MEDICO-LEGAL ASPECTS.

BY JOHN H. ARTON, M.D., WINNIPEG.

There can scarcely be a more opportune time than the present in Canada, in which to canvass the question, "What is insanity, and what its medico-legal aspects?" We have just passed through a period of excitement, in which these questions have played important parts; and, judging from the amount of irresponsible scribbling that has come, and is still coming to the surface, it may well behove us as dispassionate men, to devote some time and attention to so important a subject. It is proverbially hard to make a definition; and nowhere, perhaps, does the art of defining meet with greater difficulties than here. So far as I know, there is no satisfactory, comprehensive definition of insanity; and, what is more to be regretted, the two professions most interested in this matter, are, perhaps more widely opposed to each other on this, than on any other question. The legal profession has not hesitated, over and over again, to sit upon the medical, with regard to the ideas of the latter on insanity; while the medical profession, has as ably, though without obtaining a conviction, so far, held up its own views.

At first blush, it would appear as though the question should be entirely decided by a medical consensus of opinion, as much as this would decide a question of any other disease; but it is not so, for the question of insanity is made the pivot round which many specially fat tid bits turn; and the gentlemen of the wig and gown are especially gifted in looking after number one. Another reason perhaps for the contempt shown by the legal fraternity for our protests, lies in the prover-

bial facility with which doctors differ. This is owing doubtless to the lack of precision in mental processes, which so many of us, alas! shew;—and which, by the nature of their training, is almost impossible to the legal mind. Medicine has not yet attained the full dignity of an exact science; and, with many in our ranks, it is scarcely a science at all;—and, wherever one is tempted, in a scientific question, to leave the strict lines, and begin to theorize and generalize, he loses his position, as opposed to men who work from a firm and preconcerted basis. It is true that to-day even, it is premature to attempt a definition of insanity; but it is equally true that we have advanced so far along the path towards such a definition as to leave behind, in almost forgotten obscurity, the position held by our legal friends, now, as a century and more ago. It were foolish in us to try to define this disease in its protean characteristics;—to attempt, so to speak, to crystallize in one phrase, or set of phrases, what, by its very nature seems amorphous. We have to fall back on the dictum of one of our greatest poets, which however useless scientifically, amounts to about as much as anything in the same line which our greatest alienists can devise.

"To define true madness! What is it but to be nothing else than mad?" The legal definition, "unsoundness of mind," has the virtue of comprehensiveness: but it is a negation rather than an affirmation. It states what insanity is not, rather than what it is. If however, the courts would advance on their recognition of what *mind* is, we might agree to terms; but so long as they only recognize *intellect* as mind, there can be no agreement.

Physiologists divide the functions of the brain into three—Intellect, Emotion and Will;—and to be sane from a medical standpoint, a man must be sound in all three. The law recognizes these varieties of insanity, in effect, every day, seemingly when it suits its purpose, but the point to which this paper is intended to call attention is that the law does not give due weight to these varieties in the cases of the criminal insane. It is here that oftentimes injustice is done; and despite many efforts, even on the part of the brightest ornaments of the bench and bar, this anomalous state of matters remains from year to year *in statu quo*. I believe, in fact, that the

English law on the subject, as it appears on the Statute Books, recognizes no condition of irresponsibility in insanity. Men who have been recognized as hopelessly insane have been hanged for crimes by the same law which still adorns our Statutes. We can scarcely wonder at this, or regret it either, when we consider the alternative a hundred years ago. Then, the whip, and the rack, and the torture bed, the dark room, the chains, and all the other instruments of torment, which man's ingenuity could devise, were put into requisition in the so-called treatment of the unfortunate lunatic. Better by far a short shrift, and a broken neck, than a miserable existence eked out in such circumstances. Poor elemency that! But things have changed now, and the treatment of lunatics has a very different aspect. Therefore, if for this alone, it is worth while to rescue those whom the gods have stricken, from a punishment which they in reality do not deserve, and which may well be replaced by a merciful isolation. As time wore on, the horrid injustice of consigning the insane criminal to death, or other punishment, struck even the usually impassive administrator of the law; and judges were found here and there who actually charged the jury to acquit a prisoner if they found him of unsound mind. In 1843, in a celebrated case, an insane murderer was allowed to escape the death penalty on the plea of insanity, and the people made such a disturbance about it, that the House of Lords propounded a series of questions to the judges for authoritative answers as a guidance in such cases in the future. As far as the present purpose is concerned, the most important answers given was to questions two and three. "To establish a defence on the ground of insanity, it must be clearly proved that at the time of committing the act, the party accused was labouring under such a defect of reason from disease of the mind, as not to know the nature and quality of the act he was doing; or, if he did know it, that he did not know he was doing what was wrong." Here the whole question of responsibility rests on the intellectual capacity of the criminal, *i.e.*, his knowledge. This finding of the judge has never been placed on our Statute Book as law; but it has been regarded as a law from that time to this. We can recognize what an advance was made here; and how many really innocent lunatics must have

received the benefit of this amendment. But we hold that to-day, a much further advance is necessary. The law, or rather what stands for the law, provides a loop-hole of escape for a few; but who among us, in the habit of seeing and dealing with lunatics, fails to recognize that the intellect is often the least affected function. The most hopelessly insane is often exceptionally intellectual. I have myself, when visiting a strange assylum, mistaken an inmate for an official; and have known lunatics who could solve the abstrusest mathematical problem, and put to the blush nine-tenths of the scholarly among his visitors. Such a man is taken charge of by the state because, perhaps, he has shown some craze, which would lead him to squander his own fortune, and leave his family in poverty. He is not considered capable of managing his paternal acres; but, if the question is one of human life, he, by the above test is held, and must be held eminently responsible. Moreover, it is not the purely intellectually unstable who are the most likely to come within the clutches of criminal law. It is true, that so interdependent are the various cerebral functions, one upon the other, that in many cases, where one is involved, another is affected also; but we scarcely can recognize the jurist's pathology who makes insanity first emotional, and later intellectual; and later still, perhaps, volitional as well. In many of those very cases, where the hardships of the present law tests press most, the accused are purely emotionally insane, with a consequent loss of volition, or control over their actions; and with no appreciable intellectual defect at all. Such men are really dangerous to society; though perhaps, only at intervals; and the occurrence of these very interludes of apparent sanity is what becomes most dangerous to themselves, should they ever have occasion to stand the test for criminal responsibility.

This question of insane criminal responsibility, is not by any means a remote one. It is one in which every one of us is directly interested. Probably no man is perfectly sane at all times; and, though the diagnosis of mental unsoundness may never be made in our case, yet again it may. Sir James Stephens, one of our most eminent English judges, has recognized the narrowness and utter illogicality of the present state of matters; and has nobly striven to improve them, so far without

effect. English institutions are prone to be lasting from a law down to a wheelbarrow. They are a pig-headed people over there in many respects; and somehow, in this matter, they have failed to be moved; even when right and reason, and eloquence and learning and earnestness were all enlisted to remove a wrong. We are tempted almost to say, that the British representatives have posed successfully as lunatics by their own test. "They do not know right from wrong." Stephens has produced an argument in favour of amending the present test, which for force of reasoning and clearness of diction has few equals. Here is his definition of the disease. Sanity exists when the brain and the nervous system are in such a condition that the mental functions of *feeling* and *knowing*, *emotion* and *willing*, can be performed in their regular and usual manner. Insanity means a state in which one or more of the above named mental functions is performed in an abnormal manner, or not performed at all,—by reason of some disease of the brain or nervous system (*History Criminal Law, Eng. Vol. 3 p. 130*)." Again "criminal responsibility signifies "nothing more than liability to punishment for "crime, and a criminal act implies the existence of "*intention, will and malice*." You will notice that he holds for the possession of will in addition to knowledge, in order to make a lunatic responsible. "It is as true," says he, "that a man who cannot control himself does not know the nature of his acts, as that a man who does not know the nature of his acts, is incapable of self control," (p. 171). This man ought to have been a doctor rather than a lawyer. In 1874 Stephens compiled a bill entitled "A Bill to amend the law of Homicide" in which it was provided that homicide should not be deemed criminal if the accused person is at the time of committing the act prevented by any disease affecting his mind, (a), from knowing the nature of the act; (b), from knowing that it is forbidden by law; (c), from knowing that it is morally wrong; (d), from controlling his own conduct. The fourth test is in reality the amendment to any previous legislation, or authoritative findings on the subject. This Bill was not passed; and consequently we stand as we were. While admiring the liberality of Sir James, especially for a legal mind, we must confess that even his tests are inadequate to estimate such a subtle disease as insanity.

To attempt a summing up so far, our position at present simply is,—“Most jurists aver that no “degree of insanity should exempt from punishment “from crime, unless it has reached that point that “the individual is *utterly unconscious* of the difference between right and wrong at the time of “committing the alleged crime.” On the other hand, physicians who have given this matter a careful study, affirm that this test would only apply to persons suffering from delirium; from a furious paroxysm of mania, or from confirmed idiocy; that persons suffering from confirmed insanity are fully conscious of the difference between right and wrong; and are quite able to appreciate the illegality, as well as the consequences of their acts. Some jurists hold that the law means *the consciousness of a sound mind* when it proposes this as a test, and that “the consciousness of the insane, is an insane consciousness.” But this is simply begging the question. It may be true that in practice the English law differs from the same law in theory; and that practically it cannot be said to err on the side of severity. The fact remains, however, that it operates with uncertainty; and that, if possible, is a graver charge.

With regard to Canada, at least, the remedy lies in our own hands. There is no reason why we should supinely wait for the mother country to take the initiative in this matter of reform. It were well once in a while to shew that our boasted independence is not a pure myth, and that we can dare at least to think for ourselves. It is evident from recent events, that this same test of knowledge of right from wrong is taken in this country as the test of insanity, (see ex-Min. Jus. Campbell's Manifesto on the “Riel trial.”) The popular test here, as at home, is “does he know right from wrong?” If he does, then he is not insane; or at least not legally, or popularly insane. The elasticity of this definition if rigorously enforced, would throw open the gates of our asylums to many, who, for the safety of the commonwealth are now immured. It besides being within reach of the halter all those, who, from motor explosions (epileptics and acute maniacs) may commit murder; and, in the next hour or minute, when examined, be perfectly sane. As medical men, we know and recognize epilepsy and mania to be first cousins, but lawyers do not. Both diseases are

explosions; the one a "muscular storm, the other a storm of thought, emotion and will." After the storm has passed who can detect the difference oftentimes between the sound and the unsound?

The question of hallucinations again here presses itself on our attention. They are not always the result of imponderable undetectable changes, as so many think. In many cases these hallucinations can be clearly traced to gross and palpable lesions of the optic thalami or their plexuses. These cases are accompanied usually by atrophy of certain convolutions, which is recognizable even by the naked eye. The law takes no notice of this. I do not know how to diagnose with certainty such a condition during life. If the symptoms of lesion, of what is improperly styled "the internal capsule" be wanting, there may be nothing to lead one to these intellectualizing ganglions at all. Cross lesions, which interfere with the motor apparatus, and whose locality is much more easily appreciated, be the same in the cortex, the cortico striate fibres or the corpus striatum itself, do not so frequently have a bearing on insanity, as do lesions of the sensory areas. But because you or I cannot positively say in any given case, that a man's hallucination depends on a given lesion while he yet lives, that is no reason why he must be hanged in order to oblige us with a post-mortem. And, by the way, when such judicial proceedings have been enforced, with or without protest from our side, why should not a properly managed post-mortem be held for the satisfaction of all concerned, and the furtherance of science. It is all very well to have a coroner's inquest in order to certify that the criminal is really dead; but to that should certainly be added a careful and scientifically conducted *sectio cadaveris*.

These somewhat disjointed remarks (to which perhaps I should prefix Montaigne's motto "I have gathered a bouquet of other men's flowers and only the thread which binds them is mine own,") will have done almost more than their author hopes for, if they conduce to a discussion of the subject by men abler to deal with the new question from every point than himself. There can be but one opinion, one would suppose, among all professional and lay, as to the expediency of having this legal gap in our institutions filled up. The people at large accept things as they are, partly from ignorance of facts and partly from lack of interest.

The medical profession here, as in almost every matter of reform, becomes of necessity the leader and adviser of the laity. The popular idea of what constitutes insanity must be dissipated; together with the error that it only needs common sense to discriminate between a sane and an insane man. In truth, it needs more acumen, skill, judgment and special education probably, than any other problem we are called on to solve. And how often do the best make mistakes or fail in arriving at a conclusion. Let any one read the medical evidence in Lady Mordaunt's trial, where the most distinguished men, not only of that time, but probably of all time, investigated the question of her sanity; and how humiliating the confession we have to make, that their investigation amounted to nothing. Fortunately such cases do not arise every day. Who among our sapient editors, etc., who so glibly pronounce on questions of such fine spun yarn, would consider the author of the following lines insane:

"There is a winter in my soul,
The winter of despair;
Oh, when shall spring its rage control?
When shall the snow-drop blossom there?
Cold gleams of comfort sometimes dart
A dawn of glory on my heart,
But quickly pass away;
Thus Northern lights the gloom adorn
And give the promise of a morn
That never turns to day."

And yet he was a confirmed lunatic when he wrote these lines, which with almost incredible faithfulness and clear insight pourtray his condition and the mental disease from which he died.

As remarked before, it is a subject which is not remote to anyone. Besides, the old maxim "*Nihil a me alienum humanum puto*," every man has a personal and living interest in the question of mental alienation, and the responsibility dependent on that condition. Let the Dominion House of Commons take up the matter. Let the dead past bury its dead! We are the heirs of the future! Let a committee be appointed, say of the medical men in the House, with others, if deemed necessary, to investigate this question; and to formulate such amendments to our law on the subject as will prove a model for the mother country well worthy her imitation. By doing this our parliament will confer a lasting boon on the world at large, and deserve lasting pæans of praise from all men for all time. To break free from the trammels which a bigoted and purblind judiciary

has imposed on us for all these centuries, is a task worthy to be classed with the emancipation of slaves, or Magna Charta itself.

If by any chance, this suggestion should, even in the remote future, lead to such a desirable result, it will be only another of the boons conferred on a somewhat ungrateful public, by a profession, whose humblest member has for his motto,

“ PRO BONO PUBLICO.”

INTESTINAL OBSTRUCTION.

BY A. B. ATHERTON, M.D., L.R.C.P. & S. ED.,
TORONTO.

In these days when surgery is making such immense strides in the treatment of abdominal diseases, which only a few years ago were deemed beyond the resources of our art, it may not be without interest and profit that the subject of intestinal obstruction should be brought before this Association. Under this head it is our intention to review briefly the various diseases which lead to obstruction of the bowels, with the exception of course of hernia, which obviously belongs to a different class of cases. Much of that which I have to offer will be derived from the writings of different authors, especially from the Jacksonian prize essay of Mr. Frederick Treves. I have myself, however, met with seven cases of acute intestinal obstruction during the last five years,—two of which were seen in consultation; and if I should judge from my own experience during the last fifteen years, I should consider cases of this disease to be more common than idiopathic peritonitis, with which I fear they have been too often confounded. From a clinical standpoint, cases of obstruction may be best divided into two groups, viz., acute or subacute, and chronic. Many of the latter, however, have an acute ending.

Under the first division may be arranged—1st. Cases of strangulation by bands; 2nd. Cases of volvulus; 3rd. Cases of acute intussusception; 4th. Some cases of obstruction by foreign substances. *Chronic* cases include: 1st. Stricture of the intestine; 2nd. Fæcal accumulations; 3rd. Chronic intussusception; 4th. Some cases of obstruction by foreign bodies.

