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(HALIFAX, NOVA SCOTIA.)

A MONTHLY JOURNAL OF

MEDICINE and SURGERY.

VOL. VI.—No. 6. JUNE, 1894. Subscription $1 per annum.

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The sixty-first session will commence on the 3rd of October, and will be continued until the end of the following March; this will be followed by a Summer Session, commencing about the middle of April and ending the first week in July.

Founded in 1824, and organized as a Faculty of McGill University in 1829, this School has enjoyed, in an unusual degree, the confidence of the profession throughout Canada and the neighbouring States.

One of the distinctive features in the teaching of this School, and the one to which its prosperity is largely due, is the prominence given to Clinical Instruction. Based on the Edinburgh model, it is chiefly Bed-side, and the student personally investigates the cases under the supervision of special Professors of Clinical Medicine and Surgery.

The Primary subjects are now all taught practically as well as theoretically. For the department of Anatomy, besides a commodious and well-lighted dissecting room, there is a special anatomical museum and a bone-room. The other branches are also provided with large laboratories for practical courses. There is a Physiological Laboratory, well-stocked with modern apparatus; a Histological Laboratory, supplied with thirty-five microscopes; a Pharmacological Laboratory; a large Chemical Laboratory, capable of accommodating 76 students at work at a time.

Besides these, there is a Pathological Laboratory, well adapted for its special work. It is a separate building of three stories, the upper one being one large laboratory for students 48 by 40 feet. The first flat contains the research laboratory, lecture room, and the Professor's private laboratory, the ground floor being used for the Curator and for keeping animals.

Recently extensive additions were made to the building and the old one remodelled, so that besides the Laboratories, there are two large lecture-rooms capable of seating 300 students each, also a demonstrating room for a smaller number. There is also a Library of over 15,000 volumes, a museum, as well as reading-rooms for the students.

In the recent improvements that were made, the comfort of the students was also kept in view.

MATRICULATION.—Students from Ontario and Quebec are advised to pass the Matriculation Examination of the Medical Council of their respective Provinces before entering upon their studies. Students from the United States and Maritime Provinces, unless they can produce a certificate of having passed a recognized Matriculation Examination, must present themselves for the Examination of the University on the first Friday of October or the last Friday of March.

HOSPITALS.—The Montreal General Hospital has an average number of 150 patients in the wards the majority of whom are affected with diseases of an acute character. The shipping and the large manufactories contribute a great many examples of accidents and surgical cases. In the Out-door Department there is a daily attendance of between 75 and 100 patients, which affords excellent instruction in minor surgery, routine medical practice, venereal diseases, and the diseases of children. Clinical clerkships and dresserships can be obtained on application to the members of the Hospital staff. The Royal Victoria Hospital, with 250 beds, will be opened in September, 1893, and students will have free entrance into its wards.

REQUIREMENTS FOR DEGREE.—Every candidate must be 21 years of age, having studied medicine during four six months Winter Sessions, and one three months' Summer Session, one Session being at this School, and must pass the necessary examination.

For further information, or Annual Announcement, apply to **R. F. RUTTAN, M. D, Registrar,**
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The Maritime Medical News.

A MONTHLY JOURNAL OF MEDICINE AND SURGERY.

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CONTENTS.

Original Communications.

EXTRA-UTERINE GESTATION.

[Abstract of paper read before Halifax Branch Brit. Med. Assoc. by Murray MacLaren, M.D., St John, N. B.]

During a period of seven and one half months, and within the past year, I have had to deal with three cases of ectopic gestation, and it suggested itself to me, that perhaps extra-uterine pregnancy might be an interesting subject to take up, as it certainly is of high importance involving as it does such great danger to life. I will limit any remarks I have to make to short accounts of these cases and points arising from them. As none of the three had advanced beyond a few months I refer only to such cases. I have had no experience of extra uterine pregnancy going on to a longer period or to full term.

I will first read to you an account of these cases:

Case I. Mrs. A., aet. 26.

Father living and healthy, mother living, but health not good. Two brothers and one sister all living and well. The patient's health previous to marriage was good, menstruation came on about the age of 15, and occurred generally every four weeks, although somewhat irregular it was normal in amount, with no unusual pain.

She had been married for seven years. Some months after her marriage she was thrown from a toboggan, and owing to this accident had a very severe illness, there was severe abdominal pain, and she was supposed to have injured the pelvic organs, and for some years following, one leg (which one her friends do not remember) would, after much exercise or skating, get tired and drag. Still later she was said by a practitioner to have displacement of the uterus, and received some treatment for this condition.

She first came under my observation in January 1892, six years after her

marriage, when I attended her for a miscarriage between the second and third months. She recovered readily from this illness, and I then made an examination and found slight retroversion of the uterus, which was replaced easily. Nothing else was found abnormal in the pelvis. She had not been pregnant before this miscarriage, nor since until her last illness.

In March 1893, she had an eruption on her skin, its exact nature was not evident. In June 5th 1893, patient came to say that she had passed the menstrual period by two or three days and she wanted to know how to avoid another miscarriage, as she was very anxious to have a child. On the 9th I visited her on account of the appearance of small discharge of blood, and again on the 14th., as there was a further moderate flow, and there had been a little between the two dates, otherwise she felt in her ordinary health. There were no changes noticed in the breasts.

I was hurriedly summoned on the 17th about 9.30 a. m., and found the patient perfectly blanched, almost pulseless and with abdominal pain. She had felt a bearing down sensation or inclination to go to stool, arose out of bed, went to the closet, and the symptoms of collapse rapidly came on. I could make out some dullness over the right iliac region and there was pain on pressure. No distension was to be found in fornices when a vaginal examination was made. I considered this was a case of ruptured extra-uterine gestation at the sixth week of pregnancy, and requested a consultation. The patient was kept perfectly quiet, cold was applied locally and strychnia and digitalis given, she rallied somewhat for the next two days, but about midnight of the 20th she suddenly died.

With great difficulty I obtained permission to make an examination. On opening the abdomen the abdominal cavity was found full of blood, the right fallopian tube was ruptured, the chorionic villi were displayed, and in the rupture was the amniotic sac containing the foetus, there were no inflammatory adhesions, the right ovary was hollowed out thoroughly and embraced a part of the pregnancy, the left ovary, tube and uterus seemed normal. It was a case of tubo-ovarian gestation.

Case II. Mrs. B., aet 34.—Father, mother, three brothers and three sisters are living and well. Menstruation began at the age of eighteen, generally every twenty-eight days, but liable to be irregular and painful, as a girl she was not robust, although never ill. She has been married four and a half years: one year after marriage a child was born, instruments were used, and probably some inflammatory trouble followed as the puerperium was slow and she was ill. One and a half years later a second child was born, instruments were again used. but the mother had a speedy recovery. She had been somewhat anaemic for past few years, and laceration of the cervix on the left side has given some discomfort. On account of her anaemic and rather debilitated appearance I made an examination early in 1893, and found this condition, otherwise the pelvic organs were normal.

About the eighteenth of November, 1893, the menstrual flow was very excessive, and lasted six days, then for three weeks the patient seemed well and again (when I was sent for) the menstrual flow appeared in moderate amount, but accompanied with attacks of very severe crampy pains, some of them producing vomiting, pallor and coldness of the body. The flow continued from this date up to day of operation, 17th January, 1894, the amount varying, some days very slight, other days more marked. There was a good deal of intestinal colic, which was relieved by the passage of flatus. I could detect bi-

manually some fullness in the left fornix which gradually increased, there was pain on pressure over this region. No change was noticed in the breasts. I avoided passing a uterine sound. In the intervals of the attacks of pain and colic, the patient felt fairly well, she was kept in bed, but any attempt to stand increased the pain. The symptoms pointed to extra-uterine pregnancy.

I sent the patient to the General Public Hospital on the fourteenth of January last, and made preparations for an operation. On the 16th there was detected some dulness extending up the left side of abdomen, subsequently found to be due to a haemorrhage. On the 17th I made an abdominal incision, on opening the abdominal cavity I found a considerable amount of blood. It is a difficult matter to estimate the amount, under the circumstances, more or less exactly, but there was probably about one or one and a half pints; on the left side of pelvis was a mass made up of fallopian tube, omentum and intestines with numerous adhesions, the sac was partially ruptured. After ligaturing and removing what was possible of the sac, dilated tube and its contents and controlling bleeding points the wound was closed, a drainage tube being used on account of oozing.

The patient made an excellent and uninterrupted recovery, and went home three weeks after the operation. The contents removed were a small kidney shaped mass, either a clot or an embyro, but resembling closely an embyro, changed somewhat by the haemorrhage which had arrested the further development of the pregnancy. A somewhat similar instance is mentioned in Pozzi's work on Gynecology. There was also a large mass, the size of a walnut, resembling a very firm clot.

Out of forty two cases of extra-uterine pregnancy, Lawson Tait was able to find the foetus in only twelve instances, however the finding of the remains of placental structure in the other cases proved the diagnoses. In this case I have not had a microscopic examination made to search for chorionic villi or foetal structure. There was certainly a condition of haemato-salpynx present. This is said to arise nearly altogether from an ectopic gestation or a pyosalpynx. I did not find any such condition as the latter when making the examination previous to the illness to which I am referring, while the condition found with the whole history of the case points, I think to the former being the cause.

