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Ty – Carbolic acid – Paris Green – Belladonna

THE

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TORONTO, AUGUST, 1883.

Original Communications.

CASES OF POISONING.*

BY J. C. MITCHELL, M.B.,

It was my fortune to have the responsibility of three cases of poisoning devolve upon me, within a year; and as such are comparatively rare, in the ordinary routine of a country practice, I thought a record of the symptoms actually observed, and the treatment used, might be interesting—if not instructive—to the members of this Association.

Case I.—Mrs. S., a widow lady, æt. 58 years, living three-fourths of a mile from my office, was on the 19th November, 1881 preparing to retire for the night, at 10.30, p.m. She was troubled with rheumatism, and by mistake took a large dessert spoonful of pure carbolic acid, instead of the remedy to which she usually resorted. She at once cried out, "I have taken the wrong medicine for it is burning my throat and my stomach dreadfully." Her daughter immediately discovered the mistake, and gave the alarm, I was speedily summoned to attend and was with the patient fifteen minutes after she had taken the acid. I found her in a partial stupor, talking somewhat deliriously, great muscular relaxation, weak thready pulse, cold clammy skin, pupils of eyes slightly contracted, breathing becoming of a stertorous character. The invasion of the symptoms had been very rapid.

Previous to my arrival, the daughter had given an emetic of mustard without any effect. With some difficulty I aroused her sufficiently to drink four ounces of olive oil (all I had with me), when she recovered consciousness. I then prepared and administered an emetic of sulphate of zinc, which acted quickly and thoroughly; and soon left no doubt in our minds, as to the nature of the poison, as the atmosphere of the room was strongly impregnated with the odor of carbolic acid.

After the emesis had ceased, we gave her demulcent drinks, applied heat to the body, and had the satisfaction of leaving her in a couple of hours in a fair way to recovery. The posterior and central portion of tongue were hardened and corrugated by contact with the acid. The tongue and throat speedily healed; the stomach remained very irritable for a length of time.

Case II.—Mr. V., æt. 49 years, a respectable farmer living five miles from our village indulged frequently in the use of intoxicants. At 9 p.m., Sunday, Septem- 3rd, 1882, when under the influence of liquor he mixed half a tea-cupful of the ordinary commercial Paris-green—aceto-arsenite of copper—with water, and before any of the family were aware of his intention, swallowed the greater portion of the mixture. In an hour after I was with him. He was sensible, suffering very acutely at intervals from severe epigastric and abdom-

*Read at the Ontario Medical Association Meeting, Toronto, June 6th, 1883.

inal pains, extreme pallor of countenance with anxious expression, cold clammy skin, feeble rapid pulse, made scarcely any complaint, in fact did not speak unless addressed. After each attack of pain he vomited freely, then complained of thirst. The vomited matter was bright green and there was considerable sediment of Paris green at the bottom of the vessel.

The emesis began thirty minutes after taking the poison, partly no doubt from the action of an emetic of mustard his wife had induced him to take. Treatment consisted in giving good doses of dialyzed iron, large quantities of milk and eggs, keeping up free emesis until the green hue disappeared altogether. After that he became quite easy, but slightly stupid, pulse firmer, slower and skin warmer. Improvement lasted for more than an hour, when all the symptoms returned with much greater severity. His sufferings now were intense, great tenesmus, no diarrhœa, although bowels moved frequently, constant desire to void urine. He grew worse rapidly, and expired five hours after drinking the fatal potion.

In each of the cases related, the kind of poison taken was known, in the one ~~to be~~ ~~reported~~, the toxic agent had to be decided from the symptoms manifested.

~~Case III.~~—In the ~~small~~ village of S—— resided a Mr. T. and family, consisting of a wife and two daughters.

Mr. T. was a delicate man, æt. 53 years, the elder daughter, æt. 26 years, a very delicate girl, having had several attacks of pneumonia; the younger æt. 19 years was in the enjoyment of very good health.

On the evening of November 13th, 1882, the father and daughters were attending choir practice at a neighbouring church, leaving their mother at home, who, in their absence, busied herself in preparing some herb-tea for all to partake of, as they were suffering from severe colds.

The herbs were supposed to be only those they were constantly in the habit of using, viz., smart-weed and mullein leaves. On returning home at 10 p.m., the father and daughters drank freely of the infusion, the mother only tasting it, as there was scarcely enough for all. The father went immediately to bed, the others remained up for a time. In a few moments all began to complain of dryness and burning sensation in throat and mouth; soon the elder daughter grew dizzy, began laughing and acted like one intoxicated, then became delirious; the father and young girl complained of sickness, nausea, dizziness and strange feelings, and by the time the mother got a neighbour aroused and in the house all were insensible.

I arrived at 11.30 p.m., found Mr. T. lying in bed in a state of coma, breathing very heavily, tongue extremely dry and swollen, unable to swallow, entirely unconscious, no sensation whatever, at intervals a convulsive movement passed over his frame.

The sisters were in an adjoining sitting-room lying on beds hastily spread on the floor by the neighbors. Both were unconscious and swallowed with great difficulty anything given them. They retained some sensation. They had severe convulsions at intervals. In all three cases the countenances were of a dusky hue; the pupils of the eyes were dilated to the full; scarcely any of the iris could be distinguished, also strong external strabismus. From the marked mydriasis, together with the other symptoms present, it was evident the poison was one of the solanaceæ, and I was fully convinced that it was either belladonna or its alkaloid, an opinion, I think, pretty fully corroborated by the facts afterwards ascertained.

The stupor exhibited by all the patients was most profound, in fact the whole nervous system was prostrated and paralyzed. Sharp emetics were given to the girls, but the elder one did not vomit as freely as her sister. I gave all the patients three $\frac{1}{2}$ gr. doses of morphia subcutaneously, at intervals of an hour, and after the first injection the convulsions ceased, and after the third the

effect on the pupil of the eye of the younger girl was quite perceptible. I also gave hypodermic injections of brandy.

A message had been dispatched for Dr. McLaughlin, of Bowmanville. On the Dr.'s arrival we used the stomach pump with all three, and after removing the contents of the stomach we pumped in a strong infusion of green tea.

In spite of all our efforts the elder sister grew gradually worse, the pulse became small, thready, and at 4 a.m. rose to 160. The younger girl had shown better symptoms all through, although at one time her pulse rose to 145, and the prognosis was very doubtful. At 5.30 a.m. when we attempted to pump in some warm milk and an infusion of tea, she struggled a good deal and finally roused up sufficiently to look around, we had her removed at once to her bedroom, and gave her a good potion of castor oil. The other poor girl died at 6 a.m., having never rallied in the slightest from the time she first became unconscious. Continued giving the father strong tea, warm milk, brandy and aromatic spirits of ammonia, by means of stomach pump. It was necessary to hold his tongue protruded from his mouth all the time to enable him to breathe at all easily. His pulse varied from 130 to 170. At noon he rallied a little, opened his eyes, looked around and resisted slightly when we were using the pump. The drug, however, had done its work with an enfeebled constitution. In the afternoon he sank gradually and died at 4 p.m., eighteen hours after partaking of his herb tea.

The remaining daughter slowly recovered, but was very ill for three weeks. The tongue, throat and fauces were swollen to such an extent that but little could be swallowed for a day or so. There was complete aphonia for a time; harsh, dry cough, with considerable bronchial irritation. Quite a scarlatinal rash over a greater portion of the skin, which lasted two or three days. For two weeks the temperature of the body ranged from 101° to 103° Fahr., and the pulse from 110 to 125.

Treated symptoms as they arose, and the patient finally made a good recovery.

I may state here that Dr. McLaughlin fully concurred in my opinion as to the character of the poison. In examining the remaining herbs not used for the infusion we could find no trace of any poisonous plant, and that from which they drank the tea had been boiled too much to distinguish the various herbs. There was a peculiar narcotic odor very perceptible from the boiled herbs, the contents of the stomach, and also from the urine—withdrawn by catheter—very similar to the odor of the tincture of belladonna, with which we compared it.

Mrs. T. stated that the herbs had been gathered by the deceased husband. That he did this work in a very careless manner, just plucking them in handfuls as they happened to come. She also informed me that a large weed grew in the garden bearing a round berry of a purplish hue when ripe. I found, on inquiry, that large quantities of this weed grew in the neighbourhood, and from its description have no doubt that it is the atropa belladonna, or deadly nightshade. That the plant must be very rich in its active principle atropia is evidenced by this case, as it is not likely that more than one stalk and its leaves were in the infusion, as any larger quantity would have been observed in the small amount used.

In the fatal cases putrefaction commenced very soon after death, and the bodies were covered with livid spots. There was also a bloody discharge from nose and mouth. The smell was very peculiar and offensive. The bodies were interred the day after death, and the features were so much discolored that the caskets were kept closed at the funeral.

Very much has been written as to the antagonism of belladonna and opium, since Prosper Alpin, in 1570, first observed the

action of the latter drug was greatly enfeebled when given in combination. Dr. Anderson read a paper in Edinburgh, in 1854, showing that these drugs were antagonistic in their action upon the system. Trousseau, in his "Treatise on Therapeutics," also makes this a strong point. He says:

"Angelo Poma, Cazin, Benjamin Bell, Béhier, Lee, McNamara, Seaton, Erlenmeyer, Onsum, Bathurst Woodman and Foumüller, all give cases of belladonna poisoning cured by opium.

"In these cases it is remarkable that persons poisoned by belladonna have been able to take enormous doses of opium without showing the symptoms of intoxication from opium."

According to M. Béhier the quantity of opium required to combat the intoxication of belladonna ought to be greater than that of the belladonna taken.

In the case of the girl that recovered, although I gave her 1½ grs. of morphia hypodermically in two hours, she regained consciousness in four or five hours after, and exhibited none of the usual symptoms expected from large doses of that drug.

THE CIRCULATION IN THE CORONARY ARTERIES.

BY J. FERGUSON, B.A., M.D., L.R.C.P.,
Assistant Demonstrator of Anatomy, Toronto School of Medicine.

It is not my intention to go into a detailed discussion on the history of scientific opinion regarding the way in which the blood is impelled through the coronary arteries. I may mention that the view generally adopted is that the coronary arteries are filled from the aorta, by the recoil of this vessel after the ventricle has contracted and driven its contents into it. The main reason advanced in support of this view was, that when the left ventricle contracts and the blood is driven into the aorta, the semilunar valves are pressed back so closely to the walls of the aorta, that the entrance to the coronary arteries is completely closed. If this be true, then the coronary arteries must be filled from the aorta; but if it be not true, those vessels are filled by the heart's action directly. On this question I purpose making some short remarks.

Martin and Sedgwick have thrown some doubt upon the usual teaching of coronary circulation; but as their experiments are not very convincing, and only apply to one aspect of the question, it is necessary to look into it somewhat more fully.

Let us begin our view of the circulation in the coronary arteries at that stage of the heart's action when the left ventricle is dilated, the semilunar valves firmly closed, and the aorta contracting upon its contents and propelling them in any direction where there is an exit. At this stage of the circulatory movements the aorta steadily presses the blood onward through the system, as into the branches of the carotids and subclavian. Now, the coronary arteries stand to this action of the aorta in precisely the same relationship as do the branches of the above-named vessels. When the aorta contracts upon its contents the blood would flow back into the ventricle were it not for the valves. This, however, being prevented, the blood passes on into the various branches and sub-branches of the aorta. Among these the coronary arteries come in, and the blood is steadily driven through them in the same manner as it is through any other arterial trunk in the body. This action is not dependent directly upon the contraction of the heart and upon the action of the aorta secondary to it.

Let us now proceed a step further in the chain of events, and note carefully what takes place. The aorta is still firmly contracted upon its contents, the semilunar valves are completely closed, and the entrance to the coronary arteries are open. The ventricles now contract. At the moment this action begins, the blood is pressed firmly against the ventricular side of the valves, and the central points of these fall back first, and permit some of the blood in

the left ventricle to be driven into the aorta. If this action be carefully noted, however, it will be seen that the blood is driven from the ventricle into the centre of the column of blood contained in the aorta. The effect of this would be to cause a wave in any direction in which the blood can flow: viz., in the aorta and all its branches, among which we must include the two coronary arteries. At this moment only the central part of the valves are opened, and the blood from the ventricle is suddenly propelled into the aorta, in the form of a fluid wedge into the centre of the blood within it. The valves have not as yet had time to close back into apposition with the aorta, assuming the old view, which I believe is erroneous. It will thus be seen that though the blood flow through the coronaries is maintained by the action of the aorta, the wave in these vessels is due to the action of the heart just as it is in other arteries.

Again, when the aorta contracts on its contained blood, the three little pouches at the root of the aorta, and opposite the valves are distended by blood. From two of these spring the coronary arteries. The valves on the other hand are pouched inward, toward the centre of the entrance to the aorta, and away from the entrance to the coronaries. This is the state of things when the ventricle contracts; and long before the valves could fold back to be in apposition with the aorta, the blood wave has taken place through the coronary arteries. But this is not all. In the full and round condition of the aorta just before contraction of the ventricle, the free margin of the valves are not long enough to allow the valves to fall back into close contact with the lining of the aorta. Further, the semilunar valves cannot come into apposition with the aorta till the blood filling the sinuses of Valsalva is displaced. This, however, as carefully conducted experiments prove, does not happen. The first effect of the ventricular contraction is to propel into the aorta a narrow column of blood with great rapidity through the centre of the aortic opening. The effect of this is still further to distend these sinuses, instead of allowing them to become emptied. The attachment of the valves, the aorta, and the heart to the fibrous ring at this part of the heart also tend to prevent such a close contact between the valves and vessel.