Strangulation by bands or through apertures give rise to symptoms which are typically *acute* in their courses, and which resemble closely those

of a strangulated hernia. The similarity is rendered more marked by the fact that in both it is usually the small intestine that is involved.

Under this variety of intestinal obstruction may be placed:—1st. Strangulation by peritoneal adhesions; 2nd. Strangulation by cords of omentum; 3rd. Strangulation by Nuckel's diverticulum, the vermiform appendix, the pedicle of an ovarian tumor, and the like; 4th. Strangulation through slits in the mesentery or omentum, or through membranous adhesions.

The varieties of the foregoing class are so numerous that for practical purposes it must suffice to say that the constricting cords are of various lengths and sizes, some being found long enough to form a knot in which the gut is included, while others are so short that scarcely room enough is obtained for the application of a ligature, the lumen of the intestine being closed as in one of my cases by dragging upon the contiguous loops. Furthermore, these bands may be attached to every conceivable part of the bowel or abdominal wall. According to Treves, this form of acute obstruction occurs more frequently in males than females, the proportion being about 3 to 2. As to age, most cases are found between 20 and 40 years, being very rare before 10, and comparatively infrequent after 40. In 68 per cent., there was a previous history of some trouble which would be likely to have produced causes of obstruction. In about half of the cases this was peritonitis; in others a history of hernia; and in some few a history of accident.

In only a small proportion of the cases analysed (12 per cent.) was there any evidence of previous symptoms of obstruction, the attack reported being the first suffered from.

Volvulus, the 2nd form of acute obstruction, includes two varieties, one in which the bowel is twisted on its own mesentery or on its own axis, and another in which two coils of intestine become intertwined. The most frequent seat of volvulus is the sigmoid flexure of the colon, two-thirds of the cases reported having been found to involve that portion of the intestine. It occurs much more frequently in males than females, the proportion being 4 to 1. The great majority of cases falls between the ages of 40 and 60. Very often a previous history of constipation has been noted in this class of cases.

Intussusception, which represents the next form of acute obstruction is one very commonly met with, about one-third of all the cases being made up of this variety. Nearly one half of those reported were of the ileo-cæcal kind, next in frequency was the enteric, then the colic, and lastly the ileo-colic. More than 50 per cent. of all cases occur during the first ten years of life, and about 25 per cent. in infants under a year. In this respect intussusception differs remarkably from the two preceding forms of acute obstruction. The most common exciting cause noticed has been diarrhœa; but, according to Treves, only about 10 per cent. were preceded by this disease. In all three cases of my own, diarrhœa preceded for a day or more the establishment of marked symptoms of obstruction. One of the most striking as well as frequent concomitants of intussusception is the *passage of bloody discharges*. About 80 per cent. of the acute cases presented this symptom, and about 50 per cent. of the chronic ones. In a very large proportion there was also a marked degree of *tenesmus* present, especially in the more acute cases. A third distinguishing feature of intussusception is the presence of a more or less distinct tumor, which may be felt in about half the cases, and is apt to grow harder and more defined during a paroxysm of pain. It varies in size from that of an egg to that of the forearm, and as a rule is more or less fixed. Its length may be as much as 5 or 6 inches or more. In nearly one-third the cases the lower end of the tumor projected from the anus, or could be felt by the finger in the rectum. The *Chronic* forms of intussusception are more difficult to diagnose than the acute, and the symptoms may be protracted for months. Diarrhœa very commonly alternates with constipation in these cases, and there are intervals when the patient seems to be in fair health, although more or less emaciation necessarily accompanies the malady in its progress. Spontaneous relief may take place in any case of intussusception either by reduction of the bowel, with or without the assistance of opiates, or by sloughing of the invaginated portion and union of its ends. A partial recovery occurred also in one case reported, when a fæcal fistula formed about the seat of obstruction.

We come now to a consideration of the 4th class of acute obstruction, namely, that caused by the presence of a foreign body. More frequently,

however, the symptoms produced by such pursue a more or less chronic course, although the final result as in chronic intussusception may be brought about suddenly. These substances are of course found to be of various composition and character, and are introduced into the alimentary canal by swallowing some hard or indigestible material, which, either singly or by accumulation, brings about obstruction. Among the largest of these masses may be mentioned those composed of cocoa-nut fibre or hair. In one instance one of the former weighed 4 lbs.; and I myself saw Mr. Knowlesly Thornton remove a mass of hair and thread from the stomach of an hysterical young woman, which measured $9\frac{1}{2}$ inches in length, and was $2\frac{1}{2}$ and $4\frac{1}{2}$ inches in diameter at either end.

In Mr. T's case, however, little or no obstruction to the passage of food was caused, and the patient was fairly well nourished. Allied to this class of cases are those in which one or more gallstones or intestinal calculi are the cause of symptoms of obstruction, which are generally subacute or chronic in character. A tumor can of course be often detected in all these varieties of the 4th class of obstruction.

Turning now to the consideration of the 2nd great division of our subject we shall find *stricture* of the intestine the best representative of the causes giving rise to chronic obstruction. In almost all instances of such there will be got a history of previous attacks, somewhat similar to that which has led to complete obstruction. The rule is for these attacks to become more and more frequent as well as severe up to the end of the case. Among the anatomical lesions found are simple contraction due to the healing of former ulcers, stricture from former herniæ and old injuries, and finally that resulting from epithelioma and other growths in the intestinal wall. Cases of *stricture* generally occur between the ages of 20 and 60 years. Closely allied to stricture are those cases in which the gut is closed by the pressure of tumors, abscesses etc., from without. In most of these the obstruction is situated in the rectum or sigmoid flexure, for the reason that the swellings producing it are most frequently met with in the pelvic region. They differ from cases of stricture in being much more frequently acute in symptoms.

Fæcal accumulations, when giving rise to in

testinal obstruction, may generally be easily diagnosed from the history, coupled with the presence of a tumor, which can be more or less easily indented by firm and steady pressure of the finger.

Chronic intussusception and obstruction from foreign bodies having been already referred to, we will now turn our attention to the important subjects of *diagnosis and treatment*.

In reference to *diagnosis*, we will first enumerate the prominent features of most cases of acute obstruction. The symptoms are generally extremely *abrupt* in their onset, and may be briefly named as follows: 1st, severe pain in the abdomen, followed rapidly by frequent and persistent vomiting; 2nd, often after a few hours, there supervenes more or less meteorism, which however may be localized, and occasionally even, when the seat of obstruction is high up, may be entirely absent; 3rd, we have as a rule from the first absolute constipation, not even flatus passing per anum; 4th, after a shorter or longer period, depending upon the acuteness of the symptoms, there will appear a collapse; which is often attended by either intestinal or faecal vomiting.

The diseases with which acute obstruction is most likely to be confounded are perhaps acute peritonitis due either to perforation or other causes, cholera and dysentery. Acute peritonitis is the more apt to be mistaken for acute internal strangulation, for the reason that quite frequently cases of the latter disease have the former developed during their progress. If, however, one is called early in the case, he will find several points of difference, which will pretty certainly fix the diagnosis. In peritonitis the temperature is generally considerably raised, while in acute obstruction it is as a rule subnormal, becoming perhaps elevated some days afterwards from the supervention of inflammation. Tenderness is a marked symptom in peritonitis, while there is an almost or entirely complete absence of it in the other disease. This gives rise to a striking difference in the attitude and behaviour of the patient. In peritonitis, he of course usually assumes the dorsal decubitus with knees drawn up, and is unwilling to move or be moved. In cases of acute obstruction, however, he writhes about in bed, assuming all sorts of positions, or gets up and walks about the room like one suffering from an ordinary attack of colic, while he is even also

relieved sometimes by pressure as in that affection. Again we have a diagnostic symptom of much importance, namely, the existence of rigidity of the abdominal muscles, giving rise to a *board-like* feel; in cases of peritonitis, which contrasts strongly with the flaccid and soft abdominal walls in obstruction. Also, vomiting is a much more prominent symptom in strangulation, and becomes after a few days either intestinal or distinctly stercoraceous. It is exceedingly rare for it to attain such a character in peritonitis, and then generally only at the close of a fatal case. Furthermore, constipation is almost invariably absolute after obstruction has become established; except perhaps in cases of intussusception, which however, on account of the bloody discharges that are generally present, are not likely to be confounded with peritonitis. It is only the ultra acute cases of intestinal obstruction which would be mistaken for an attack of cholera, such as strangulation near the stomach or acute cases of intussusception in very young children. The prevalence of the epidemic at the time may aid us in deciding between them, while cramps and a severe diarrhoea accompanied with rice water discharges would generally serve to make us sure of the diagnosis. From dysentery we may generally readily diagnose obstructions by the absence of febrile disturbance, and by the greater severity of the pain and vomiting. From my own experience in three cases, where I had I think good grounds for believing that I was dealing with intussusception, I would be inclined to lay considerable stress upon a difference between the discharges of dysentery and those of intussusception, to which no one as far as I am aware has called any special attention. I was myself particularly struck by the *bright-pink* colour of the serous dejections in these cases, which seemed to me to contrast very remarkably with the dark dirty hue of those of dysentery. In my cases also I saw very little if any mucus, though the absence of this may have been due to the fact that the rectum was not involved, no tumor being felt by the finger per anum. Furthermore, any blood seen was of the same bright red colour, and thus differed materially from the dark clots generally observed in cases of dysentery.

Although the diseases above referred to are perhaps the chief of those which may be mistaken

for acute obstruction of the bowels, yet there are several others which resemble it more or less closely, but which can be usually easily enough distinguished from it by the previous history of the case, and by the presence of some well-known diagnostic symptom. It must suffice merely to enumerate in this connection the following:—hepatic, renal, or lead colic, cases of acute irritant poisoning by arsenic, or some similarly acting substance, acute meningitis, etc. Strangulated hernia is of course always to be thought of, and search made for any of its various forms.

Having made a diagnosis of intestinal obstruction, let us now consider the kind of *treatment* applicable to the disease in its different forms; and first we will pass in review a few of the non-operative measures which may be resorted to in dealing with such cases. Opiates undoubtedly occupy a prominent position, and are of much service both in relieving pain and retarding the symptoms of collapse, while at the same time they tend to promote a cure by preventing the irregular peristaltic action of the bowels, which acts so potently both in the production and continuance of many attacks of the disease. They would be especially useful in acute intussusception and volvulus. Next come enemata and insufflation of air. The enema generally employed is simple warm water, to which is sometimes added soap, ox-gall, or oil to aid in softening and rendering fluid any fecal mass that may be present in the colon. It has been affirmed that injections cannot be made to pass beyond the ileo-cæcal valve, and would therefore be useless in affections of the bowel above that point; but it is now we think pretty generally admitted that they do often overcome this barrier, especially if the patient be well under the influence of an opiate or anæsthetic. In order to render the enema more effective, it is often advisable to introduce a long flexible tube, such as that attached to a stomach pump. Great care will be required to pass this successfully, for it will otherwise often coil itself up in the rectum, instead of moving on into the colon. We have derived on many occasions much benefit in making this manœuvre, by occasionally throwing in a few ounces of water, so as to distend the gut, and thus lessen the chances of the end of tube bringing up against its walls. Also we think a cork-screw like motion will often materially assist it in its

onward progress. The cases most likely to be relieved by enemata are intussusception and obstruction from faeces; also perhaps some cases of volvulus, where indigestible articles of diet have given rise to the disease. Insufflation of air is said to have proved successful in reducing an intussusception after enemata of warm water have failed. In order to prevent the escape of the air or fluid where large quantities are injected, an obturator of cotton rag or an inflated rubber ring may be used. Aperients are to be condemned in all cases of acute or subacute obstruction. They may however be employed in chronic fecal accumulations, although it must be seldom even in these that enemata will not prove as good and a safer remedy. Recently, in Germany, washing out of the stomach and small intestine by means of the stomach-pump or by syphon-action, has been employed in obstruction cases. It is claimed that by thus emptying the distended alimentary canal above the seat of disease, the bowel will be placed in a condition more favorable for spontaneous relief.

Metallic mercury, which at one time was held in high repute in the treatment of obstruction, and subsequently fell into disuse, has again been extolled of late in France as a remedy, especially in cases of stercoraceous accumulations. It is not supposed to act simply by its weight, but is thought to insinuate itself in a condition of fine division between the intestinal wall and the obstructing mass, and thus helps to loosen the hold of the latter and consequently aids in its expulsion. In several such cases M. Matignon reports prompt relief from its use, after purges and enemata had failed to dislodge the offending substance. The doses administered varied from two to eight ounces, and were in most cases several times repeated. In one case nearly 2 lbs. were taken altogether and with success. No ill effects were ever observed from the remedy. Massage and electricity have also been used with advantage in some of these cases, but they will probably be found rather to occupy the position of adjuvants to other methods of treatment than otherwise. Indeed, manipulation of the tumor of an intussusception materially aids an enema or insufflation in bringing about reduction; and it is easy to understand that in cases of fecal accumulation when no inflammation is present, it may also be of great service.

Finally, let us consider the operative procedures which may be undertaken for the relief of intestinal obstruction. If rest in bed with abstinence from food, one or more full doses of morphine, a few large enemata through a long tube, and one or two washings out of the stomach do not succeed in bringing relief in a case of *acute* obstruction within two or three days, it is advisable to perform laparotomy without further delay. Heretofore the operation has been usually put off for a much longer period; but with our improved knowledge of these cases, and consequent more early and certain diagnosis, an earlier resort to opening the abdomen will without doubt lead to much better results. Besides, since it has been learned that the peritoneal cavity is not such a sacred or dangerous precinct to invade as was once thought, there need not now be such hesitation in undertaking the operation. It is pretty generally admitted that delay is more to be blamed for previous bad results than the operation itself. According to past statistics only about one recovering out of three have been reported, and it is more than probable that if all cases had been made public the proportion of unsuccessful ones would have been found to have been considerably in excess of that estimate.

The operation is generally performed in the median line below the umbilicus. When we have opened the abdominal cavity we proceed to search for the cause and position of the obstruction. When this does not immediately appear, we may generally find it most readily by feeling for the collapsed coils of intestine, which as a rule lie below the brim of the pelvis, and tracing them upwards to the point of disease. Having discovered this we will have to vary our course of action according to the cause of the obstruction and the condition in which we find the parts. If a band or cord be the source of trouble we must divide it, two ligatures having been applied, one on either side. In cases of strangulation through slits or apertures, it will be advisable after reduction, to close the opening by suture. It is well also in all these cases to examine the parts carefully in order to ascertain whether or not there may be more than one constricting band present, for in some instances such have been found at the autopsy.

