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THE CANADA LANCET

A MONTHLY JOURNAL OF
MEDICAL AND SURGICAL SCIENCE,
CRITICISM AND NEWS.

VOL. XVII. TORONTO, MAY, 1885. No. 9.

Original Communications.

OVARIOTOMY.

BY DR. A. M'DONALD, EDINBURGH.

Read before the Obstetrical Society of Edinburgh.

CASE I.—M. P., aged 23, unmarried, was admitted in January 24, 1884, complaining of a large swelling in the abdomen, of pain in the right side, of sickness, and of only being able to digest milk diet. Two years ago she suffered severe pain in right side and inability to eat. In August last she first noticed the swelling, and since that time it has rapidly increased in size. She had considerable menorrhagia and metrorrhagia from May till August last year.

Condition on admission.—Abdomen extended to size of eight or nine month's pregnancy by a tumor of slightly uneven outline, but, on the whole, of smooth contour. Tumor projects very far forward inferiorly, and seems to be more to the right than left side. Percussion note is dull over anterior surface of tumor, clear in flanks from back. Tumor appears to move slightly under anterior wall with forced inspiration. Measurement round umbilicus $35\frac{1}{4}$ inches; about $1\frac{1}{2}$ inches below umbilicus measurement is 38 inches. From right anterior superior spine to umbilicus, $9\frac{1}{4}$ inches. From left anterior superior spine to umbilicus $8\frac{3}{4}$ inches. From symphysis pubis to umbilicus, $8\frac{1}{4}$ inches. *Per vaginam.* Tumor presses down into anterior half of pelvis, displacing uterus to the left and backwards. Uterus appears movable at brim. No part of tumor is found in the pouch of Douglas. Sound enters towards the left and upwards, nearly 3 inches. *Per rectum.* Small body of uterus is distinctly felt apparently separate from the body of the tumor. On February 6th the patient was, after due preparation, submitted to operation. The room had been sprayed for some hours, and the usual antiseptic precautions were

employed, except the use of the spray during the operation. The abdomen was opened with ease. It was then found that the tumor was attached to the right broad ligament, and that there were considerable adhesions of its upper anterior part with the great omentum. Otherwise the tumor was free; the only considerable cyst in the tumor was tapped and about a pint of fluid run off. The edges of the tumor were now surrounded with sponges, and the tumor incised. The hand was then passed into the interior, the multitude of small cysts forming its mass were then broken up, and the contents squeezed out. In this way the tumor was lessened in bulk so as to pass through the abdominal wound, which originally measured about $3\frac{1}{2}$ inches. The omental adhesions were now fully exposed, and the attached part of the omentum was divided into a number of separate portions and tied by catgut ligatures. The pedicle was very broad and rather thin and short. It was transfixed and tied with silk ligature by the Staffordshire knot. As it seemed to ooze a little after being tied and the tumor separated from it, the loose ends of the thread were brought round the base of the pedicle and again tied. The sponges were now removed from the abdomen and the whole cavity thoroughly sponged out. The omentum was carefully inspected and no bleeding point discovered. The ligature was now cut short and the pedicle dropped. The abdominal wound was secured by deep and superficial sutures and the wound dressed with protective and salicylic wool and a flannel bandage. The patient was put to bed, surrounded by hot bottles, and a brandy enema administered. The operation lasted $1\frac{1}{4}$ hours. The solid weight of the tumor was 4 lbs. and the fluid above 12 lbs. The patient's recovery was excellent, though somewhat attended by persistent sickness and vomiting, which lasted for the first ten days after the operation, during which time she was fed by enemata. In the first few days the temperature ranged from 100 F. to 101.8, after that it became normal and remained so. Deep stitches removed on the seventh day, union complete. Patient improved daily after vomiting ceased, and was dismissed on March 10th, 1884, perfectly well.

Remarks.—Since the patient returned home I have heard that she continues to keep well. It is to be noted that the way the tumor was fixed

above by the omentum, and below by the pedicle, rendered its removal a little difficult. The fact, also, that its mass being made up of small cysts with thick contents did not permit of its bulk being materially lessened by tapping, I was obliged to incise it and break up its contents. Some anxiety was caused by finding that the fluid contents of some of the cysts, when subjected to microscopic examination by Dr. Foulis, were found to contain sarcomatous elements. This led to a special examination of the tumor, and the detection of sarcomatous thickening of certain portions of its walls. But, as there were no proliferating masses on any part of the surface of the tumor, we have the best reason to expect that the patient will do well, having escaped infection from the sarcoma.

CASE II.—M. P., æt. 21, no children, admitted December 18, 1883, complaining of pain in the right groin. Twelve months ago patient was suddenly seized one evening with a sharp pain in her right side; mustard was applied and relief was obtained for the time. From that time till now patient experienced at times a feeling of heat in the side. Menstruation natural. Health always good.

Condition on admission.—General appearance flabby and chlorotic. Abdomen distended to about the size of a seventh month pregnancy. The tumor is more developed towards the left than the right. Measurement round the most prominent part of tumor, about an inch below umbilicus, is $30\frac{1}{4}$ inches. From umbilicus to right anterior superior spine, $6\frac{1}{4}$ inches; to left anterior superior spine, $6\frac{1}{2}$ inches. Tumor feels smooth all over, appears to move with respiration. Percussion in right flanks clear, on left somewhat dull. Anteriorly over whole tumor is marked dullness. Fluctuation and fluid thrill are felt throughout the tumor. *Per vaginam.* Posterior part of pelvis and entire inlet are blocked by a tumor which moves in unison with abdominal tumor to a certain extent. The uterus is displaced to the left and upwards. Cervix uteri can be reached, but with some difficulty. Sound passes up and forwards without pain $2\frac{1}{4}$ inches.