In addition to the above, direct experiment goes to show, that the blood wave in the coronaries, and also the blood stream, is synchronous with that in the carotid. A medium sized cat was taken; and, after bringing it under the influence of chloroform, the carotid and coronary arteries were carefully exposed. A small hollow needle was inserted into each. The end of the needle in the vessels pointed towards the heart. On removing the little wires which closed the hollow in the needles, the blood issued from both in jets at exactly the same time. This could only happen under the condition that both coronary and carotid arteries are filled directly by the heart's systole. I then cut a small branch of the carotid, and also of the left coronary; and with the same result, that the blood issued at the same time, and with equal rapidity. The cat was then killed. The heart and attached vessels carefully removed. The aorta was tied at the descending part of the arch, and the other branches at some distance from the arch. Water was then passed into the left ventricle through the auricle by means of a syringe, until the ventricle and the stumps of the vessels were full. The left coronary was now cut, and the ventricle suddenly and firmly compressed. This would have the effect of forcing open the aortic valves, and causing them to fall back upon the walls of this vessel if the old view of their action be correct. But instead of the valves closing the coronary arteries, as might have been supposed, the fluid escaped freely from the cut in the left coronary. This seems to prove that the systole of the left ventricle does force the blood directly into

the coronary arteries; and that the stream through these vessels is maintained by the elastic and muscular action of the aorta in the same way that it is in the other branches that spring from it.

LEPROSY FROM MR. HUTCHINSON'S STANDPOINT.

BY JAS P. W. ROSS, M.B., L.R.C.P., LONDON, ENG.,
Physician to the Toronto Dispensary, Girls' Home, and Home for Incurables, Surgeon to the Children's Hospital.

(During my term as Mr. Jonathan Hutchinson's dresser at the London Hospital in the spring of 1879, the following case of leprosy fell to my lot. Mr. H. delivered a clinic of which I took notes. After examining the manuscript he consented to its publication in a Canadian medical journal. During last winter while sojourning in California, residents of the Sandwich Islands were thrown in my way about the time that the newspaper world was agitated over the subject of leprosy so prevalent in that part of the Pacific Ocean. Several cases of the disease occurring among American residents on the islands were brought before the public and long articles were published describing the ravages of leprosy. False reports were circulated that these were merely sensational rumours in the interests of southern sugar planters to damage the chief industry of the islands. I was astonished to hear from authentic sources that leprosy did exist there to an alarming extent among the natives; that one island was specially set apart for the reception of the lepers; that a government medical officer was specially appointed to watch over their interests; that the disease has been increasing so rapidly that the authorities are much concerned to discover a means of suppressing it. The hope that in this connection the views of so eminent a surgeon on such an interesting subject may be interesting to those who have never seen them published is my only apology for the present article. Mr. H's. study of the disease in Norway, and his subsequent researches matured his opinions of four years ago, I am unable to state any changes they may have undergone since then. It is probable that the ætiology of leprosy will always be a matter of dispute.)

Family History.—The patient is a school girl eleven years of age; parents English; both healthy; have lived in comfort all their lives. Some eleven years ago they went to India; patient was born on board ship; under the care of native nurses for six years. Her parents returned to England when she was six years of age; no history of syphilis; no history of leprosy in the family.

History of Disease.—Four years after leaving India (fifteen months ago), a dusky red spot was noticed at the back of the heel. This first drew attention to the child's condition. Anæsthesia may have been present before she left India, but was unnoticed. Other spots have since developed.

Present Condition.—Her face does not present the usual "leonine" aspect characteristic of the worst forms of tuberculous leprosy. The patches simulate lupus. The diagrams show the positions of the patches. Those most marked are on the right elbows and on both knees. They are white and anæsthetic in their centres, raised of a dusky red color and hyperæsthetic at their peripheries; the intervening integument is of a dusky hue, dry and abnormally anæsthetic, most marked in the lower part of the left leg, along the courses of the musculo-cutaneous and anterior tibial nerves. The dorsal and plantar surfaces of the left foot are also anæsthetic; this accounts for the chilblains present, as the parts have been unable to appreciate extremes of heat and cold. The disease is fairly symmetrical; the left side is affected more than the right. The anæsthesia in the left arm and leg, greater than in the right arm and leg; appetite good; feels well; is a bright happy dispositioned child.

History.—I do not intend to enter deeply into the history of leprosy, but will only mention a few facts. The disease diminished in frequency prior to the Reformation. It gradually left England as our forefathers

advanced in agriculture. Their food became gradually changed; the proportion of fish to other food was greatly reduced; cereals were planted; bread and vegetables took a more prominent place in their bill of fare. The country was farmed, forests became fields, and cattle were raised for food. Fish were so little used that in the reign of Henry VIII. a law was passed compelling the people to have fish at their tables four times a week to prevent the ruin of the fishermen.

Leper hospitals were established, chiefly along the seaboard, where the disease was the most prevalent, but as the malady left us these were closed. The Orkneys were the last lingering places for the disease; the Cornish fishers suffered from it up to a late date. I hear that even yet, endowed leper houses exist in Cornwall. Still a few cases are to be found in the Orkneys. A gentleman sent me a very old book in which I found a paragraph to the following effect: "Leprosy is due to two causes, one an inherited taint, the other the use of fish as an article of diet, especially salmon and the livers of any of the different varieties."

Fish were not so well cured then as they now are, and consequently must have been less wholesome. Less fish is now used. There are more consumers to share the disproportionate increase in the supply of fish. More meat and less fish is the prevailing fashion. The largest leper house in Norway is at Bergen, and here is also the largest fish market in the world.

Aetiology.—All cases of leprosy are, in my opinion, due to dietetic causes, to a special poison introduced into the blood by some article of diet containing it. What is this article of diet? Fish is blamed, and the "fish theory" seems to me to be the most plausible.

Hardship has been quoted as a cause. This does not accord with the histories of my cases. English officers sent to India, surrounded by every comfort, now and then become lepers. They suffer no hardship.

Climatic Influences cannot be a cause, as leprosy is a disease of all climates. It is to be found amidst the sunny hills of India, along the cold sea coast of Norway, among the tropical isles of the Atlantic and Pacific Oceans; it survives the cold of the Orkneys andof New Brunswick, how then can climate be adduced as a cause, except in so far as it may affect the food?

Contagion is given as a cause, but this I cannot admit. The contagiousness of leprosy has yet to be proved. I do not even believe it to be contagious in any erratic manner, as by co-habitation or sexual intercourse. In the olden time it was confounded with scabies and syphilis, and upon these errors it established its contagiousness. Medicines that obtained reputations for the cure of leprosy may have done so on their merits in scabies and syphilis.

Fish Diet is the next cause to be taken up. Fish to cause leprosy may be decomposed; they may be of a poisonous species; they may be used at a season when fish, especially in the tropics, are unwholesome; they may be salted; they may be improperly cured; they may be apparently harmless in moderation, but poisonous in excess. Some fish are injurious at certain seasons of the year. Some are more poisonous than others.

Locality as a cause. Leprosy affects chiefly dwellers on the sea board, and along the banks of rivers. It is said to occur inland where no fish are caught. But the people may eat salted or cured fish, and I believe, furthermore, that many cases called leprosy are simply cases of leucoderma.

The patient whose history has been related was brought up in India by a native nurse. She wanted for nothing. She underwent no hardship. The natives of the district were subject to outbreaks of leprosy. Several were lepers at the time of her residence there. The people ate largely of salt fish. Her father did not use it himself more than twice a month,

but the child may have been fed on it frequently by the nurse if she relished such food. Another patient was a gentleman in good circumstances who had enjoyed every comfort. He had always been a healthy man until leprosy developed. No history of syphilis. Had lived for some years at an African sea-port where prawns were very plentiful. Being fond of them he frequently indulged his appetite. He became a leper and returned to England.

Another patient had leprosy of the mixed variety; there were large tubercles on his face; his trunk and limbs were studded with numerous white anæsthetic patches; anæsthesia very marked. A pin could be run into him through the centre of the spots without causing pain. The edges were hyperæsthetic. No history of syphilis. Had used stimulants very moderately; made several voyages, as captain of a vessel to the West Indies. Remained there five or six weeks at a time, but usually lived on the ship while in port; ate food provided by natives. One cannot think that a short six weeks' stay in the tropics could cause leprosy if climate alone originates the malady.

Another case originated in a cold climate. In Norway, as I have stated, the disease is prevalent, but the English, French, Germans, etc., who visit the country, are not affected by the disease, except in very rare instances. This case is the only one of the kind known to me. A German officer went to Norway to fish. He was in easy circumstances, but lived, ate and drank with the poorest of the fishermen while there. He ate some of the very worst kinds of fish, only used by the poorer classes—badly cleaned and badly cooked. It is among these classes that leprosy is so prevalent. If the cause were climatic, rich and poor should suffer, for they breathe the same air and enjoy the same sunshine. Numbers of foreigners go to Norway to fish, but I have neither heard nor read of any other case of leprosy among them. Is it not reasonable to suppose that in this case the cause was dietetic, and the food at fault bad fish? In the tropics, rich and poor are affected; the effects of season in the hot climates on the fish would account for this; wholesome during the cool season, it is known to be unwholesome during the rest of the year. It is just as likely that the rich should use them, the year round, as the poor.

Another case was that of an Irishwoman who went to India in good health. She became a leper. The disease began in the eyebrows. She suffered from ophthalmia, caused by the formation of tubercle in the coats of the eyeball. It set up an irritation which soon ran on to the inflammatory stage. There was nothing special in her diet; no evidence that the disease was due to the eating of fish. She lived in a leprous district.

Another patient, a lady, left England to keep house for her brother in the Barbadoes; was in good health and enjoyed every comfort. Remained eight years. Indulged her appetite for turtle; it was one of her favourite dishes, and pronounced by the natives to be very wholesome food. Certain other varieties of fish were said to be injurious, but she had never eaten any of them. Although a Jewess, the long residence of her ancestors in England sets aside the theory of hereditary taint. At the age of forty she returned to this country a leper.

I have yet to see a case of leprosy primarily developed in England. All the cases seen by me in English people have been developed elsewhere. Occasionally cases are reported as true leprosy originating in England, owing to the numerous sources of error, one must accept such statements with caution. Some years ago after writing to India for information regarding leprosy, I received a reply from an eminent member of our profession, stating that in one part of the country the natives lived on the most abominable kinds of fish, but were

free from leprosy. I was taken somewhat aback. This was soon after proved to be untrue. Meeting the military governor of the same district about the same time, I asked him a few questions concerning the health of the district, and learned that leprosy was very prevalent and that the management of the lepers had engaged much of his time in his official capacity.

A gentleman some time ago wrote an article on fish, and stated that 800 tons left Billingsgate market daily. I confronted him with the statement, but he assured me that it was taken directly from the books. He looked again, and acknowledged that only eighty tons left daily. Thus you see what great caution we must exercise before accepting any statement.

Varieties of leprosy.—There exists two varieties of leprosy: 1st, the tuberculous; 2nd, the anæsthetic.

In the *tubercular* variety there are deposits of tubercle in the cellular tissue. These may occur in any part of the body. It resembles syphilis in this respect. In the iris it causes iritis; in the cellular tissue of a nerve sheath its pressure effects produce anæsthesia in the part supplied by the nerve.

In the *anæsthetic* variety there is a tendency to the formation of tubercle. The anæsthesia is of two kinds, diffused and local. The diffused results from the overgrowth of the cellular tissue of the sheath of a nerve trunk, giving it an irregular fusiform appearance. The local is caused by the same process in the tactile corpuscles or nerve endings. Concurrently with it atrophy of the skin takes place in the part affected.

The difference between the two kinds of leprosy is only a difference of degree. A patch may be said to have—

1st. An edge, raised, thickened, dusky, red colored, and hyperæsthetic.

2nd. A centre, depressed, white colored, and anæsthetic.

3rd. A surrounding zone of dry, dusky, and often abnormally anæsthetic integument.

Hyperæsthesia of the edges is due to the local irritative inflammatory action that takes place there, and causes over sensitiveness of the nerves.

A small patch, which has not undergone atrophic changes in its centre, following the inflammation, is hyperæsthetic throughout, as compared with the surrounding integument; but as soon as this secondary change takes place, sensation in the part becomes lost. In characteristic small patches this change occurs early, so that though diminutive, they may be typical spots.

Diagnosis.—This in the early stages is difficult, even to those accustomed to see the disease. It requires much careful observation to pronounce a man a leper at this stage of the malady. Some years ago a large number of Norwegians were emigrating to America, and the Americans fearing the introduction of leprosy, compelled them to undergo a medical examination. As the Norwegian surgeons said this was of little use; many a leper might escape detection, owing to the inability of those unaccustomed to the disease to diagnose it in its early stages. The appearance of a dusky patch on the skin is not sufficient to prove the existence of leprosy. I would in one advanced case on first sight have called the disease lupus. The chilblains present on her feet were merely an accidental addition tending to complicate the diagnosis; such additions may occur, but are not necessarily present.

Differential diagnosis, from lupus by æsthetic phenomena being absent and the tissue being boggy.

Syphilis by previous history, condition of the teeth and the physiognomy.