Cases of volvulus are not well suited for relief

by laparotomy, as it is found difficult to deal with the enormous dilated coil of sigmoid flexure, which is generally the seat of the disease. Puncture of the gut may be employed to relieve the distention and thus enable us to reduce the part; but the volvulus is apt to reappear after a little time. A case of my own, which I think was one of this form of obstruction, finally recovered after a dozen or more punctures through the abdominal wall with a small hypodermic trocar. The punctures were made at different times during the several days that the excessive meteorism lasted, and seemed on each occasion to afford marked relief. I would advise caution however in puncturing the distended bowel in such cases, for there can be no doubt that unless the instrument used be very small there is danger of extravasation of the intestinal contents through the openings made in the gut. I know that such oozing from the punctures may, and does occur, for I have seen it in two instances in which, after laparotomy had been performed, I was obliged to let out the gas from the distended coils of intestine before I could return them into the abdominal cavity. After a few minutes, however, the openings seemed to close sufficiently to prevent any further exit of faecal matter. One of these cases recovered and the other lived till the 7th day after the operation, so that I think the punctures did not lead to any serious complication. And here, let me say that the great distention of the bowel met with in these cases gives rise to the chief difficulty in performing abdominal section for the relief of intestinal obstruction. It is almost if not quite impossible to prevent the distended bowel from escaping externally, and it is equally impossible to put it back in its place before its size is reduced by puncture. I would be inclined to try the insertion of a gum elastic tube into the colon in cases of volvulus, so as to permit of the escape of gas by that method. If all else fails, a faecal fistula can be established above the seat of obstruction.

When a portion of intestine is found to be gangrenous, whether in cases of intussusception or other form of obstruction, it must be excised. After doing this it is considered better in all cases (except those in which the upper part of the small intestine is involved), to secure the cut ends of the bowel by sutures to the abdominal wound, rather than to proceed at once to unite them to each

other; because the increased length of time required to complete the latter operation would very much augment the shock produced, and consequently be much more likely to lead to a fatal result. On a future occasion, if the patient recovers, that object can be attempted under a much more favorable condition of things. When practicable, cases of *stricture*, whether due to simple constriction or caused by cancerous or other growths, are to be dealt with by resection of the bowel and removal of the diseased mass, the ends of divided gut being attached as above mentioned to the external wound. When excision is inadvisable or impossible, an artificial anus must be made. When the seat of disease is known to be in the sigmoid flexure or rectum, left lumbar or inguinal colotomy may be at once resorted to if thought best, without a previous central abdominal opening being made. Cases of *simple stricture* may generally be temporized with for some time before it will be necessary to operate for their relief. Much may be accomplished in this way by careful dieting and the use of nutrient enemata. When, however, we have good reason to suspect malignant disease, it is a question whether it will not be better to excise the part early, so as to afford the patient some chance for a permanent cure.

An *intussusception* is of course always to be reduced if possible. When too firm adhesions have already formed to permit of this being safely done, it is probably better to at once cut away the invaginated portion, and secure the ends of gut to the laparotomy wound. Every precaution must of course be taken in all resections of the intestine to prevent the escape of its contents into the peritoneal cavity. If a *calculus* or *foreign body* prove to be the cause of trouble, the bowel may be laid open and the offending substance removed, unless indeed it can be readily moved along towards the anus. In case the gut has to be cut into, the wound must be carefully approximated by fine silk sutures in such a way as to bring the peritoneal surfaces closely together. In cases of obstruction from *fecal accumulations*, we can afford to delay operative measures so long as there is any prospect of getting rid of the mass either by enemata, metallic mercury, cathartics, or manipulative procedures, and it must be seldom indeed that these will not suffice to afford relief.

RHINITIS ATROPHICA--WITH REMARKS ON CATARRH IN GENERAL.

BY G. STERLING RYERSON, M. D., C. M., L. R. C. S. ED.

Lecturer on diseases of the Eye, Ear, Throat and Nose, in
Trinity Medical College, Toronto.

To the practitioner in general, the nature, pathology and treatment of catarrh are as an unopened volume, and the word is only too often associated in his mind with incurability. To the public, the word is almost synonymous with offensive breath, and it is popularly believed that is the forerunner and friend of consumption. These ideas have been assiduously fostered by designing persons, and the country has been overrun with catarrh doctors and nostrum vendors of all sorts. It is with a desire to put the facts in a clearer light that I am induced to pen these lines.

In the first place the question will naturally arise what is catarrh,? It has been shown by Bosworth, Cohen, and others, that it is an inflammation of the lining-membrane of the nose—a rhinitis—and like inflammations in other parts ends in resolution, in hypertrophy, in ulceration, or in atrophy. It is liable to extend to the pharynx trachea and bronchia. I do not know that it has ever been proved to cause tuberculosis. Bronchitis and asthma are often caused by it. Contrary to the generally received opinion fetor is the exception rather than the rule, not more than five per cent. of the cases being attended by this symptom. It is probable, though not yet certain that all the varieties of catarrh are but different stages of the same complaint. Thus we see rhinitis simplex in the father followed by rhinitis atrophica in the child. It is remarkably hereditary, and occurs in many members of the same family.

Now as to the varieties of catarrh. The first and commonest is *rhinitis simplex*, characterized by an excessive flow of mucus, worse in damp weather, and when the patient's general health is not good. There are no organic changes visible on examination of the part; no fetor.

Post Nasal Catarrh is a very common variety of simple rhinitis, affecting the pharyngeal vault and upper pharynx. The nasal mucus membrane may also be affected. The glandular structures are often hypertrophied. The symptoms are dropping in the throat, discharge generally worse in the morning, causing hawking and peculiarly disagree-

able nasal secretions, hoarseness in the morning wearing off towards noon, and deafness from Eustachian tube and middle ear catarrh.

Congestive rhinitis or erectile catarrh is an inter-current condition, generally associated with rhinitis simplex. Sudden closure of the nasal passages on one or both sides is the principal symptom. It passes off after a variable time, and is followed by a profuse flow of clear mucus. It is due to a sudden engorgement of the venous sinuses of the nose.

Hypertrophic rhinitis is a true hypertrophy of the epithelial glandular and connective tissue elements of the pituitary membrane. The amount of discharge from the nose is as a rule not very considerable. It is satisfactorily treated by means of the electro-cautery. Evulsion of the membrane I only mention to condemn.

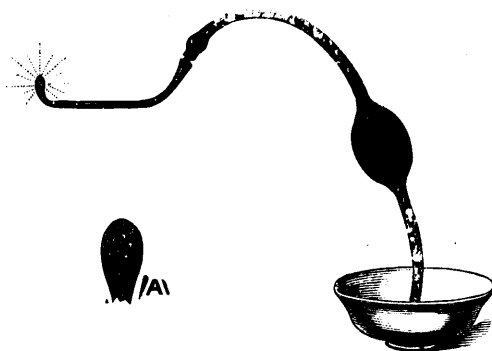
Ulcerative rhinitis, is frequently confined to one nostril. It sometimes goes on to the formation of an abscess in the nose. It may also cause perforation of the septum. Caries is an occasional accompaniment. The nostril affected is swollen, reddened and painful to the touch if the affection is acute. If chronic, it is unattended by pain, but hard crusts form which are attended with some discomfort. The nose bleeds easily when touched. I do not include in this group cases of syphilitic diseases of the nose.

Ozena. By this term I mean discharge of offensive matter from the nose, unattended by apparent change in the mucous membrane. The disease is not in the nasal cavity itself, but in the accessory cavities. The prominent symptom is the discharge of large quantities of fetid muco-pus mixed with blood, and various foreign substances deposited by the inspired air. The causes cannot be laid down with certainty. It may result from general debility, but is quite as apt to be found in persons of good constitution and robust physique. I think that the term *Ozena* should be restricted to this form of disease, and not applied to all forms of offensive discharge from the nares.

Fetid nasal catarrh or *rhinitis fetidus*, is a condition resulting from a long continued atrophic rhinitis, or dry catarrh. It is attended by the discharge of exceeding fetid masses of dried mucus. The odor is very penetrating and will remain in one's consulting room for some time after the patient has gone. The bones are atro-

phied and the nose is often flattened as the result of the preceding atrophic catarrh.

Atrophic rhinitis, a form of nasal disease which forms the heading of this paper—is an affection growing out of rhinitis simplex or hypertrophica, as I believe from clinical observation, and presents the following symptoms: Excessive irritability of the parts with more or less tingling and pain. The sense of smell is generally impaired; thin, dry, closely adherent crusts make their appearance. Their colour is grayish yellow or greenish, and they consist of inspissated muco-pus mixed with various impurities. They are very tenacious and difficult to detach. There is a constant sense of discomfort in the nose and this is increased to actual pain if the temperature of the inspired air be much lowered. The thin crusts soon become thicker and harder. A thick viscid fluid is poured out of the membrane. This dries very quickly and forms crusts. They have a peculiar and musty odor, not highly offensive as in fetid catarrh. Superficial ulcers form on the mucous membrane, having a grey unhealthy look. The pharynx is sometimes involved giving rise to a dry, glistening condition; highly uncomfortable to the patient. Upon examination of the part, the mucous membrane will be seen to have a peculiarly dry parchment-like appearance. The nasal cavity will seem to be ex-



ceedingly spacious, owing to the atrophy of the turbinated bone. Masses of dried muco-pus may be seen adhering to the parts. If these be removed the membrane will be found to be reddened and occasionally presents superficial ulcers.

As regards the *treatment* of this this variety, the indications are:

1st. Thorough cleansing; 2nd. Stimulation, to render discharge fluid; 3rd. Gradual arrest of discharge. The cleansing can be effected by means

of a hard rubber syringe with a large nozzle in the hands of the physician. The patient will find the douche made by Stevens & Son of this city, after my instructions, to be convenient. The gravitation douches, as Thudichum's, are dangerous, as they are apt to drive the water up into the middle ear and cause acute suppuration of that cavity. Any crust that remains should be gently removed by the forceps or probe. It generally takes several days to thoroughly cleanse the parts, and until this is done it is useless to do anything else. Once accomplished, it must be kept up by the free use of salt and water by the douche, once or twice a day. Then stimulation can be used according to the following formulæ :

R	Argent nit.	grs. $\frac{3}{4}$;
	Amyli pulv.	grs. 154—M
R	Argent nit.	grs. $1\frac{1}{2}$
	Amyli pulv.	grs. 154—M
R	Argent nit.	grs. $2\frac{1}{3}$
	Amyli pulv.	grs. 154—M

Gradually increasing strength of powders to be insufflated. Or the following :

R	Pulv. Sanguinariæ.	
	Pulv. Myrrhæ	aa ʒ i.
	Lycopodii pulv.	ʒ ii.
R	Pulv. Galangæ	
	Pulv. Amyli	aa ʒ i.

Having fulfilled these indications, use a mild astringent as Zinci Sulph., Zinci Iodid., Alum, or Tannin, about five grains to the ounce, in the form of spray. When the treatment is systematically and carefully carried out, I venture to predict a satisfactory result—not merely in this but in all varieties of catarrh. It is obvious from what I have stated that a successful result depends upon a proper diagnosis and the selection of the remedies for the variety of catarrh in the given case. The general health will in most cases require attention on the usual principles, and will require modification to meet any special symptoms which may arise.

Correspondence.

UNPLEASANT EFFECTS OF ANTIPYRIN.

To the Editor of the CANADA LANCET.

SIR,—While using drugs of recent introduction, it is well, if not our bounden duty to the profes-

sion, to place on record any unusual and especially any alarming symptom that may present itself. Antipyrin is of comparatively recent date, and has been considered perfectly free from danger in doses of 30 grains repeated.

Prof. Stewart, of McGill College, Montreal, in his excellent report on Antipyrin, quoting from Pavay, states "That collapse never occurs, that it possesses marked advantages on account of its freedom from dangerous effects."

The following case seems to show that there may be some exceptional effects produced by the use of this remedy. On the 7th of Oct. last I was called to Mrs. B., æt. 45, a patient in the fourth week of typhoid, whom I had been attending, and considered convalescent. Her temperature was 103.6°, pulse 120, respiration 30, fine crepitation throughout the lower portion of both lungs. I thought Antipyrin the best selection as an antipyretic, judging that it would produce less depression than either quinine or salicylate of soda. I happened to have with me just one dram and divided it into five equal powders of 2 gr. each. I ordered one every three hours. Next morning early a messenger was sent with the unwelcome news that the patient was dying. On my arrival I found her in a state of severe collapse. Cold perspiration stood in drops over her face and parts of her body, cold hands and feet, temperature 95°, pulse feeble and flickering, impossible to count it. I was, indeed, alarmed, and expected to lose my patient. I immediately gave her ammon. carb. and digitalis, with whiskey at short intervals, and applied artificial heat around the body. I was very much pleased to find that this treatment counteracted the unpleasant symptoms, and am still further pleased to know that the patient has ultimately recovered. Two or three days afterwards her daughter drew my attention to a patch of purpuric maculæ about the size of the palm of the hand on the back, just below the seventh cervical vertebra. This was, no doubt, the characteristic eruption that results from the use of antipyrin, but it was not observed on any other part of the body.

As antipyrin lowers temperature by dilating the capillaries of the skin and exposing a large volume of blood to the external temperature, I think, in a case of this kind digitalis would prove a valuable antidote by its contractile effects upon the arteri-

oles. Perhaps my selection of the conditions was not judicious for the administration of antipyrin; but, even granting that, the above is a sufficient warning for me, at least, to feel my way with caution before administering doses of 30 gr. Since the above case occurred I have observed two cases, with similiar results, recorded. One, also, in a typhoid patient, almost exactly similar by Strauss in *Berlin, Klin, Wochenschrift*.

Yours, etc.,
W. GRAHAM.

Brussels, Ont., Nov. 23, '85.

To the Editor of the CANADA LANCET.

DEAR SIR:—Do you not think it is time for the medical profession to resent the pestering questionings, about our private business, by parties who are paid for looking after the sanitary arrangements of the country? We have spent years of the best of our lives and considerable means, to qualify ourselves for the practice of our profession, so as to gain a living for ourselves and families; and many of us can hardly make both ends meet. Yet we are continually being pestered and hectorred to tell every body all we can, so that no one will need to employ us; so that we may live on the wind and be laughed at for our pains.

It is all right, and the bounden duty of Government to look after the health of the people; but, it is a piece of gross imposition to expect medical men to help them without any remuneration. Our present Local Government is composed chiefly of lawyers; let them try to get their brethren to unite and answer all kinds of questions for the guidance of the public, so that there will be no litigation, and see how they will succeed.

But after all, it is the medical men themselves who are chiefly to blame. If they would just decide to answer no professional questions unless accompanied by the usual fee, the pestering would soon cease. Can you give any sound reason, why they should do otherwise?

ANTI-HUMBUG.

December 14th, 1885.

ERYTHEMA OF FAT PEOPLE.—Dr. E. J. Kemps says: For the erythema and itching between the thighs and on the buttocks of fat people, either calomel or bismuth subnitrate, rubbed on dry, will make you proud of yourself.—*Louv. Med. News*. Sept. 12th.

Reports of Societies.

HAMILTON MEDICAL AND SURGICAL SOCIETY.

Nov. 3rd, 1885.

Regular meeting, Dr. Stark, Vice-President, in the chair.

Dr. McCargow exhibited a specimen of glioma of the brain. The patient had been under the care of Dr. G. L. Mackelcan, German, aged 40, married but separated from his wife because he did not support her; had acted strangely a few days before his admission to the Hospital, on the 17th of Oct., 1885. He was morose, would not answer questions. He walked with assistance with a shuffling gait. He seems drowsy, but when roused answers questions and then relapses into the drowsy state again; complains of pain across his forehead. There is no loss of tendon reflex. He voids his urine and fæces in bed. Pupils natural, left slightly dilated. No albumen in the urine. Gradually sank and died on Oct. 25th. Diagnosis: cerebritis and abscess of the anterior lobe of cerebrum.

P. M.—Body well nourished. Scalp congested. Dura mater very much congested, adherent to calvarium in front and torn in separation, also adherent to brain along both sides of falx; adherent at base of brain in front. On section, found a mass of sarcomatous matter as large as a lemon, in the left anterior lobe of cerebrum.