Case III was a patient of Dr. H. I. Rankin, Woodstock, N. B., and I am indebted to him for kindly supplying me with notes of the history of the case. Her father suffers severely from atonic dyspepsia; her mother has been almost a cripple for years from chronic rheumatic arthritis. There are five brothers and one sister living and well.

Mrs. C., aet 31, had been married five years and had never borne any children. The menstrual period began at the age of 15, occurred every four weeks, and lasted three days. It was moderate in amount, and regular in time. Three years after marriage and two years ago, the patient had an attack of menorrhagia which lasted, despite medical treatment for some five months when the uterus was curetted, and the menorrhagia ceased. This was thought to be due to a miscarriage, otherwise the patient had been healthy, and worked hard. There was slight leucorrhœa, but not sufficient to cause discomfort. In November 1893, the period was two days late, the amount was scanty and without the usual pain. The two subsequent periods were also delayed a day or two, the amount being very scanty and dark in colour the first day, and then

colourless. During the second day of the third period, a sudden and severe abdominal pain came on late in the evening when the patient was in bed, the next day, she felt better but was uneasy and very anxious. Ten days later she had a second severe pain at night, and looked rather pale, pulse 84, temperature 99. She rallied from this and had a slight bloody discharge. In another week there was a third attack, and the severest, it began with fainting, then agonizing paroxysmal pain. She appeared very white about the lips and finger tips, the extremities were cold, pulse 90, and temperature 99.2, vomiting also. The breasts took on the changes seen in pregnancy. On the 29th of January last, I received a telegram from D. Rankin, asking me to come to see a case of extra-uterine gestation and to be prepared to operate. I found the patient presenting every appearance of being very ill, anxious look, weak and in pain. There was marked pain across the lower part of abdomen and especially so on the left side, there was abdominal distension and palpation gave rise to increased pain. Under anæsthesia, a considerably large mass was readily made out bi-manually, rising out of the pelvis, the fulness being greater on the right side, although the pain was principally on the other side. The uterus was three quarters of an inch enlarged and was contained in the mass just mentioned. Assisted by Doctors Rankin and Hand, I made a mesial incision and after a little delay, on account of thickened and inflamed peritoneum and adhesions, opened into the abdominal cavity. Here was found a considerable amount of blood, and that the enlargement was made up of an amount of adherent intestines, uterus and a right fallopian gestation, the sac of course having ruptured, the foetus was found and removed, and the broad ligament was transfixed, and the ligatures placed at the outer and inner ends of the sac, which was then removed. There was marked adhesive peritonitis also on the left side of pelvis in the pouch of Douglas. As there was some oozing of blood a drainage tube was introduced, and wound closed. The patient never rallied from the operation, pulse that night being 130. Next morning pulse 120, temperature 99.2, and in the evening, pulse was 120, temp. 99.4, the blood oczing was slight, so the drainage tube was removed. The following day she felt worse and was restless, and at 9 a. m. pulse was 127, and temperature 100.4, some vomiting. She was given calomel followed by a seidlitz powder, but was evidently sinking. Pain was persistent, but not severe, pulse became weaker and increased to 146, temperature 101. Vomiting became almost incessant, and patient died fifty-six hours after being placed in bed. I have here the foetus and the parts removed, there were a few drops of pus observed on the proximal end of the tube. The foetus seemed to be of the male sex. Dr. Rankin has kindly loaned me the specimen. He certainly deserves great praise for his careful study of the case, correct diagnosis and appreciation of the gravity of the condition.

As regards the *causes* of extra-uterine gestation, Spiegelberg says: "They must be in some obstruction "which renders the passage of the "ovum into, and through the oviduct, "impossible or difficult, or else they "must be looked for in the so called "migration of the ovum." "The ob-"struction in the tube may be com-"plete or merely due to a loosened "calibre, which allows the spermatozoa "to reach to the ovule, but does not "permit the latter when fecundated, "and consequently increasing in size "to reach the uterine cavity. When "there is complete occlusion of one "tube, the spermatozoon may pass "through the other, which is patulous,

"and across the abdominal cavity to "the adjacent ovary of the abnormal "side, and there effect impregnation, "after which the ovule is grasped and "retained by the tube belonging to "its ovary. The obstruction is gener- "ally produced by peritoneal ad- "hesions and bands which fix and "bend the tube more than is usual." "This view is in harmony with the "fact that extra-uterine pregnancy "in the majority of cases affects "multiparæ who have been more or "less sterile for some years previous- "ly (for such anomalies are generally "due to previous puerperal periods, "and tend to make conception diffi- "cult) and also the fact insisted on "by Hecker that left sided tubal "pregnancy is the most frequent "since pelvic inflammations are known "to occur more often on the left than "on the right side. Pozzi says "adhesions of the ovary secondary to "attacks of local peritonitis which "are common with salpingitis, dis- "appearance of the ciliated epithelium, "or the presence of a small tubal "polypus obstructing the normal "migration of the ovule are the most common causes." A review of these cases bears out generally these quoted remarks: In case I. the cause is not clear, but it is evident there was something at fault in her generative organs, for during a married life of seven years, she had no children, (although anxious to have them) one miscarriage, and a tubal pregnancy. It is impossible to say what was the nature of the injury before mentioned, and the effect it had upon the pelvic organs. She had some little gyne- cological treatment at a subsequent date.

Case II however evidently had some inflammation following upon her first confinement, and upon the same side as the tubal pregnancy.

Case III had been married five years and never had borne children, three years after marriage she had had what was probably a miscarriage with per- sistent menorrhagia for which curetting was performed.

It would be well in the case of sterile women or in those who have not borne children for some years, that any pelvic complaint or question of pregnancy should receive more than ordinary attention, bearing in view the possibility of such a complication. A number of the symptoms occurring in these cases are worthy of attention. *(a) Attacks of severe pain* were well marked symptoms in cases II and III being caused by partial ruptures of the sacs and by the peritonitic changes. *(b) Menorrhagia* was present in case II, while slight losses were noticeable in the other two cases. *(c) Intestinal Colic*, said to be frequently present was well marked in the second case, and was due to the matting of the intestines, while in the third case where the same condition existed, although to a less extent, it was not noticed. *(d) Changes in the breasts* were observed in the third case only. *(e)* Blood from the ruptured sacs in cases I and II did not pursue the course which one might expect fluid to take and be more or less evenly distributed across the abdomen, but percussion indicated that it was princi- pally restricted to the side of the preg- nancy in case II, and was so in case I for the first two days or so.

The question of *treatment* can happily be spoken of with decision. One may be in doubt about the diagnosis, but generally an exploratory incision will be the safer course. Should the diagnosis be made previous to rupture of the sac, operation would undoubtedly seem to be the proper procedure. In collapsed conditions following rupture and haemorrhage, the cataclysmic form so-called it may be necessary to wait for the patient to rally somewhat before operating, but it is unadvisable to wait too long for rallying is often the means of bringing on another and fatal haemorr-

hage, I often regret that case I was not operated on even with the danger of collapse in an already collapsed condition.

Those cases in which small ruptures have taken place accompanied with peritonitic adhesions demand as do the others, abdominal section, ligature and removal of sac.

Since writing the above I have heard from Dr. W. S. Muir of a case of ectopic gestation, which has just occurred in his own practice, and in which rupture suddenly occurred fourteen weeks after the date of the last menstrual period, and was soon followed by a fatal haemorrhage.

A CASE OF TUBAL PREGNANCY, UNIQUE IN A MEDICO-LEGAL ASPECT.

By J. Austin Payzant, M.D.,
Halifax, N. S.

In recording this case, we do so not only for its pathological interest, but as one *unique* from a medico-legal standpoint, owing to the fact of a charge having been preferred against the defendant of having produced *fœtal abortion*, on the deceased by the administration of drugs, thereby causing her death. Elizabeth H. aet 35, multipara, married but separated from her husband, and had been living with a man named Innis for some length of time. She last menstruated early in September, and in October having passed the usual time for the next period became alarmed that she might be pregnant, and Innis called on a reputable physician in this city, asking him to bring on her menses, which of course he refused to do, and at the same time told him the consequences of such an act, and advised him not to attempt anything of the kind. Innis said in reply that he would have nothing more to do with it.

On Nov. 3rd I was called in consultation with Dr. Gow to see said E. H., who was suffering from colicky pains in the lower portion of the abdomen, and in the region of the uterus, they did not seem to be very severe. On getting the history of the case, we found that she had been taking a nostrum called penny-royal pills, which are used for the purpose of procuring abortion and are supposed to contain ergotine. Examination revealed no other evidence of miscarriage, or the presence of any tumor, therefore we came to the conclusion that the pills must have caused the pain by bringing on uterine contractions, threatening abortion so prescribed potas. bromide and viburnum prunifolium, also ordered her to take no more of the pills. Pain passed away very shortly, and as far as I could learn did not occur again until Nov. 25th, when Innis called me to visit her immediately as he thought she was dying. I found the patient pulseless and suffering from great pain in the abdomen, examined her and made the diagnosis of internal hemorrhage from an extra uterine pregnancy. Dr. W. F. Smith being present at the time we administered stimulants but they were of no avail, and she died about half an hour after my arrival.