Leucoderma, by the absence of the raised edge of the patch, absence of thickening in the surrounding skin, absence of the dusky red color of the margins of the spots, and the red brown color of the intervening integument.

Treatment.—No one can do much to help the victim of leprosy in its later stages. I have no faith in the many vaunted remedies. The patient should be removed to a healthy climate away from the cause of the malady, whatever our increased knowledge of the disease may prove it to be. Fish should not be eaten by them. The patient last mentioned returned to her native English climate, her face improved, the tubercles diminished in size until her face looked almost natural. For the last nineteen years she has been enjoying good health. Her left ulnar nerve is still completely paralysed. The only article she has taken as a medicine, latterly, is port wine; to it she attributes her improved condition. It is an interesting fact, but I do not think the wine did what she credits it with.

Prognosis.—The longest lease of life given to a leper is said to be eighteen years. Many die much sooner. The disease is incurable.

Death.—Death is brought on either by exhaustion or by the setting in of some low form of inflammation.

Comparison.—Leprosy can best be compared to gout—its nearest parallel. Both are hereditary; both are dietetic. Each may overleap a generation, and affect the next. Neither are contagious.

[Professor Schmidt, of New Orleans, recently told me that when working some years ago on the pathological histology of leprosy, he had discovered what he took to be fat crystals. They were identical with what Koch has recently discovered as the bacillus tuberculosis. Prof. S. is not a believer in Koch's theory and thinks that Koch has discovered nothing but a fat crystal.]

Were not his fat crystals true bacilli? Leprosy is a tuberculous disease; it is hereditary. If we find bacilli in tuberculous disease, they ought to be found in leprosy, and if the bacillus tuberculosis is the cause of the one I see no reason why pathological research may not yet prove it to be the cause of the other, and that thus the long mooted point, the cause of leprosy, be forever set at rest.

IS CONSUMPTION CONTAGIOUS?

BY W. J. WILSON, M.D., RICHMOND HILL.

As there was some discussion under the above head in connection with Dr. Graham's able paper on the "Bacillus Tuberculosis" at the last meeting of the Ontario Medical Association, I thought the notes of a case which occurred in my practice about three years ago might prove interesting.

B. W., æt. four months; family history good, and no trace of phthisis or syphilis discoverable in either family.

Has had no illness up to present, is plump, fat, and well nourished. The mother was forced to wean the child when about a month old, and was confined to her bed, so that she could not attend to it by cerebral anæmia. The child was fed on cow's milk from a bottle, and thrived well for a time, having no digestive troubles.

It was attended by a nurse, who was well advanced in consumption, and had free expectoration.

The child slept with the nurse, who, by the way, was in the habit of keeping it close to her face during sleep, and consequently was exposed to her breath for hours together. Nothing unusual was noticed in the child's condition for the first three or four weeks after the nurse's arrival, when it began to lose flesh and cough slightly. This cough and wasting gradually increased, and finally I was called in to see what was the matter with the child, and on examination I found well marked and far advanced phthisis, with frequent cough and great emaciation.

The child died in its eighth month, or three months after the first symptoms were noticed, and four from the first attendance of the nurse.

I may mention in connection with the above history that the same nurse, who has since died of consumption, attended five

other children, and four out of the five died of some wasting disease, said to be similar to B. W., but as I did not see any of them I am unfortunately unable to state its nature.

Selections: Medicine.

Functional Vomiting of Hysteria.—In an article in the *Practitioner* for March, 1883, Dr. Bristowe, of St. Thomas's Hospital, throws a strong light upon the pathology and treatment of this very troublesome malady. He shows that in many instances the irritation exists not in the stomach, as we have hitherto supposed, but in the œsophagus, and that food artificially made to pass over the seat of irritation will be retained, the system nourished, and health restored.

In the spring of last year an aggravated case of hysterical vomiting was admitted into St. Thomas's Hospital. The girl had been constantly vomiting for about four months, and, as a result, was extremely thin and weak. No sign of abdominal disease. Various remedies and plans of feeding were tried without success. It was then suspected that the food never reached the stomach at all.

The act of deglutition was—it had always been—perfectly performed. The mouthful descended to the œsophagus, and then at the end of a minute or two, after the patient appeared to suffer from a great deal of discomfort, she brought it up, as was her custom, without violent straining, but with efforts that fairly well resembled those of vomiting. There were never any clear symptoms of indigestion, no uneasiness after food, no flatulent distension, or tendency to eructate. She vomited all kinds of food, liquid or solid, equally, no matter how little or how much was taken. It seemed impossible that she could vomit from the stomach without the most violent efforts, the minute proportion of milk, ice water, and raw beef which were often administered to her, which, nevertheless, she did reject (after swallowing) almost without change and almost without effort.

Dr. Bristowe's experience furnished him with three examples of a somewhat similar condition. The first, that of an elderly clergyman who suffered from megrim and a peculiar spasmodic affection of the œsophagus. Some time since he took at night a dose of morphia for the relief of a threatened attack of megrim, without the expected relief or even sleep following, until half an hour or so after breakfast next morning, when he became drowsy. He felt satisfied that the drug had lain in his gullet all night, and that it had only been carried into his stomach with his breakfast. This suspicion was on other occasions confirmed, for since then the dose has either behaved similarly or has been rejected in the morning.

The second case was that of a hospital patient, a man over fifty, who had suddenly about a week before admission become incapable of swallowing. Here, the impediment was clearly in the upper part of the œsophagus. An instrument was passed into the stomach. The patient swallowed, after the withdrawal of the instrument without the slightest difficulty, and the dysphagia never returned.

The third case was that of a young man, aged twenty-four, in whom functional vomiting eventually caused death. The only lesion discovered was dilatation of the œsophagus, with hypertrophy of its walls. Dr. Bristowe goes on to say: "I now naturally attached more importance than I had done to the history which he gave of his illness; I admitted that his dilated and flaccid œsophagus had formed a virtual impediment to the entrance of food into his stomach; I became impressed with the important practical fact, that in œsophageal obstruction vomiting may be delayed for half an hour or more, as it is habitually in pyloric stricture; and above all things, my unfortunate experience taught me the importance, in all obscure cases of persistent vomiting, of not omitting to examine the œsophagus, or try the effects of injecting food directly into the stomach."

To return, then, to the case first mentioned, of which complete details are given.

She had been suffering for some three years from an hysterical affection of the hip-joint, and was admitted in May, 1882, for the gastric symptoms. Although the joint affection persisted, it formed a less prominent subject of complaint than it had done previously.

From the first she continued to vomit after whatever was taken; the vomit consisting mainly of the food swallowed and mucus, and the sickness generally coming

on a few minutes after ingestion. It was sometimes, however, delayed for ten minutes or a quarter of an hour. She was ordered a dessertspoonful of milk every half hour, which she vomited. A teaspoonful given at the same interval was likewise ejected. Small quantities of solid food answered no better. After being fed for three weeks by the rectum alone, another attempt was made at giving milk by the stomach, but with unsuccessful result. On the 11th June a tube was passed along the œsophagus into the stomach and three ounces of milk were thus introduced. There was a little impediment met with in the lower part of the gullet, but it was readily overcome, and was evidently not due to any organic disease. The milk thus injected did not provoke any feeling of sickness, and remained in the stomach without causing discomfort.

It was intended to feed her daily by the tube, but she never required it again during her stay in hospital. For the next day or two she took milk in small quantities, returning a little of it only occasionally. Two days after the use of the tube, she began to take a tablespoonful of milk every hour, which she retained. The allowance of food was daily increased until, at the end of two or three weeks, she was taking daily a fair quantity of milk, together with two eggs, fish, pudding, and bread and butter. The nutrient enemata, however, were persisted in for a day or two longer, and were then discontinued, partly because their more nutritive ingredients had been withdrawn for administration by the mouth, partly because the bowels which had hitherto been constipated became loose. To the last the patient appeared to have no desire to take food, and to derive no pleasure or comfort from taking it. Only on one or two occasions did she vomit any of it. The continuance of the diarrhœa retarded recovery, so that she did not appreciably gain flesh, and in fact, when she left the hospital she had only gained two pounds. She was discharged on the 29th of July. A month or two later there was a recurrence of the vomiting, and her mother brought her to the hospital to have the œsophagus tube re-introduced.

"I have little to add by way of comment. There is no doubt of course that in most cases of hysterical vomiting, it is the stomach that rejects the food. But it is obvious that in an undetermined minority of cases of such vomiting, it is the œsophagus rather than the stomach that is in fault, and if in such cases, the irritability or spasm of the gullet can only be overcome, and the food swallowed be allowed to reach its destination, the vomiting will cease. If one has reason to suspect the latter condition to be the cause of his patient's symptoms, it is fortunately easy to put the question beyond doubt by having recourse to the œsophagus-tube or stomach-pump; and if the answer be in the affirmative, to cure the patient of her malady by the repeated use of the instrument and artificial feeding. There is reason, however, to hope that a single introduction may suffice to effect a more or less permanent cure."

Bacillus Tuberculosis not a Parasite.—M. le Professeur Grasset (Montpelier) does not regard the bacillus tuberculosis as parasitic. He says for the bacillus to be parasitic, it must be an independent being, like the tinea or the acarus, without any possible analogy in the healthy or morbid economy. But if the bacteria are anatomical elements like the giant cell, all the recent researches, however full of interest, in no wise demonstrate the parasitic nature of tubercle. The main question, then, is to know if in certain anomalous morbid particular circumstances, bacteria cannot be seen to develop in the organism without the entrance of any germ from without, solely by the transformation of the normal elements of our tissues. On this point MM. Bèchamp and Estor, whose works I have carefully followed, seem to me to have clearly demonstrated, (1) that there exists in our tissues molecular granules—the ultimate atom of physiological divisibility; (2) that these molecular granules can be cultivated in suitable media outside the body and live as ferments of their own life; (3) that the same granules are in certain anomalous or pathological conditions susceptible of being transformed into bacteria. Conclusive experiments prove these facts; pieces of liver placed immediately in paraffin, chromic acid, or even a fusible alloy, present in their centre foci of granules and bacteria after a certain time. There is, however, nothing of a parasitic nature. The same occurs in the pathological conditions, where Estor has likewise found bacteria. Hence granules isolated or grouped

and bacteria, are in no wise parasitic separate beings grafted upon the organism. They are histological elements, nothing more. Remark well that every time new histological elements have been discovered this specificity of form, this characteristic element is thought to have been found. As with the "cancer cell," "the tubercle cell," "the giant cell," so is it to-day with the bacteria. The most careful study, then, always shows that this specificity of form does not exist, that there is only specificity of function. I am convinced that in this doctrine of Bèchamp and Estor lies the only way of reconciliation between clinicians and actual investigators. The laws of the economy, the spontaneity of disease, are too much neglected when a germ from without is necessary to develop the furuncle, while all explains itself clinically—if these bacteria can be produced by a morbid change of the normal elements of our tissues. Note, moreover, that thus we attack the interpretations of M. Pasteur, merely, and not the facts, for his most brilliant achievement is that from vaccinations. This agrees much better with the old theory of virus than with the parasitic ideas. What parasite can be attenuated and give immunity from itself. In a word, bacteria does not prove parasitism, because the bacteria can be formed in the body without a germ from without. Now, to return to tuberculosis, recent researches render concise and complete the pathology of this disease. They show in what lies the element of transmissibility; but if they support the virulent nature—the contagious character—of the disease, they are no more proof of its parasitic nature than the experiments of Villemin.—*Gazette des Hôpitaux.*

DR. BEARD'S "BROMIDE COMP."

℞ Sod. Brom.
Potass. Brom.
Calc. Brom. ..... āā gr. x.
Lithiæ Brom ..... gr. v.
Potass. Iod ..... gr. iip.
Liq. Arsenicalis ..... gtt. ij.
Tr. Capsici ..... gtt. i.
Aq. ..... ad. ℥ i.
℔ Sig.—One dose.

TREATMENT OF STYES.—For hordeolum Dr. David Webster has used calcium sulphide, a granule (gr. 1-10 each) each hour until ten have been taken, repeated daily, with marked benefit.—*Archives of Medicine.*

AND now we have yet another rival to atropia in ophthalmic therapeutics in the shape of the hydriodate of hyoscyamin. A report of twenty cases in which it was used at Prof. Seeley's clinic is published by Dr. Tangeman in the Cincinnati *Lancet and Clinic*, May 5th. In all cases only one drop of a four-grain solution was used. The ciliary muscle is affected in five minutes, while, mydriasis is usually complete in ten minutes. Even spasm of accommodation yielded in this time. The paretic condition begins to disappear in thirty-six to forty-eight hours, and accommodation is normal in four or five days. In the matter of time, then, it holds a place between atropia and homatropia. It is moreover claimed that it causes much less dryness of the throat or other disagreeable symptom than either atropia or duboisia, while producing its first effect quicker than either.—*Clin. Med. Review.*

WHILE he does not consider them sufficiently distinctive to warrant a diagnosis, yet Dr. Alois Biach, in *Wiener Med. Presse*, February 11, 1883, gives the following as to symptoms usually observed in cancer of the pancreas (*Med. and Surg. Reporter*): 1, Pain; 2, various dyspeptic disturbances; 3, pancreatic salivation; 4, pancreatic diarrhœa; 5, fatty diarrhœa; 6, the so-called "lipuria;" 7, the presence of a tumour in the epigastrium, which occasionally pulsates; 8, bronze coloration of the skin in occasional cases.—*Med. Review.*

To prevent the skin from discolouring after a blow or fall, take a little dry starch or arrowroot, merely moisten it with cold water, and lay it on the injured part. This must be done immediately, so as to prevent the action of the air upon the skin. However it may be applied some hours after with effect.—*Pharm. Record.*

THE EXTENSION OF VICE.—Prof. J. Edwards Smith has devoted a year to the study and discovery of adulterations in homœopathic medicines. When adulteration strikes the attenuated gossamer fabric of the *sim. sim. cur.* materia medica, we may well believe that vice reaches every fibre of our social system.—*N. Y. Med. Record.*

WINNIPEG desires a Medical School.