Dr. McCargow, who agreed with Dr. Mackelcan in the diagnosis, said there was no vomiting nor paralysis present in the case, but the patient was considerably emaciated. The early symptoms were of a neuralgic character.

Dr. Mackelcan described a case of a soldier who sought admission to the Hospital, and was supposed to be malingering, who dropped dead suddenly. The P. M. showed an abscess of the brain.

Drs. Stark and Ryall described cases in which a number of abscesses of the brain were found after death.

Dr. Macdonald related a case of a noted chess-player who died suddenly, and a number of abscesses were found in the cerebrum.

Dec. 1st, 1885.

Regular meeting, Dr. White, president, in the chair.

Dr. McConochie was elected a member of the

Society. Dr. Malloch introduced a case of multiple fracture, with nerve lesion. Patient, aged about 15, met with an accident on the 17th of August last by being drawn up between a belt and pulley. The left arm sustained a fracture of both radius and ulna; the pulse could be felt in the radial and ulnar arteries. Both bones of the right forearm were also fractured, and dislocated backwards at the elbow; no pulse could be felt at the wrist. The dislocation at the elbow was reduced, but on flexing the forearm, was produced again; a fracture of the coronoid process was suspected. An anterior and posterior pad was applied to the elbow after reduction, and secured by a figure-of-eight bandage, junk splints adjusted and the arms flexed and laid on pillows, the dressings were changed and readjusted as required. For some time passive motion was used. The left arm has made a complete recovery. The right arm has some loss of sensation in the distribution of the ulnar nerve, which is improving, and the elbow joint is gaining more power of motion. Pronation and supination are present to some extent.

Syme's amputation of the ankle joint. Patient was admitted to the Hospital Sept. 18th, under the care of Dr. A. Woolverton; age 53 years; occupation, blacksmith. Father dead, cause of death unknown. Mother was strong and healthy, lived to the age of 74 years. Had one brother who died at 40 years of age of kidney disease. One sister is alive and healthy so far as known. Had pleurisy in 1872 but completely recovered. Two years ago he had his left foot amputated, after being injured by a stone falling on it. Present trouble began last January with a pain in the heel, and some swelling. The foot improved about April, but got worse as the summer advanced. It was painted with tinct. iodi. and blistered, which relieved the pain but did not reduce the swelling. Had ague during the summer, during which the foot improved. Came into the hospital Sept. 18th, when he was unable to put his foot to the floor on account of the pain. Limb was put up in plaster which was removed about the 18th of Oct. It was again put up in plaster which gave him constant pain. On its removal the foot was found considerably swollen. It was then blistered and poulticed without relief. On the 22nd of Nov. fluctuation was evident just below the external malleolus. On the 25th a trocar was introduced, and considerable pus drawn off. Urine contained

nearly 50% albumen, and also casts. Dr. McCargow exhibited specimens of bone taken from the case. Dr. Macdonald thought that by standing on one leg at his work, too much pressure was brought to bear on the ankle joint. It would be interesting to have the urine examined, to see whether or not any diminution in the quantity of the albumen has occurred. Dr. Ridley said the condition of the kidney may have followed the disease of the ankle joint. Dr. Ryall thought the kidney affection might have been merely a coincidence. Dr. Malloch thought the case was primarily one of kidney disease.

Dr. McCargow showed a specimen of tumor removed from a patient under Dr. Malloch's care at city hospital, admitted Nov. 27th, 1885. B. S. æt. 25. Father and mother alive and healthy. One aunt on the mother's side, and an uncle on the father's side had tumors. That of the uncle occurred on the neck. It was removed but is growing again. Patient has eight brothers and six sisters younger than himself, all strong and healthy. He never was sick until present trouble began three years ago, when he noticed a small lump on the outer side of the elbow. He continued to work, the tumor being painless and causing no trouble. It steadily increased in size for about eight months, when it reached the size of a hen's egg, and he had it removed. Six months after he noticed a tumor growing in the same place, which grew about nine or ten months, when he had it again removed. The second operation was performed in April, 1884. About Christmas he noticed the growth returning in the same place, since which time it has grown to about the size of the first. Present condition: on the outer side of the left elbow there is a large lobulated mass, part of which is ulcerated upon the surface; on the inner side of the arm is a smaller one not ulcerated. Nov. 28th the arm was amputated at the shoulder joint by flap operation, the outer flap being formed by the whole of the deltoid muscle. The glands in the axilla were swollen, and it is thought the disease will recur. Examination of the tumor with the microscope showed it to be encephaloid cancer.

Dr. Malloch also related a case which came under his notice in 1874. Patient was a man past 50. The tumor was situated between the hip and knee, and was the size of the head. Some thought it was a fatty tumor. The patient died in three or

four months from time of admission to hospital. The glands in the groin were not affected, but the pelvis was filled with secondary growths, also the lungs. Dr. Philp made some remarks on the previous case, and described the history before admission to the hospital.

BRANT MEDICAL ASSOCIATION.

The usual quarterly meeting of the Brant County Medical Association was held at Brantford on the 1st of December. There was a good attendance of members present. The following officers were elected for the ensuing year, viz: Dr. Winskell, President; Dr. A. T. Henwood, Vice-President; Dr. Sutherland, Paris, Sec-Treasurer. The following new members were elected: Dr. Addison, St. George; Dr. Johnston, Burford; Dr. Sutherland, Paris; Dr. Mott, Paris.

Dr. Addison, St. George, read a paper upon Typhlytis and Dr. Burt gave the history of several recent surgical cases under his care.

Dr. Philip introduced the subject of the proposed amendments to the Ontario Medical Act advocating their adoption. The following resolution was moved by Dr. Addison, St. George, seconded by Dr. Johnson and carried—"That the proposed Amendments to the Ontario Medical Act approved at the last meeting of the Ontario Medical Council, and which will be submitted for approval to the Legislature at the next session, receive the cordial endorsement of this Association believing that such Amendments are just and necessary to the proper carrying out of the Act, and in the best interests of the Public and the profession alike.

A number of routine matters was disposed of, after which the Association adjourned to meet again in Brantford on the first Tuesday in March.

Selected Articles.

SUPRAPUBIC LITHOTOMY, AND SUTURING THE BLADDER.

The *Med. News* reviews this interesting subject as follows:

"Within a year Sir Henry Thompson has operated for the removal of stone in the bladder by the suprapubic operation four times, and each time successfully. This measure of success has led him to

make public some strong expressions in regard to the merits of this form of lithotomy. After speaking of the capabilities of lithotrixy, in the *Lancet*, for July 25, 1885, he says: "The problem thus left remaining for solution, is, what is the best cutting operation for hard calculi (urates and oxalates) which weigh from about two ounces and upwards, as well as for those not quite so large, which are so peculiar in form (as occasionally, but very rarely, happens) that the lithotrite fails to grasp, or retain them? I think there is no doubt about the answer—viz., that it is the suprapubic, and not the lateral position." And, again, "Finally, I think I am quite justified in believing that unless the operator has had a large experience of lithotrixy (and there are not many of whom this can be affirmed) the high operation would generally be a safer proceeding than crushing for a calculus which is hard and much above an ounce in weight." In the same number of the *Lancet*, Professor Humphrey recalls attention to an operation of this sort which he did in 1848 successfully, and expresses his surprise that the suprapubic operation has not been more frequently performed.

These testimonials to the present appreciation of the operation of suprapubic lithotomy in England mark a distinct advance in public sentiment there, where hitherto this method has had but the faintest and most qualified acknowledgment, and, from Sir Henry Thompson himself, hitherto open contempt. Now, however, that so eminent and so conservative a surgeon has given his sanction to the suprapubic operation, its good may be said to have received the guinea's stamp, and to be current in all the Queen's dominions.

It is now about ten years since the merits of this, then almost abandoned method, were made the subject of thorough study in this country, and warmly championed upon theoretical grounds, as well as supported by analysis of a very large number of cases. At once it began to be practised with increased frequency in America; then it was taken up with new assurance in Austria; then in Holland; then in Germany, where it has always had some friends; then it had a genuine revival in France, and now it has secured the approval of the highest authority in regard to operations for stone in the bladder in Great Britain.

It would appear, therefore, that the time has passed for arguing about the worthiness of suprapubic lithotomy, as a general method; since the old prejudices have gone down so completely before the arguments used in its support, and the improvements introduced in its technique. It would seem that the future of stone operations remains with Bigelow's operation of litholapaxy and suprapubic lithotomy, and the only questions which have now a living interest with regard to the latter are those which pertain to the proper selection of cases and the manner of performing it. In regard to the

selection of cases it would not be easy to improve on what we have quoted above from Sir Henry Thompson. As to the technique, the plan of forcing the bladder up out of the pelvis by introducing a colpeurynter into the rectum and distending it with air or water, as was first done by Peterson, of Kiel, appears to be of great value. It may, perhaps, be responsible for the moderate hemorrhage reported in some recent cases, on account of the pressure it effects upon the venous plexus at the neck of the bladder; but it cannot be doubted that it has contributed much to the ease of performing the operation, and invited men to take it up who otherwise would not have done so.

In regard to after-treatment, the most important question concerns the employment or rejection of suturing the bladder.

This would appear to be no question at all if such brilliant results could be obtained regularly as have been affirmed in a considerable number of cases. Thus Bruns, who was the first surgeon to suture the bladder after lithotomy, secured uninterrupted union of the wound in his first two cases, both being little children. This was in 1857 and 1858. (These operations are often erroneously attributed to Lotzbeck, who simply reported them. They were done in Brun's clinic. The bladder was sewed up during the Crimean war by Baudens, after the removal of a bullet by suprapubic cystotomy; recovery followed. Although this was not a lithotomy, it deserves to be mentioned, as the first case, so far as we know, in which an attempt was made to secure primary union of the bladder after an operation for the removal of a foreign body.) The variety of methods of closing the wound after suprapubic lithotomy is very great, but they may all be divided into those which close the bladder wall independently and those which close this and the wall of the abdomen together. The latter procedure has not been often carried out, although it has sometimes secured a brilliant result. The former has been done a considerable number of times, probably not much less than a hundred. The results have been so far from uniformly successful that it may be seriously questioned whether or not suturing the bladder be a method to be recommended. It will be admitted that this question can only be answered in the affirmative, if theory alone be considered. And, however imperfect may be the success as yet attained by it, the ideal operation of lithotomy must be held to include closing the wound, and securing primary union. This has been done a good many times, and can be done yet more.

But, in the present state of the technique of suprapubic lithotomy, we think it safe to qualify our statement that suturing the bladder is to be regarded as essential to the ideal operation. The ideal operation implies conditions suited to it, and, without going into details, we think it will be ac-

knowledge that such conditions are not found in a considerable number of cases of stone operations. Suturing the bladder is manifestly out of place in cases in which the condition of the bladder is such as to preclude the idea that it can heal up by primary union, or in cases in which free drainage is manifestly a desideratum. Again, it is not suited to cases in which the size, shape or position of the bladder, or of the neighboring parts is such as to make the procedure very difficult, or to prevent its being accurately—we may say perfectly—carried out. In these cases, certainly, it is far better to treat the wound after suprapubic lithotomy like the wound of perineal lithotomy—that is, to leave it open, and to secure free drainage through it.

For cases in which suturing the bladder is suitable, Znamenski recently proposed to bevel off the internal mucous edges of the wound, because he believed they got caught and turned in between the united edges when the sutures were tightened, and so prevented union. And Vincent has still more recently suggested beveling off the external edges of the wound in the bladder, so that, when the stitches are drawn upon, a larger fresh surface shall be brought together, and the chances of union thereby be increased. This idea, which he never put into practice, has been taken up and carried out by Géza, of Antal, who reports in Langenbeck's Archiv, Bd. xxxii. 2 Heft, 1885, under the title "Eine Modificirte Sectio alta," a case of lithotomy, and a case of removal of a morbid growth, in both of which he secured primary union by suturing the bladder in this way. The first patient was dismissed cured in twelve days, but was really fit to be dismissed in nine days. The second patient made an equally prompt recovery.

The plan of Dr. Géza consists in exposing the bladder by the usual method, after distention of the bladder and the rectum, and then in freshening an elliptical space a little longer than the proposed incision in the bladder and from one to one and a half centimetres in width. This freshening is carried so deep at the line of the proposed incision that there is little left but the mucous membrane of the bladder, which is afterwards incised and the stone removed. The sutures he uses are of silk, regdered antiseptic with corrosive sublimate; catgut, he believes, gives way too soon. Each stitch is to be applied so as to include all of the bladder wall, except the mucosa. The wound in Dr. Géza's case was covered with Lister's dressing, and a soft catheter left in the urethra.

It is worth while to call attention to this proposition of Dr. Géza, because it is ingenious, and, reasoning from the analogies of operations for vesico-vaginal fistula, its execution may be expected to make the sutures much more reliable than when they were applied in a simpler fashion. It is to be noted, too, that this is a very different thing from the Lembert suture, which is very good

in its way, but which seems to offer less hope of prompt union from the apposition of two serous surfaces than this one does from its apposition of two fresh-cut surfaces. In addition to this, the fact that it has already proved so successful in the hands of its proposer is strong recommendation to its further employment.

No study of the plans of suturing the bladder after suprapubic lithotomy would be complete which omitted consideration of an ingenious method used in 1876 by Dr. Starr, of Georgia, his patient recovering in sixteen days. This case was first reported by Dr. Dulles, in an article on suprapubic lithotomy in the *American Journal of the Medical Sciences* for July, 1877, and again, by the operator in the *Atlanta Medical and Surgical Journal* for December, 1877. The suture used was of silver wire; it was interrupted; each stitch was passed into the abdominal wall at one side of the wound and made to include a small portion of the outer layers of the bladder wall; it then passed across the incision and included a similar small portion of the outer layers of the bladder wall on the other side; it then passed up through the abdominal wall to the surface. When drawn tight it slightly inverted the bladder walls and brought the edges of the abdominal incision close together. It is easy to see that this form of suture must tend to prevent burrowing of discharges between the bladder and parietes of the abdomen, while it gives a good hold to the stitches which close the bladder itself.

The success obtained by Dr. Starr in its use should encourage others to imitate him. Certainly no better result could be asked for than he obtained.

We sincerely hope that American surgeons will not be backward in contributing their share to the solution of the problem as to the best way to conduct this operation. Its present standing is largely due to their courage in defending and practising it at a time when it was held in much lower esteem than it is now; and we believe the genius in dealing with practical questions in medicine and surgery, which has always been conceded to them, cannot fail to prove of great value if applied to the question of the best method of treating the wound after suprapubic lithotomy."

THE PHYSIOGNOMY OF DISEASE.

Dr. J. B. Walker gave the following clinic on this subject in the Philadelphia Hospital.—*Med. and Surg. Reporter*:

Just as we are able to recognize the features of our intimate friend and call him by name before he makes his identity known to us, so with the outward features of disease; there is a physiognomy, a feature or external expression of internal disease that is more or less characteristic. But,

just as we find it difficult to so accurately describe the features of a friend to a third party that he can recognize him, so is it with the description of this physiognomy of disease. But, let the third person once see our friend, and he will thereafter recognize him: so it is with disease.

Malarial Fevers.—When a patient is pale and anæmic, the mucous surfaces pallid, conjunctiva pale, tongue pale, lips blanched and but slightly colored, we may suspect some malarial cachexia. In this connection, Dr. Walker makes a strong argument for the use of capsicum in malarial fevers; he thinks it is not ordered nearly enough. It seems to aid and increase the power of quinine and prevents it from deranging the stomach.