An inquest was held and I was called on to make an autopsy. On opening the abdominal cavity I found it contained about two quarts of blood and clots. On examining the pelvic organs I observed a tumor about the size of a large walnut occupying the middle third of the right fallopian tube. On the upper surface and inner half of the tumor there was an irregular opening about $\frac{1}{8}$ of an inch in diameter through which blood had evidently flowed into the peritoneal cavity. On laying the tumor open it was found to contain recent blood and a partially organized clot, about an inch and a quarter in length pointed at each end and curved on itself.

From the concavity projected an ir-

regular mass. There seemed to be no distinct evidence of placental tissue or an embryo. The fallopian tube was closed at both ends of the tumor but its extremities were open for a short distance, the *ostium internum* being abnormally patulous. The right ovary was apparently normal, except perhaps rather small. It contained no corpus luteum whatever. The left tube was normal, and to the left ovary were attached two small cysts about the size of a small walnut, containing fluid. Section of the ovary showed a corpus luteum not altogether typical of pregnancy but more resembling that of menstruation. The uterus was normal in size, the cavity being about three inches in depth and contained a decidua covering the upper half of the fundus and fitting into the cornua.

Taking all these conditions together I was inclined to the opinion that pregnancy was not present, but that the hematocele was caused by effusion of blood into the tube from some other pathological condition, but said that a microscopical examination might possibly reveal pregnancy. After the inquest, I placed the specimen in alcohol which on hardening both the surface of the clot and the inner walls of the sac exhibited a shaggy, thready appearance, suggestive of chorionic villi. The coroner's jury found a verdict of death from natural causes. Innis was then arrested on the above charge, also a charge of attempted abortion was preferred, and Dr. D. A. Campbell was engaged by the prosecution to make a microscopic examination of the contents of the tumor, the result of which was that pregnancy was found to be present. After a trial lasting some days during which much interesting and expert evidence was adduced the charge of tubal abortion was ruled out by the judge, owing to its having been proven that tubal pregnancy according to statistics of cases recorded usually ruptures in from the eighth to the fourteenth week, this case being at about the tenth week. Innis was also acquitted of the further charge of attempted abortion by the administration of drugs, from the fact that it could not be proven that he actually bought the pills and gave them to the woman or placed them where she could get them, although circumstances were strongly against him.

Result of microscopical examination made by Dr. D. A. Campbell.

The microscopical examination in this case was confined to the cyst in the fallopian tube and its contents.

Portions of the out-growth from the blood clot and cyst wall were teased out, mounted in Farrant's medium, examined and compared with chorionic villi obtained from another specimen.

Other portions were hardened embedded in celloidin sectioned and stained with haematoxylin and eosin. The characteristic appearance of chorionic villi was quite apparent. No trace of the embryo could be observed.

A REPORT OF TWO CASES OF FRACTURE OF THE OLECRANON SUCCESSFULLY WIRED.

By N. E. MacKay, M. D. C. M., M. R. C. S. Eng., Surg. V. G. Hospital.

[Read at the 25th Annual Meeting of the Nova Scotia Medical Society held at Bridgewater. June 1893.]

Case No. i.

Wm. G. a lumberman aged 20, was admitted to the P. & C. Hospital on the 8th of September 1886, suffering from an un-united fracture of the olecranon. He gave the following history:

Ten weeks ago he fell through a hole in an old wharf, and struck his elbow heavily against a plank. On getting up he found the power to extend the forearm greatly weakened. The elbow was painful and swollen for a few days. He went to a bone-setter who told him that the joint was dislocated; and gave his arm a few wrenches and assured him that the dislocation was reduced,

and that he would be all right in a few days. Patient went about for five or six weeks with his arm in a sling in the flexed position. Finding the joint getting no better he consulted a doctor who told him that the olecranon process was fractured. The limb was then put up on a straight anterior splint.

When admitted the olecranon was found fractured; ⅛ to ¼ of an inch between the fragments in the extended position of the arm, and 1 to 1½ in. in the flexed position; the circumference of the joint 1 in. greater than that of its fellow; the power to extend the forearm weakened and the olecranon freely movable from side to side. Patient's general health was very good.

On the 14th of September I performed the operation of wiring the olecranon under a spray of carbolic acid and with strict antiseptic precautions. The elbow, arm and forearm were first washed well with soap and water and scrubbed by a skin-brush and afterwards washed with carbolic acid solution 1 to 20. The patient being now etherized and an Esmarch bandage applied to the arm high up I made a vertical incision 2½ inches long over the most prominent part of the olecranon. This incision laid the joint freely open. I now carefully removed the soft structure from the ends of the fragments. The direction of the line of fracture was very obliquely downwards and forwards. There was no attempt at union of any kind. The arm being now held well flexed and the soft structures held well apart by two assistants I removed a thin slice from each fragment with a Hay saw, and drilled two holes obliquely in each of them from their periosteal surfaces, but not so deep as to encroach upon the cartilages of the joint. All the bleeding points were then ligated and the wound was well douched with bichloride solution 1 to 3,000 and cleansed of every shred and loose tag. The fragments were now brought in perfect coaptation and held there by medium size platinum wire twisted up. There was no drainage inserted in the joint, but a catgut drainage was placed in the wound in the soft parts. The wound which was brought together with interrupted sutures of catgut was dressed with a Lister's dressing: and the arm was put up in the straight position on an anterior splint. The operation took an hour and a quarter in its performance.

On the day after the operation the temperature rose to 100 degrees in the afternoon. It was normal on the second day and remained so until the evening of the fourth day, when it rose to 100 degrees. He now complained of pain at the bend of the elbow. The dressing was removed and quite a swelling was found over the radio-humeral articulation. The wound looked well. An ice-bag was applied at once to the joint and kept on for 3 days and nights in succession. From the 18th, the fourth day after the operation, till the 21st his temperature ranged from 99 degrees in the morning to 101 degrees in the evening, when it became normal and remained so. The pain in the joint ceased now and the swelling subsided. The wound healed by first intention. On the 20th of October, the 36th day after the operation firm bony union was found to have occurred.

To restore the natural movements of the joint active and passive motion were now commenced. This was supplemented with stimulating liniments, shampooing and massage. On the 18th of December the patient was allowed to go home to spend the Christmas holidays. He could not easily touch his forehead with his hand. Before leaving he was instructed to exercise his arm well, and to chop wood every leisure hour he had, as this form of exercise taken in moderation would help to restore the natural movements of the joint better than any other kind he could take. On the 9th of Jan. 1887, he returned to the hospital with all the movements of the joint, flexion, exten-

sion, pronation and supination, completely restored. On the 12th I removed the wires and on the 25th, the 133rd day after the operation, he was discharged cured.

Since the operation was performed this patient has worked for three or four years in the lumber woods of Washington Territory. He is at present working in a smelting furnace in a silver mine in Montana. On the 21st of last May I addressed to him the following letter: "Dear Sir,—Would you kindly let me know how your elbow has been doing since it has been operated on? Has it given you any trouble since, and can you use it as well as the other?"

To this communication I received the following answer.

Philipsburg, Montana, May 29, 1893.
Dear Doctor,—

I am glad to say that my arm is perfectly sound, that is, as far as using it is concerned; but it is a little tender if I happen to strike the elbow against anything, outside of this I cannot tell the difference between the two arms.

Respectfully yours,
WM. G.

CASE NO. 2.

W. B. aged 23, a porter on the Intercolonial R. R., consulted me on the 28th day of Dec. 1892 for injury to his left elbow. The following history was elicited from him:

On the morning of the 28th day of December 1892, the ground being covered with light snow and very slippery, his feet slipped as he entered the door of the freight-shed and he fell heavily upon his elbow striking it against a granite sill in the door. The elbow at the time pained him intensely. On attempting to extend the forearm he found the power to do so impaired and that he could only do it with pain and difficulty. His general health was good.

Within an hour of the time of the accident he consulted me at my office. On examination I found the joint painful and swollen; the power to extend the forearm weakened; and the olecranon detached and freely movable from side to side. I ordered him home and put the limb up in the extended position on a straight anterior splint well padded, and urged upon him to keep the arm absolutely quiet, and directed cold evaporating lotions to be kept on the joint constantly. This treatment was continued for a week. In spite of the rest and the cold lotions a large quantity of fluid accumulated within the joint. The fluid became absorbed so very slowly that the surfaces of the fragments became blunted before it was sufficiently absorbed to permit them to come in contact, so that, no union of the fragments took place, nor could in future be hoped for. As soon as the tenderness left the joint, a pad of cotton wool was applied over it with a figure-of-eight-bandage, with a view of promoting absorption of the fluid and of bringing the fragments together. This treatment was continued for two weeks. Finding no attempt at union of any kind I advised an operation, and at the same time explained to the patient fully the object and nature of the operation and its possible risks. On the 18th of Jan. 1893, I *wired* the olecranon. The operation was performed with full antiseptic precautions. The region of the joint, arm and forearm were thoroughly washed first with soap and water, afterwards with a solution of carbolic acid 1-20, and for an hour or two before the operation the elbow joint was kept wrapped up in lint soaked with carbolic acid solution 1-40. The patient being etherized and an Esmarch bandage applied high up the arm, and the joint again washed with an antiseptic solution, an incision three inches long was made over the most prominent part of the olecranon, beginning at its upper border. This incision laid the cavity of the joint open. There was no union of the fragments. My assistant flexed the elbow well and held the soft struc-

tures well apart with retractors, the surfaces of the fragments were then carefully and thoroughly curetted with a Volkman Spoon, and two holes were drilled obliquely in each fragment from their periosteal surfaces, but not so deep as to encroach upon the cartilages of the joint and a medium size silver wire passed through them. All the bleeding points being secured and the joint douched thoroughly with bichloride solution 1-6000 the fragments were brought in perfect apposition and held there by the silver sutures twisted up. The ends of the wire were cut short and turned down. The wound was brought together with catgut and dressed with finely powdered iodoform and iodoform gauze dry. A very narrow strip of oiled silk was placed next to the wound over its edges. This I always use in every case where I want to get union by first intention. No drainage was used in this case. The limb was put up in the extended position on a straight anterior splint which extended from near the axilla to the palm of the hand. The patient suffered no pain and there was no rise of temperature during the after treatment of the case. The first dressing was left undisturbed for 10 days. When it was removed the wound looked well and was healed. The protective was left off now, and the wound otherwise dressed as at first.