Dr. Macdonald performed ovariectomy on Dec. 26, 1883. On entering the peritoneal cavity the omentum and a portion of the bowel were found adherent to a large cyst, which occupied the right

side of the abdomen. On the left side the same cyst was bare, the aspirator was passed, and about 90 oz. of a dark amber colored fluid drawn off. On attempting to remove the cyst it was found to pass deep down into the very base of the pelvis, so that it was impossible to complete the removal without 1. separating the bowel adhesion: 2. opening the broad ligament so as to get the cyst gradually enucleated from between its folds. In doing so some hemorrhage occurred, necessitating very numerous ligatures. The tumor, towards the uterine end, was firmly adherent to the broad ligament, so that the latter had to be partly included in the pedicle and partly torn into small pieces and tied. The pedicle proper was very thick and hard and short, and proceeded from the right upper angle of the uterus. On examining for the left ovary there was found protruding from the left broad ligament, in the site of the normal ovary, an elongate bowel-like cyst, with exceedingly thin walls, which occupied the left iliac and left lumbar regions. Over its anterior surface, and firmly adherent thereto, passed a considerable knuckle of intestine. As far as could be judged, the cyst bulged between the layers of the meso-colon. The bowel was firmly adherent to this cyst down to its pedicle proper, which proceeded from the left upper corner of the uterus in the same manner as the other cyst from the right. There was considerable difficulty and much bleeding during the separation of the bowel from this cyst, numerous ligatures being used. During process of separation of cyst it burst, and a large quantity of clear serous-looking fluid was squeezed out. Pedicle was now secured close to uterus, and its other adhesions tied in portions and divided. There was seen to be still some oozing from right side and floor of the pelvis, but no distinct bleeding points could be described. Abdominal wound was brought together in the usual fashion after the cavity had been well sponged out, wound dressed, a glass drainage-tube having been introduced into its lower angle. Patient put to bed with hot bottles, and a brandy enema given. The patient was much exhausted after the operation, and a second enema was given. On day of operation at 5 p.m. pulse was feeble, 130 per min. Dressing changed. There was squeezed from sponge and sucked from glass tube 5 oz. of sero-sanguineous fluid. An ounce of brandy ordered every 2 hours. 10 p.m.,

pulse stronger; temperature, 100.2. (Dec. 27) 10 a.m.: Wound looks healthy; 9 drachms sero-sanguineous fluid sucked from tube. Pulse firmer, ordered to diminish brandy by one-half. 5 p.m., Dressing changed; 8 drachms sucked from the tube. Temp. 100, pulse 139. One-ninth grain of morphia and $\frac{1}{8}$ gr. atropine given hypodermically. Dec. 28, 10 a.m.: Patient seems easier. 1 oz. sanguineous fluid got from tube and sponge. Temp. 99.2, pulse 128. 2 p.m.: Temp. 100.4, pulse 140. Dec. 29: Hypodermic of morphia and atropine given at 1.30 a.m. and 10.30 a.m. At latter hour discharge was septic and offensive. Dr. Macdonald washed out abdominal cavity with warm carbolic lotion 1-100. 3 p.m.: Temp. 100.8, pulse 150; another hypodermic given. 10 p.m.: Abdomen again washed out. 12 p.m.: Temp. 102.4. Dec. 30: Temp. gradually rose to 103, then 104 at 6.50, when patient died. No post mortem allowed.

Observations.—This case presents points of special and unexpected difficulty. Considering that there was no free fluctuation in the tumor and that the patient was a healthy woman, there appeared no ground to expect unusual operative difficulty, except in the fact mentioned in the case that the tumor projected deeply down on the right side of the uterus. It would almost appear that in this case we had to deal with two huge enlargements of the Fallopian tubes. At any rate, from the peculiar shape of the tumor on the left side, there is the best reason to regard this as most probably of tubal origin. The parts comprising the broad ligament were so disfigured by pressure of the cysts that it was impossible even with the most careful scrutiny, to detect any trace of ovaries or tubes to make certain that the cyst originated in the tubes. But the close connection of each pedicle the tumors possessed with the upper angle of the uterus seems to imply an origin from the tubes. I cannot help thinking that, notwithstanding the severity of the case, all might have gone well had she not had in the large wound some rather putrid pus. The drainage-tube seems to have been a source through which the putrid fluids were made septic. I need hardly say that we used every precaution in our power by protecting the end of the tube from the air to avoid this result. Be this as it may, it is evident that the patient died of septicæmia in spite of all efforts.

POLYPOID FIBROMA OF THE BLADDER.

BY J. FULTON, M.D., M.R.C.S., ENG., L.R.C.P., LON.

Prof. of Surgery Trinity Medical College, Toronto;
Surgeon to Toronto General Hospital, etc.

Primary neoplasms of the bladder are exceedingly rare, and when they occur attract no small degree of interest from a surgical point of view. Sir Henry Thompson in his work on the Urinary Organs (second edition) says: "Tumors proper to the bladder are of rare occurrence. Simple fibrous growths, chiefly in the form of polypi springing from the walls of the bladder and wholly unassociated with the prostate, are the rarest of all forms, known to me personally only in museums. Prof. Gross, of Philadelphia, in his admirable work on "The Urinary Organs" also states that polypoid fibroma is exceedingly uncommon, "excluding the cases recorded by Lusitanus, Kirchner, Sylvius, Rollin and other older authors, and those in which villous hypertrophy is a prominent feature of the growth, fifteen cases of fibrous polyp have been collected, of which eight occurred in males and seven in females, their ages varying from thirteen months to 56 years. In only six were the subjects impubic, the average age being the 20th year. The duration of the disease ranged from five weeks to three years, the average being fourteen weeks. Dr. Stein, of New York, in an excellent monograph on this subject states on the other hand, that polypi are more common in early life than any other kind of tumor. The subject of the present history was a male child aged one year and eight months, the youngest of a family of eleven; eight living and three dead. One died of inflammation of the bowels, another of croup, both under one year, and the third a little girl of five years of age was accidentally killed. The parents were perfectly healthy, and this child was healthy at birth, but at the age of three months he had some eruption of the scalp which the doctor called "scald head." This was soon relieved by treatment, after which he seemed perfectly healthy until some months afterwards when he appeared to be suffering from internal pain and swelling of the scrotum. The parents consulted the ordinary medical attendant, who thought the child was ruptured, and recommended them to obtain the advice of a neighbouring practitioner. Upon examination he diagnosed hydrocele and removed the fluid. This was about two weeks after the child first began to complain.