R. Quinine sulph., gr. c.
Oleo resin. capsici, gr. xii.
M. and div. in pil. No. 1.
S.—Two pills every four hours.

Bright's Disease.—In this disease, while there is no absolute certainty in the appearances presented in the face, yet the physiognomy is sufficiently characteristic to cause us to suspect the disease when certain peculiarities are observed. When, while there may not be marked œdema, there is yet sufficient puffiness of the face to cloud or displace the ordinary lines: when the blood vessels are distended, showing us red lines in the cheeks and nose, when there is sagging of the cheeks, a fullness of the jowls, and a peculiar earthy, pearly pallor, we have reason to look for Bright's disease. There is often noted a peculiarity of gait, consisting of a difficulty in keeping the equilibrium, due, most likely, to the influence on the brain of an imperfectly depurated blood, owing to the faulty action of the kidney.

From a distance, the face may sometimes present a ruddy hue, but closer examination will demonstrate this to be due to dilated blood-vessels and ecchymotic spots. The superficial arteries and veins of the head and neck are tortuous and dilated, being sometimes visible from a distance. The arcus senilis is another evidence often found. Atheroma of arteries and arcus senilis are surface indications of granular nephritis. But such appearances may be present when there is no Bright's disease, as, for example, the result of syphilitic infection or chronic alcoholism. Œdema (general) or ascites rarely occur in a marked form in granular or interstitial nephritis, but it may occur when this form of the disease is complicated with an attack of *catarrhal* nephritis, to which form dropsy peculiarly belongs; it may also occur in the waxy form, but is not so common there.

Carcinoma.—Dr. W. calls especial attention to a peculiar glistening sheen of the surface (not unlike moonlight on the water) as very characteristic of carcinoma. It is not always present, but when it is observed it is a very strong sign; indeed, Dr. W. has only seen it once where the autopsy has

failed to reveal cancer, and in that case he is not certain that the disease may not have existed in some portion of the body not examined. The illustrative case had an expression of suffering, while the skin was much jaundiced. This glistening sheen is scale-like, so to speak; not scales that you can scrape off, but the glistening surface is marked by lines that do not glisten. It is most frequently present on the surface of the abdomen.

Typhoid Fever.—There is flushing of the cheeks (no sordes in the illustrative case, because the nursing is good); apathy is marked, so much so that flies walk unnoticed over the face; the eyes are half closed, the mouth open, and he breathes through it.

This being a typical case of typhoid, Dr. W. made a few remarks on the disease. When the morning temperature is below 102° and the evening temperature not above 104°, it is a satisfactory condition. While the eruption may occur in tubercular lesions, yet it does so so rarely that they may be considered characteristic of typhoid. They are circumscribed, elevated, and rosy; rarely punctate, but occasionally become vesicular. They will disappear on pressure and after death. They generally appear on the trunk, but rarely on the extremities, though he has seen them on the hands. In order to be sure about the disappearance on pressure, we should place a finger on either side and stretch the vessel, for if we simply press on the spot and remove the pressure, the pressed-out blood will flow back so rapidly that we cannot be sure whether it has disappeared or not.

DANGERS OF ANTITHERMIC REMEDIES.

In a recent therapeutical conference, Dr. Dujardin-Beaumez discusses resorcine, kairine, thalline, and antipyrine, and advises caution in their use, of the first three agents especially, from their active toxic effects. After referring to the eminently antiputrefying and antifermentive properties of resorcine, he states that he had used it in pyrexia without obvious effects, probably on account of the smallness of the dose. He finally abandoned it altogether in the treatment of rheumatism and typhoid fever, not so much on account of its want of power as because he observed toxic symptoms. Resorcine is not only an irritant, it is also a toxic agent; and in his experiments upon dogs it was determined that a dose of thirty centigrammes per kilo of weight of the animal produced convulsive phenomena, and death was caused when the proportionate dose was increased to ninety centigrammes. After death, visceral congestions were discovered, and especially very intense pulmonary engorgement, as in animals poisoned by carbolic acid. Man is even more susceptible to the effects of resorcine than dogs. Munel reports a case in

which a single dose of three and a half grammes (fifty-three grains) rapidly induced a condition of great gravity, which, however, was finally overcome.

Dr. Beaumez says, "While recognizing resorcine as less toxic than phenic acid, I conclude that it is a dangerous antithermic agent, for I found in my typhoid patients treated with resorcine the same depression of forces, the same adynamia, the same pulmonary congestion, which I had found in those to whom I had administered phenic acid. I have therefore abandoned this medication, and I believe that, even in Germany, resorcine is not much employed internally, but it remains, on the contrary, a very valuable remedy for external use in the treatment of unhealthy wounds."

Kairine is an antithermic acting by diminishing the respiratory power of the blood and destroying hæmoglobin. The recent researches of Brouardel and Paul Loyer confirm this view, and show that thalline and kairine exert the same destructive effect upon hæmoglobin. Moreover, contrary to the usual action of antithermic agents, kairine and thalline have no influence whatever upon fermentations. "Kairine should therefore be rejected from therapeutics; it is a dangerous drug, since it only produces antithermic effects by destroying the hæmoglobin and profoundly altering the blood, circumstances which should be avoided in the infectious febrile diseases."

Antipyrine is less toxic than either resorcine or carbolic acid. While it takes a gramme of resorcine per kilo to kill a rabbit, it takes 1.60 grammes per kilogramme of antipyrine. The toxic effect, moreover, is almost the same; it produces tetanic and paralytic symptoms analogous to those caused by strychnine-poisoning. It cannot be doubted, therefore, that antipyrine acts upon the cerebro-spinal axis, and it is probable that it lowers the temperature by modifying the nervous heat-centres. Contrary to kairine, antipyrine does not appear to change the liquor sanguinis, and particularly the hæmoglobin. It has also hæmostatic properties which Henoeh declares superior to those of ergotine and of chloride of iron. (This is worth bearing in mind in treating hæmoptysis.) Antipyrine diminishes the urinary secretion, but increases the action of the glands of the skin, which renders it inconvenient to use it in cases of tuberculosis. Like the phenols and oxyphenols, antipyrine is an antiferment. The study of recent antithermics shows that the effects of these new agents vary with the nature of the fever; a temperature of 104° in a phthisical patient will be lowered by fifty centigrammes of antipyrine, while in a typhoid case it might be without effect.—*Bull de Therapeutique*, August 30.

WHY DOCTORS' BILLS ARE SOMETIMES UNPAID.
—One reason why bills of physicians are unpaid is

negligence in collecting them. This is especially the case when mechanics and other persons of limited incomes are treated. Despite the temptations which constantly beset the honest clerk, and others of his ilk, to dodge pecuniary responsibility through the many avenues of medical charity, there is at first an inclination to pay the doctor, if reasonable opportunities are offered for so doing. Too often, however, the medical attendant, actuated by false pride on one hand and an eagerness for business on the other, allows the money question to be in abeyance until the bill becomes relatively of startling size. The clerk and mechanic, as a rule, are persons who are accustomed to pay small bills, and to do so frequently. They themselves are paid weekly, and if provident, calculate their expenditures regarding board, room rent, clothes, and family necessities to a nicety. They belong to the pay-as-you-go class, although their business is on a small scale. The trouble, however, is that the family physician generally places himself above that scale and suffers accordingly. If his bills were presented even weekly he might have a chance to be served with the same consideration as the grocer, the butcher, and the baker. But he believes it unprofessional to be pecuniarily concerned, and the consequence is that the patient gets into the habit of believing that the doctor's bills are the hardest of all to pay. It does not appear to him that there is so much necessity about it. The doctor by his indifferent manner gives him to understand that there is no pressing necessity about it, and the patient acts accordingly. The bill consequently runs on until in the course of weeks and months of attendance it amounts to possibly fifty dollars or more. The patient paying week by week for what he is taught to believe by the ordinary tradesmen are his cash necessities has nothing left for the forced luxury of medical services, the large bill becoming a mill stone about his neck. If he reasons with himself he must acknowledge that the dues are just, but how to get blood out of a stone is a dreadfully perplexing problem with him. He may possibly commence to economize, in order to offset what he coaxes himself to believe is an infliction, for few men receive a doctor's bill joyously. But pressing necessities for ready cash in his household present themselves and offset his best intentions. The medical attendant in the meantime sends his collector. The latter always arrives at an inopportune moment. He is generally as much out of place under the circumstances as is the skeleton at the feast. He is sometimes not even treated as a friend who comes to help the impecunious sufferer out of difficulties. His purer motives are misinterpreted, and his smiling overtures are received with studied coolness. If he talks of discharging obligations to the doctor, the good wife, who was once sick, is now well enough to take her part. The visits were

made oftener than was necessary, at least so she now thinks, and the charges were exorbitant; at all events the doctor must be patient until they get the money. But alas! the medical attendant waits in vain, even long after the enterprising collector has given up the case. Little Johnny is taken sick in due time. The doctor is sent for and will not come. The family are now righteously angry. Then the retaliatory spirit asserts itself. What might have been treasure on the earth for the expectant creditor, has been transferred to an account that can only be collected hereafter. Johnny's father feels indignant and independent. Hereafter he will do his doctor business on cash principles, and he takes Johnny to the Out-Patient Department of the New York Hospital, pays his dollar and takes his choice. His pretended poverty is counterbalanced by his respectability, and he reproaches himself for not taking advantage of such opportunities before. The only way, under the circumstances, for the doctor to get such patients back again, is to secure an appointment in the Department, and be privileged to treat them for nothing.—*Med. Record.*

NEW RESEARCHES UPON BRIGHT'S DISEASE.—Prof. Semmola deduces the following conclusions (*La Med. Contemp.*) from the results of his latest experimental and clinical researches upon Bright's disease:

1. Albumen can traverse the renal tissue without any previous alteration in the histological elements of the kidney, and without leaving any trace of its passage.

2. If the passage of albumen be persistent, the first effect is hyperemia with intraglomerular and intratubular hemorrhage, and the capsule is distended in a mass after boiling, and sometimes is simply raised and separated from the glomerulus by an empty space. There is also observed considerable migration of leucocytes without any alteration of the epithelium. The urine contains hyaline cylinders. These are the first results of an inflammatory action in relation with the functional activity of the kidney.

3. If the functional process persists beyond even eight or ten days, especially with the injection of albumen in the proportion of one gram for every thousand grams of the animal's weight, the invading process is attended by a mild inflammatory action, in addition to a turbid swelling of the epithelium of the tubules, fatty degeneration, and thickening of the intratubular connective tissue.

This proves that the functional activity which the kidney must sustain in the gradual and prolonged elimination of unassimilable albumen, is apt to provoke successively in different parts of the organ an inflammatory process, which, commencing in simple hyperemia, may result finally in the establishment of interstitial nephritis. Prof. Sem-

mola is convinced by repeating the experiments and injecting very minute quantities of albumen, in order to have the experiments well under control and preserve the life of the dog for seven or eight months, that they will result in producing the last phases of the large white kidney—that is to say, the atrophic kidney.

4. The histological alterations in the kidney persist for some time after the injection of the albumen without producing a continuation of the albuminuria.

5. Along with the elimination of albumen with the urine is also observed albuminoholia; that is to say, the elimination of a certain quantity of albumen with the bile.

In relation with the above experiments, Prof. Semmola proposes to continue his researches on the pathology of Bright's disease with the following experiments to determine:

1. The comparative influence upon renal elimination produced by the injection of albuminose, which is presumably more assimilable, such as serum of blood, albumino-peptones, white of egg and milk.

2. The influence of albuminous injections upon the crisis of the blood, and upon the elimination of a quantity of albumen greater than that injected.

3. The influence of albumen injections upon degree of activity in the combustion of nitrogenous matters and upon the production of urea.

4. The influence of albuminose injections upon the dyerasic condition of the blood, and their relations with the production of anasarca.—*Lon. Med. News.*

A VALUABLE REMEDY FOR HEADACHE.—The *Phys. and Surg. Investigator* calls attention to the following treatment for many kinds of headache.

"We lay no claims to originality, nor do we know who the originator was, but having used it for a year or more, and in many cases with remarkable results, we feel disposed to give it our indorsement, and desire to make it more generally known. The remedy is nothing more or less than a solution of the bisulphide of carbon. A wide-mouthed, glass stoppered bottle is half-filled with cotton or fine sponge and upon this two or three drams of the solution are poured. When occasion for its use occurs the mouth of the bottle is to be applied to the temple or as near as possible to the seat of pain, so closely that none of the volatile vapor may escape, and retained there four or five minutes or longer. For a minute or so nothing is felt, then comes a sense of tingling, which in a few minutes—three or four usually—becomes rather severe, but which subsides almost immediately if the bottle be removed, and any redness of the skin that may occur will also quickly subside. It may be re-applied, if necessary, several times in

the day, and it generally acts like magic, giving immediate relief.

We believe this was the basis of a once popular nostrum. The class of headache to which it seems especially adapted is that which may be grouped under the broad term of "nervous." Thus neuralgic, periodic and hysterical headaches are almost invariably relieved by it. True, the relief of a mere symptom is quite another thing from the removal of its cause, yet no one who has seen the distress and even agony caused by severe and frequently recurring headache (and who has not?) but will rejoice to be able to afford relief in so prompt and simple a manner; besides it is sure to secure the hearty gratitude of the patient if he has suffered long. As to the *modus operandi* we have nothing more definite than a theory to offer, and that is that the vapor being absorbed through the skin produces a sedative effect upon the superficial nerves of the part to which it is applied. We know by experiment that its influence is not due to its power as a counter-irritant. We however know that it does act, and if we do not clearly see in what way it acts, that is no more than can be said of several other remedies which are firmly established in professional favor and confidence."

THE NATURE AND TREATMENT OF OZENA.—At the International Medical Congress held in London three years ago M. Lœwenberg, of Paris, referred, in the discussion on ozæna, to the invariable presence in the nasal mucus of those affected with ozæna of a special microbe said to be unique and characteristic. It was a micrococcus of very large size, which always occurred in pairs and chains, and was for the most part motionless. In 1878, M. B. Fraenkel affirmed that the mucus secreted in ozæna consisted for the greater part of pus-corpules plentifully strewn with micrococci. The only writer besides Lœwenberg who has made extensive researches on the micro-organisms of ozæna is M. E. Fraenkel, and, what is not so very unusual in these matters, the observers differ considerably from one another in their respective descriptions of the micro-organisms to be found in cases of ozæna. But Lœwenberg explains the difference by pointing out the divergence in the methods employed to detect the micro-organisms. He examines simply the masses that are discharged from the nose in ozæna, whilst Fraenkel investigated the secretion that soaked into the plugs of cotton-wool with which he treated his cases of ozæna. Lœwenberg, in a pamphlet recently published, believes that ozæna is a specific disease due to the presence and growth of his micrococcus; it is also regarded as a contagious affection. Energetic parasitocidal or antiseptic treatment is the necessary sequence of the above conclusions. He employs a nasal douche made with a weak solution of corrosive sublimate, of which the strength to commence with

should be 1 part of the sublimate to 10,000 parts of water; it should gradually be made stronger as the patient becomes accustomed to its use. Insufflations of impalpable boric acid powder are also recommended. Lœwenberg claims to have had a remarkable success in his treatment of "rinitis chronica atrophicans fetida."—*Lancet*.