The day after the operation I was surprised to find that the patient could not move his forearm, wrist or fingers. There was complete motar paralysis of all the muscles supplied by the median, ulnar and musculo-spiral nerves. Common sensation and that of general sensibility to pain were only very slightly affected. This is not an uncommon occurence after injuries to mixed nerve trunks such as compose the brachial plexus. The fingers became flexed, especially the two last phalanges, which were over-flexed, giving the fingers somewhat of the appearance of claws, "Main en Griffe" of French writers. There were no signs of improvement in the paralysis until about the end of the third week. The order in which motion was restored was as follows:—Extensors of the thumb, extensors of the wrist and fingers, flexors of the thumb, and flexors of the wrist and fingers. Nothing was done for the paralysis for the first two weeks further than what rest and time would accomplish. About the end of the second week I began the use of electricity in the form of the farradic current. Each application occupied 8 or 10 minutes and the current used was of very moderate strength. At first the paralyzed muscles responded sluggishly to the electric current. Subsequently the electricity was supplemented by stimulating liniments, shampooing and massage. This treatment was continued for two months until motion was completely restored in the paralyzed muscles. The progress towards recovery was very slow. About the end of the 3rd week I began passive motion in the joint. This was done with great care and gentleness as the union of the fragments was not yet very firm. Between the 6th and 7th week the union being now firm, active motion was commenced. Henceforward the treatment consisted in active and passive motion, electricity, stimulating liniments, and massage all of which was carried out by the intelligent co-operation of the patient. Patient was discharged well on the 1st of May. The wires have not been removed yet, but should they at any time cause irritation I will remove them. Patient resumed work on the 1st day of June. He can do the same amount of work as he always did without suffering any pain or inconvenience. All the natural movements of the joint are perfectly restored.

REMARKS: There is nothing of importance to record in connection with Case No. 1. What at first threatened to be a serious complication was warded off by the timely application of ice-

bags combined with absolute rest of the joint. Case No. 2 is of interest in consequence of the complication which supervened. Paralysisis a complication which is not often met with as a sequela to a surgical operation. I do not find it mentioned as a probable complication in any of our surgical text-books. I never met with a case of it before in my practice. Its rarity makes it more interesting to a surgeon. The paralysis was doubtless caused by the pressure of the tournequet on the trunks of the ulnar, median and musculo-spiral nerves. With regard to the operation of *wiring* the olecranon a great majority of surgeons are opposed to it. They claim that although there are no very considerable risks in connection with such an operation yet it is not warranted by the necessities of the case. They also say that ligamentous union, the kind of union we generally get in these forms of fractures—is attended with very little impairment to the functions of the joint, and consequently an operation is not indicated. In my two cases there was no attempt at union of any kind and as the surfaces of the fragments were blunted when I advised an operation no union could in future be hoped for without surgical operation. For my own part I would favour an operation in every case of recent fracture of the olecranon in which considerable effusion of fluid has taken place in the joint cavity, provided always that there is entire absence of inflammatory symptoms, and that the patient is young and healthy. The operation is easier performed while the surfaces of the fragments are fresh and hence it is less likely to be followed by complications. I might here add that no man should undertake so delicate and important an operation unless he is a gentle and skilful manipulator and that he is morally certain that he can keep sepsis out of the wound during the operation and its after treatment. On the latter point Sir Joseph Lister says that "no man is justified in performing such an operation unless he can say with clear conscience that he considers himself morally certain of avoiding the entrance of any septic mischief into the wound." On the importance of gentle and skilful manipulation to one who practices the handicraft of surgery I would refer you to an address on surgery delivered by Mr. Lawson Tait, President of Mason College, Birmingham. His subject was *Surgical training, Surgical practice and Surgical results.* Vide British Medical Journal 1890, Vol. 2. p. 267.

In conclusion let me say that the cases above reported are the only cases of *wiring* the olecranon I have had in my practice.

Correspondence.

A VISIT TO AMERICAN HOSPITALS.

I notice in the last number of your valuable journal you venture to promise that you will publish in your next issue some notes of my recent visit to the hospitals of Baltimore, Philadelphia and New York. That you may keep faith with your readers, I must hurriedly try and fill a small part of your space.

In the first place, it may be safely said without fear of contradiction, that American surgery takes rank to-day with that of any country in the world. The prophecy made by a distinguished English surgeon during a recent visit to New York, must soon be fulfilled. He said that as it was considered necessary in order to finish a medical education that the student should visit some or all of the great capitals of Europe, and study the methods and teachings in these centres of medical science, he would have in a very short time to include in this visit one or other of the great schools of medicine in America, to make this plan of study complete.

On this side of the Atlantic we are

untrammelled by old habits and customs, and there is a greater readiness to accept the many radical changes in technique made necessary by modern discovery than in the cities of the Old World. This fact, coupled with the undoubted ability and skill of our leaders in medical and surgical work, makes the operating-room of the American surgeon well worthy a visit by the advanced student. The newness and freshness of the American hospital strikes you as being in strict accord with the great principle which underlies modern surgery,—asepsis.

My first visit, which is always made with great pleasure, was to the gynecological operating room of Dr. Howard Kelly, at the Johns Hopkins Hospital. Here one sees almost daily all the operations on the female pelvic organs, performed with all that perfection of detail that is the chief characteristic of Dr. Kelly's work.

During my visit, he did five abdominal sections, with other smaller operations, including two hysterectomies; an ovariotomy; and two cases of removal of the adnexa; one for a ruptured tubal pregnancy, with internal hemorrhage, a very serious case; the other for a large pyo-salpinx.

All the hysterectomies are now done by the intraperitoneal method; great care being taken to close out the field of operation from the peritoneal cavity. The cervix is divided by a V-shaped incision, the cut surfaces brought together and firmly sutured. Every bleeding point is carefully searched for and the hemorrhage arrested by a fine silk suture; the edges of the divided peritoneum are then brought together across the pelvis and united by a number of sutures, making a smooth roof of serous membrane over the seat of operation. Dr. Kelly uses silk almost exclusively in his abdominal operations. In closing the abdominal wall, he uses three sets of sutures; first the peritoneum is united by a fine silk continuous suture, next the muscles and fascia are brought together with interrupted silk sutures, both being buried, and finally the wound in the skin is closed by a continuous subtcuaneous suture.

The operation for rupture of the sac in a case of extra-uterine foetation was one of great interest. The patient was in bad condition having had symptoms of internal hemorrhage just previous to the operation. A small opening was first made in the abdominal wall from which a dark bloody fluid escaped in considerable quantity, the opening was quickly enlarged and many clots now came to the surface; with his hand the operator now hastily scooped out the blood and it seemed but the work of a moment to find the sac and at once to seize the tissues between the uterus and sac with an artery clamp, the ovarian artery was thereby compressed, and the danger of further hemorrhage was over. He now proceeded with greater deliberation to clamp and tie off the whole mass. The case illustrated admirably the immense advantage of the artery clamp. By means of this instrument we can, without any delay, temporarily arrest bleeding from any point within reach, and in that way save the patient from one of the greatest dangers of an operation—hemorrhage, while the operator gets a few precious moments to think of the next step in an operation. It is a most valuable little instrument, and a dozen of them is always better than a half-dozen at an operation.

While at Baltimore, I had also the good fortune to witness Dr. Halsted, the chief surgeon of the Johns Hopkins, perform his operation for the removal of cancer of the breast. It is a most radical operation, and is a great lesson on the importance of removal of apparently healthy tissue for a very considerable distance beyond the seat of the growth.

My own experience has often led me

to believe that the profession have been very slow to recognize the fact that the spores of the cancer organism quickly invade the tissues surrounding the growth without making any change in its apparently healthy look, and that operations for cancerous tumors will remain almost as hopeless as the disease, until we learn that an operation for malignant disease must be done early, and that we must cut wide and deep beyond the disease if we wish to offer any hope of cure. The operation of Dr. Halsted is the true operative surgery of cancer of the breast.

He first removes the gland, taking all the skin covering it, then his incisions were made to expose the whole surface of the pectoralis major muscle, especially up to its point of insertion. The greater part of this large mass of muscle is now removed; next the fascia covering the pectoralis minor is cut away, and that muscle itself is next removed. This completely removes one wall of the axilla, and lays open fully that cavity with its vessels and its mass of loose tissue and glands. He then completes his operation by removing everything from the axilla but the vessels and nerves. One of the marked features of the operation is the thorough removal of the contents of the axilla. Dr. Halsted will, I believe, shortly publish his results and present quite a number of cases that have been operated on over three years without any return of the disease.