At this date there was no suspicion of anything being wrong with the bladder. The little patient seemed better for a short time after the removal of the fluid, but soon began to complain as before, especially when he attempted to urinate. The effort at micturition was attended with a good deal of straining and bearing down pain, and the child was constantly pulling at the prepuce. The parents again took the patient to the consulting surgeon and gave him an account of the symptoms. He immediately suspected stone of the bladder. He did not sound him at the time, however, as he had no suitable instrument, but told them to call back in a week or ten days. It was about two weeks before they returned, the symptoms evidently not being very urgent at that time. The surgeon administered chloroform, introduced the sound and examined carefully. He could detect no stone, but felt some thickening of the anterior wall of the bladder. Considerable hemorrhage followed the introduction of the sound. The child continued to strain very much in urinating, and now and again seemed threatened with retention of urine. A few days after the introduction of the sound, there was again some hemorrhage from the bladder; these were the only occurrences of hemorrhage. The amount of blood was not great—probably about half a teacupfull. The surgeon in charge then advised the parents to take the child to the Toronto General Hospital for treatment, and he was admitted under my care. At the time of his admission his mother stated that he had not passed any urine for nearly 24 hours. The abdomen was enlarged and felt quite hard as if the bladder was ready to burst. I introduced a catheter, but was astonished to find that only a small quantity of urine mixed with muco-pus escaped. On placing my hand over the abdomen it still felt quite hard, and there appeared to be a solid mass between the point of the catheter in the bladder and my hand, for which I could not account. On examination per rectum, I made certain that the instrument was in the bladder, and the posterior wall of that viscus felt quite normal. On the supposition that it might be an abscess in the abdominal wall, I ordered the child to be put to bed, to have a warm poultice applied, and a few drops of laudanum administered. This gave great relief. As might have been expected there was considerable febrile disturbance; skin hot and dry. The bowels were kept freely open. On the following day the catheter had again to be introduced as the child was still unable to pass any urine. After drawing off the urine, which was small in quantity and mixed with pus, I introduced a very soft catheter with the view of leaving it in, but it was not long until the child, in one of its fits of straining which came on at intervals of a few minutes, forced it out with great violence. I then introduced a small silver catheter with a short beak and tied it in. Through this the urine escaped for the next two or three days. In the meantime there was no amelioration of the symptoms—the child was evidently growing rapidly worse. I had held out no hopes of the child's recovery to the mother from the first. Fearing that the catheter might increase the irritation I removed it, and drew off the urine as required by means of a gum-elastic catheter. Although somewhat puzzled at first in regard to the diagnosis, I had now come to the conclusion from a close scrutiny of the history, that it was a case of polypoid fibroma of the bladder. I stated my conclusions to several of my confrères, but they seemed incredulous. Some thought it was a perineal abscess, and advised me to make an incision. This opinion was, in some measure, justified by the fact that the urethra was enlarged, and pus from the bladder escaped through it during the last day or two of the child's illness, but as I had watched the case closely and examined the parts carefully, I felt certain there was no abscess. The passage of a small polypus about this time verified my diagnosis. The child died on the 11th day from the date of admission, and a *post mortem* examination revealed the true nature of the case. The bladder was completely filled to distension with polypoid growths which sprang from a pedicle about an inch in width and a quarter of an inch in thickness, and was attached to the left anterior wall of the bladder. The coats of the bladder were thickened except at the summit, which had ultimately given way by ulceration. Urine and pus escaped into the abdominal cavity and brought on fatal collapse. The ureters and pelves of the kidneys were very much dilated, and the kidneys more or less congested. The urethra and neck of the bladder were also dilated. The polypoid growths which were globular in shape, smooth and even, have shrunk very much since placing the specimen in alcohol. Under the microscope the tissue appears lax and

succulent, and made up of delicate interlacing filamentous tissue. It is not very vascular, and is covered with a reflection of the mucous membrane, the cells of which are normal. Prof. Gross tells us in his admirable work above referred to that "these tumors occasionally co-exist with urinary calculus, or they may be encrusted with crystals of triple phosphates, and that they evince a remarkable predilection for the neck of the bladder."

The symptoms of polypoid fibroma are chiefly of a mechanical character, viz. : difficulty in micturition, sudden stoppage of the flow, painful retention accompanied with great straining, requiring the frequent use of the catheter. The occasional passage of a small polypus as in the present instance, will at once establish the diagnosis. There is usually very slight hemorrhage, which may only be occasioned by the introduction of instruments. There is frequently pain at the head of the penis as in stone of the bladder. In females a protrusion of the tumor from the urethra is a valuable symptom. In this connection a most interesting case was published by Mr. Stanley in the *Medical Times and Gazette* of 1852 (page 106) in which, from continued retention of urine, some of it was forced into the imperfectly closed urachus which gradually reopened until the urine reached the umbilicus and escaped. The patient was a male child 13 months old.

The differential diagnosis of polypoid fibroma may be made by having regard to the train of symptoms just stated. It occurs at an earlier age than papillary fibroma, and unlike it, bleeding is not a frequent sign, and when it does occur is only trifling in extent. It may be diagnosed from carcinoma of the bladder, from the fact that the latter is rarely primary, and is attended with the cancerous cachexia—from calculus of the bladder by the introduction of the sound. From hypertrophy of the prostate by the introduction of the finger in the rectum. The prognosis of this affection is most unfavorable as when it is not removed by surgical procedure, a fatal issue invariably occurs from retention of urine and its effects upon the kidneys.

The treatment of tumors of the bladder is palliative and radical. The former consists in administering remedies to allay pain and spasm, the use of the catheter when required and the arrest of hemorrhage when it occurs. Among the earlier operators in these affections was Civiale. He en-

deavoured to remove them by avulsion and the use of the lithotrite; but his success was not very encouraging. Cystotomy is the only rational method of treating these growths. They may be removed by avulsion, enucleation, ecraseur, or ligation. The fact that the operation has been several times successfully performed should encourage us in its performance whenever suitable cases present themselves. Billroth, after having first verified his diagnosis by opening the bladder through the perineum, divided the recti muscles at their insertion, opened the bladder transversely, and removed the tumor by avulsion. The patient was discharged cured on the 23rd day. Dr. Mass, of Breslau, in 1876, suggested a plan which it would be well to have recourse to before subjecting the patient to a cutting operation. It consisted in pouring water into a double current catheter (with a large eye) inserted in the bladder, in the hope that the out-flow may entangle the growth in the eye of the instrument. In this way he succeeded in three cases in removing small pedunculated mucous polypi. The lithotrite might also be used to remove portions of the growth for examination. In females the short and easily dilated urethra and absence of the prostate renders access to the tumour tolerably easy of accomplishment and the risk is much less; not unfrequently also the tumor protrudes through the urethra and may be ligated or pulled well down and removed by avulsion. In the case before us, from the nature of the growth and its attachment, an operation would, in all probability, have been attended with success if the diagnosis had been made with certainty sufficiently early, *i. e.*, before the disease had progressed to the stage of ulceration of the bladder. In any similar case occurring under my care in future I should have no hesitation in performing cystotomy with a view to the removal of the growth. The operation has met with a large measure of success in the hands of Sir Henry Thompson and others.

SURGERY OF THE SPINAL CORD.*

BY J. CAMPBELL, M.D., L.R.C.P. ED., SEAFORTH, ONT.