INFLUENCE OF CIMICIFUGA UPON PARTURITION.
—After a *résumé* of the medical history of the drug, Dr. Knox (Chicago Gynæcological Society), gave the results of his clinical observations in one hundred and sixty cases of labor,—fifty-seven primiparæ, ninety-three multiparæ—in which black cohosh had been exhibited. The average duration of the first and second stages of labor, in normal cases, in primiparæ, was seventeen and three hours respectively. Under the influence of black cohosh, the duration of the first and second stages of labor, in the fifty-seven cases observed, was six and one-quarter and one and three-quarters hours respectively. The average duration of the first and second stages, in normal cases, in multiparæ, was twelve and one hour respectively. Under the influence of black cohosh, in the ninety-three cases observed, the average duration of the first and second stages was three hours and twenty-seven minutes respectively.

From these clinical observations Dr. Knox drew the following conclusions:

1. Cimicifuga has a positive sedative effect upon the parturient woman, quieting reflex irritability, nausea, pruritus, and insomnia, so common in the last six weeks of pregnancy; it always renders them less distressing, and they often disappear under its administration.
2. Cimicifuga has a positive antispasmodic effect upon the parturient woman. The neuralgic cramps and irregular pains of the first stage of labor are ameliorated, and often altogether abolished. In fact during the first indiscriminate use of the drug in all cases, I had the mortification, with a few women, of terminating the labor so precipitately, and without prodromic symptoms, as to be unable to reach the bedside before the birth.
3. Cimicifuga relaxes uterine muscular fibre, and the soft part of the parturient canal, by controlling muscular irritability, thus facilitating labor and diminishing risks of laceration.
4. Cimicifuga increases the energy and rhythm of the pains in the second stage of labor.
5. It is my belief that cimicifuga, like ergot, maintains a better contraction of the uterus after delivery.

It is his habit, however, to administer fifteen to thirty minims of the fluid extract of ergot after the birth of the fœtal head, and he has had but few opportunities of testing this effect of the cohosh. His method of administration has been to give fifteen minims of the fluid extract of cimi-

cifuga in compound syrup of sarsaparilla each night for four weeks before the expected confinement. One fluid ounce of the fluid extract of cimicifuga to three fluid ounces of compound syrup of sarsaparilla—dose, one teaspoonful—makes just the required quantity.—*Jour. Am. Med. Ass.*

RECOVERY FROM MALIGNANT PUSTULE.—Dr. W. E. Buck records this case (*Brit. Med. Jour.*)—Mr. F—, aged thirty-one, a veterinary surgeon, experienced on October 6th a stinging sensation at the back of the right wrist. A small bleb was formed, which he scratched off, and there was some tenderness of the elbow and armpit. He had a slight rigor. On October 8th he was seen by Dr. Meadows, who prescribed some salicylate of soda and tincture of aconite, in frequent doses, as his temperature was 104°, and the rigors continued almost the whole of the day. A black eschar began to form on the afternoon of the 8th, and on the 9th it became about the size of a sixpence; its base was red and œdematous, and surrounded by some vesicles in a circular shape. The temperature was nearly 104°; the patient felt cold, and the tongue was foul. I visited the case with Dr. Meadows, and we injected pure carbolic acid under the eschar, using an ordinary hypodermic syringe. Unfortunately we could only introduce a small quantity, as it oozed out in the withdrawal of the syringe, and with it a serous looking fluid. I dried some of this fluid on a cover-glass, stained it with methyl-violet, and found the well-known bacilli of anthrax. We prescribed large and frequent doses of soda-hyposulphite, and ordered also a large quantity of meat. Under this treatment he rapidly improved. On October 12th we again injected carbolic acid. The temperature came down, and, as the patient said he felt all right, the hyposulphite of soda was reduced to three times a day. The eschar did not finally separate for nearly six weeks, and the ulcer then soon healed. I believe that the main remedy in this case was the injection of pure carbolic acid, a mode of treatment which does not seem very painful. There was a clear history of the disease, which was contracted exactly twelve days before its first appearance, Mr. F— having examined the flesh of an animal that had died from anthrax.

EXCISION OF THE HIP.—Dr. Wm. Alexander, of Liverpool, closes an interesting paper on excision of the hip, in the *Med. and Chirurgy. Journal*, as follows:

1. That hip disease should, in the earlier stages, be treated by that absolute and perfect rest obtained by means of Thomas' splint.

2. That this treatment, thoroughly and persistently carried out for a long period, will cure a large percentage of joint diseases.

3. Unfortunately, this treatment cannot and is not persistently carried out amongst the poor.

4. Many of these patients could be saved by excising the joint when a decided second stage of hip disease has been reached. Excision is best performed by severing the femur above the trochanter, clearing out the acetabulum, and maintaining the opposing bones so far apart that their surfaces can resume a healthy condition and the aperture be filled up with fibrous tissue. By this means an excellent false joint is formed, or, if the adhesions become too firm, a good stiff joint.

5. That the advent of the stage of this disease suitable for excision is indicated by repeated formations of abscesses around the joints.

6. That when the supra-trochanteric mode of excision cannot be performed with any chance of success, then the alternative is either continued expectancy or amputation.

7. That it is a great mistake to imagine that all softened bone or infiltrated tissue should be cleared away by the operator. All he has got to do is to clear a space, where the operations of nature, in dealing with diseased or disabled tissues, can be carried out as easily and expeditiously as possible. The operator should remove all manifestly dead tissue, but the doubtful should be left alone to be dealt with by nature.

THE BLOOD IN TYPHOID FEVER.—The systematic examination of the blood during and after acute specific fevers would, we believe, yield results of very high importance, and we recommend such a subject of study to our younger scientists. The investigations should be made from many points of view. Thus, the corpuscular richness, the relative quantity of hæmoglobin contained in each red disc, the state of the fluid portion, both as to its quality and quantity, should each receive consideration. Dr. Frederick Henry, of Philadelphia, has made a partial investigation of the blood during and after typhoid fever. He finds that the number of red discs is about the normal during the fever, but is very much less than normal after the fever. This apparently paradoxical observation is explained on the ground that during the pyrexia the fluid portion of the blood is diminished in quantity, causing a relative plethora. After the fever has subsided, the "water" of the blood again becomes normal, and the red corpuscles assume their proper portion in relation to it. Thus we have a genuine anæmia, which really existed, though masked, during the fever. Dr. Henry is of opinion that patients suffering from typhoid fever should take water as a medicine, as well as to relieve thirst. Similar views have been expressed by other physicians.—*Lancet*.

CANNABIS INDICA AS A NARCOTIC.—H. Lewis Jones, M. B., Cantab., gives the following in the *London Practitioner*:

This drug has proved of great use in a number

of cases where I have desired to produce sleep, especially where sleeplessness was accompanied by delirium. In the delirium of typhoid fever and erysipelas, and in delirium tremens, it is most valuable, a few doses being sufficient to give refreshing sleep. It is important to give the drug in sufficiently large doses. Two or three grains of the extract can be taken in the form of pill every four or every six hours; frequently the first dose is sufficient. I now prescribe cannabis indica as the routine treatment in all cases of delirium tremens coming under my care, whether simple or complicating injury or disease.

In only one case has there been complaint of hallucinations. It had been ordered for a case of typhoid fever with much sleeplessness, in an excitable young woman; after two or three doses she asked that the drug might be discontinued, saying that it caused her to see visions of beautiful gardens and the like. All the other patients have been hospital cases. It is possible that among educated people mental disturbance would be more frequent. I have heard of one case where two grains of the extract were said to have made a woman temporarily quite mad. Personally doses of the extract of Indian hemp, up to four grains, produce a mild narcotic effect, the only abnormal sensations noticed being numbness of the extremities and slight mental confusion.

REMEDIES FOR SKIN DISEASES IN THE FORM OF SPRAY.—Dr. Hardaway highly recommends spray as a vehicle in the treatment of affections of the skin. His usual habit is to prescribe a solution of definite strength from which the bottle of an ordinary handball apparatus is filled, and the patient is then directed to throw the fine spray on the parts affected. Any substance that is "sprayable," either in its liquid form (diluted or pure) or in a state of solution, may thus be employed,—*e. g.*, carbolic acid, sulphate of zinc, lotions of grindelia robusta, thymol, liq. picis alkalinus, and fluid cosmoline (medicated or not). In the case of the fluid cosmoline, the tube of the atomizer should be large. The spray finds its greatest range of usefulness in diseases affecting large areas and in that class of disorders accompanied by itching and a more or less unbroken cuticle,—*viz.*, pruritus, urticaria, papular eczema, and the like. In generalized pruritus he had had good results from spraying on a lotion of the following sort: carbolic acid, three to four drachms; glycerine, one ounce; and water, a pint. After the bottle of the atomizer had been filled, he sometimes directs the patient to add from five to ten drops of the oil of peppermint. The atomizer-bottle should be thoroughly shaken before the bulb is compressed, in order to diffuse the peppermint through the mixture, as otherwise it would merely float on top. In many instances the spray is far superior to mopping on lotions with a sponge

or rag, being neater and less troublesome, getting the remedy more evenly and uniformly applied over the surface, and usually giving more speedy relief.—*Jour. of Cut. and Ven. Dis.*

THE TREATMENT OF PUERPERAL ECLAMPSIA.—M. Chambert, in his *Thèse pour le Doctorat en Médecine*, Paris, 1884, (*Medical Chronicle*), gives an account of eight women attacked with puerperal convulsions, one of whom died. The treatment pursued was uniform, and the same as recommended at the conclusion of his thesis. The value of his thesis consists in a concise statement of the treatment which is at present generally accepted in Paris as the best, although violently opposed by Professor Pajot and other eminent obstetricians.

M. Chambert's conclusions are :

1. A woman presenting the following symptoms, albuminous urine, œdema of the lower limbs, headache, troubles of vision, etc., should be placed on an "absolute milk diet."

2. After convulsions have occurred the bowels should be cleared out, and then an injection should immediately be given containing six or eight grammes (90 to 120 grains) of chloral, according to the intensity of the convulsions. If the temperature rises this should be repeated after two hours, and if the convulsions still persist, the patient should inhale chloroform. The usual formula for the injection is—new milk $\bar{5}$ iij, yolk of one egg, chloral hydrate grs. 90.

In a plethoric patient, with symptoms of congestion, it is permissible to bleed to an amount not exceeding 16 ounces.

3. In every case the termination of labor should be hastened, provided dilatation of the os is complete, the forceps being applied or version employed if there is the least delay in the expulsive stage of labor.

The milk regimen should be continued till albuminuria has completely disappeared, and if, after labor is over, convulsions threaten or actually occur, a draught of 90 to 120 grains of chloral may be expected to arrest the attacks. Milk regimen, chloral and chloroform are the most powerful means of modifying the unknown cause, which produces puerperal eclampsia.—*Am. Med. Digest.*

THE TREATMENT OF GANGRENOUS INTESTINE IN STRANGULATED HERNIA.—In a paper having the above title, W. Mitchell Banks, F.R.C.S., (*London Medical Times*), sums up the following conclusions:

1. That when gangrenous gut is discovered in a hernial sac, no attempt whatever should be made to divide the stricture.

2. That practical experience is required to determine the expediency of drawing down into the hernial opening a fresh piece of bowel.

3. That the cases appropriate for resection of the

gut must be very few, requiring, as it does, that the patient should be young and vigorous, with abundant reparative power; that the hernial sac should not be full of putrid pus or evacuations from a perforated bowel; and that the operation should be done in daylight, and with competent assistance and antiseptic precautions. So far the statistics of resection of gangrenous bowel show a mortality of 52 per cent., whereas by making an artificial anus all the patient's immediately dangerous symptoms are relieved, while he has a chance of subsequent cure (a) by spontaneous closure of the aperture; (b) by the use of the enterotome or the rubber tube; and (c) by the employment of resection at a later stage, the statistics of which show a mortality of only 38 per cent.

4. That in resecting a bowel it is not necessary to have an apparatus to distend it, and that while the fingers of an able assistant will generally serve to control the divided ends, it may be necessary to use some simple clamping instrument having parallel blades and covered with rubber.—*Id. Med. Jour.*

SCHULTZ'S METHOD OF RESUSCITATING THE NEW BORN CHILD.—At the last annual meeting of the Medical and Chirurgical Faculty of Maryland, Dr. Neale (*Med. Record*), illustrated Schultz's method of resuscitating the new born child in case of asphyxia. The child is held by the shoulders, the thumbs resting upon the thorax, the child's head toward the operator, and its anterior surface to the front; it is then swung upwards so that its feet perform a revolution, and lie between the head and the operator's body, the trunk being then in a state of forced flexion. The original position is then resumed by a reverse movement, and the repetition of these movements constitutes the method. Dr. Neale regarded it as more effective than Marshall Hall's or Sylvester's, and related a case in which resuscitation had been secured after ten minutes, the measures mentioned and all others having been tried in vain.

NEVER OVERLOOK AN OVER-DISTENDED BLADDER.—A writer reproduces the histories of several cases of retention of urine, in which the over-distended bladder was mistaken for abdominal tumor. In the comments following, a case is related in which the writer was called in consultation to examine a woman recently confined, in whom incontinence of urine had led to the suspicion of vesicovaginal fistula. The withdrawal of three quarts of offensive urine cleared up the diagnosis.

The case last related recalls very vividly an incident in the lying-in ward of the Charity Hospital, which occurred some years ago, in the days of Prof. Frank Hawthorn. A two-hundred-pound negro woman recently confined, was "passing her water in bed" to the satisfaction of the nurse and

the resident student. But to the professor, on his morning visit, the words in quotation were ominous. A gum-elastic catheter was introduced in the presence of the medical class, and to the present writer, more especially, it did seem that the flow of urine would never cease.—*Wd. Med. Jour.*

FROSTBITTEN FINGERS AND TOES.—Dr. Lapatin, in the *Proceedings of the Caucasian Medical Society*, advises that fingers and toes which have been slightly frostbitten, and which subsequently suffer from burning, itching, and pricking sensations, should be painted, at first once, and afterwards twice a day, with a mixture of dilute nitric acid and peppermint water in equal proportions. After this application has been made for three or four days, the skin becomes darkened and the epidermis is shed, healthy skin appearing under it. The cure is effected in from ten to fourteen days. The author has found this plan very effectual amongst soldiers, who were unable to wear their boots, in consequence of having had frozen feet. They were, in this way, soon rendered capable of returning to duty.—*British Med. Jour.*, Sept. 5th.

The *Denver Medical Times* puts the matter of abortion in the following forcible anecdote: A woman carrying her 12-months' old child consulted a doctor to have an abortion performed, giving as her reason that she could take care of one child, but not of two. "So you want one of them destroyed?" suggested the doctor. "Yes," replied the mother, with lowered voice and dropping her head. The doctor seized a hatchet and rushed at the child in her arms as if to brain it. "In Heaven's name," shrieked the woman, "Do you mean to murder my darling?" "Madam," replied the doctor, "you want one of your children killed. I prefer to kill the one in your arms, for in attempting to kill the other I might possibly also kill you, and thus be a double murderer."

HYDRASTIS IN UTERINE DISEASES.—Dr. Shives-tizeyeff writes to the *Moscow Medical Review* of the satisfactory results he has obtained by the use of hydrastis canadensis in uterine hæmorrhages of various kinds due to hyperæmic conditions of the organ. He gives 20 drops of the fluid extract. The same remedy is, he says, useful in cases where the uterus is enlarged with ulcerated mucous membrane, giving off a copious exudation. Also in cases of dyspepsia due to disorder of the female sexual organs. The drug acts, according to Shatz and Mendes de Leon, on the vessels of the uterus, not, like secale cornutum, on the muscular strictures: but it is at present doubtful to which of the three alkaloids—hydrastin, berberin, and another which is not yet known—the hæmostatic action is due.—*Lancet*.