Boracic Acid.—Edmund Dana, jr., states, that while cold water and alcohol hold in solution only 18 grains of this acid to the fluid ounce, hot water dissolves 80 grains, but on cooling all except 18 grains precipitates. Hot glycerine on the other hand dissolves 180 grains, and retains the whole amount on cooling. The acid is not soluble in paraffine, wax, vaseline, oil or spermaceti. Vaseline cold or hot does not affect it, but does readily unite with the boracic glycerine at a high temperature and remains permanent on cooling. He suggests the following formulæ as a substitute for the mixtures of vaseline and boracic acid, which he thinks are simply mechanical and sometimes irritating on account of the action of the undissolved crystals upon the ulcerated surfaces:

Glycerite of Boracic Acid.

℞ Acid. boracic ..... ℥iij.
Glycerinæ..... ℥i.

M. Dissolve the acid in the glycerine suspended in a hot water basin until dissolved.

Acid Boracic Ointment.

℞ Acid. boracic. glycerit ℥ij.
Ceræ albæ..... ℥ij.
Vaselinæ..... ℥xij.

M. Mix the wax and vaseline together and while hot add the glycerine slowly with constant stirring while cooling.—*Druggists' Circular.*

Compound Cubeb Paste.—

Take of—Powdered cubebs	½	lb.
Carbonate of iron	3	ounces.
Powdered jalap	1½	"
" nitre	2	"
Carbonate of soda	1	"
Compound kino powder	1	"

To be formed into a paste with balsam of copaibæ. Dose—one drachm three times a day.—*Mag. of Pharm.*

Lotion for Sub-acute Eczema of the Hands:—

℞ Ext. Grindeliae Robustae fld. ℥ ij.-iv.
Aquæ Oj. M.
Fiat Lotio.

Cloths should be saturated with this and applied to the skin in such a manner as to allow evaporation to proceed until they are dry. The lotion is again applied to the cloths *in situ* and allowed to go on as before. —*Arthur Van Harlingen in Phil. Med. Times.*

The Origin of Respiratory Murmurs.—Chomiakoff and Kotovshtchikoff having repeated the experiments of Aufrecht and Halbertsma, and completed a series of experimental researches of their own, conclude as follows: 1. Aufrecht's theory is incorrect; that is, the bronchial respiratory murmur does not in the least depend upon the movements of quiescent air-columns within the lung. 2. The bronchial murmur originates exclusively in the larynx; the friction of the air against the walls of the large bronchi does not give rise to these sounds. 3. The vesicular respiratory murmurs are of a compound nature. A large part of them have a laryngeal origin; that is, the bronchial murmur originated in the larynx, while passing through the normal tissues of the lungs, changes its characters; and is heard on the lung-surface as a vesicular murmur. The remaining part of the vesicular sounds originates on the periphery of the lung, but the authors are not as yet able to elucidate its mechanism.

A New Galactagogue.—According to Dr. Anderson, nursing women in Jamaica are accustomed to drink an infusion of the leaves of *Gossypium barbadensis*. Six or eight leaves are sufficient to make a cupful of this infusion which, when sweetened with sugar, has a very pleasant taste, may be taken to the extent of four or five teacupfuls in the day without inconvenience, and invariably stimulates the flow of milk.—*Gaz. Méd. de Paris.—Med. News.*

Injections of Tea as an Antidote to Opium, (swel)—Two injections (8 oz. each) of green tea in strong infusion succeeded in overcoming alarming symptoms of acute opium poisoning. Theine and caffeine should be preferably used when at hand. In every case it is indispensably necessary to wash out the stomach. In three cases of alcoholic poisoning the author has also proved the benefit of injections of tea.—*N. G. in L'Union Med.*

Toxicity of Poisons.—M. Delaunay made a communication to the Biological Society to demonstrate that diseased animals support strychnine less well than those that are healthy and vigorous; and that a dose of poison possesses a toxicity in proportion to the amount of water with which it is administered.—*Le Prog. Méd.*

Surgery.

Fracture of the Neck of the Femur and of the Trochanter Simulating a Luxation of the Hip.—D. A., æt. 47, labourer, entered Hopital de la Pitié on the 19th of October, 1881, in the service of M. Verneuil. He was a vigorous well-made man, a confirmed drunkard. Four days ago he fell from a height of about 12 feet, and since then has been utterly unable to move the right lower limb. He cannot state exactly what part of the body struck the ground first when he fell, but declares that a physician, who was immediately summoned, diagnosed a luxation of the hip, and made many vain efforts at reduction. Sent the next day to the Hopital de Corbeil, he was likewise treated for a luxation, these trials though made under chloroform proved as fruitless as those of the night previous. The patient was then sent to M. Verneuil. On admission the following symptoms were found: Enormous swelling of the entire right thigh and of the corresponding hip with great and extensive ecchymosis. Apparent shortening of the limb, abduction and rotation outwards. Considerable swelling of the gluteal region. Abolition of all spontaneous movement, and impossibility of the patient's raising his heel or of correcting the vicious position of his leg. Abduction and rotation outwards only may be produced, but give rise to great pain; rotation inwards, abduction and flexion are impossible. Palpation gives no precise indications on account of the great infiltration of the region. Indeed the head of the femur can be felt nowhere. It appears, however, that the great trochanter has undergone a movement of ascension. No crepitation. Percussing the heel gives rise to no pain in the hip joint. No retention of urine. Temperature axill. 98°6. The patient was examined by many surgeons, some of whom diagnosed *luxation*; others, with M. Verneuil, *fracture*. On the 21st of October the patient was chloroformed and examined. Still M. Verneuil could not find the head of the femur, nor elicit crepitation. In spite of energetic tractions, he could not succeed in bringing the thigh into forced flexion, adduction and rotation inwards, neither could he succeed in extending the limb to its normal length, and during all these manœuvres, the great trochanter moved with the rest of the femur, rising and descending with it. In face of this result M. Verneuil cannot believe in a fracture of the neck of the femur, otherwise the tractions that he made were sufficiently energetic to have corrected the deviation. He concludes then that there is a luxation forwards, and proposes to reduce it the next day with the pulleys. That evening delirium tremens came on, and two days afterwards the patient died. Autopsy: Considerable effusion of blood in all the tissues of the thigh, rising in the sheath of the psoas above the iliac fossa. At this point between the iliac fascia and the muscle is a collection the size of the fist filled with black clots and bloody serum. Notable effusion of an analogous serum in the knee joint. The femoral head was in its normal position in the cotyloid cavity. *Simple fracture of the neck and multiple fracture of the great trochanter.* The fracture of the neck is intra-capsular in front and extra-capsular behind. The fragments are entirely separated; the inferior fragment is retained by Bertin's (Ilio-femoral) ligament alone, the sole portion of the capsule which remains entirely intact. The great trochanter presents a double fracture. 1st. An oblique fracture extending from the inner and upper part of the great trochanter to its lower and outer part, being prolonged backwards so as to separate into two equal parts the lesser trochanter and encroaching for three centimetres upon the diaphysis of the femur. 2nd. A transverse fracture of the upper fifth of the great trochanter. All these fragments present no impaction or even apposition, in a word, they are immobilised by the interposition of portions of muscles which they have torn or perforated, and in which they were enveloped doubtless at the time of the injury. On account of this muscular tearing, one of the osseous fragments has undergone a notable ascension backwards and inwards, and is found at a considerable distance from the surface of its corresponding section.

This observation is interesting both from a clinical and from an anatomical point of view. Clinically it shows: 1. The difficulty of the diagnosis of affections of the hip, and particularly it shows how very slight, at the patient's bedside, are the differences which separate luxation forwards from fracture of the neck. 2. The terrible gravity of surgical lesions in alcoholics and the reserved prognosis which should always be

given in such cases. Anatomically it is remarkable for the extent of the fractured surfaces and the importance of the muscular lesions. The disposition of the different osseous fragments thus enveloped in the muscles may, up to a certain point, account for the absence during life of crepitation, and of pain provoked by pressure upon the two extremities of the fractured limb. In order that there should be pain, and especially crepitation, it is necessary that the fragments should be in contact with one another. Now this contact was here rendered impossible by the interposition of the muscular fibres.—*Le Prog. Méd.*

ANASTOMOSES OF THE MEDIAN NERVE WITH THE ULNAR IN THE UPPER PART OF THE FOREARM.—At the *Société Anatomique* M. Verchère presented some specimens of unusual nerve distribution. In two of them there was a very fine nervous filament arising from the median at the point where the branches are given off from this trunk to the flexor muscles, being directed from without inwards, passing beneath the pronator teres and flexor sublimis muscles, beneath the ulnar artery and terminating in the ulnar nerve by means of a small plexus. This small plexus presents ascending and descending branches, the latter of which are lost in the ulnar nerve and are connected by other finer filaments to each other. From one of its branches sets out the filament which innervates the two internal fascicles of the deep flexor. On the tract of this anastomosis there are small descending branches starting from its convexity and which are distributed to the deep flexors. On another specimen, from the median nerve, at the point where the anastomotic branch usually arises, sets out an oblique descending branch which is lost in the substance of the flexor sublimis; not so high upon the ulnar nerve arises a filament which goes to the two internal branches of the flexor profundus, then at two millimeters from its origin a long slender filament is directed outwards, passes behind the ulnar and after a considerable tract is distributed to the upper extremity of the flexor sublimis very near the point where this muscle was entered by the median filament.

M. Verneuil had asked M. Verchère to make these researches, as he entertained doubts of the usual theory of nerve regeneration. In a case of neuroma of the middle of the arm he had resected four centimetres of the nerve expecting to have paralysis of the flexors, the next day to his great astonishment he found the innervation of the forearm and hand intact. These anomalies in the distribution of the nerves of the arm are pointed out by the older writers, but the more recent classical authors are silent on the subject. M. Verneuil is less and less convinced of the capability of a cicatrised nerve to convey nervous currents—either centrifugal or centripetal. He considers nerve suture an illusion as far as regards the re-establishment of nerve function. There is not a single positive example demonstrating this fact. It is only in neuromas, old lesions, slowly developed, where the collateral nerve circulation has been progressively developed that this re-establishment has been observed.

M. Cornil stated that in animals after section of a nerve the regeneration has been followed step by step, the nerve tubes reappearing with their normal structure in the cicatricial tissue and that this regeneration coincides with the re-appearance of movement and sensibility in the paralysed parts.—*Le Prog. Méd.*

REMOVAL OF AN ULCERATED SCIRRHUS OF THE BREAST BY THE AID OF CAUSTIC ANÆSTHESIA.

BY M. JULES GUERIN.

In the month of January last, a lady æt. 60 consulted me about a tumor of the right breast of seven or eight years duration. It was nearly four inches in diameter, occupying the whole of the breast, being irregular, nodulated in shape; hard to the touch; adhering to the skin, and having two small reddish fissures on the surface from which a small quantity of colored liquid oozed. The rest of the skin was pale, but traversed by large and prominent veins. The tumor was not adherent at the base and could be readily moved; no enlarged glands in the axilla. The general health was bad, and there was a catarrhal bronchitis of eighteen months duration, accompanied by frequent cough and copious expectoration; pains in the kidneys, and cardiac trouble, characterized by frequent intermittance of the pulse, presenting a condition little favorable to operative procedure, which was however decided upon and carried out as follows: I applied around the tumor, about four-fifths in. from

its border, a circular, or rather elliptical layer of Vienna paste, four-fifths of an inch in height and breadth, closely applied and limited by a double band of diachylon plaster. The patient instructed to inform us of the progress of the cauterization stated after a quarter of an hour, that all painful sensation which had been very moderate, had ceased; I, however, left the caustic applied five minutes longer—twenty minutes in all. The caustic having been removed, the surface cauterized, was wiped with lint soaked in vinegar, when a perfectly even blackish band was found. The breast having been raised, I passed a very fine platinum wire between the tumor and subjacent areolar tissue, in order to keep it elevated during the operation. I then incised horizontally and circularly the whole of the cauterized band; this was done without causing the least pain or hæmorrhage, and as if without the knowledge of the patient. Having thus detached from its cutaneous circumference the whole of the tumor, I tore it out with my fingers, dividing with scissors some opposing fibrous bands. The operation lasted ten minutes; but two or three spoonfuls of blood were lost and only one small artery required a ligature, which came away two days after. The patient complained of no pain throughout the operation. The wound was syringed out daily and dressed with lint soaked in a lotion of carbolic acid (1-100) and alcohol (1-4). No febrile movement ensued: the appetite and sleep most satisfactory. But what is most surprising, the cough and copious expectoration ceased almost completely after the eighth day. The cicatrization was most regular. Healthy granulations touched occasionally with nitrate of silver, and dressed alternately with glycerine and carbolic lotion regularly and gradually filled up the excavation. The border of the wound, remaining from the circular half of the cutaneous eschar remained in place more than three weeks, in the form of a band dry and closely adherent to the cutaneous cellular tissue. It separated but gradually in pieces. During this process, two facts were evident, viz.: That the very firm and adherent eschar formed an insurmountable barrier to the passage of the secretions of the wound, and thus prevented all absorption thereof. Such is the first serious operation performed with the aid of caustic anæsthesia. I leave it to surgeons to decide from it, its possible applications, and to the future, to point out how far this method shall—I do not say supplant,—but, assist in certain cases anæsthesia by chloroform.— *Translation from Gazette des Hôpitaux.*