One of the novelties of Gynecology, catheterization of the ureters, which Dr. Kelly introduced to the profession over a year ago has been very much improved by him. He now uses his cystoscope, and after moderate dilatation of the urethra, the patient is placed in the knee chest position, and with this instrument the wall of the bladder is inspected and the ureteral orifices plainly seen. By this means the use of the ureteral catheter is made comparatively easy. Dr. Kelly was kind enough to give me an exhibition of the use of these instruments in his private hospital.

It will certainly prove a most valuable addition to our means of investigating diseases of the bladder and kidneys in the female.

In the operation on the case of pyosalpinx a very striking illustration of the practical application of bacteriology to surgical practice was presented. The case was one of an abscess of considerable size, and in the endeavor to work around it to remove it the sac was ruptured and the pus poured into the peritoneal cavity. The field of the operation was, however, well walled off from the upper part of the peritoneal cavity and the infection was limited. Very careful washing, of course, followed the removal of the sac. Just after the sac ruptured the operator directed one of the assistants to take a drop of the pus to the bacteriological labratory to have it examined as to the variety of infectious germ it contained. In about ten minutes he returned and reported that it contained gonococcus; this was a cheerful report; as that micro-organism is not strongly septic in the peritoneal cavity, or as the operator expressed it "the peritoneum can take care of any number of these germs, the patient will likely do well."

I also saw some very interesting surgery with Dr. Keen of Philadelphia, and in New York at the German and Mt. Sinai hospitals. With Dr. Gibney at the hospital for ruptured and crippled the surgery of joints can be thoroughly studied.

It is worthy of note that the operation for the radical cure of hernia is growing in favor with the profession and with certain restrictions as to age is now performed very often with excellent hope of complete and solid closure of the hernial opening. The operation of Halsted or Brassini is looked upon with most favor.

I have already made this letter longer than I intended, and I will close by relating an incident which indicates that it is to the great west we must look if we wish to study progressive surgery. A western surgeon who was among the visitors at the John Hopkins informed us that in Chicago when a surgeon performs the operation of castration he substitutes for the organ removed a celluloid testicle, which he said made things look ship-shape, the patient being happy in the possession of it and rejoicing in his well-balanced condition.

I cannot close without extending my warmest thanks to our distinguished fellow-countryman, Dr. Osler, the physician in chief of the Johns Hopkins Hospital. He is most kind to Canadian visitors, and I am indebted to him for many social and professional courtesies.

E. FARRELL, M. D.

EDINBURGH, May 14, 1894.

MY DEAR C.:

Have you heard of Bier's method of treating tubercular disease of joints by an artificial congestion? There are some cases being treated in the Infirmary here at present according to this method, and it appears to be remarkably beneficial. Dr. Auguste Bier, of Kiel, the author of this system, is a young German surgeon, assistant to Professor Esmarch, and has just been in Edinburgh, on his first visit to Britain, so we have had the benefit of his personal explanation of the method. If you ask him for his theory, he says he has none. It was a consideration of the curious but well known fact that tubercular affections are almost unknown in cases of heart disease accompanied by passive congestion, which suggested to him his ingenious plan. Suppose the affected joint is the elbow. A bandage is applied from the fingers upward to just below the elbow. Then at a short distance above the elbow a constricting band is applied pretty firmly. As you will see, the result is a passive congestion and oedema about the joint. Experience and study of the individual case can alone determine how long the constricting band can be kept on at a time, but it can generally be kept on all day, and removed at night, and as time goes on, may be kept on continuously. It takes from three to four months as a rule to get the first indications of improvement, and the treatment must be carried out patiently for many months before a cure is obtained.

Where abscesses are present, they are aspirated and injected with iodoform emulsion before the bandaging is done. This treatment may be applied to various structures other than joints, and has been tried in lupus, by using cupping-glasses over the lupus-patch, but apparently this has not been very successful. It has, however, been applied with complete success in the case of a tubercular abscess of the tongue.

I saw a few days ago a very remarkable instance of conservative surgery. A railway guard was brought to the Infirmary who had been run over by a freight train and sustained a compound comminuted fracture of the right humerus just below the shoulder. There were two large wounds, the skin was separated from the subjacent tissues widely over scapula and pectorals and shoulders, being only attached in a narrow bridge on the inner side of the arm, and being much excoriated and bruised over the scapula. The axilla was distended with a huge blood clot. The humerus was comminuted and the muscles pulped. But the patient's strength was good, and when Mr. Caird examined the limb he found that the nerves had escaped destruction, for sensation was normal in the hand, the radial pulse was all right, and the venous circulation was fairly good.

It was therefore decided to make an attempt to save the limb, and it was carefully cleansed and an antiseptic dressing applied, with splints, and an extensive apparatus to keep the bones in position.

The patient is getting on very well, the temperature being seldom over 100°, and generally normal. The car which passed over his arm was loaded with eight tons of bricks, and the total weight of the car is estimated at twelve or thirteen tons.

In the "alcoholic" ward there are some interesting cases of neuritis: at present there are no less than half a dozen. The peculiar hyperæsthesia is very well marked. Swathing in cotton wool and bandaging is found to give great relief, and for the paralytic condition, as well as the pain, massage is employed, a professional masseur (Swedish) visiting the ward daily. In one of the cases there is well marked drop-wrist.

One of the most interesting things I have seen here is the private laboratory of Dr. Milne Murray, who is well known as one of the most skilful electricians in the country. He constructs a great deal of his own apparatus, and two or three larger rooms at his private hospital are entirely filled with electrical instruments. Dr. Milne Murray spends most of his afternoons at work in these rooms, experimenting and devising new apparatus. The delicacy of some of these instruments is wonderful. For instance, a rise of temperature, amounting to no more than $\frac{1}{1000000}$, or nearly one-millionth, of a degree Fahrenheit has been registered by Dr. Murray. His experiments are almost in the domain of physiological electricity, and some of his demonstrations are very surprising and beautiful. It will interest you to know that he is a firm believer in Apostoli's treatment of uterine fibroids. He attributes the incredulity of those who deny its efficacy to their ignorance of electrical methods and to faults in detail. It is certain that very few men have the skill and special knowledge of Dr. Milne Murray. He does not look for diminution in the size of the tumour, but almost invariably controls the hæmorrhage, usually a notable diminution in this respect taking place after ten or fifteen applications, or from five to six weeks. Treatment must, however, be carried out much longer to effect a cure. In some cases there is also decrease in the size of the tumour. He showed us one such case; a woman aged about 34 had a uterine fibroid as large as a six-months pregnancy and severe hæmorrhages. Treatment had been employed twice a week for ten weeks before the hæmorrhage was much relieved. Now instead of being "unwell" profusely for seven days at a time, the period is only two days, and the tumour is so much reduced that it can just be felt, about the size of a lemon above the pubis. This would not have been a good case for oophorectomy, as one of the ovaries was adherent, and still is, at the *back* of the uterus.

Let me wind up with a little "yarn." Once upon a time an old friend of mine now of large reputation as a gynecologist, was sent for to assist another doctor in a tedious case of labor, and after due examination and consideration, performed the delicate and skilful operation of turning. It turned out, however, that the infant which had given so much trouble was inanimate. My gynecological friend, who was in great need of suitable material for frozen sections, or some such scientific investigation, preferred his claims for the body with such persuasive sweetness of manner, and so skillful a representation of the economy in funeral expenses, which would result from its being handed over to him, that he became the proud possessor of a subject, which was forthwith draped in a copy of the "Times," and the doctors drove off in triumph in their cab.

Presently, as they drove merrily along, satisfied with the work of their hands and the results of their scientific operation, they were startled by the mew of a cat, which had apparently concealed itself under the seat. The dismal mew was repeated, and at the same time a rustling of paper revealed to the horrified ears of my scientific friends the true source of these wails. What a moment for these worthies! What was to be done? Said the family doctor: "It is certainly your place as the consultant, to restore this child to its parents." A flush of distress and perplexity mantled the shakesperian forehead of my friend of the frozen sections, but only for a moment, and he replied with that placid and winsome smile of his, "Not at all; I have turned. You will now *re*-turn."

S.

Book Reviews.

The American Text Book of the Theory and Practice of Medicine, by Wm. Pepper. Published by W. B. Saunders, Phila.

The second volume of this work has been received. The favorable criticism which has already been accorded Vol. I. can be applied to this book as well. It opens with an interesting article on the "Biology of bacteria, infection and immunity," in which prophylactic and curative inoculations are discussed. The articles on the whole are excellent and contain much valuable information, which is presented in an attractive manner. There is a very good and complete account of diseases of the pancreas, and the article on Intestinal Parasites is full and well illustrated. Altogether this work will be found a very serviceable addition to the libraries of medical men.

The Maryland *Medical Journal*, one of our most valued exchanges, has donned a new dress, with a change in the business management. It is the only weekly journal in the Southern States. and is published in Baltimore, a city which is rapidly coming to the front as an educational centre. It is the determination to improve the *Journal* in every respect, and in this effort we wish them every success.