The very interesting and important subject of what now generally goes by the name of "Railway Spine," has, during the last year, been attracting

*Report on Surgery Ont. Med. Association, 1884.

renewed interest. This has been owing in a great measure to the publication of Page's work "On the Injuries of the Spine and Spinal Cord." Mr. Page has been for a number of years surgeon to one of the greatest railway corporations in England, and, therefore, had a very extended experience of all possible railway injuries, and particularly of cases of so-called "Railway Spine." He contends that cases of what are commonly called "concussion of the spine," do not exist, except in the imagination of the surgeon making the diagnosis. By concussion he means the cord receiving an injury of such a nature as to give rise to pronounced symptoms, without, at the same time, the vertebræ, ligaments or membranes receiving any hurt.

It is well-known that Mr. Erichsen has been a strenuous advocate of the theory that the great majority of cases of railway injuries having for their symptoms, spinal symptoms, are due to concussion of the spinal cord. The first one hundred pages of Mr. Page's book are taken up with combating this view of Erichsen, and it appears to me that Mr. Page's attempt has been successful. He, at least, conclusively shows that the vast majority of cases of concussion of the spine are nothing more nor less than cases where the lumbar muscles or ligaments of the spine have been sprained or ruptured. Erichsen contends that many cases of "concussion of the spine" received in railway accidents never recover, while Page, on the other hand, maintains that these so-called cases of spinal concussion always do recover. While representing the reaction, Mr. Page's recent work certainly favors an undue belief in the certainty of recovery in cases of this sort.

Erb presents the matter more fairly than either of these writers. Accidents which occur in railway collisions, as other accidents, may lead to a long train of nervous symptoms, and when death has resulted, a post mortem examination may show little apparent cause for the fatal result. In the greater number of these cases the pathology is a riddle, which, for its satisfactory solution, will need a great deal of experiment and careful and extensive post mortem investigation. The great trouble in coming to an opinion as to the nature and cause of a train of nervous symptoms following a railway injury is not whether we have to do with a functional or organic change, but whether we have to do with an actual or feigned train of

symptoms. Usually the patient's symptoms are of such a nature that the physician can come to a conclusion without much trouble, but where he has to do with an intelligent and unscrupulous man who expects a large sum from a railway company, the case is one of extreme difficulty. In many of these cases it is quite impossible to come to a certain diagnosis.

In the words of a recent writer, the "needed clinical work, it seems to us, in the study of 'railway spine' is the determination of clearly defined types of the disease, and the investigations of the variations from this type, and the certain relation of objective symptoms to the disease." That serious and even fatal effects may arise from changes in the cord where it has not received any direct injury has been abundantly proved. In the current number of one of our periodicals there is a very instructive case reported, by Dr. Edmunds, of a soldier who was struck in the back with a bullet. He fell immediately, and had to be carried out of action. The bullet entered the back two or three inches from the spine, and the surgeon who first attended him considered that the spine was severely injured, because the patient had lost complete control over both lower extremities. Patient had paralysis of the bladder and rectum also. There was cystitis and a bedsore over the sacrum before death, which occurred five months after the injury. At the autopsy there was no fracture or indication of fracture, or dislocation of the vertebræ to be found. The cord was seen to be much atrophied and softened about the level of the wound. On hardening the cord in Müller's fluid, it was seen that there was universal myelitis and softening for about two inches opposite the wound, this gradually passing below into sclerosis of the lateral and anterior pyramidal tracts, and above into sclerosis of the posterior columns. There was no indication of hemorrhage, either external or into the substance of the cord. Its surface was uninjured. This was undoubtedly a case of pure "spinal concussion." The immediate paraplegia following the injury could not have been due to any other cause. The case is then one of very great importance, as it proves most conclusively that we can have from a severe shock sufficient changes brought about in the spinal cord to cause death, and that these changes were in the first place nothing more or less than "concussion of the spine."

Very recently the opinion appears to be gaining ground that we may have tabes dorsalis arise from peripheral causes. That, in fact, an ulcer in the foot may be the *fons et origo mali* of this formidable disease. The origin of the disease in such cases is explained by first a peripheral neuritis gradually extending along the course of the nerves until it reaches the posterior roots, and there a similar process gives rise to a subsequent sclerosis of the posterior columns.

SURGICAL DISEASES OF JOINTS.

BY H. P. YEOMANS, M.D., MT. FOREST.

Report on Surgery, Ont. Med. Association.

In cases of very great distension with continued pain in the later stages of acute or subacute synovitis, Barwell recommends puncture and withdrawal of the fluid. This is accomplished with a sharp small tubular needle, having a rubber tube attached. Pressure is made by an elastic bandage around the knee so as to press out the fluid and prevent the entrance of air. The rubber tube may be filled with a solution of carbolic acid and held above the joint until the puncture is made. After the needle has entered the cavity containing the fluid, the tube may be lowered and its free open end placed in a carbolic solution. By this means tension is relieved, and consequently pain; means must afterwards be adopted to lessen inflammation such as cold, or in some cases heat, etc.

Suppurative synovitis may, after evacuation, be treated by complete rest and thorough drainage. The temperature falls or rises as the pus is retained or thoroughly washed out.

In hip-joint disease rectal examination has been employed in addition to other methods of diagnosis. The symptoms discovered by a rectal examination are pain on pressure upon the os-innominatum behind the acetabulum—enlargement of the intra-pelvic glands, thickening of the bones, depression, flexibility, mobility, or destruction of the post-cotyloidean surface, congestion of the soft parts pelvic abscess—one or other of these symptoms may be found in different stages of the disease.

With regard to treatment, Dr. Hutchinson deprecates the application of any retentive apparatus whatever. The patient wears a high heeled shoe on the sound limb, is provided with a pair of crutches and allowed to go about. He points out

“that immobility is secured by reflex contraction of the peri-articular muscles, aided by intracapsular effusion and the voluntary effort to keep the joint at rest on account of the pain which motion produces.”

Splints of all kinds allow more or less mobility of the joint and interfere with freedom of the patient in moving about in order to obtain necessary exercise. There appears to be considerable difference of opinion as to the efficiency of all the various appliances and methods of treatment.

Reports of Societies.

MICHIGAN STATE BOARD OF HEALTH.

(Reported for THE CANADA LANCET).

The annual meeting of the Michigan State Board of Health was held in Lansing, Mich., April 14, 1885. All the members were present. The president's address was the first order of business. He congratulated the Board on what it had achieved. He thought it would be well to continue holding sanitary conventions in different places in the State. He spoke of the probable advent of Asiatic cholera, and thought that it might tax the Board to its utmost. The Board had done all it could to prepare to resist the disease, but should be ready for further action. If the bill before the legislature becomes law, the powers of the Board will be increased. He advised police regulations in cities, to prevent unsanitary conditions; and said that health officers of cities, villages and townships, especially those recently appointed to that office, should be instructed in regard to their duties.