The Control of Hemorrhage in Amputation at the Hip.—Mr. Jordan Lloyd suggests an application of the elastic bandage to control the circulation during amputation or excision of the hip-joint as a great advance over the abdominal tourniquet or Davy's lever. His procedure is as follows. The limb is first emptied of blood by elevation, combined with gentle frictions towards the trunk. A strip of black India-rubber bandage about two yards long is doubled, and then intrusted to an assistant after passing it between the thighs, its centre being between the tuber ischii of the side to be operated upon and the anus. A common roller bandage (thigh) is then laid lengthwise over the site of the external iliac artery. The ends of the rubber are now to be firmly and steadily drawn in a direction upwards and outwards, one in front, one behind, to a point above the centre of the iliac crest upon the same side. They must be pulled tight enough to check pulsation in the femoral artery. The front part of the band passing across the compress occludes the external iliac, and runs parallel with and above Poupart's ligament: the back of the band runs across the great sacro-sciatic notch, and by compressing the vessels passing through it prevents bleeding from the branches of the internal iliac artery. The ends of the bandage thus tightened must be held by the hand of an assistant placed just above the centre of the iliac crest, the back of the hand being against the surface of the patient's body. A piece of wood may be held in the hand to diminish the pain from prolonged pressure. In this way an elastic tourniquet is made to encircle one of the innominate bones, checking the whole blood-supply to the lower extremity. When the band is once properly adjusted, the assistant has only to take care that it does not slip away from the compress or over the tuber ischii; the former is prevented by securing pad and tourniquet together with a stout safety-pin; the latter by keeping the securing band well above the iliac crest, or even more safely by looping a tape beneath the elastic near the tuber ischii, passing it

behind under the sacrum and having it held in this position.

Mr. Lloyd recommends this method with full confidence, having employed it in four cases of amputation at the hip-joint, one excision, one nerve-stretching, and one exploratory operation. He considers it perfectly satisfactory.—*Lancet.—Phil. Med. Times.*

INJECTION OF PEROSMIC ACID.—PROF. WINIWARTER reports the case of a man with a soft sarcoma in the right side of the neck as large as a baby's head, and adherent to the vessels and nerves of that region. As it could not be operated upon, Prof. Winiwarter decided to practice injections of perosmic acid. For fourteen days he injected daily about three drops of an aqueous solution (1 to 100) of the acid, at the end of which time the tumor was completely broken down. The broken-down parts mixed with sero-pus, were evacuated by an incision, which rapidly cicatrized. One month after treatment was begun there was no trace of the tumor. The skin was intact, and there were no symptoms of local inflammation. This treatment was afterwards adopted in a similar case of sarcoma of the shoulder, in a number of cervical tumors, in cervical adenitis of scrofulous origin, etc. It was also employed in glandular tumors of a carcinomatous nature. The dose in some cases was as much as half a syringeful. Several years ago Dr. Moore used acetic acid in similar cases in the Middlesex Hospital.—*Gaz. Méd. de Nantes.- -Med. News.*

TREATMENT OF STYES.—Louis FitzPatrick, L.R.C.S., in the *Lancet*, says: The local application of tincture of iodine I have found, after many trials, to exert a well-marked influence in checking the growth of the stye. This is by far preferable to the nitrate of silver, which makes an unsightly mark, and often fails in its object. The early use of the iodine acts as a prompt abortive. To apply it the lids should be held apart by the thumb and index finger of the left hand (or a lid retractor, if such be at hand), while the iodine is painted over the inflamed papilla with a fine camel-hair pencil. The lids should not be allowed to come in contact until the part touched is dry. A few such applications in the twenty-four hours is sufficient, and I have never seen a single instance in which, after this treatment has been resorted to, the stye continued to develop itself.—*Louis. Med. News.*

DIAGNOSIS OF LINGUAL ULCERS.

CHIEF POINTS.	CARCINOMATOUS.	SYPHILITIC.
AGE.	Usually after 4 years. Excpus.	U'sually before 45 Excpus.
SITE.	Usually on one side Tends to invade floor of mouth.	On the upper surface often in middle line.
EDGE.	Defined, infiltrated, hard, everted.	Less defined, may be excavated and sloughy, not infiltrated or everted Another s. myositis inter-titial and diffuse
PAIN.	Constant. Darting into ear, etc	Comparatively slight
FIXITY.	Marked, from tendency to invade floor of mouth	Not marked
GLANDS	Submaxillary lymphs soon involved, and hard.	Glands affected less rapidly, and to a much less degree. Post Cervic as well as Submax Goes less hard.
PROGRESS	Steady. Often rapid. Resists treatment.	Slow. Often stationary Amenable to treatment
ORIGIN	In a slight abrasion, a fissure or crack, wart (rare).	In a "lump"
PREVIOUS HISTORY AND CONCOMITANT SIGNS.	Perhaps of irritation.	Of syphilis

—*Brit. Med. Journal.*

LOOSE BODIES IN THE KNEE JOINTS.—These bodies, familiar to all surgeons, are believed by Dr. Oliver Pemberton (*Lancet*, May 19, 1883) to be due to a chipping or breaking off of the joint surface, and that as time goes on the loose body thus produced is found to present appearances according to its age and, as it were, to the extent of wear and tear in movement it has undergone: at one time being cartilaginous or fibrous, or osseous or mixed, as the case may be, the ultimate shaping and structure of the body being doubtless greatly influenced by the predominance of the rheumatic habit.

He removes them by incision.—*Med. and Surg. Rep.*

GOODELL ON ADMINISTRATION OF ETHER.—One of the chief lessons I have learned from my experience during the year is to administer ether. Hitherto I have, in common with most American surgeons, given this anæsthetic by a closed cone in such a manner that the patient breathed her own air over and over again. I am now disposed to think that this is a very unsafe mode, and that to it is due, in large measure, the alarming prostration of the patient while undergoing the operation. For instance, among the twenty-five cases of last year, cases 70, 71 and 82, presented such profound symptoms of shock that the operation had to be suspended until hypodermic injections of brandy and of ether

were made, and some degree of reaction had set in. In cases 70 and 71, it was indeed with great difficulty that the women were kept from dying on the table, while case 85 clearly died from œdema of the lungs. Now I do not find such alarming symptoms referred to in any report of cases by British operators. I am therefore forced to the conclusion, that either under the strain of rivalry they do not operate in very desperate cases, or their mode of administering anæsthetics is a safer one than ours. Fully impressed with this idea, I have lately been using Dr. Allis's improved inhaler and have thus far found it to act promptly, safely and economically.—*M'd. Med. Jul.*

In urethral stricture "I have," says M. Diday, "in order to avoid confounding it with a spasm and to overcome this, if it exists, an infallible method. When the end of the sound is in contact with the coarctated portion of the canal I suddenly put the following question to the patient: 'How long is it since you have been with a woman?' If it is a simple spasm the sound immediately enters."—*Lyon Méd.*

Midwifery.

The Causes of Head Presentations.—Mech (*Arch. f. Gynak, N. Y. Med. Jul.*) regards the frequency of head presentations as being due to the muscular movements of the fœtus. Extension of a limb, if it meets sufficient resistance, acts upon that portion of the fœtal body contiguous to the limb extended. The most resistant part of the uterus is in the pelvic regions, the most movable, at the fundus and sides. The vertical position, whether the head or the breech is in advance is then the most favorable to stability. Should the breech be in advance extension of the legs, acting upon the resistant pelvis, would most likely cause the fœtus to change position. If the head was in advance the extended feet would act at a disadvantage against the softer parts of the uterus, and the fœtus would be more apt to remain at rest. So also if the arms were extended, they would act upon the softer parts of the uterus above the pelvis. The further the head has advanced into the pelvis the more stable the position. The limbs are usually directed towards the side walls of the uterus which are more yielding than the front, and the right side than the left, where the descending colon and its contents are located. This accounts for the greater frequency of the first position, whether of the head or of the breech, and indeed the same holds true of the transverse position.

Post-Partum Polypoid Tumours.—Dr. H. G. Landis said the physician is sometimes blamed for not completely delivering the placenta, when the real condition is due to other substances than placental tissue.

1. Blood polyps may form after delivery, consisting only of coagulated blood.

2. Blood polyps *may* be associated with retained fragments of placenta or membrane.

3. The same condition may occur with strips of decidua, prematurely detached.

4. The decidual membrane may undergo hypertrophy in places, giving rise to a sessile tumour of some magnitude and causing secondary hemorrhage, septicæmia, etc.

To the few cases on record the writer added the details of two cases observed by himself.

Dr. John Morris, of Maryland; Dr. Watkins, of Kentucky; and Dr. H. O. Marcy, of Massachusetts, cited similar cases.—*Med. News.*

Migration of the Ovule by Vibratile Cilia.—In support of this view late experiments have been made in female guinea pigs in heat, the results of these observations, through defective conditions, were not altogether satisfactory. But in frogs at the menstrual epoch in the clearest manner was observed a complete covering of epithelial cells with vibratile cilia, upon the internal surface of the peritoneum. This epithelium did not exist in males nor in females at any other season. Quite lately very active ciliated epithelial cells have been found upon the peritoneum of female tritons.—*L'Un. Méd. du Nord Est.*

After-pains.—Dr. E. L. Horriott, of Jacksonville, in his Report on Obstetrics to the Ill. Med. Soc. says (*Weekly Medical Review*) that he has accidentally discovered that aromatic sulphuric acid is the best remedy for after-pains.

THE
Canadian Practitioner,
(FORMERLY JOURNAL OF MEDICAL SCIENCE.)

To Correspondents.—*We shall be glad to receive from our friends everywhere, current medical news of general interest. Secretaries of County or Territorial Medical Associations will oblige by forwarding reports of the proceedings of their Associations.*

TORONTO, AUGUST, 1883.

THE TORONTO PUBLIC SCHOOL BOARD.

We learn from the Toronto dailies that the efforts of the Medical Health Officer to effect sanitary improvements in the City Public School buildings have met with the disapproval of the Board. Indeed some of the members question his right to inspect and make public the condition in which he found the buildings. In noticing these objections, Dr. Canniff said to a reporter: "As the Medical Health Officer, to whom is entrusted the health of the whole city, I felt it my duty to make myself acquainted with everything connected with the public health and especially public buildings. No buildings could be more important than those in which the youth of our city are detained for many hours of the day, and that naturally turned my attention to them. I have yet to learn that I am not justified not only in visiting the public schools, to see that the sanitary arangements are complete, but in stating, when asked by reporters, the condition in which I found them. In doing so I had no intention whatever of reflecting on the Committee or the Board as a whole. If it had been a question with me whether the board would be glad or otherwise in my taking such action, I would naturally have thought that as a public body entrusted with the interests of children and the public generally, they would have been glad to have received suggestions from the Medical Health Officer, whose duty it was to be more particularly acquainted with sanitary matters." The Editor adds: "This opinion will probably be concurred in by most people. That a majority of the Board do not think so is evident from the fact that they voted down a motion of Dr. Kennedy's to place a medical man on the Sites and Buildings Committee, Dr. Kennedy contending that the members of the Committee knew little or nothing of the duties required of them." The Chairman, in reply, said he was willing to have such assistance "for what it was worth." By this it seems that the Board thinks the Committee is competent to make all necessary sanitary arrangements without the aid of the Medical Health Officer or any other medical man. How far this Committee is qualified to discharge this duty we may judge from the authoritative statements contained in an article published in the *News* of June 27th. This article, we believe we are correct in saying, was written by the Chairman of the Committee. He says, speaking of the proposed alteration of the school buildings: "Whenever it is practicable the down-pipes from the roofs of the buildings are connected with the closets, in order that the rain thus collected may assist in flushing the closets, but nothing except liquid matter is allowed to flow into the public sewers; and the pipes are so constructed that the surface water will flow into them at a distance of about three feet from the bottom of the pit. The Committee has always regarded it as of the utmost importance to allow only the liquid matter to escape into public sewers, believing that the health of the citizens might suffer if all the contents of the pits were to be washed into the sewers, for which there are so many places of exit for impure gases. It has been stated that the Medical Health Officer, during his visits to one of the schools since they were visited by the Committee, intimated that the closets should be completely emptied into the sewers, but the members of the Board who have considered this matter carefully for years (!) do not

agree with the officer in this particular, and in fact would not consent to pursue any such course, believing that if followed the results would be injurious to the public health."