DELIRIUM IN BRIGHT'S DISEASE.—On the occasion of a case of delirium in Bright's disease being read at the Paris Hospital Medical Society, Dr. Quinquaud observed (*Gazette hebdomadaire*, August 28th), that in clinical practice great difficulty often exists in determining whether this symptom arises from primary cerebral disease, or is an uræmic manifestation. But there is a very simple means of determining the point; for if analysis of blood obtained by cupping reveals an excess of urea, we have to do with uræmic accidents. This is almost a constant rule whatever may be the pathogeny of the uræmia. There is no proof that excess of urea in the blood is the proximate cause of the morbid manifestation, but when uræmia exists, this excess is almost always met with.—*London Med. Times*, Sept. 5.

SUBINVOLUTION OF THE UTERUS.—Dr. F. Ellingwood (Chicago) considers fluid extract of ergot and bromide of potassium as specifics in subinvolution. Regarding the benefit to be obtained from electricity we quote as follows: "Electricity is a most powerful adjuvant, and if used in the form of the mild galvanic current, will rapidly produce an amelioration of the symptoms, and, if used immediately subsequent to confinement, will absolutely prevent the conditions, and the long train of evils which will surely follow, and will restore the whom rapidly to its normal state. The galvanic current, judiciously applied, will accomplish this restoration in three weeks."—*Weekly Med. Review*.

TREATMENT OF HICCOUGH BY COMPRESSION OF THE PHRENIC AND PNEUMOGASTRIC NERVES.—To properly perform this operation, Dr. Grognot advises us (*Bull. gén. de thérap.*) to use the thumb and index finger, one on either side symmetrically, applying pressure sufficiently strong to cause the spasm to disappear. One or two minutes, as a rule, sometimes less, are sufficient; meanwhile the patient's head must be kept immovable. Four or five centimetres of the inferior clavicular portion of the sterno-cleido-mastoid muscle lie directly over these nerves, and it is here that the pressure is to be made.—*Med. and Surg. Rep.*, Oct. 10th.

ASTRINGENT FOR THE URINARY TRACT.—Gallic acid is probably the best hæmostatic in bleeding from the kidneys, bladder or urethra. It should be given at frequent intervals, in doses of about ten grains, and is best taken in water.—*Med. World*.

WE understand that Dr. Wallace, of Liverpool has successfully performed resection of the female bladder for cancer by abdominal section, being we believe, the first time the operation has been performed in this country. The patient is progressing favorably, seven days having elapsed since the operation.—*Lancet*.

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THE MILK DIET.

For a long time past the belief has been propagated by the medical profession that milk is a food suitable for all ages and conditions of man. But it is quite possible to overdo even a good thing and that is just what we believe has happened in regard to milk as a diet. To make this statement good requires but little reflection, and less scientific information. If for no other reason, individual idiosyncracies will always stand in the way of any attempt at setting up a uniform diet. That this has been the tendency for a generation all must admit. Milk has been persistently extolled and held up to all, whether in sickness or health, as the food of foods. The young, the middle aged and the old are recommended to use it. When sickness overtakes us the injunction becomes imperative, and now we must partake of it, and live on it, whether we have been able to do so before or not. A milk diet is all the rage—the fashionable diet, and even in the calm domain of medicine fashion is not wanting in power and contagiousness.

In making these remarks it is not intended to disparage milk as an article of diet, but rather to ascertain its proper place as food. A thing good in a general sense, may be bad in a particular sense. To this rule, milk is not an exception to the extent that present opinions and practices would lead us to think.

Nature designs milk as the first aliment for the

young. Its constituent elements are exactly suited to the wants of the organism. For a time these conditions work out this design. Soon a change comes over the infant organism, usually ushered in by the process of dentition. Slowly but surely, the child voluntarily and instinctively relinquishes its favorite food. Gradually too, nature's generous fountain dries up, and the child is left to draw on other forms of food allotted to man's use. This looks very much like a hint from nature not to use milk after the period of complete dentition. From these facts we learn at least two things. First, that the infant organism is peculiarly adapted to the assimilation of milk. Secondly, that this peculiar adaptation is in a large measure diminished during and after the period of dentition. It follows, as a natural consequence, that adults have a smaller capacity than children for the assimilation of a milk diet. We know well, that many adults are unable to digest milk in any form. Some young children, even, are unable to do so. Most persons can dispose of a moderate quantity, but this affords no proof of adaptability.

These remarks are also supported by evidence taken directly from nature herself, by the common people. The cheese-maker never searches for the true ferment of milk in the stomach of the bullock. He always goes direct to the stomach of the calf, where he knows he will find it in greatest abundance. Here, we have a scientific explanation of facts, known from observation and experience. It is not assuming too much to say, that this gastric ferment, in the young, is assisted in the work of assimilation by the other secretions of the alimentary tract. Notwithstanding these unquestioned advantages, there are times in the history of the young, in severe cholera infantum, for example, where the continuance of milk is certain death. In drawing our comparisons, we should also bear in mind, the great difference between human and cow's milk. The former containing less casein coagulates much less firmly, and altogether is more easily digested. Nevertheless, experience has proved that children may do very well on cow's milk, with proper care and attention.

If our points are well taken, caution would seem to be suggested in recommending the use of milk to adults, even in a state of health. This is especially true of sweet or uncoagulated milk. The artificial coagulation of cow's milk is much

more perfect than that accomplished in the adult stomach. Hence buttermilk, and peptonized milk are more easily appropriated and much more suitable to the greater number of individuals. (See *Therapeutics of Buttermilk*, LANCET, August, 1883.) It is in this form that the porridge eaters of Scotland and Ireland use milk. When we come to consider milk as diet for weak digestion, and those prostrated by acute disease, we tread on dangerous ground, and if possible, words must be more thoughtfully and carefully spoken. It is hard to believe that disease creates anew a tolerance for milk. It is exceedingly unlikely, that a stomach which habitually rebelled against milk, in a state of health will become tolerant in a state of disease. The chances are all against such a belief. Again, consider how irrational it is to ask a person laboring under such an exhausting disease as typhoid fever, to live, weeks together, on a diet on which he would have starved, when well. As in the case of the child with cholera infantum, we have to consider also the probability of the formation and accumulation of firm and indigestible coagula, causing gastric and intestinal irritation and increase of temperature. This last difficulty may be effectually overcome by using only milk previously peptonized. This has the disadvantage however, of sometimes causing relaxation of the bowels, especially in cases where a tendency that way already exists. There is reason to fear that many valuable lives have been sacrificed at the shrine of the goddess of unreasoning routine. The whole question needs a more careful and patient investigation than it has yet received. Until such time as we have more convincing proof of the universal adaptability of milk, a middle course will be the safest to pursue. A mixed diet of broths, minced or pulped meats and jellies, eggs, farinaceous articles, and milk, in cases believed to be suitable, will be found, on the whole, to answer any indication, and to give the most satisfactory results.

LEPROSY IN NEW BRUNSWICK.

We have before us a most interesting report on Leprosy in New Brunswick, by Dr. J. C. Taché of Laval University and Dr. A. C. Smith, of the Medical Council of New Brunswick, and visiting physician to the Lazaretto at Tracadie. The report was prepared in answer to a series of questions

submitted by His Excellency, the Minister of Foreign Affairs of the government of the Sandwich Islands.

The disease is known only in the two Counties of Gloucester and Northumberland, where it has existed for many years. It is the true Elephantiasis græcorum, and appears under two forms, viz: tubercular and anæsthetic leprosy, which so-called forms are, however, in the opinion of Drs. Taché and Smith the result of one common morbid state. In the former the skin and mucous membranes are chiefly involved; in the latter the nervous system. It is a specific disease characterized by the slow development of nodular growths in connection with the skin, mucous membranes and nerves; and, in the latter case, by the super-vention of anæsthesia, and a tendency to ulcerative destruction. The disease rarely attacks the extremes of life, and indeed early infancy seems to possess complete immunity from it, early adult life showing the greatest number of cases. The progress of the disease is very variable, sometimes destroying life in a few years, while in other cases it lasts for a long period. There are now two cases in the Lazaretto which have lasted with constant symptoms for the respective periods of forty-six and thirty years. The early symptoms are a general uneasiness, drowsiness, irrepressible instinctive anxiety, undefined and not very severe pains followed by hyperæmia, hyperæsthesia, insensibility, maculae, pemphigus, atrophic manifestations, and alopecia, especially of the eyebrows.

It is more common in the male sex than in the female, but the proportion varies as to time and place. It attacks persons of all races in proportion as they are exposed, lepers of French, English, Scotch and Irish descent having been known in New Brunswick, as also lepers of mixed origin. The persons afflicted with leprosy have with three exceptions belonged to the classes of farmers, fishermen and lumbermen and a mixture of them, being neither in affluence nor in destitution. The habits of the people generally are good, their sanitary surroundings as good as in neighboring parishes—domestic and personal cleanliness vary; food is abundant and of good quality, and they are robust, healthy and long-lived.

The circumstances which favor the development of leprosy in individuals and in groups of individuals are the close intimacy of family

life and the great sociability of the people. It does not appear that any particular circumstances of life favor the progress of the disease when once established in an individual, beyond what applies to all ailments, viz: anything which tends to depress the patient either mentally or physically has the effect of hastening the final scene.

While in the opinion of the writers the disease does not appear to be hereditary, they recognize the fact that offspring of leprous parents have transmitted to them certain organic peculiarities which render them easier preys to the disease when they are exposed to it. In answer to the question whether leprosy is dependent on or connected with syphilis or any other disease the reply is pointed, viz: that leprosy is a disease *sui generis*, and has no connection whatever with any other disease. The cause of the propagation of the disease Dr. Taché holds to be *contagion*, at the same time he recognizes the fact that leprosy is occasionally produced spontaneously. In support of the theory that the disease is contagious he instances a case of leprosy developed in a healthy young man by a discharge from a leprous ulcer coming in contact with his shoulder, the skin of which has been abraded by carrying the coffin containing the body of a deceased leper. Though his genealogy was traced for several generations back there had never been any leprosy in his family. His sister developed the disease a few years after. One husband of a leprous woman and one wife of a leprous husband have had the disease in New Brunswick. The disease is frequently manifested in the sexual organs, and the inference drawn is that if the disease can be transmitted by actual contact, sexual intercourse may be a means of so transmitting it. Lepers are not permitted to mix freely with other members of society, but segregation has not latterly been as fully carried out by violent measures as it was formerly. The clergy unceasingly use their influence with the people in the direction of segregation, and with the happy results that all lepers with two exceptions have for many years resorted to the Lazaretto and remained there till the time of their death. The Lazaretto is maintained at the public expense, the inmates are under the care of Sisters of Charity, an dard ministered to by a chaplain and visited by a physician. The sanitary conditions are good, and though all is on a modest scale it

has answered the purpose. The attendance and nursing are excellent, and the unfortunate inmates rendered as happy as they can be under such hopeless conditions.

The number of lepers in the institution in May 1885 was twenty-one, and the tabular report for the past ten years shows a decrease in the province from thirty-six in 1875, to twenty-five in 1885. This diminution in the number of lepers is due in the opinion of the authors of the report, to segregation of those affected, and to the improving condition of the population. The history of the disease shows that all medication is useless for its cure, but shows also that good hygienic conditions alleviate to a great extent the suffering of those afflicted, and lengthen the term of life left to them. The disease always kills unless the patient is carried off by some intercurrent disorder—spontaneous cure being unknown. Dr. Taché cites an interesting case which space will not permit us to give, from which he draws the following conclusions: That leprosy may attack a person free from any hereditary taint; that the fecundity of a woman may be preserved even when the malady has lasted a long time; that cohabitation may not communicate the disease; that children are born healthy, notwithstanding the existence of leprosy in the parents, although they may acquire it.

UNPROFESSIONAL ADVERTISING.

The question of unprofessional advertising is an old one, one which has been discussed from time immemorial, especially by the older members of the profession, who it may be supposed having made their mark by superior skill and hard work, object strongly to having their locality invaded by some young doctor, who by liberal use of printer's ink, flaming signs etc. makes or attempts to make a vigorous invasion of the older practitioner's territory. Now while the code may press heavily upon a young man who has thoroughly prepared himself for his profession, while he may and in most cases does grow restive under the silence imposed upon him, he sometimes adopts means for advertising himself which are certainly more unprofessional than gaudy fanlights, finger boards and all the other objectionable ways of letting the public know where he is. We refer to the charges made

by some regularly qualified practitioners for professional work. The term professional charge is hardly the proper one to use—price would be a better word to apply to the money paid for such jobs. No doubt many a young physician, struggling with pecuniary difficulties would be glad to gain a hold in his community by charging fifty cents for an office consultation did not the *esprit de corps*, properly belonging to the profession, prevent him from stooping to such means to establish a practice. There might be some excuse for such action in the case of a man struggling for existence, with whom it is fifty cents or nothing. But what shall we say of men well-endowed with this world's goods, who for the sake of increasing their popularity with a certain class, do a regular office practice at fifty cents a consultation, and *throw the medicine in*. Is not this a system of advertising more pernicious than the method of the man who says: "I shall put my name in the dailies, I shall put up all the signs I choose, I shall advertise myself openly, and what are you going to do about it?"

It is pretty generally admitted that no members of the community do more charitable work than medical men, but if they work for charity, then for any sake let it be called charity, and do not let the charge be lessened. If a man choose to pay visits, or give advice gratis surely he has a perfect right to do so, just as much right as has a grocer to give away packages of tea, or a dry goods merchant to present pieces of flannel to the poor of his neighborhood. But when a bill is paid let the patient understand fully that he is paying for say only one half the visits, and that the Dr. presents the rest of the bill. This will protect other members of the profession, who may not have the inclination to do much work for charity, and at the same time tend to keep up a certain amount of respect for professional services in the eyes of the poorer classes. Perhaps some of the fifty cent men consider themselves sufficiently paid at fifty cents a consultation, *medicine thrown in*. No doubt the advice is in such cases nearly as watery as the medicine, and the patient is not much the gainer after all. This "medicine thrown in" sounds very like the "prize in each and every package" cry which we hear from the mouths of touters of candy packages, etc., at the doors of booths in a circus ground.

Naturalists tell us they are undecided whether it is the sense of sight or smell, which guides the turkey buzzard to the spot where the carcass lies. The bird may not have been seen in the vicinity for days, but let an animal die and be drawn out to the fields, and lo! they appear from the north, south, east and west, as if coming from the clouds. These same students of nature would be equally puzzled to explain how certain members of the *genus medicus* find their way to the scene of an accident. Explanation is difficult, but true it is that some men seem to scent an accident in the air, and localize it with unerring precision. They come as if from the clouds, but are sufficiently material to make themselves well-known to the reporter and bystanders. They have even been known to suggest to the medical man of the family when a consultation would suit them etc. Then there is the society advertising dodge, so well known, by which the Dr. makes himself agreeable to so many mammas, the "lodge" advertisement and others too numerous to mention. If we allow ourselves to moralize on the subject, and to ask why such a state of affairs should exist, we are met by numerous difficulties. Is it because the profession is sadly overcrowded? The answer is, not more than that of the law, and yet we do not hear of the same heartburnings among the members of that profession. The medical student is regarded by the ordinary lay mind as a being rather outside the pale of common decency, but as soon as he can sign himself M.D., and has begun practice all this is changed, he then takes his place as a respectable citizen, and by common consent is at least as good as his cousin the lawyer, and it cannot therefore be any inherent badness that makes the M.D. prey upon his brother's flock.