The Secretary read a report of the work of the office during the past quarter. Ten thousand copies of the document on the restriction and prevention of contagious diseases were distributed. The Secretary also stated that the outbreak of smallpox at South Boardman had been suppressed.

At the last meeting of the Board, the subject of proposed legislation relative to diseased animals, and also relative to a standard for milk, had been referred to a committee, and bills relating to those subjects had been introduced into the House of Representatives.

The Secretary reported that there had been considerable effort to get the legislature to lower the

standard test for dangerous oils, and to do away with the use of the tester adopted and recommended by this Board. It was claimed that the changes were needed in the interests of small manufacturers. The proposed change would lower the standard about ten degrees. A resolution was passed deprecating the lowering of the test now required for illuminating oils.

The Secretary read the report by Surgeon Geo. M. Sternberg, U.S.A., now at John Hopkins University, on his experiments on lower animals in feeding, and in making injections of culture-fluids of poisonous cheese, with the view of learning the nature and source of the poison.

Dr. Vaughan gave a report of his experiments with poisonous cheese. He had secured in a crystalline form a substance from poisonous cheese which would produce in man symptoms common to cheese poisoning. There might be other poisons in poisonous cheese. He had not yet fully studied the poison he had obtained. It gave reactions like those of a ptomaine.

The Board recommended a sanitary survey of the cities and villages in the State, and the adoption of such measures as may be necessary to place them in a good sanitary condition.

Selected Articles.

FORTY YEARS' EXPERIENCE IN MIDWIFERY.*

BY W. SYMINGTON BROWN, M.D., OF STONEHAM, MASS.

The art of midwifery belongs to prehistoric times; the science of obstetrics is the latest recognized of all the ancient sciences. There is no branch of medicine which demands more skill, presence of mind, or justifiable daring than midwifery. It needs a man who can neither be overwhelmed by disaster nor unduly elated by success,—one who has the courage and honesty to do whatever is best for his patient, irrespective of consequences. Of such men no profession possesses a superfluity.

It is a strange fact, however, that only sixty years ago practitioners in midwifery were not admitted as Fellows to the College of Physicians, London, on the ground of inferiority, and the Royal College of Surgeons did not require candidates for its diploma to undergo an examination in obstetrics. This odium has nearly disappeared in our day, but

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a single item illustrative of its vestiges may be cited. I refer to the fact that the popular encyclopædias of our own day make no reference to the lives of prominent obstetricians, such as Smellie, Levret, or Nægele. Hundreds of insignificant names are recorded in Appleton's, Chamber's and Johnson's Encyclopædias, but a profound genius like William Smellie—writer, teacher, inventor and artist—is not even mentioned.

During a short visit to Scotland, in 1878, I met a lady, thirty-five years old, at whose birth I officiated obstetrically. And I had attended more than a hundred midwifery cases before that one. I wish I possessed a record of them all. While a medical student I served three years as assistant to the late Dr. James Paterson, Professor of Midwifery in the Andersonian University, and delivered many women among the destitute poor of Glasgow. During the last nineteen years I have kept a moderately full record. The whole number, dating from 1840, must exceed 2,000 cases.

In 1842 forceps were rarely used. It was a period of reaction, and many physicians entertained a strong prejudice against their employment, except in extreme cases. Dr. F. H. Ramsbotham, physician to the Royal Maternity Charity, London, in summing up the symptoms warranting recourse to forceps says: "If the pains have entirely disappeared, if the strength is failing, the spirits sinking, the countenance becoming anxious, if the pulse be 120 or 140 in the minute, the tongue dry, brown, and raspy; if there have been two or three rigors; if there be green discharge; if the head have been locked for four hours, and made no progress for six or eight hours; if the patient be vomiting a dark, coffee-ground-like matter; if there be hurried breathing, delirium, or coldness of the extremities." *then* we may use the forceps—before sending for the undertaker.

I recollect attending one case in Glasgow during a long-drawn-out week. The woman was very poor, and had been compelled during the whole period of gestation to sit from fifteen to eighteen hours a day, winding pirns, in order to earn a bare subsistence. There were no alarming symptoms, but the abdominal muscles seemed to be powerless. I sent for Dr. Paterson, and requested him to help her flagging powers with the forceps, but he declined to do so. The case did not come under any of Ramsbotham's excuses. At last the poor woman got tired of waiting; she sent for a doctor with fewer scruples and was instrumentally delivered. This case made a deep impression on my mind, and, in fact converted me to the faith which I hold to-day.

In this paper I propose to state very briefly the principal conclusions I have arrived at under six heads, namely: Forceps, Turning, Ergot, Anæsthetics, Antiseptics, and Craniotomy. Before doing so, however, allow me to make one remark in regard to

the language employed. Although what follows may appear like laying down the law in a somewhat curt fashion, such is not my intention. What follows are simply my own opinions on certain obstetrical problems colored by the personal medium. Nobody is more anxious than I am to be set right where I have been wrong. The late Dr. J. C. Warren, in his classical work on "Tumors," gives us this good advice: "He (the surgeon) must get the opinion of other surgeons. Even those who have not so much experience as himself may afford him excellent hints, and strike out from his own mind thoughts which without this collision would not have been elicited." Dr. Barnes also truly asserts that "there is no man whose experience is so great that nothing is left for him to learn from the experience of others." Such societies as this one answer that purpose.

FORCEPS.

I prefer curved to straight forceps. They are about as easily applied, and are less liable to slip. If a beginner can only afford one it should be a long pair, either nickel or silver-plated. But it is convenient to own a short pair, and I always carry one in my obstetrical bag, along with a No. 6 gum-elastic catheter (male), a Davidson syringe, a hypodermic syringe, a few feet of flat covered wire (such as milliners use), ether, ergot, chloral and whiskey.

The short forceps may be used at any time when their employment will benefit the patient or her coming child. We should *not* use them merely to save our own time. But the long forceps (when applied within the uterus) should seldom or never be used without a consultation. Indeed, it is a wise precaution, in most difficult or dangerous cases, to call in a brother practitioner to share the responsibility. I make it an invariable rule to pass a soft catheter into the bladder before applying forceps. In some cases using the catheter helps progress, even when forceps are not needed. If the rectum contains solid fæces I also give an enema of warm soapsuds.