We read this a second time and a third, to see if we have comprehended the meaning of the learned chairman. We believe that all of the closets in connection with the schools are privies, not water-closets. At all events, it is said that nothing but liquid matter is allowed to flow into the sewer, and the closets are generally emptied once a year (although the Health Officer was informed the closets at the Dufferin School had never been emptied, having been in use for some five years, we believe). What, then, is meant by the statement, that where practicable the rain-water is used to assist in flushing the closets? If we understand the chairman, the opening of the pipes to carry off the liquid matter is placed three feet from the bottom. There is then allowed to collect three feet of fæcal matter in the pit. When it rises above that the liquid will be drained off. Are we to understand that all the solid matter sinks to the bottom. Our own observation is that it often floats on the fluid. But how in the name of common sense is the occasional flow of rain-water to assist in flushing the closets? The simple fact is, the rain-water adds to the danger which attends decomposing fæcal matter. During the summer, the liquid portion, at least, would in a great measure pass away by soakage and evaporation, and the danger become less; but the occasional rainfall supplies suitable conditions to keep up active fermentation. So, when the children return to the schools in September, which is usually a hot month, they stand a good chance of contracting poisonous material.

This is the present attitude of the Committee, after having "considered this matter carefully for years!" No, they would not consent to have the fæcal matter carried away, because forsooth, it would be injurious to the public, if all the contents of the pits were to be washed into the sewers. The simple fact is, that all the excretory matter from the schools flowing into the sewers, would be as a drop in the bucket to the volume of fæcal matter now poured into the sewers from different sources. Then the liquid matter may be quite as deleterious as the more solid.

THE MEDICAL SCHOOLS IN TORONTO.

We have received the Annual Announcements of the Toronto and Trinity Medical Schools for 1883-4. We are glad to know that both are prosperous, and that their growth is quite in proportion to that of our flourishing city.

We note with pleasure that the Faculty of the Toronto School of Medicine "having found the summer session of 1883 successful beyond their expectations, have decided to make it a permanent feature in their course of instruction."

We are also glad to notice that the Toronto School Announcement of this year contains a complete catalogue of the very excellent museum in connection with that institution. Dr. Oldright, who has had charge for the last twelve years, had a large amount of material to commence with, has been making large additions every year from various sources, has worked most assiduously in putting his specimens in proper shape, has arranged the contents in a most convenient and suitable way, and now, as the result of his labours, can point to a collection which is as creditable to himself as we hope it will be useful to the students connected with his school.

The system, carried out for years, of having the clinical teaching of both medical schools in the hospital so arranged that it will be available for all the students in Toronto, will still prevail in the coming session. The students will thus be enabled to attend a course of practical hospital teaching which can scarcely be excelled on this continent.

DOMINION MEDICAL ASSOCIATION.

The next meeting of this Association will be held in Kingston on Wednesday and Thursday, 5th and 6th September. At the last meeting held in Toronto, it will be remembered a discussion took place on that portion of the report of the nominating committee which recommends Kingston as the next place of meeting, and an amendment in favour of Montreal was defeated by a fair majority.

It was thought by many that a meeting in the "Limestone City" might awaken more interest among the Profession of that vicinity in the proceedings of the Association than has hitherto been manifested. There are many other reasons for the choice, and we hope the selection will prove a wise one. As Kingston is easily accessible both by land and water, there is no reason why the meeting should not be a large one.

We are authorized to request members of the Association to send titles of the papers they intend to read to the General Secretary, Dr. Osler, of Montreal, as soon as convenient. It is desirable that a printed programme should be ready for distribution among the members on the morning of the first day, and it will be a very simple matter for the Secretary to prepare this if he gets due notice respecting the papers.

The members from the west may either take the boat at Toronto about two in the afternoon on the day before the meeting, thus reaching Kingston about daybreak on Wednesday morning, or leave by train about seven or eight on Tuesday evening. Arrangements are being made with railroad and steamboat companies for reduced fares.

ONTARIO MEDICAL ASSOCIATION.

Dr. D. Clarke, President of the Association, has named the *personnel* of the committees for the next annual meeting as follows:—Necrology—Chairman, Dr. Bryce, Toronto; Drs. Lepper, Meaford; Patterson, Markham; Smith, Pyne, Marshall, and Martin, Toronto; Dickson, Day, Harrowsmith; Webster, Norval; Sonnett, St. John's, Radford, of Galt. Audit—Chairman, Dr. Elliott, Lindsay; Drs. Armstrong, Markdale; Irving, Kirkton; Miller, Woodhill; Robinson, Markham; Stutt, W. Flamboro'; Ward, Napanee; Wilson, Richmond Hill; and Geo. Wright, Duncan, Sweetnam, Sinclair, Hunter, and Wallace of Toronto. Arrangements — Chairman, Dr. Mullin, Hamilton; Drs. Case, Leslie, Philp, and Woolverton, of Hamilton; Inksetter, Dundas; and Vanderburgh, Merritton. Papers and Business—Chairman, Dr. Nevitt, Toronto; Drs. McLean, London; Hunter, Ballantrae; Fairchild, Brantford; Todd, Georgetown; Wood, Delhi; Thom, Streetsville; Duncan, Thamesville; Fraser,——; and Drs. Canniff, Buchan, Riddel, Stark, and Ferguson, of Toronto. Medicine—Chairman, Dr. Harvey, Watford; Drs. Hunt, Clarksburg; Gillies, Teeswater; Caw, Parkhill; Beaton, Orillia; Battersby, Port Dover; Rae, Oshawa; Nation, Uxbridge; McTaggart, London; Orr, Hastings; Macdonald, Hamilton; and Barrett, Geikie, Davidson, W. H. Aikins, Carson, McFarlane, Playter, O'Reilly, and Sheard, of Toronto. Ophthalmology and Otology—Chairman, Dr. Palmer, Toronto; Freel, Stouffville; Henderson, Kingston; Hamilton, Port Hope; O'Reilly, Fergus; Powell, Edgar; Stalker, Ripley; McKechnie, Thorndale; Mitchell, Enniskillen; and Drs. Ryerson, Reeve, Rosebrugh, McPhedran, and Holmes, of Toronto. Surgery—Chairman, Dr. Burt, Paris; Campbell, Seaforth; Street, London; Christie, Flesherton; Digby, Brantford; Yeomans, Mt. Forest; McNaughtin, Erin; Hurlburt, Brucefield; Dupuis, Kingston; Bascom, Uxbridge; Burrows, London; McLean, Goderich; and Drs. Fulton, Oldright, Aikins, Zimmerman, A. H. Wright, Thorburn, Wagner, Burritt, of Toronto. Obstetrics—Chairman, Dr. J Ross, Toronto; Drs. Ghent, Priceville; Bogart, Campbellford; Groves, Fergus; Hillary, Aurora; Smith, Sparta; Turver,

Parkdale; St. Clair, Paris; Rosebrugh and Malloch, Hamilton; Lovell, Ayr; O'Gorman, Hastings; McCrimmon, Lucknow; Gould, King; Freeman, Milton; Baird, Pakenham; Bray, Enfield; Kitchen, St. George; and Drs. Workman, H. H. Wright, Burns, Strange, Macdonald, and King, of Toronto.

THE RELATION OF HOSPITAL STAFFS TO STUDENTS.

The *New York Medical Record* discusses in a very sensible manner the letter of an Ex-Resident of one of the New York hospitals. The Ex-Resident begins his letter with the rather startling assertion that the clinical advantages given to the medical student are inadequate when compared with the material at the disposal of the hospitals. He maintains his proposition in a style that cannot be gainsaid. The hospital physicians, as a rule, to which we are glad to know of several shining exceptions, do perform their duties to the students in a perfunctory manner. It is to be hoped that the patients profit more than the majority of the students by the presence of such men on the hospital staffs. The fault is not all upon one side. The physician is to blame perhaps more than the student, for he has the knowledge which the student has a right to be made a partaker of; and the physician should strive to make that knowledge attractive and useful to the student. An enthusiastic teacher will always manage to have diligent and attentive pupils. The student, if he sees a teacher dull, apathetic, in a hurry, passing over cases with a few general questions and a rapidly written prescription, will soon shrug his shoulders and barely stifle a yawn at the ordinary run of cases, but will prick up his ears at the faintest rumour of some great surgical operation, which he will rush off to see and endeavour to get a front seat, and spend an hour or more in watching the facility with which the eminent surgeon cuts, saws, sews and twists, then will go home and sigh for a similar case for *himself* to operate upon.

The minute investigation of each case occupies time, occasions trouble, inconvenience and many times entails loss to the physician; but the gain to the student is incalculable. The methodical examination of a chest, for instance, how often is a student shown how to conduct such an examination, and told what sounds have been heard and their meaning explained?

In the matter of a consultation of the staff, how many students ever saw how such a consultation was conducted. As a rule the patient is examined by each in turn, or perhaps has been examined in a semi-private manner, and the examiner's dictum been left with the resident surgeon. But, how often does the student know more than the result of the consultation, would not the detailed reasons for the mature opinion of each consultant be of use to the student, who perhaps in his first month in practice will be called upon to hold a consultation on a similar case.

Very few students have an opportunity of administering anæsthetics, and it is not often that a practical course is given detailing the manner of administration, the dangers incident to them, and the means of obviating them. The *Record* speaks strongly on this point, and we entirely agree with it

WOMEN ON GENERAL HOSPITAL STAFFS.

At a recent competitive examination for the house staff of the Mount Sinai Hospital, Dr. Josephine Walker, a graduate of the Woman's Medical College of the New York Infirmary, was a successful candidate, and received the appointment.

Dr. Caroline S. Pease has been appointed a member of the staff of the Troy Hospital, Troy, N.Y.

Mr. Mulcahey can see no earthly reason why women should not be allowed to become medical *men*.

We welcome with great pleasure the appearance of the *Journal of the American Medical Association*. It is to contain thirty-two pages of reading matter weekly. The contents of the first number consist in Original Articles, Notes on Medical Progress, Editorials, Correspondence and Medical Societies. The *Journal* is somewhat similar in appearance to the *Philadelphia Medical News*. The promptitude of the editor is to be commended in thus fulfilling the promise made at the last meeting of the Association.

A General Index of the Transactions of the Association from the date of its organization to the present time, is in course of preparation. By sending *one dollar* to the Treasurer, Dr. Richard J. Dunglison, P.O. Box 2386, Philadelphia, a copy can be secured.

Those wishing to subscribe to the Journal of the Association can do so by forwarding their address and five dollars to the *Journal of the American Medical Association*, 65 Randolph street, Chicago, Illinois.

The American Ophthalmological and Otological Association met July 16, at the Hotel Kaaterskill.

Meetings of Medical Societies.

TORONTO MEDICAL SOCIETY.

Regular meeting, June 14, the President in the chair.

Dr. Cleland was proposed for membership.

Dr. Cameron showed a boy aged eighteen with the following history: He is the third child; was born at full time. One of his sisters has suffered from rheumatism. At five years he took scarlet fever; was much reduced, but no otorrhœa or anasarca; at six years had St. Vitus' dance, which lasted seven months. At this time he complained of his nose. At twelve years he went to work on a farm, and kept well till three years ago, when he had zona for three weeks; after this, whenever he got wet, a rash came out on lips and they would swell. About a year later the throat and nose got sore; difficulty in swallowing, and scabbing in nose, followed by discharge and offensive breath; kept getting worse till a year ago in April, when he went to the hospital, where he stayed for a month and improved under carbolic spray and internal medication; has been subject to otorrhœa from left ear, and when in hospital got erysipelas. His present symptoms were aggravated by catching cold. Besides the otorrhœa, he presents the somewhat rare condition of adhesion of the soft palate to the pharynx, with perforation. Dr. Cameron considers it a case of congenital syphilis, the adhesion being due to the breaking down of gummata.

Dr. Palmer, referring to the presence of tinnitus, remarked on the cause, viz.: rarefaction of the air in the naso-pharyngeal space. He prophesied complete deafness, unless a communication was established between the mouth and naso-pharynx.

Dr. Reeve remarked that ar opening in the membrana tympani might accomplish the desired end; but he did not advise it.

Dr. Cameron thought that the perforations in the soft palate allowed sufficient communication; operations for that purpose had usually been unsuccessful. He suspected necrosis of the bones in the nasal cavities; if so, their removal would doubtless improve the condition.

Dr. Macdonald presented a heart containing only two cavities, viz., an auricle and a ventricle. History: K—— æt. twelve, tall for her age; an inmate of the Orphans' Home; has always been cyanotic; heart's action laboured, with a presystolic murmur at the base, but heard to the left of the sternum at the second intercostal space; breathing regular; has had no pain; death caused by tuberculosis. The condition of the heart was only discovered *post mortem*.

During life the foramen ovale was supposed to be patent.

Dr. McPhedran considered the murmur to have been due to the arterial and venous streams meeting in the single cavity.

Dr. Cameron referred to the theory of the formation of the normal heart from a single blood vessel.

Dr. Sheard explained and illustrated Kolliker's idea. The tube is bent upon itself, the septum being formed by the coalescence of the walls of the vessel. This septum grows downwards, ultimately completing the separation between the ventricles.

Dr. Cameron was of opinion that the septum grows from below upwards, as, if any deficiency is found, the opening is above, not below.

Dr. Sheard said that such cases were due to the great size of the foramen ovale. In them it extends below the auriculo-ventricular ring.

Dr. Ryerson showed a temporal bone which was carious to a large extent on the superior surface of petrous portion. It was removed from a man æt. 32, having the following history: On morning of 24th May was seen by Dr. Sweetnam; had great pain in head, dizziness, seemed rather silly and out of his senses; temperature 101°. Anorexia, constipation. History of chronic discharge from right ear. Symptoms varied in severity for a couple of days when he was advised to go to the Hospital by his medical attendant, which he accordingly did. When seen by Dr. Ryerson on the 26th, he had great pain in head. Vomiting of most offensive material. Quick weak pulse, loss of appetite and fever. He wandered about in his night dress during the day, and otherwise acted in a delirious fashion. There was a thin brownish and very offensive discharge from right ear. He was almost absolutely deaf. Ophthalmoscopic examination was negatived by the restlessness of patient, there was no swelling or venous enlargement over mastoid process.