A Retrospect of Surgery: January, 1890—January, 1894. Prepared by Francis J. Shepherd, M. D., C. M., Surgeon to the Montreal General Hospital; Professor of Anatomy and Lecturer on Operative Surgery, McGill University.

This volume is reprinted from the Montreal *Medical Journal*. It consists of abstracts of important contributions to surgical literature, interlarded with criticism, suggestions and hints by the writer, who is well versed in everything relating to surgery. To anyone who wishes to obtain a condensed and reliable account of the advance made in surgery from 1890 to 1894 no better work can be recommended.

Essentials of Nervous Diseases and Insanity, by John C. Shaw, M. D. Saunders Question Compends. W. B. Saunders, Philadelphia, 1894.

This compend is one of the best of the series, and many useful additions have been made in the second edition. In the small space of 190 pages Dr. J. C. Shaw has sought to simplify and condense the essential facts in connection with diseases of the nervous system and insanity. He has been able to produce a work not only of value to advanced students but to young practitioners as well. The illustrations are numerous and well executed, and the work of the publisher is good.

Louisville, Kentucky, and Rochester, New York, are two cities in each of which a new medical journal has appeared in March of this year. From a literary and scientific point of view both promise well. Financially they are bound to succeed, for, judging from the first issue, all is grist that comes to their advertising mill.

Maritime Medical News.

JUNE, 1894.

EDITORS.

D. A. CAMPBELL, M.D.....Halifax, N.S.
A. W. DANIEL, M.D., M.R.C.S..... St. John, N.B.
MURRAY MACLAREN, M.D., M.R.C.S.. St. John, N.B.
JAMES MACLEOD, M.D.....Charlottetown, P.E.I.
JOHN STEWART, M.B.....Pictou, N.S.
G. M. CAMPBELL, M.D.....Halifax, N.S.

Communications on matters of general and local professional interest will be gladly received from our friends everywhere.

Manuscript for publication should be legibly written in ink on one side only of white paper.

All manuscript, and literary and business correspondence to be addressed to

DR. G. M. CAMPBELL,
9 Prince Street, Halifax.

We have to thank many of our subscribers for a prompt remittance. There are still some to hear from.

FOUR fatal cases of diphtheria have recently occurred in Charlottetown and one in the country near by. P. E. Island has enjoyed a singular immunity from this disease for many years. Since mortuary statistics were began in 1881, and indeed for several years previous to that date, not a single case of death from diphtheria had been reported in Charlottetown. An epidemic broke out in one section of the country about two years ago, but by the prompt action of a local board of health it was confined to two school districts and in a short time stamped out. Of the fatal cases recently occurring none came under proper treatment or the cognizance of the local board of health for at least one week after the disease had declared itself. They also all occurred in one section of the city, with bad hygienic surroundings, in houses with wet cellars and where all the other concomitants of this filth-disease abounded. The other cases, where well authenticated as diphtheria, can be less distinctly traced to their source, but are most likely due to contagion from this nidus of the disease. There is now, happily, little fear of an epidemic. Dr. H. D. Johnson, who is acting as health officer during the illness of Dr. R. Johnson, aided by an energetic board of health, is taking every precaution against such a contingency. He is doing good service in bringing to the notice of the board the futility if not also the fatuity of burning sulphur in the upper rooms of houses while their damp and filthy cellars are overlooked. More power to his elbow!

WE will not in this issue refer to the treatment of diphtheria further than to say that in the cases coming under our observation recently where the larynx became involved we found much benefit from the fumigation, under a tent, of calomel 10 to 15 grs. every two hours, or more frequently if the symptoms were urgent. Under this treatment the laryngeal symptoms improved simultaneously with the coughing up of soft grayish masses now and then streaked with blood. We believe this treatment will often obviate recourse to tracheotomy or intubation. We would like also to draw the attention of our readers to recent recommendations to add tr. nuc. vom. 3 to 8 drops, according to the age of the patient, in the 24 hrs. to the general systemic treatment. If strychnine injected in the neighborhood of paralysed muscles, notably those of respiration, is found a valuable agent this drug ought to be indicated as a preventive of such a dangerous complication.

It not infrequently happens that the physician is baffled on the appearance of patches on the tonsils as to a diagnosis between follicular tonsillitis and true diphtheria. As the decisive practical distinction between diphtheria and pseudo-diphtheritic angina, in their earlier stages, is the presence or absence of the specific Klebs Loeffler bacillus, a bacteriological examination alone furnishes the most certain and rapid means of making an exact diagnosis of diphtheria. But laboratory experiments are beyond the reach of practitioners in our small towns and villages. A simple method of recognizing this specific bacillus would be a desideratum much to be desired. The nearest to such a consummation that we know of is that of Dr. Wyatt Johnston. It is based on the fact that the bacilli are distinguished by their rapid growth on albuminous substances; that within eighteen to twenty-four hours after being sown they became quite distinct, while putrefaction bacteria do not attain any material dimensions in that time. It is as follows: "Hard-boiled eggs are tapped and shelled with forceps, so as to leave a smooth, glistening, moist surface. With a platinum wire, or an ordinary needle, or a bit of silver suture held in an artery forceps, the diphtheritic membrane is touched and the instrument drawn lightly three or six times across the exposed white of the egg. To guard against contamination the egg is turned upside down in a common egg cup previously sterilized by allowing a flame to enter it for a second or two. The careful aseptic precautions so generally needed in bacteriology are not needed in studying the diphtheria bacillus, because its growth is so rapid as to outstrip contaminating organisms. The appearance of the colonies grown in this way is exactly the same as when grown on blood serum. If the specimen is to be conveyed some distance or shipped to a laboratory the egg and cup can be wrapped in paper for shipment and the box in which it is packed can be kept warm for a time by packing in it a bottle of hot water."

The meeting of the Canadian Medical Association, which is to be held in St. John this year, opens on the 22nd of August. The month of August rather than September has been chosen as it was thought it would be more convenient for the members. We hope there will be a large representation of members from the Maritime Provinces. They will have the advantage of attending at the same time the meetings of the Maritime Medical Association and New Brunswick Medical Society. It is also to be hoped that a number of papers will be prepared by our men. The local committee has on hand the making of arrangements for the meetings, which arrangements will be announced as soon as completed.

The grave injustice sought to be done Dr. Bliss of Amherst, at the inquest lately held in this city, cannot be passed without notice. The injustice is more conspicuous, as the doctor seemingly has no legal remedy against the coronor's verdict. In our opinion, the evidence did not in any way justify the verdict given. We are sure Dr. Bliss has the sympathy not only of the profession, but also of the intelligent public, in this affair.

We are obliged to hold over a communication from Dr. C. D. Murray, this issue.

The following papers have been promised for the meeting of the Nova Scotia Medical Society at Yarmouth:

Dr. W. S. Muir, *Truro*—(1) Notes on a Case of Extra-Uterine Pregnancy; (2) Notes on a Case of Intestinal Obstruction.

Dr. H. H. McKay, *New Glasgow*—(1) "Iodide of Potassium as a means of

early diagnosis in Phthisis ;" (2) Notes on a case of "Puerperal Eclampsia."

DR. C. A. WEBSTER, *Yarmouth*—"Epidemic Diseases occurring in Yarmouth County."

DR. T. C. LOCKWOOD, *Lockeport*—"Alcohol as a Remedial Agent."

DR. W. E. JENKINS, *West Dublin*—"Tussis Hysterica."

DR. C. A. FOSTER, *Bridgewater*—"Tubercular Meningitis."

DR. A. P. REID, *Halifax*—"Water Supply of Towns."

DR. CARLETON JONES, *Halifax*—"The Problem of Infantile Feeding."

DR. D. N. MORRISON, *Oxford.*—"Antipyrine and its Rivals."

DR. A. HALLIDAY, *Lower Stewiacke*—"Epilepsy."

DR. D. G. TURNBULL, *Musquodoboit*—"Some Facts and Fancies concerning Influenza."

DR. D. A. CAMPBELL, *Halifax*—"Treatment of Empyema."

PERSONALS.

DR. HAMILTON, a recent graduate of Dalhousie College, has opened an office at 219 Brunswick Street.

DR. ARBUCKLE, of the Victoria General Hospital, has opened an office at Annapolis.

DR. ANGWIN has removed her office to 32 Grafton Street.

DRS. BLACK and SINCLAIR are away, visiting American hospitals.

Books and Pamphlets Received.

The Relation of the Patellar-Tendon Reflex to some of the ocular reflexes found in General Paralysis of the Insane.

A Series of Wools for the Ready Detection of "Color Blindness."

Clinical History of a Case of Spindle-celled Sarcoma of the Choroid, with a study of the microscopic condition of the growth.

By Charles A. Oliver, M. D., Phila. (Reprints from Proceedings American Ophthalmological Society, 1893.)

Retrospect of Surgery: January, 1890—January, 1891. By Francis J. Shepherd, M. D., C. M., Montreal.

Essentials of Nervous Diseases and Insanity: Their Symptoms and Treatment. By John C. Shaw, M. D. 2nd edition revised. Published by W. B. Saunders, Phila.

Selections.

THE MEDICAL RAVEN.