How should the forceps be applied? In Scotland the woman is placed on her left side, with her hips projecting from the bed. In this country the the dorsal position is preferred, and it is the one I most frequently use. Lately I have tried a new way, which has certain advantages. The woman lies on her back in the centre of the bed or anywhere, and is not moved at all. Of course, it is not convenient to use long forceps in this position; but, when practicable it avoids the appearance of preparing for a surgical operation, and I think the less fuss we make the better it is for our patient.

In most cases I insert each blade at the side of the pelvis, without regard to the position of the child's head. If the vertex presents, you can scarcely go wrong by following this rule, and it

saves the patient the annoyance of searching for an ear and other annoying manipulations. I make traction only during a pain, and relax pressure when the pain abates. I think it is advisable to pull with a slight pendulum motion, instead of using direct traction, on the same principle that it is easier to pull down a pair of tight pantaloons by drawing on alternate sides than by pulling on both sides at once.

ERGOT.

As a means of shortening labor, ergot is seldom employed nowadays. The forceps have crowded it out of use for that purpose. But as an agent in promoting uterine contraction, after delivery of the placenta, and especially in cases of threatened flooding (some women have a hæmorrhagic idiosyncrasy), it is a valuable remedy. One reason why ergot has fallen into disrepute is the poor quality of many specimens offered for sale. Dr. Squibb's aqueous extract rarely disappoints me. It should be borne in mind, however, that no drug is readily absorbed during extreme depression.

After much blood has been lost our main reliance should be placed on other agencies, such as injections of very hot water and mechanical pressure. The accoucheur's hand inside the womb, with external counter-pressure, is the most reliable method. In milder cases I have succeeded in arresting severe hæmorrhage by injecting hot water and vinegar into the flaccid uterus. But the water must have a temperature of 130° F. in the basin, as it cools during its passage along the tube.

TURNING.

As this operation requires no surgical instrument, it obviously antedates the forceps, and, since the days of Ambrose Paré, has been a favorite with many practitioners, and even with skilled midwives. I was acquainted with a physician who, if one might draw an inference from his usual practice, seemed to think that nature had made a mistake in placing the child upside down in the womb. In our own day the late Sir James Simpson, Dr. Barnes, and Dr. Braxton Hicks have done much to bring version into favorable notice. On one occasion, before labor had fairly commenced, while making an external examination, I detected the child's head above the brim, and succeeded in converting a cross presentation into a normal one by the Braxton-Hicks method. I was agreeably surprised at the ease with which the change was effected. But, notwithstanding the plausible arguments advanced by Simpson, Barnes and others, I have come to the conclusion that turning, after the evacuation of the liquor amnii, is a very dangerous operation for the child, and not much safer for the mother. I admit that cases occur where no other alternative (except Cæsaean section) is left us. If we conclude to turn, the operator's left hand should be used, and, in most cases, it is better to bring down one foot than

two feet. The accoucheur's left hand is the obstetrical hand *par excellence*. Physicians should learn to use it adroitly more than they do.

ANÆSTHETICS.

The foremost question under this head is, Do anæsthetics injure the patient? I am pretty sure that they do not. Since 1849 I have used ether, chloroform, or a mixture of the two with alcohol, in every case where the woman was willing to breathe an anæsthetic. Some object; they are afraid to take it, and these I do not urge; but the majority are glad to get it before the labor is over. As a general rule I do not give ether during the first stage.

High authorities tell us that there is a greater tendency to post-partum hæmorrhage after ether or chloroform has been administered. During the last sixteen years I have not employed chloroform in midwifery practice, except as a remedy for convulsions; but I believe that ether, in moderate doses, does not tend to bring on flooding. Ether is seldom given to the extent of unconsciousness. The patient knows what is going on, and can render voluntary assistance when solicited.

A small dose of ether acts beneficially in two ways: it blunts sensibility to pain and allows the abdominal muscles to aid in propulsion. Without ether the patient's will-power is instinctively exerted to delay the labor; with it the canal is more likely to be relaxed, and the voluntary muscles are not so much restrained. The contractile power of the womb itself is not affected by moderate inhalation of ether.

ANTISEPTICS.

Cleanliness is a good thing in midwifery, and antiseptics are its aides-de-camp. A young doctor who keeps his nails in mourning will eventually have to mourn the absence of a lucrative practice. Still it is possible to have too much of a good thing. Dr. Thomas, of New York, has recently taken a stand on this subject which most physicians would call ultra. The rules and regulations he lays down might possibly be enforced in a hospital, but hardly in private practice. And even if they could be carried out, I question the advantages of trying to surround a physiological process with all the paraphernalia needed in a surgical operation. Carbolic acid has had its flood-tide, and begins to ebb. Corrosive sublimate will probably follow suit at no distant day. Please observe, I do not object to disinfectants or antiseptics in themselves. Both of the chemicals mentioned will no doubt, be used occasionally with advantage. But I believe that carbolic acid nearly killed Dr. Thomas Keith, and not a few unfortunate patients have suffered from its wholesale reckless employment. I greatly prefer a weak solution of iodine, prepared with iodide of potassium, which may be diluted with water without precipitation, or a hot

solution of permanganate of potas. In ordinary cases absolute cleanliness is all that is needed. The routine employment of vaginal injections is likely to do more harm than good. I concur in the opinions expressed by Dr. Adams, of Framingham, in his interesting paper read at your last meeting. Dr. William Godell's suggestion that lying-in women should be encouraged to assume the erect posture early, with a view to facilitate the removal of clots and *débris*, is an excellent one.

As already hinted, it is a good plan for the obstetrician to wash his hands, keep his finger nails pared pretty close, and to fill the small remaining space with softened soap before making a vaginal examination. A Syracuse æsthetic M.D. kindly suggests that no harm would result if he also washed his hands afterward.

CRANIOTOMY.

During the last nineteen years I have performed craniotomy three times, all of the cases occurring in the practice of other physicians. No operation tries a surgeon's nerve more than this one. When we are sure that the child is dead, of course it is plain sailing. But there are cases when the fœtal heart cannot be distinctly heard, and yet the child is alive. To plunge a perforator into a living child's skull, and deliberately take its life, with the view to save that of its mother, is, to say the least, a sad alternative. I hope I shall never feel compelled to do it again. In these days of successful abdominal surgery, would we not be justified in appealing to the patient to allow us to perform the Cæsarean section or laparölytrotomy? But we should not wait till the woman is at death's door before operating. In this, as in all other life-saving operations, promptness and decision win the day.