The Doctor practised a free incision about 1½ in. long, down to bone over mastoid with view of local depletion. Bled freely for an hour or more, after which patient seemed a good deal better. Pain much less, symptoms however, soon recurred. He became gradually comatose and died on June 7th. Post-mortem next day by Dr. Sheard revealed large quantity of serous fluid beneath dura mater. Brain congested. Pus along base of brain and a collection of pus in substance of hemisphere at some distance from surface and separated at some distance from carious bone by comparatively healthy brain substance.

Dr. Ryerson in remarking on case pointed out the importance of attending to discharge from the ear, and that in the vast majority of cases the pus came from the middle ear. He stated that of 76 cases of abscess of the brain collected by Gull and Sutton, 25 or nearly one third were caused by ear disease. Lebert states that at least one fourth of all cases are from this cause. Field of London states that of 500 cases of perforation of membrana tympani from *all causes*, one per cent. died of abcess of the brain. The history of these cases was generally this:—Earache and discharge for a period varying from a few months to forty years. A blow on ear or a severe chill, then follow fever, intense headache, dizziness, distressing noises in ear, nausea vomiting, constipation, loss of appetite, delirium, twitching of muscles, paralysis of face, of extremities of same side, coma, and death.

The pathological processes were suppurative inflammation of lining membrane of middle ear, ulceration of same, periostitis, ostitis, caries, and necrosis.

The question might arise in such a case as the above, would perforation of the mastoid have been advisable? Probably not. An instance was mentioned in which the symptoms were held to justify the operation. The relief although great was only temporary.

Dr. Cameron wished to know if œdema above and below the zygoma had been noticed in the first mentioned case.

Dr. Reeve pointed out that suppurative otitis may, in many instances, be prevented by free and early local depletion, irrigation, solution of atropin, and the use of Turkish and other baths.

Dr. Ryerson, in answer to Dr. Cameron, said that there was no œdema in this case—he had often noticed it in mastoid disease.

Dr. Sheard showed a peculiar cyst—it was in connection with both ovaries—these being in a state of suppuration. The question was, ovarian or parovarian? He inclined to the opinion that it was an ovarian cyst.

The President presented a specimen of pleuritis and endocarditis. At the autopsy, on cutting into the left pleural sac, what seemed almost to be a third pleural covering was seen. It was placed between the visceral and costal layers—being very slightly adherent to the latter.

After the paper for the next meeting had been announced, viz.: "Taking Cold," by Dr. Ryerson, the Society adjourned.

Regular meeting, June 28th, the President in the chair.

Dr. Cleland was unanimously elected to membership.

Dr. King sent an interesting specimen, with notes. ~~In his absence the notes were~~ read by the Secretary.

~~Dr.~~ King presents facts concerning a twin pregnancy of 7 months duration, the last three of which the patient carried a living and a dead fœtus. The latter together with the membranes and placenta and the placenta of the living fœtus were exhibited. Dr. King was called to see Mrs. P———, about four miles out of the city about one o'clock on Tuesday morning, the 26th inst., and on arrival learned that she was in veritable labour, though two months short of her full time, and that she had been in labour since 7 o'clock on the morning of Monday. It was a case of multipara, one confinement producing twins. The pains were constant but not very strong and patient very much exhausted, and bore a most anxious look. Digital examination revealed os well dilated and some uncertain presentation which he could not at first define. Owing to the excitable condition of patient he administered chloroform, and passed the hand into vagina when the diagnosis became positive after rupturing the membranes. The presenting part was a dead fœtus of four months growth, lying transversely head to left side. By easy manipulation it was removed still enveloped in the membrane. The membrane which accompanies the specimen being removed, the dead fœtus was found to have the head flattened by the growth of the living fœtus as found by inspection of the specimen. An attempt to remove the placenta by gentle traction failed, and further digital examinations revealed the protruding bag of waters of a second fœtus which by pressure against head was found to be alive and presenting naturally. Pressure upwards permitted escape of aforementioned placenta. In a few minutes this child was delivered, subsequently both placentas came away with gentle traction. The placentas are included in the specimen presented. The funis of the dead fœtus was between 3 and 4 inches longer than that of the living one by actual measurement. About April 1st, the mother was called by telegram to a dying brother and received a shock, she however, left immediately on a long journey by rail, reaching the get-off station in the night. Not being met by friends, she undertook to walk to her destination a distance of two miles, and was so ill, that she had to sit down and tarry for some time by the way before completing her journey. Ever since she felt as if "something was not right," she was different from what she had been on previous occasions. The following points appear to be the chief ones:—

a. The living fœtus had undergone seven

months of gestation, and to-day still gives promise of living.

b. The appearance of the dead fœtus would correspond in development with the time the patient had been pregnant, on April 1st., viz. 4 months.

c. The presence for three months *in utero* of the dead fœtus, does not appear to have affected the living fœtus detrimentally to any appreciable extent.

d. Both fœtuses were female.

e. Funis of the dead 3 inches longer than that of the living.

f. The firm consistency of the placenta of dead fœtus in contrast with that of the living one.

g. Fluid expelled with dead fœtus dark and grumous, but very little odor of decomposition.

h. The living child weighs about four and a-half pounds.

Dr. G. Wright considered that the fœtus could not have been dead for three months. Dr. Davidson thought the fœtus to be between the fifth and sixth months. Probably pressure had produced the fatal termination.

Dr. G. Wright presented a pathological specimen from an interesting case of Hodgkinson's disease, with the history.

The paper for the evening was to have been read by Dr. Ryerson—in his absence, the President called for Cases in Practice. Cases were given by Dr. Duncan, Dr. Spencer, and Dr. G. Wright, which were discussed in a conversational manner. The hour for adjournment having arrived it was on motion, resolved to adjourn over the months of July and August, the next meeting to take place on the first Thursday of September.

RIDEAU AND BATHURST MEDICAL ASSOCIATION.

The annual meeting of this Association was held at Arnprior, on Wednesday, 27th June; all quarters of the district being well represented. After routine business the President delivered his annual address, and reported upon the business of the recent meeting of the Medical Council. A general discussion upon details, relating to the district followed.

Papers were read by Dr. MacFarlane, Almonte, upon the *Bowels in Typhoid Fever*, and by Dr. Groves, Carp, on *Lead Poisoning*. Dr. Burns, Almonte, reported a case of gunshot wound of abdomen. The papers were very exhaustive, and evidenced much research and original thought. The discussion following each paper was general, and entered in by all.

The officers are as follows:—Dr. Cranston, Arnprior, President; Dr. Manoch, Ottawa, First Vice-President; Dr. Groves, Carp, Second Vice President; Dr. Hill, Ottawa, Treasurer; Dr. Small, Ottawa, Secretary.

And a Council composed of Drs. Dickson, Armstrong, Rattray, Baird, Burns, Bell, Grant, Sweetland, and H. F. Wright.

Book Notices.

Annual Announcement of the New York Polyclinic. Session 1883-4.

Annual Announcement of the Toronto School of Medicine. Forty-first session 1883-4.

Sixteenth Annual Announcement of the Detroit Medical College. Session 1883-4

Fifty-first Annual Announcement of Faculty of Medicine of McGill University. Session 1883-4.

Twenty-Third Annual Announcement of the Bellevue Hospital Medical College. Session 1883-4.

Report of Proceedings Illinois State Board of Health, Quarterly Meeting at Springfield, June 29, 1883.

Second Annual Announcement of the College of Physicians and Surgeons of Chicago. Session 1883-4.

Official Guide Book to the Canadian Pacific Railway Lands situated in Manitoba and Northwest Territory.

Guatamala: An address delivered at the opening of the California State Medical Society, April, 1883. By Dr. L. C. Lane.

Weekly Health Bulletin and Meteorological Record for Province of Ontario. By

P. H. Bryce, M.A., M.D., Sec. Provincial Board of Health.

List of Premiums, Rules and Regulations, Fifth Annual Exhibition of Industrial Exhibition Association of Toronto. Sept. 11 to 22. Competition open to the world.

Closing Exercises of the Practitioner's Course of Lectures in the Hahnemann Medical College and Hospital of Chicago, Ill., 26th March, 1883.

The Medical Register has become "The Polyclinic," and is conducted by the Faculty of the Philadelphia Polyclinic and College for Graduates in Medicine. It appears monthly.

Weekly Health Bulletins and Meteorological Reports of the State of Michigan, and monthly Mortuary Statistics of the City of Lansing, Mich., for the month of June. By Henry B. Baker, M. D., Sec. State Board of Health.

Quarterly Retrospect of Surgery. Prepared by Francis J. Shepherd, M.D., C.M., M.R.C.S., Eng., Surgeon to the Montreal General Hospital, Lecturer on Anatomy, Operative and Minor Surgery, McGill University. Reprinted from the *Canada Medical and Surgical Journal*, June, 1883.

The Medicinisch - Chirurgisches - Correspondez-Blatt is the name of a new monthly published in the interest of German-American Practitioners by Dr. Marcill Hartwig, of Buffalo, N. Y. It is well issued in the superior style of American journalism, and must prove a great boon to those for whom it is more especially intended, and an excellent source of information and medical news to all.

Dio Lewis Monthly, No. 1, vol. i, for August, 1883, now lies before us. The persistent and successful efforts of Dio Lewis to popularize sanitary science and present the vital questions it involves in an attractive and pleasing form, are so well known that no further commendation of this new venture is required beyond the plain announcement of its timely and comely appearance.

On the Disposal of Sewage. Paper No. 11, issued by the Provincial Board of Health of Ontario.

This is a valuable pamphlet, whose wide diffusion will do much to disseminate sound views upon this important and vital subject, and accomplish much good, we trust, throughout the land.

The Microscope and its Revelations. By W. B. Carpenter, M.D., LL.D., F.R.S., etc. Sixth Edition. New York: Wm. Wood & Co; Toronto: Willing & Williamson.

This work is published in two volumes form the April and May numbers of Wood's Library, 1883. It is probably the best treatise written for the general microscopist, although it contains nothing purely medical.

Handbook of the Diagnosis and Treatment of Diseases of the Throat, Nose and Naso-Pharynx. By Carl Seiler, M.D. Second edition. Revised and enlarged; with 77 illustrations. Philadelphia: C. Lea's Son & Co, 1883. Toronto: Ure & Co. Price $1.75.

After a lapse of four years a second edition of this excellent little manual of Dr. Seiler, makes its appearance. Numerous additions have been made, especially in the section on the nasal cavities. The illustrations have been both increased and improved; and in every way the work continues to deserve a perpetuation of the large share of professional favour it has already received.

Therapeutic Handbook of the United States Pharmacopœia. By Robert F. Edes, A. B., M. D., (Harvard); New York: Wm. Wood, & Co., 1883.

A nicely gotten-up book, printed and bound as a companion to the new edition of the U. S. Pharmacopœia and containing about 400 pages. The therapeutic hints are little more than hints. The usefulness of the work we do not consider to be commensurate with its size, nor with the labour necessary to compile the information contained therein. Towards the close of the book a few non-officinal drugs are mentioned such as coto, nitro-glycerine, trimethylamine, etc. Then follows a classified list of remedies, and then a list of poisons and their antidotes, amongst which we notice that the antidotes for atropine are curiously named: belladonna, stramonium, hyoscyamus, evidently a typographical error—but one of sufficient magnitude to have attracted the eye of the proof-reader.

The Practitioner's Ready Reference Book. By Richard J. Dunglison, A.M., M.D. Third edition. Thoroughly revised and enlarged. Philadelphia: P. Blakiston, Son & Co., 1883.

This is probably the most remarkable book ever written by a man of Dr. Dunglison

son's calibre. It contains the most curious admixture of heterogeneous pieces of information (nearly always useful) it has ever been our lot to meet. Nevertheless the attainment of a third edition in six years attests the filling of a want. Unfortunately it does not at the same time attest the existence of a high standard of attainment amongst those to whom it has proved most useful. The weakest part is the section on Poisons and Antidotes. Many parts, such as "How to use a Galvanic Battery," "How to Apply Trusses," etc., taken from such works as Tibbits' and Wood's, are excellent. All sorts of subjects are treated of, and in this last edition numerous and important additions have been made. To recent graduates it will, of course, prove most serviceable.

The Pathology and Treatment of Diseases of the Ovaries. By Lawson Tait, F.R.C.S., Edin. and Eng., Surgeon to the Birmingham Hospital for Women, etc. New York: William Wood & Co. Toronto: Willing & Williamson.

Mr. Lawson Tait is well known as one of the most progressive surgeons of the day. His more recent operations in abdominal and pelvic surgery have been followed by results both brilliant and successful. He has laid down the following Surgical law, "That in every case of disease in the abdomen or pelvis, in which the health is destroyed or life threatened, and in which the condition is not evidently due to malignant disease, an exploration of the cavity should be made," and considers that the abdominal cavity may be opened in such cases with "perfect safety." His operation for the removal of the ovaries and Fallopian tubes is generally known as "Tait's operation," but is called by himself the "removal of the uterine appendages." His reports of cases of this description, as well as those of abdominal section for gall stones, pelvic suppuration, etc., are very interesting. This is the fourth edition of the work, but when compared with former issues shows many changes and additions. Every practitioner should know what Lawson Tait is doing, and the simplest way to acquire such knowledge is to read this book.