Once upon a midnight dreary,
The doctor slumbered weak and weary
And all the town could
Hear him snore.
While he lay there sweetly napping,
Suddenly there came a tapping
Like a ramgoat madly rapping
His hard head
Upon the door.
"Get thee up," a voice said loudly,
"Come in haste," it added proudly,
Like a man who owned a million
Or much more.
But the doctor never heeded;
Back to dreamland fast he speeded,
For such men as that he needed
In his practice
Nevermore.
For long months that man had owed him,
Not a cent he'd ever paid him,
And the doctor now will dose him
Nevermore.

—*Atlanta Medical and Surgical Jour.*

COMMON MISTAKES OF DOCTORS.

To promise a patient that you will cure him.

To promise to call at an exact specified time.

To promise that the malady will not return.

To promise that you can render more efficient service than your fellow-practitioner.

To promise that your pills are not bitter or the knife will not hurt.

To promise that the chill or fever will not rise so high to-morrow.

To allow your patient to dictate methods of treatment or remedies.

To allow yourself to be agitated by the criticisms or praises of the patient's friends.

To allow yourself to buoy up the patient when the case is hopeless.

To allow yourself to make a display of your instruments.

To allow yourself to experiment or exhibit your skill uncalled for.

To allow yourself by look or action in a consultation to show that you are displeased, and that if you had been called first matters would have been different.

To allow yourself to indulge in intoxicating beverages.

To allow yourself to rely wholly upon the subjective symptoms for your diagnosis.—*Ohio Medical Journal.*

THE PLACENTA IN UTERINE AND TUBAL ABORTION.—Pilliet (*Progres Medical*, April 7th, 1891) has studied two distinct cases of tubal abortion and compared them with many other reported instances of this condition. The chief characteristic of tubal abortion is its incompleteness. After the destruction or expulsion of the fœtus portions of placenta remain attached to the tube and continue to develop. The same occurs in many cases of early uterine abortion, hence placental polypi or tumours—"placentoma" or "deciduoma"—develop. Dropsical hydatidiform chorionic villi, representing an abortion several years past, have been removed from the uterus with the curette. But the parasitic remains of the placenta are far more commonly seen, if not constant, after tubal abortion. In tubal gestation ending in abortion small hæmorhages set in, then a free show, corresponding to the expulsion of part of the ovum. Slight oozing follows, then the tube fills gradually, and at last another considerable loss of blood occurs. The presence of a piece of placental tissue explains this phenomenon. When, therefore, after a loss of blood resembling in clinical history an abortion, a tube remains enlarged and tender, and, when uterine hæmorrhages continue, without complete return of the tube to its normal proportions, tubal gestation, and incomplete abortion may be diagnosed. Hence an operation is indicated to anticipate the risks of intraperitoneal rupture. The persistence of portions of placenta after abortion appears easy to explain. At term the blood sinuses of the uterine tissue have widened and coalesced so as to form a single layer of blood between the maternal and the fœtal structures. Hence complete detachment of the placenta is easily effected. In abortion the above-named condition has not developed, detachment becoming more difficult. In tubal abortion the placenta becomes closely united to the tubal wall, which cannot undergo the complicated changes that occur in the uterine tissue in normal pregnancy.

EXAMINATION OF SPUTUM.—Zenoni (*Centralbl. f. inn. Med*, March 24th, 1894,) first recalls how mucus has been shown to stain with anilin dyes, and how this fact has been used to distinguish the sputum of pneumonia from that of bronchitis, as, for example, with Biondi's three-colour stain. The author, however, prefers saffranin. Bizzozero showed how the mucin in cells stains yellow or brownish yellow with saffranin, whereas the nucleus and rest of the cells stain red. The author spreads a thin layer of sputum on a cover glass, and allows it to remain under alcohol for a quarter of an hour or longer to coagulate. A half concentrated watery solution of pure saffranin is then applied. If examined against a white ground the bronchitic sputum appears yellow, whereas the pneumonic sputum looks red, the difference being due to the albuminoïdal nature of the latter sputum. If these two kinds of sputum are mixed distinct traces of

yellow are visible. The method is useful for distinguishing between them.—*Ex.*

RELAPSES IN TYPHOID FEVER.—From a careful study of fifty consecutive cases of typhoid fever with relapse, obtained from the records of Guy's Hospital and from other data, Stewart (*Practitioner*, No. 309, p. 184) arrives at the conclusion that so-called relapses are genuine second attacks, presenting all the phenomena of the first attack and due to reinforcement of the large intestine from the small. This reinfection is believed to generally take place at a definite period in the original attack and is probably effected by the passage of sloughs over healthy lymphoid follicles. Constipation was found to be an important predisposing cause of relapses. The opinion is expressed that the prognosis of relapses is good because a certain degree of immunity has been acquired by reason of the first primary attack, and fatal complications are less common.—*Med. News.*

THREE KINDS OF HEAD PAINS.—Dr. Dana, New York (in *The Post-Graduate* for April), calls attention to the three following varieties of head pains: (1) Migraine, which is constitutional; (2), headaches of a diffuse kind and are due to overwork, eye-strain, etc., and (3) neuralgia. Migraine patents suffer most in damp weather and in the spring. Neuralgias of the head are of two forms (*a*) supra-orbital, infraorbital and dental forms, and (*b*) Tic douloureux. The first group of neuralgias is usually due to decayed teeth, or cold. The second form is rare, comes later in life, and oftener in men than women. It is extremely obstinate, and may last for many years. Tic douloureux is frequently associated with obliterating arteritis. This gives rise to nerve anæmia and degeneration. Nitroglycerine and aconite sometimes relieves, by acting upon the arteries, lessening their tension. Hypodermic injections of strychnine is often helpful.—*Dom. Med. Monthly.*

GUAIACOL.—In a recent discussion before a society of one of our larger American cities, some twenty experiments with guaiacol in phthisis, pneumonia, tertian ague, typhoid fever, rheumatic fever, and influenza were reported. The dose was about thirty drops rubbed upon the skin. In every case the temperature had come down from 104° F., or thereabouts, to the neighborhood of 100° within a few hours after the application, and remained down for several hours. In every case, as nearly as the writer can remember the report, there was profuse sweating as the temperature descended. The trouble with the method, however, was that most, if not all, the patients suffered from severe depression of the bodily powers during the fall of temperature, in many cases extremely disquieting to the sufferer. During the discussion of the report, other experiences from private practice were related in which the prostration following similar use of the drug had been extremely alarming.—*N. Y. Medical Journal.*

CALOMEL IN ACUTE BRONCHITIS OF CHILDREN.—Dr. De Holstein (*La Semaine Medicale* No. 2, 1894) recommends calomel in the treatment of acute bronchitis of children. In four out of five cases of very grave bronchitis, with high fever, rales, frequent respiration and severe cough, it exerted an actually abortive influence. In the fifth case, the improvement was manifest the next day, after an aggravation in the evening. It is prescribed in the following form:

Calomel (gr. ¼).....cgms. 4
Sugar (℥jss).....gms. 40

Divide into four powders. One every two to three hours in a tablespoonful of milk.

The dose may be increased in children over four years.—*Lancet-Clinic.*

SPECIFIC DIRECTIONS FOR USING WATER IN NERVOUS DISEASES.—Dr. F. Peterson (*American Journal of the Medical Science*) says:

Anæsthesia (cutaneous.—Short cold jet and fan douches of strong pressure to the anæsthetic areas. Temperature, 50° to 70°. Duration. one minute. Daily.

Angio-paralytic hyperidrosis of the feet.—Prolonged cold foot-bath with chafing, or fan douche of cold water to the feet. Temperature, 60°. Duration, twenty minutes for bath, five minutes for douche.

Chorea.—Cold plunge beginning at 90°, daily reducing until 70° is reached. If anæmic, spinal spray, jet or fan douches, at first warm until patient becomes accustomed to them, then gradually reduced to 60° or 50° (Duval).

Epilepsy.—Cold shower baths and cold sponge baths daily are beneficial. The shower baths should be rain-like in character—that is, not too forcible. In many cases a morning and evening bath (the "half bath") proves very serviceable. The "half-bath" is taken in a bath-tub only half filled with water, and when taken should be accompanied by energetic rubbing of the patients by an attendant. This bath lasts five minutes, and the temperature should not be under 50° and not over 70° F. Where there is evidence of hyperæmia and increased blood-pressure in the head, the cold cap is useful.

While these are the general indications for hydrotherapy, certain measures are often of use at the time of seizures. During a fit or during a *status epilepticus* it will be observed that there is one of two vascular conditions present: either the face is pale and there are signs of brain anæmia, and in this case warm wet compresses should be applied to the head and genitals, accompanied by friction of the trunk upward, the body being placed with head low and arms uplifted; or there is turgescence of vessels in the head, the face is red, the carotids beat strongly, and under such conditions a contrary procedure is indicated—cold compresses to the head, neck and genitals, strong wet beating of the feet, with a high position of the head. Daily applications for thirty seconds.

Headaches, neuralgias, and migraines.—If anæmic, heating cephalic compresses (wring out thin linen bandages in very cold water; wrap head in capelline manner, and cover with one or two layers of dry linen or flannel). Apply at bed-time. Upon removal, envelop head in dry cloth and rub it dry. If hyperæmic, leg bandages (a piece of toweling a yard long is dipped in cold water at one end—one third—thoroughly wrung out, and wrapped closely about each leg, so that the wet surface is next the skin and the dry portion envelops the wet two or three times; or wet stocking may be put on and covered with dry towels). These are applied at bed-time and retained through the night. In many headaches, especially of a congestive character, a prolonged cold foot-bath (twenty minutes, 60°) or the fan douche to the feet (five minutes 60°) is very palliative.