The medical profession is deeply indebted to Dr. Thomas for his efforts to popularize laparölytrotomy. I understand that he tried the operation several times on the cadaver before performing it on a patient. Nearly all great surgeons have been in the habit of doing this. In this case the principal difficulty will be to get the consent of the patient and her friends in season to be of any service. We all love to put off the evil day, or even the evil hour, and so the golden opportunity slips through our fingers. But as successful results in this line increase the dread of the operation itself will decrease, and obstetric surgery may achieve a new triumph in the salvation of human life.—*Boston Med. & Surg. Journal.*

SUGGESTIONS FROM DISPENSARY EXPERIENCE, FOR THE SURGERY OF GENERAL PRACTICE.

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It has often seemed to me that the experience gained in the many dispensaries of our large cities

is not made of as much service to the profession as it might be, and that it would not be amiss if those who have the advantages which these positions afford would occasionally try to put into accessible shape the lessons which they have there learned, and lay them before their brethren for adoption or correction. And, because I have had to learn by experience some things which it would have been better for my patients if I had found out in some other way, I have thought it might be worth while for me to invite your attention to certain notions in regard to the kind of surgery which occurs in general practice, which I have gathered during the past ten years, and which, if they are correct, may be helpful to others; if they are incorrect, I shall be glad to have them criticised.

I. THE DIAGNOSIS OF SURGICAL LESIONS.

I trust I shall not be deemed officious in urging the importance of thoroughness and discernment in making up a diagnosis as to what is the nature of the lesion for which one is consulted by a sufferer. Every writer, and every lecturer, dwells, more or less, upon this point. But, in spite of all that is said and written, mistakes are constantly being made, which greater care would have prevented. I have seen fractures treated as contusions, and contusions as fractures, over and over again. I have seen a patient treated for a fracture at the lower end of the radius with a time-honored Bond's splint, who had nothing the matter near the wrist, but who had a severe and dangerous contusion of the elbow-joint. I have seen hydroceles treated for years as herniæ, and have been called to operate for strangulated inguinal hernia when there was only a hydrocele of the cord, innocent and easy to cure. I have seen a psoas abscess mistaken for a hernia, and over and over again sinuses of the face, due to disease of the root of a tooth, treated in vain as simple abscesses, the recognition of the cause and the removal of the offending tooth being followed by a prompt recovery. I do not care to cite many mistakes of my own, but I cannot forget my mortification once when caught napping by an ulcerated knee, the syphilitic nature of which was indicated and easily demonstrated when a more experienced surgeon asked to see the other leg. On the other hand, I have known lesions to be characterized as syphilitic on what I thought to be an unwarrantable suspicion, and a cross-examination to show that what a patient called a chancre could not possibly have been the initial lesion of syphilis. Now, such errors should not be passed over, or hushed up, when we are speaking among ourselves, or we shall miss the advantage of being taught the necessity for constant vigilance and thoroughness in examining our patients. Of course, this is not the place to discuss the diagnosis of various lesions; but it may be worth while to call attention to the importance of making our

examination include, not only the part believed by the patient to be injured, but also the surrounding parts—muscles, bones or joints, as the case may be—for some distance above and below. The opposite and corresponding parts should often be looked at, for purposes of detection or comparison. Nor should we hesitate to call to our aid the probe or the exploring needle, both of which are valuable and harmless instruments in judicious hands. Two little points, in regard to the sinuses of the face, I would like to speak of. One is the well enough advocated examination of the teeth, by inspection and tapping, to detect a state of abscess in the alveolus; the other I do not remember to have seen recommended. This is, to test a suspected salivary fistula by bringing a drop of the discharge into contact with a drop of the tincture of chloride of iron on a white surface—a piece of white paper will do—when, if the discharge contain saliva, it will give the pink color which indicates the presence of the sulphocyanide of potassium, a normal ingredient of saliva. And, before dismissing this subject, I think a word may be said as to the failure, when one is really at a loss, to get the opinion of some one who is more familiar with our subject than we are. However proper the motives may appear which lead to this, they cannot avert from the patient the consequences of error or delay in diagnosis or treatment; and I believe it would be greatly to the advantage of our patient and ourselves, if we accustomed them to the idea of having a consultation before a case becomes extreme.

2. THE CLEANSING OF WOUNDS.

My own experience has led me to the belief that this salutary proceeding is sometimes overdone. When we see a scalp-wound, or a laceration of the face, covered with a scab, even though it be not a very handsome one, good surgery does not, I think, require us to take it off, unless the appearance of the neighboring parts indicates that an inflammatory process is going on under it. Nor, when a crushed finger is enveloped in dry covering of blood and machinery grime, need we think our patient's safety depends upon a thorough removal of these. On the contrary, I should say his rapid recovery often depends upon our letting them alone. But scabs that cover pus may always be removed with advantage; and foul secretions, or accumulations, can only do harm, and must be cleaned out. So the cleansing of wounds is not only an æsthetic, but also a salutary, procedure. As to the method of cleansing, I am a convert to the views of Mr. Sampson Gamgee, who never uses a liquid for cleansing when it is not specially indicated. Careful mopping with dry cotton or lint will do far more than those who have not tried it would imagine. Rubbing is rarely called for, but just touching with the cotton or lint, and pressing it down with more or less firmness, as the circumstances require. But, when the case demands it,

we must not hesitate to rub firmly, even a little roughly, or to pick off or cut off what sticks tight to the healthy tissues. However, we should not eschew the use of water too tenaciously. It is often indispensable, and, combined with a little permanganate of potash—just enough to make a transparent, pink solution—it is a *sine qua non* in dispensary practice, as a disinfectant and deodorant. This combination, it seems to me, excels every other so-called antiseptic; and carbolic acid, I may say, I never use as an antiseptic at all. In this connection, I wish to emphasize what I think is a very important matter in washing of wounds and sores, namely, that the same fluid should never be used twice; that is, it should not be dipped from a basin and allowed to flow from the wound or sore into the same vessel, and then dipped up and used again, and so on. The best way of washing a wound would be to let the water run upon it from a hose with a regulated force. But almost, if not quite, as good as this, is the plan of having one vessel to hold the wash and another to catch the drippings, and to apply the wash by letting it fall in a steady stream from a clean sponge or a mass of oakum. The size of this stream, and its force, can be easily regulated by the force with which the sponge or oakum is squeezed, and the height at which it is held. If the dripping mass be grasped in the hand and held with the thumb up, by well-regulated squeezing a single stream can be made to fall from the dependent portion in exactly the place and way we wish.