The Diseases of Women, a Manual for Physicians and Students. By Heinrich Fritsch, M. D., translated by Isidor Furst. New York: Wm. Wood & Co., 1883.

This book, with its brilliant covers, forms the March number of Wood's Library of Standard Authors. It is an eminently practical work, as shown in many little points throughout the various descriptions, etc. For instance, in stating that it is necessary to insert two fingers into the vagina for the purposes of diagnosis, "the middle finger is always inserted behind the first, even in multipara. The expert causes little pain, for the penis is thicker than two fingers." In speaking of vaginal irrigations he details a convenient method of carrying them out, but we submit that it is not a very efficacious one, as the patient is directed to be in a sitting position. The description of the characters of the fluids obtained by tapping the various ovarian and abdominal tumours is good. The wood cuts are unusually clear, and many of them are new. We can cordially recommend the work to those for whom it is intended—more especially as no preface sets forth the many reasons that induced the author to supply a long-felt want, nor his peculiar fitness for the self-imposed task.

A Treatise on Therapeutics Comprising Materia Medica, and Toxicology with especial reference to the application of the Physiological action of Drugs to Clinical Medicine. By H. C. Wood, M.D., Philadelphia: J. B. Lippincott & Co., 1883.

This well-known work which has now reached its fifth edition, preserves its pristine energy. The author has not lagged by the wayside, but has brought the subject matter quite up to the onward march of the times. His classification is more or less based upon Physiological grounds. But as he says "a system of classification is merely a row of pegs upon which to hang our ideas and facts." It makes little difference if the system be to our taste or not, provided the ideas are handy and the facts correct.

His method of treatment is to give a short definition and description of the class and sub-class and of the various members of the sub-class. He takes up the Physiological action, Therapeutic uses, Toxicology and mode of administra ion of the chief or more important remedies. The various theories deduced from experimentation and the experiments themselves, are placed in a very clear light, and a short criticism where it appears necessary is appended. He freely assents to or boldly disagrees with

previously recognized opinions, yet is always reasonable, impressing one with his individuality, yet avoiding dogmatism. The information is culled and condensed from the best sources, domestic and foreign, in many cases confirmed or contradicted by personal experimentation.

A valuable general index, also an index for diseases, close a volume which we heartily commend to the Profession as embodying in a concise form the latest researches in Therapeutics.

Personal.

Prof. Huxley has been elected President of the Royal Society.

M. Pasteur, has organized a commission for investigating the cholera in Egypt.

Dr. O. S. Wiestanley has returned from his trip to the Old Country.

Dr. Uzziel Ogden is now in Italy. He will return to Toronto in September.

Dr. Mullin, of Hamilton, is President of the Canada Medical Association this year.

John A. Lidell, M.D., æt. 60, died suddenly in New York, on the 8th of July.

Dr. Heneage Gibbes has been appointed to the Chair of Physiology and Histology in the Westminster Hospital.

W. T. Sedgwick, Ph. D., has been made Professor of Biology at the Massachusetts Institute of Technology, Boston.

Prof. John Marshall, of University College, succeeds Sir Spencer Wells as President of the Royal College of Surgeons.

The Professorship of the Buffalo Medical College has been offered (so it is reported in the *Medical News*) to Dr. Roswell Park, of Chicago.

Dr. Herbert Mickle (Trinity '81), who spent two years in London, where he took the M.R.C.S. and L.R.C.P., Lond., has returned to Canada.

Dr. J. T. Duncan has been appointed Associate Coroner, in and for the city of Toronto, the resignation of Dr. Riddell having been accepted.

Dr. F. S. Dennis has been appointed Professor of Surgery at Bellevue Medical College, to fill the vacancy caused by the death of the late Dr. Van Buren.

Dr. Burns, of Toronto, was well pleased with the kind treatment he received from the genial and hospitable medicos of Montreal, while there in July.

Dr. John A. Octerlony has been elected Professor of Obstetrics and Diseases of Women and Children, at the University of Louisville, to succeed Dr. Theophilus Parvin.

Dr. Reginald Southey, having been appointed Commissioner in Lunacy in the place of Dr. Robert Nairne, resigned, has ceased to be Physician to St. Bartholomew's.

Dr. John C. Dalton has resigned the Professorship of Physiology in the Coll. Physicians and Surgeons of New York, and has been succeeded by Dr. John G. Curtis.

Dr. Grant, *of Ottawa, passed through* Toronto, July 6th, on his return from the Northwest Territory, where he made a rather extended tour of three weeks' duration.

The names of Dr. Sullivan, of Kingston, and Dr. Grant, of Ottawa, are mentioned in connection with the vacant senatorships. Better appointments could not, we believe, be made.

The Professorship of Anatomy and Surgery in Trinity College, Dublin, is vacant, owing to the appointment of Dr. Alexander Macalister to the *Chair of Anatomy* in Cambridge.

Dr. Burnham, oculist and aurist, who since graduating has spent eight years in England (being six years resident at Moorfields) and the Continent, has settled in Toronto.

Mr. Geo. Fleming, LL.D., President of the Royal College of Veterinary Surgeons, has been appointed Principal Veterinary Surgeon to the Army, irrespective of seniority.

Her Majesty has signified her intention of conferring the honour of Knighthood upon Mr. Edwin Saunders, F.R.C.S. Eng., F.G.S. Mr. Saunders has been for many years Dentist to the Royal Family.

Dr. Theophilus Parvin, of Indianapolis, was elected Prof. of Obstetrics and Diseases of Women and Children at Jefferson Medical College, Philadelphia, in place of Dr. *Ellerslie Wallace, resigned.*

Dr. Spina, Koch's opponent, has been nominated Professor of General and Experimental Pathology at the University of Prague. The *N. Y. Record* says this may be

considered an endorsement of the value of Spina's work.

The Kingston Women's Medical College have appointed a faculty as follows: Obstetrics, Dr. M. Lavell; Surgery, Dr. M. Sullivan; Anatomy, Dr. Garratt; Materia Medica, Dr. Oliver; Medicine, Dr. Saunders; Medical Jurisprudence and Sanitary Science, Dr. Fenwick; Institutes of Medicine and Histology, Dr. Phelan. Botany and Chemistry will be taken in the Arts course of Queen's College.

Miscellaneous.

The *N. Y. Record* says the bacillus tuberculosis may have killed many men; it has made two—Koch and Spina.

The Cholera appears to have got a foothold in Egypt. If the Arabian Cholera is really that plague which always makes its way into Europe, and from thence to this continent, we may begin to look out in about two years time.

The Medical Colleges of the United States now in existence number 110, while the total number in Canada is only 9. The schools of the United States graduated 4,299, out of a total of 12,454 matriculates, at 34.6 per cent.—*Gaillard's Med. Jnl.*

Removal of Freckles.—The careful application of a small piece of the ointment of the oleate of copper at night upon retiring will usually remove freckles. The ointment is usually prepared by dissolving one drachm of the salt of oleate of copper in sufficient oleopalmitic acid.—Shoemaker.

Are French flats healthy? Yes, very. Are people in them healthy? No. Why? They have to starve and go half naked to pay the rent. Why are these flats called French flats? To distinguish them from American flats? What are American flats? The people who live in French flats.—*Cin. Lancet and Clinic.*

A Sanitary Convention is to be held in Muskegon, Mich., under the auspices of the State Board of Health of Michigan, on the 23rd and 24th instant. A very interesting programme has been prepared, and reduced railway fares may be obtained on applying to C. P. Donelson, M.D., of Muskegon, the Secretary of the Convention, for certificates.

How to Drive Flies Out of a Room.—Observations made by M. Rafford, a member of the Societié d'Horticulture at Limoges, show that a castor-oil plant having been placed in a room infested with flies, they disappeared as by enchantment. Wishing to find the cause, he soon found under the castor-oil plant a number of dead flies and a large number of bodies had remained clinging to the under surface of the leaves. It would, therefore, appear that the leaves of the castor oil plant give out an essential oil, or some toxic principle which possesses very strong insecticide qualities. Castor-oil plants are in France very much used as ornamental plants in rooms, as they resist very well variations of atmosphere and temperature. As the castor-oil plant is very much grown and cultivated in all gardens, the Journal d'Agriculture points out that it would be worth while to try decorations of the leaves to destroy the green flies and other insects which in summer are so destructive to plants and fruit trees. Anyhow M. Rafford's observations merit that trial should be made of the properties of the castor-oil plant, both for the destruction of flies in dwellings and of other troublesome insects.—*British Med. Journal.—Cin. Lan. and Clin.*

Every doctor, ought to have an opinion, and ought to be able to give it to others in a way that can be comprehended; the science of medicine no longer consists of technicalities.

Thus men will be forced to study their cases closely, thereby becoming more intelligent practitioners of the healing art.

Thus the narrow minded selfish egotist will have to give an opinion and abide by it.

Thus the man who by reason of age, and position, and influence, who cries the loudest for the code of ethics and tramples it underfoot without fear, will be forced to rely on merit intrinsic not on past reputation. The young man's mouth will not be shut, while the old man's is open.—*Nash. Jour. Med. and Surg.*

The Dangers of Experiment.—A short time since Professor Jolyet, of Bordeaux, nearly lost his life in endeavoring to demonstrate, by Grehaut's method of inspiring hydrogen, the lung capacity to his pupils. (*British Medical Journal,*) He had prepared the hydrogen gas, but, wanting some acid, he sent for it to a neighbouring laboratory, poured some into the apparatus, and

then made the inspirations necessary for the demonstration. The acid he had used, though sold as pure, contained arsenic, so that, instead of pure hydrogen, M. Jolyet had inspired arseniuretted hydrogen. Notwithstanding sudden feelings of illness, he had the great courage to continue his lecture to the end, but was obliged to go home immediately, overcome by a fearful attack of headache, vertigo, and symptoms of syncope. Still more serious symptoms supervened, which caused great alarm, and during some days M. Jolyet was very ill. Fortunately, there were no serious results, and although still very weak, M. Jolyet is, to the great joy of his pupils, quite out of danger.—*Louis. Med. News.*

Medical Amenities.—Dr. John Woodward was often elected on the Council of the Royal Society, from which he was expelled in 1710 for his grossly insulting remarks to Sir Hans Sloane. When the question of his expulsion was discussed it was pleaded in his favour that he was such a good-natured philosopher, but Sir Isaac Newton, who was in the chair, remarked that, "in order to belong to that Society a man ought to be a good moral philosopher, as well as a good-natured one." Woodward brought an action against the Council to be reinstated, but did not succeed. He afterwards quarrelled with the celebrated Dr. Mead, and meeting him accidentally under the gate of Gresham College, they drew their swords. Woodward's foot slipped, and he fell. "Take your life," said Mead. "Anything but your physic," replied Woodward, with his usual sarcasm.—*Med. Times and Gazette.*

Adulteration in Spain.—This practice has not escaped attention by the authorities even in Spain. One Spanish magistrate at least may lay claim to originality in dealing with sophisticated articles. "All articles," runs a proclamation, "in the shape of wines, groceries, and provisions, which upon examination and analysis are proved to be injurious to health, will be confiscated forthwith and distributed to the different charitable institutions."—*Med. Times and Gazette.*

It was a promising young man who on being asked by the professor of obstetrics what he would do in a case of post-partum hæmorrhage, replied with great promptness, "I would run like hades (old version) for the nearest doctor."

Sueing for a Diploma.—A member of the class of 1883 of the College of Physicians and Surgeons, Baltimore, who was a rejected applicant for a diploma, petitioned the Superior Court to issue a writ of *mandamus* upon the Faculty for a diploma, and claiming $2000 damages. Hereafter it may be as well for the Medical Council to demand of the students before matriculation a course in Common Law, in order that in case of rejection at the examination they may know how to proceed to gain their diploma with the least trouble and expense to all parties.

To Keep Instruments from Rusting.—Professor Olmstead, of Yale College, recommends the following mixture as efficacious to preserve to knife blades their bright metallic surface: Melt slowly together six to eight parts of lard with one of resin and stir until the mixture is cold. If it is deemed desirable to thin it, this may be done by the addition of coal oil or benzine. It should be applied to the perfectly clean surface, as it will not stop oxidation once begun.

A New Synonym for Quinine.—At Croton, New York, common drugs are sold at all the stores. Recently an Irishwoman entered one of them, and said to a new clerk: "Would yees be afther putting up for me a pound of Queen Anne's powders?" The clerk took down a package of Royal baking powder and was doing it up, when she exclaimed—"Not that at all, at all; me Pathrick is sick wid the African faver." "The what fever?" inquired the clerk. "The faver 'nagur," replied the woman. "An yees should see poor Pathrick shake. He hasn't a tooth left." The woman got the quinine which she wanted.—*Gaillard's Med. Jnl.*

The Number of Years a medical student has to spend at a medical institution prior to being admitted to examination for a medical degree in various countries is as follows (Vratch): Sweden, ten; Holland, Italy and Switzerland, six; Norway, eight; Denmark, six and seven; Belgium, six; Russia, Austria, and Hungary, five; France, England and Canada, four; United States, three or two; Spain, two.

Birth.

Ferguson.—At 321 Spadina Avenue, on July 22nd, the wife of Dr. J. Ferguson of a son, stillborn.