Hysteria.—For erethetic type: Wet pack, 60° to 70°, for one hour or more, followed by massage (Putnam Jacobi); or the rain-bath at 75° to 65° for thirty-five seconds daily at twenty pounds pressure (Baruch). For depressed type: Cold affusions while standing in warm water or hot-air bath, followed by rain-bath for thirty seconds at 85°, daily reducing until 60° is reached, this to be followed by spray douche for five seconds at 65°, or jet douche for three seconds at 65° to 55°. Reduce douche gradually to 50° or less, increasing pressure from two pounds to thirty (Baruch).

Hyperæsthesia (cutaneous) Long-continued cold douches to affected area. Daily twenty minutes at 70° to 80°.—*Ex.*

Treatment of Cholera.

Dr. Chas. Gatchell, of Chicago, in his "*Treatment of Cholera,*" says: "As it is known that the cholera microbe does not flourish in acid solutions, it would be well to slightly acidulate the drinking water. This may be done by adding to each glass of water half a teaspoonful of **Horsford's Acid Phosphate.** This will not only render the water of an acid reaction, but also render boiled water more agreeable to the taste. It may be sweetened if desired. The **Acid Phosphate,** taken as recommended, will also tend to invigorate the system and correct debility, thus giving increased power of resistance to disease. It is the acid of the system, a product of the gastric functions, and hence, will not create that disturbance liable to follow the use of mineral acids.

Send for descriptive circular. Physicians who wish to test it will be furnished, upon application, with a sample, by mail, or a full size bottle without expense, except express charges. Prepared under the direction of Prof. E. N. Horsford, by the

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New York Post-Graduate Medical School and Hospital.

TWELFTH YEAR—SESSIONS OF 1893-94.

The POST GRADUATE MEDICAL SCHOOL AND HOSPITAL is continuing its existence under more favorable conditions than ever before. Its classes have been larger than in any institution of its kind, and the Faculty has been enlarged in various directions. Instructors have been added in different departments, so that the size of the classes does not interfere with the personal examination of cases. The institution is in fact, a system of organized private instruction, a system which is now thoroughly appreciated by the profession of this country, as is shown by the fact that all the States, Territories, the neighbouring Dominion and the West India Islands are represented in the list of matriculates.

In calling the attention of the profession to the institution, the Faculty beg to say that there are more major operations performed in the Hospital connected with the school than in any other institution of the kind in this country. Not a day passes but that an important operation in surgery and gynecology and ophthalmology is witnessed by the members of the class. In addition to the clinics at the school published on the schedule, matriculates in surgery and gynecology, can witness two or three operations every day in these branches in our own Hospital. An out-door midwifery department has been established, which will afford ample opportunity to those desiring special instruction in bedside obstetrics.

Every important Hospital and Dispensary in the city is open to the matriculates, through the Instructors and Professors of our schools who are attached to these Institutions.

FACULTY.

Diseases of the Eye and Ear.—D. B. St. John Roosa, M. D., LL.D.: President of the Faculty: W. Oliver Moore, M. D., Peter A. Callan, M. D., J. B. Emerson, M. D., Francis Valk, M. D.
Diseases of the Nose and Throat.—Clarence C. Rice, M. D., O. B. Douglas, M. D., Charles H. Knight, M. D.
Venereal and Genito-Urinary Disease.—L. Bolton Bangs, M. D.
Diseases of the Skin and Syphilis.—George T. Elliot, M. D.
Diseases of the Mind and Nervous System.—Professor Charles L. Dana, M. D., Græme M. Hammond, M. D.
Pathology, Physical Diagnosis, Clinical Medicine, Therapeutics, and Medical Chemistry.—Andrew H. Smith, M. D., Wm. H. Porter, M. D., Stephen S. Burt, M. D., George B. Fowler, M. D., Farquhar Ferguson, M. D., Reynolds W. Wilcox, M. D., LL.D.
Surgery.—Lewis S. Pilcher, M. D., Seneca D. Powell, M. D., A. M. Phelps, M. D., Robert Abbe, M. D., Charles B. Kelsey, M. D., J. E. Kelly, F. R. C. S., Daniel Lewis, M. D., Willy Meyer, M. D., B. Farquhar Curtis, M. D.
Diseases of Women.—Professors Bache McEvers Emmet, M. D., Horace T. Hanks, M. D., J. R. Nilsen, M. D., H. J. Boldt, M. D., A. Palmer Dudley, M. D., George M. Edebohls, M. D., Francis Foerster, M. D.
Obstetrics.—C. A. von Ramdohr, M. D., Henry J. Garrigues, M. D.
Diseases of Children.—Henry D. Chapin, M. D., Augustus Caillé, M. D.
Hygiene.—Edward Kershner, M. D., U. S. N.
Pharmacology.—Frederick Bagoe, Ph. B.
Electro-Therapeutics and Diseases of the Mind and Nervous System.—Wm. J. Morton, M. D.

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In 1400 bottles given to medical men, as samples, positive *GOOD RESULTS* can be given from over 200 answers received from those by whom *Malto Peptonized Porter* has been thoroughly tested and used. There has *NOT BEEN ONE SINGLE FAILURE* reported, but all pronounce that it is the most perfect *concentrated liquid food, tonic, and antidyspeptic* preparation ever put before them.

In no single instance has it been rejected by the most delicate stomach.

Where the stomach has been so irritable that no food could be retained, *Malto Peptonized Porter* has acted like a charm, and there has been *no difficulty* thereafter in the stomach *retaining food.*

In the many cases in which *Malto Peptonized Porter* may be indicated are the following

(a) Convalescence from acute diseases—such as typhoid fever.

(b) Atonic Dyspepsia.

(c) In persons of consumptive tendencies. Here it has been found to be a most perfect substitute for Cod Liver Oil—the malt giving the fats producing elements necessary to the supply of the wasted tissues, with the other ingredients furnishing the tonic and stimulating effect required.

(d) In the treatment of cases of Alcoholism. In all cases in which it has been used it has answered admirably in allaying the irritation, vomiting, and consequent desire of stimulants of an unhealthy nature.

(e) In wasting diseases of children.

(f) For administration to nursing mothers.

(g) Where there is sleeplessness from flatulence, over-taxed brain and nervous system.

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THE NEW METHOD FOR THE ADMINISTRATION OF TOXIC MEDICAMENTS.

Diurnules and Diurnal Tablet Triturates.

The principle of this new method of Diurnal Medication consists in dividing the FULL DAILY DOSE into 12 small equal doses, one of which is to be administered every two hours.

It is almost impossible for the practitioner to have at finger's end the ordinary minimum and maximum dose of each alkaloid, glucoside and similar active principles.

"AS AN ILLUSTRATION," SAYS DR. E. TROUETTE, "TAKE THE EXAMPLE OF DIGITALIN

"At the moment of prescribing this substance, one cannot recall exactly the maximum dose in milligrammes which may be given to an adult in 24 hours; one's memory must be very trustworthy to justify the prescription of a dose of 1½ milligrammes; and it is, besides, necessary that chloroformic amorphous digitalin of the Codex be specified, for there are other digitalins—the crystallized digitalin of the Codex, for example, which may not be prescribed without danger in a dose beyond one milligramme. Adding to this the fact that, if the physician specifies nothing, the pharmacist must supply the chloroformic amorphous digitalin of the Codex, what, then, will be the result? Fearing to prescribe a toxic dose, we risk the giving of a quantity inadequate to the purpose in view.

"All physicians are aware that, in order to obtain a rapid and energetic action, it is often necessary to skirt the boundaries of toxicity. A physician cannot possibly, however, have access to his formulary every time he is called upon to prescribe a dangerous medicament; the same hesitation arises at each prescription of a very active substance, unless he confines himself to the use of several drugs comprising his daily routine.

"With this Diurnule method all dangerous medicaments are so divided that, *however toxic*, the maximum dose to be given to an adult in 24 hours shall be exactly divided into 12 doses. For example, the maximum dose of chloroformic amorphous digitalin of the Codex being 1½ milligrammes, the 12 Diurnules together will contain 1½ milligrammes. For crystallized digitalin of the Codex, of which the maximum dose in 24 hours is one milligramme, each Diurnule should contain one-twelfth of one milligramme, in such manner that, if the physician wishes to prescribe the maximum dose to be divided amongst the 24 hours, he will prescribe one Diurnule every 2 hours, or two Diurnules every 4 hours, or three Diurnules every 6 hours, etc. If it be desired at the outset to give the maximum dose, in certain urgent cases which the physician will alone be able to judge, according to the nature of the patient or of the malady, the 12 Diurnules may be prescribed in a single dose.

"There will thus be no inconvenience arising from the voluntary or involuntary substitution of one digitalin for another; the dosage of each being in proportion to its activity, and consisting of one-twelfth the maximum dose, which will always represent the same action.

"The physician will no longer have to exert his memory to recall the maximum dose of such and such a medicament; he will have to remember only the figure 12—the *duodecimal*."

We should be pleased to receive your request for our literature upon this subject and for samples of both DIURNULES and DIURNAL TABLET TRITURATES.

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