The question will in all probability remain unanswered, but we should be greatly gratified if some of the fifty cent consultation men, and twenty-five cent vaccination men would give us some explanation why they pursue a policy which lowers them in the eyes of their patients, makes bad blood between members of the profession, and eventually keeps money out of their own pockets.

A NEW HYPNOTIC.

A new hypnotic has been brought forward by Drs. Dujardin-Beaumetz and Bordet. The name

of the compound is phenyl-methyl-acetone, which being rather cumbersome has been replaced by the name *hypnone*, on account of its therapeutic use. From experiments made by Popof and others it appears the compound undergoes a decomposition, resulting in the formation of carbonic and benzoic acids, and is eventually eliminated by the kidneys in the form of hippurates.

It is a liquid at 20° C., and its boiling point is 198°. It has a specific gravity of 1015 to 1032; is not soluble in water, and has an odor resembling cherry-laurel. Its formula is $C_8 H_5 Co CH_3$. It was discovered by Friedel in 1857. The dose for an adult is from three to five drops, and is best administered in a little glycerine in a capsule. It produces profound slumber, and is said to be superior to chloral or paraldehyde in the insomnia of alcoholism. It was given to nine patients for fifteen days without producing any symptoms of intolerance. Owing to the elimination of acetone by the lungs, the breath became offensive. One advantage of the new drug is the small dose necessary to produce sleep.

THE COCAINE HABIT.—From Chicago comes a note of warning as to the abuse of cocaine. Dr. Bradley, a prominent physician had been addicted to the use of the drug in excess, and in a few months became a mental and physical wreck, and at the same time had injured the health of his wife and five children, some of them seriously. It appears to be more fascinating than alcohol, opium, chloral, etc., and the victim seems even more helpless to throw off its yoke. Several physicians have testified to its baneful influence, stating that it works ruin much more rapidly even than that *bête noir*, morphia. Cases of poisoning by the drug are noticed, in which recovery took place under the action of stimulants and digitalis. The habit has been formed in several instances under the direction of physicians, who, being desirous of breaking off some other habit, substituted a much worse one.

RHEUMATISM IN VINEGAR MANUFACTURE.—Mr. Robson calls attention (*British Medical Journal*) to the fact that persons exposed to the fumes of vinegar are more subject to rheumatic affections than others. Acute rheumatism, rheumatic gout, lumbago and tonsillitis form the majority of cases

of disease among the workmen employed at the vinegar brewery, of which Mr. Robson has medical charge. It is generally accepted by the workmen themselves that the vapors to which they are exposed cause these affections. Mr. Robson's theory is that the elimination of effete material by the skin is interfered with by the action of the acetic acid, which checks free perspiration. He further suggests that the acetic acid may, when introduced into the system, be changed by a chemical process into lactic acid.

THE LIGATURE IN OVARIOTOMY.—Dr. Lawson Tait, writing to the *British Med. Journal*, Nov. '85 expresses his preference for ligation of the pedicle in ovariectomy. Dr. Keith, of Edinburgh, prefers the cautery, which he calls "the only perfect method of dealing with the pedicle, for by it all risk of after-bleeding is avoided." Dr. Tait mentions the fact that he has lately performed his one hundred and thirty-second operation for cystoma since January 1st., 1884, without a single death. In ligating, he uses the Staffordshire knot, and states that his only case of after-bleeding was due to his not using that knot.

PERMANGANATE OF POTASH IN AMENORRHOEA.—This drug in grain doses three times a day will be found useful in cases where the flow is too small in amount, or where it is delayed. Ringer states that it has been known to establish the function even after the lapse of two years. Dr. Döring, of Chicago, in a report as to its efficacy, states that to be of use it must be given in considerably larger doses, two to four grains thrice daily midway between meals, but that in such case it deranges the stomach. He also advocates the use of large draughts of mineral water to be taken after the permanganate. Dr. Döring's larger dose should be taken in capsules. Mr. Ringer prescribes it as follows:

R Permanganate of Potash, 1 gr.
Kaolin,
Petroleum Cerate, of equal parts
q s., ft. pil, l.

Sig. One three times a day.

MIDWIFERY PRACTICE AFTER EXPOSURE TO SEPTIC POISON.—The majority of competent observers no longer claim that it is necessary to quit attendance upon cases of labor after exposure to septic poison.

It is held that thorough disinfection is all that is required for the safety of the patient. Dr. Angus MacDonald, of Edinburgh, emphasizes this—but makes his disinfection process very thorough, viz: complete change of clothing, hot bath, hands, face, beard and hair rubbed with turpentine, then with a solution of bichloride of mercury, after which he states there is absolutely no danger of carrying infection to the patient.

PERSISTENT CONSTIPATION.—Dr. Davies writing to the LANCET, gives the following treatment as having restored a case of obstinate constipation in a young man *æt.* 23. He ordered Ext. cascara sagrad $\mathfrak{z}\text{i}$; Tr. nucis vom. $\mathfrak{m}\text{x}$; Tr. belladonnæ $\mathfrak{m}\text{v}$ to be taken in water night and morning; the abdomen to be rubbed firmly from right to left for ten minutes every morning, and the diet to consist largely of porridge, brown bread and stewed fruits, with total abstinence from tea. The result was most happy, as the patient was cured in three weeks.

TREATMENT OF SCABIES.—Dr. Comessati, in *Pharmack Zeit*, 1885, gives the following as his treatment for itch. The whole body is washed at night with a solution of hyposulphite of soda, four ounces to one pint of water. The next morning the skin is sponged with dilute hydrochloric acid, one ounce to a pint of water. The chemical reaction gives sulphur, sulphurous acid, and sodium chloride, and one application is usually sufficient to cure the disease.

HOW TO TAKE A PILL.—Dr. Ashwallis in *The Med. & Surg. Rep.* recommends practitioners to try Hanna's method when patients affirm that they "cant take a pill." The directions he gives are: place one or two pills *under the tongue*, then take a mouthful of water and swallow just as in the act of drinking. He says that invariably the patient is astonished to find the objectionable pellet gone and sometimes examines his mouth with the finger to assure himself it is not there. The explanation is that in the act of drinking the tongue is carried back upon itself, and the current forces the pill down the *œsophagus*.

HYDROPHOBIA INOCULATION.—M. Pasteur has now under his charge 78 patients for treatment of hydrophobia. Four little children are to be sent

to him from Newark, N.J., by S. S. Canada. It is stated that the French Government intends asking the Chamber for funds to enable Pasteur to establish a hospital for the treatment of rabies. No doubt a number of patients will be sent from Milwaukee, where there is just now a large number of cases, one death having occurred from the disease.

PILOCARPINE IN ALCOHOLIC INSOMNIA.—Dr. A. B. Isham (*Medical News*) gives his experience as to the effect of this drug in the insomnia produced by the excessive use of alcohol. He gives one-third of a grain of the muriate, and says that the patient wakes from sleep wonderfully changed for the better both mentally and in appearance. He believes that it lowers cerebral blood pressure, aids in the elimination of alcohol and increases the absorption of oxygen. He also recommends it for the depression following a debauch.

ANOTHER CURE FOR STAMMERING.—A writer in the *Popular Science News* gives the following as a method for the cure of stammering: "Go into a room where you will be quiet and alone, get some book that will interest but not excite you, and sit down, read two hours aloud to yourself, keeping the teeth closed. Do the same thing every two or three days, or once a week if very tiresome, always taking care to read slowly and distinctly, moving the lips but not the teeth.

ADMINISTRATION OF PARALDEHYDE.—The following formula is given by M. Hereboullet, *Gaz. hebdom. de méd et Chir.*, as a good one for the administration of paraldehyde:

Paraldehyde,	-	-	150 grains.
Alcohol (90 per cent.)	-	-	720 "
Syrup,	-	-	900 "
Tincture of Vanilla,	-	-	30 "
Distilled Water,	-	-	450 "

One drachm of this contains fifteen grains of paraldehyde. Dose not to exceed four drachms.

TREATMENT OF WARTS OF THE PENIS.—Nussbaum treats the small soft warts which frequently cover the penis, by first washing them twice daily in salt and water, and afterwards sprinkling with calomel. The reaction of the residual sodium chloride and mercurous chloride produces mercuric chloride or corrosive sublimate. This treatment,

he claims, cures the warts rapidly without causing the least pain or detention from business.

APPOINTMENTS:—Dr. A. D. Williams, gold medallist of Toronto University, 1870, has been appointed to the chief command of the General Hospital at Georgetown, British Guiana. The salary is from \$5,000 to \$6,000.

THE LATE W. H. VANDERBILT.—We regret to announce the death of W. H. Vanderbilt. His name deserves to be held in kind remembrance by the medical profession as the donor of half a million dollars to the College of Physicians and Surgeons of New York.

ERROR.—In Dr. Grant's article in last month's issue an error inadvertently crept in. On page 95, 2nd column, 15th line from bottom, malignant asthma should read malignant *anthrax*.

PERSONAL.—Dr. J. W. Rosebrugh, of Hamilton, Ont., has been elected a Fellow of the British Gynecological Society, and a corresponding member of the Boston Gynecological Society.

Dr. Frank Hamilton Mewburn, son of Dr. Mewburn of this city, has resigned the home surgery of the Winnipeg City Hospital, which he held for nearly four years, and has been appointed Medical Officer to the Lethbridge Coal Mines, N. W. T.

The death of Dr. Albert H. Smith, of Philadelphia, at the early age of 52 years, is announced in our exchanges.

CORONER.—D. C. Leitch, M.D., of Dutton, Ont., has been appointed Coroner for the County of Elgin.

WILLIAM MARSDEN, M.D.

It is with profound regret that we notice the death of Dr. Marsden, one of the oldest and most prominent physicians in Quebec. Dr. Marsden was born in Lancashire, Eng., in 1807, and was consequently in his 79th year. He came to Quebec in 1812, was educated in the Royal Grammar School there and completed his medical education in London and Paris, and received the license to practice in 1830. He has therefore been in active practice for upwards of half a

century, and filled many important positions in connection with his profession. He was an M.D. of Harvard University, and Bishop's College, Lennoxville, conferred upon him the honorary degree of M.A. For many years he was president of the College of Physicians and Surgeons of Quebec, of which he was senior Governor. He was also an honorary member of various literary societies, and at one time contributed largely both to the medical and secular press. He published a complete history of Asiatic Cholera, its etiology and pathology, commencing with its outbreak in India in 1817. Before the incorporation of the Quebec Medical School and Laval University, he for many years delivered, with great success, courses of lectures on anatomy and physiology, surgery, materia medica and botany. He took an active part in the establishment of the Canada Medical Association and was one of the presidents. He took a deep interest in sanitary reform, and was as energetic in his efforts to prevent the introduction of small-pox into his native city as he was nearly half a century ago to perfect his system of quarantine against an invasion of cholera. The deceased has led a long, useful and busy life, and has literally died in harness. His death is a public loss, and his bereaved family have our respectful sympathy in their affliction.

Notes, Queries and Replies.

A correspondent desires answers to the following queries :

1. The best treatment for seasickness.
2. How to prevent laceration of the perineum, and the best method of treatment when it occurs.

Books and Pamphlets.

EPILEPSY AND OTHER CHRONIC CONVULSIVE DISEASES.—By W. R. Gowers, M.D., F.R.C.P., etc. New York: W. Wood & Co. Toronto, Williamson & Co.

Good ale needs no broom ; therefore it is quite unnecessary, in introducing this work to the profession, to annex to the author's name, the whole of his caudal appendage. The book is good all through. It will be best appreciated by those who are already best acquainted with the diseases treated of. It is, however, not improbable that

junior readers may regard the past, devoted chiefly to the semeiology and statistics of epilepsy, and taking up more than half of the volume, as unnecessarily long and too liberally diffuse; but whoever, young or old, sets determinedly to work, will find the work growing in favour the farther he advances in its careful perusal; certainly when he reaches the last four chapters, devoted to the Pathology, Diagnosis, Prognosis and Treatment, he will say that his patient devotion is amply rewarded. Indeed it might not be wrong to suggest to those who have little surplus time at command, to take up these chapters first, not however with the purpose or desire of ignoring those preceding: for they are of absolute requirement in the satisfactory study of the others following: but because his appreciation of the latter will be so high that he cannot refrain from reading all that precedes, and he will certainly read again with avidity and with augmented profit, the terminal four above indicated.

A TREATISE ON NERVOUS DISEASES, their Symptoms and Treatment, by Samuel G. Webber, M.D., Clinical instructor in Nervous Diseases, Harvard Medical School, Boston. New York: D. Appleton & Co. Toronto: Williamson & Co.

This work presents in a small compass the essential points as to etiology, symptoms, diagnosis and treatment of nervous diseases. The author's style is plain and pointed. He appears to say just what is necessary and no more: few books being found with less padding than this one. The work is intended for the use of the general practitioner, and we believe the writer has made a valuable addition to the literature of the subject, being sufficiently limited to render it handy for easy reference. It is not intended for specialists, many parts being greatly condensed. One of its best features is the condensation of the anatomy and physiology of the nervous organs found in the second chapter, and which must prove very useful to the general practitioner who has not time to keep himself fresh on these difficult and intricate subjects. The introductory remarks, as to the methods of testing sensation and motion will be of very great service to those who have not had the opportunity of devoting much time to the study of nervous diseases. The book is carefully and thoughtfully written and will repay a careful

perusal by students and men who are doing a general practice.

THE MANAGEMENT OF LABOR AND OF THE LYING-IN PERIOD, by Henry G. Landis, A.M., M.D., Professor of Obstetrics in Starling Medical College, etc., 8vo. pp. 334. Philadelphia: Lea Bros. & Co., 1885. Toronto: Williamson & Co.

This addition to obstetrics appears in a very attractive form, the typographical appearance being excellent. The author is clear and concise, and we have no doubt the work will be of value to the young practitioner. It supposes an acquaintance with "the anatomy and physiology of the parts involved, and of the mechanism of labor," and is intended simply as a "guide to practice." The result is that it is nearly useless to the student, while it cannot rank as a treatise which an experienced practitioner would care to consult. The *raison d'être* of the book is not therefore very apparent. The subject matter is all good, and the opinions expressed entirely orthodox; but nothing new has been brought forward. It may save time in referring to larger treatises for simple facts without details.

GRIP FOR 1886.—*Grip* Publishing Co., Toronto: This is the 13th year of publication of Canada's Comic Journal. Improvements are promised for the current year in the way of increase in size, alteration in style and improved facilities for the production of cartoons. The price will remain the same. The CANADA LANCET and *Grip* for 1886 will be supplied for \$4.50.

Births, Marriages and Deaths.

On the 27th of Nov., Jacob Smith, M.D., of Ridgetown, Ont., in his fifty-fifth year.

On the 1st Dec., C. J. Philbrick, F.R.C.S., E. C.S., of this city in his 70th year.

On the 7th Dec., W. C. Edmondson, M.B., of Oshawa, aged 29 years.

On the 10th Dec., Chas. E. Cotton, M.D., of Cowansville, Que., aged 69 years.

On the 15th Dec., S. Cory, M.D., of Stamford, in his 81st year.