3. THE CONTROL OF HEMORRHAGE.

An important part of the preparation of a wound for dressing, is the control of hemorrhage—I do not mean the hemorrhage from large vessels, but that from small ones, such as are usually encountered in the surgery of general practitioners. Our colleague, Dr. Roberts, has, I think wisely, deprecated the routine use of styptics, and I quite agree with him that, for almost all small vessels, the pressure of a well-applied dressing will do all that is needed in the way of controlling hemorrhage. Such a dressing may be made of dry lint, bound on with moderate firmness—actual tightness is not called for—and often one will have, in a little while, an imitation of nature's favorite method of healing, by the formation of a scab, made up of dried blood and the tissue of the dressing. The essentials for controlling moderate hemorrhage are dry dressings and moderate compression. Pressure alone is sufficient to control the bleeding from scalp-wounds, which are sometimes spoken of as if they were troublesome to deal with. It is remarkable, at times, to hear men describe the pains they have been at to ligate an artery of the scalp, in view of the fact that this is never indispensable. A compress and a bandage will control any vessel in the scalp, and almost anywhere else; and, if an unruly patient is likely to pull a bandage off, a pin,

even a common one, may be thrust under the vessel and brought out again beyond it, so as to hold it as long as any one could wish. If still greater security be desired, it can be had by adding a "figure 8" to this pin. And here I wish to add a word as to the need for stopping bleeding. I will go a little further than Dr. Roberts in regard to the innocence of hemorrhages which sometimes cause great uneasiness. Many of these hemorrhages are absolutely beneficial. Of course, one need not be foolhardy; but such hemorrhages as come from superficial wounds may be regarded with the greatest equanimity, and no one need get flustered in trying to stop them. In my own experience, I often encourage bleeding to a considerable extent, as in the case of incisions for felons and palmar abscesses, and the like, and have never felt that I lost anything by being deliberate. Hemorrhage from small vessels can often be controlled by a firm pinch with the forceps, or the vessel may be drawn out and twisted round several times. This will often obviate the necessity for ligatures, in operations such as circumcision of infants or children. Sometimes the arteries in the fingers will bleed in a most troublesome way. If the bleeding cannot be stopped by pressure or torsion, it can be controlled by a pad of lint and a few circular turns of adhesive plaster. Persistent hemorrhage from an alveolus, in one with a hemorrhage diathesis, I have controlled, when plugging gave only temporary relief, by injecting a fine stream of cool water against the bleeding point. Bleeding from the wound of the palmar arch can, I believe, almost always be controlled by a pad and bandage.

4. DRESSING OF WOUNDS.

Dry Dressing.—Nature's method of protecting wounds is by the process of scabbing; and when we reflect upon the successful way in which this operates in all the lower animals, and often in man, too, we may wonder that it should be almost a matter of routine to remove scabs in surgical practice. It may gratify our curiosity, it may even aid our study at times, but it is often of no advantage to the patient to remove from a disfigured face, or a cut head, the crusts which are nature's reliable antiseptic dressings. From what I have seen, I believe it is best to leave such crusts undisturbed whenever possible, and if they are objectionable, in an æsthetic sense, simply to cover them with something better looking. Further, it may be said that an artificial scab made with lint, or tarlatan, or thin muslin, and collodion, forms one of the best dressings for simple incised and not a few lacerated wounds, which have ever been devised. In hospital practice, I see many cut heads and simple incised wounds, even after the removal of tumors, which go to a prompt and uninterrupted healing under the first dressing of this sort. Similarly, scabs may be formed by allowing lint to become saturated with the oozing of a wound exposed to

the air. Dry powders, such as earth or bismuth, or calomel, or powdered borax, or boric acid, or iodoform, may also be used to promote the formation of a crust. In all these cases, however, it is important to watch lest the crust bind down offensive discharges, as any scab may do; when this happens, the crust must, of course, be removed, and the wound cleaned. In the case of strumous ulcers and the weak granulations of large burns, I have had the happiest results from setting aside ordinary dressings, and applying a powder in this way. In these latter cases, I have sometimes practiced exposure of the granulating surface to the air until the serous film covering them has coagulated and formed a species of skin over them. And to my astonishment, I have seen such a film actually transformed into thin skin without displacement. This is a fact which I believe does not accord with the accepted laboratory idea of new skin formation; but it is a fact, nevertheless. And I would especially urge upon others this plan of treatment in the class of cases referred to—old burns and strumous ulcers—which are, I believe, often kept open by the ointments and other warm and moist dressings used to promote their healing.

Water Dressing is another good dressing, which I believe is too little appreciated. I have seen a number of wounds of the fingers and hands, for example, done by machinery, in which rapid and painless recovery has followed the application of wet lint, which was wetted again as often as convenient, with a lukewarm or cool solution of common borax. Patients with such injuries I have often dressed with cold water, and told them to dip the finger or hand, as the case might be, in a solution of a teaspoonful of powdered borax in a pint of water, warm or cool, as they found more pleasant, without removing the first dressing.

Lead-water and Laudanum is but little better than cold water, so far as my experience would indicate; although it is suited to cases that are especially hot and painful. But I believe this ought never to be covered up, as it very often is, with impervious coverings. It is not an uncommon thing for me to see a cut hand, or a contused joint, or a painful fracture, covered with lint soaked in lead-water and laudanum, with a piece of waxed paper over this, and next a bunch of oakum, the whole bound to a splint with many layers of bandage. My inquiries have usually elicited, from patients treated in this way, the most expressive assurances that they had suffered much, often having passed a sleepless night after these dressings were applied; and I have, I think I may say invariably, found that the suffering disappeared when I changed the dressing for a light lint, dipped in lead-water and laudanum, and held in place by a thin, light bandage, so applied as to leave part of the lint exposed to the air and consequently to evaporation of the lotion, with no splint at all, or

the lightest and smallest kind possible. What makes a recent injury hot and air-proof, I have found usually a painful dressing.

Dilute Alcohol is another refreshing dressing, if it be allowed to evaporate, and removed at the first sign of pain.

Carbolized Oil, which is, perhaps, not such a very common surgical dressing nowadays, I have found to become very quickly offensive, and I now hardly ever use it. If renewed often enough, it is, however, soothing and healing.

Ointments.—To discuss fully the ointments in use in simple surgery, would require more time than you have to give me. So I may, perhaps, be justified in stating that the most universally applicable ointment for open wounds which I know of, is one made of equal parts of carbolic acid ointment and oxide of zinc ointment. This has seemed to me to do more good than any other ointment in the case of granulating surfaces, unless they were syphilitic, and in these, I think, mercurial ointments sometimes do better. A little point in regard to the use of ointments is, that they should be confined, as nearly as possible, to the open surface. A piece of lint or muslin should be spread with the ointment, and trimmed down to the exact size of the sore. If spread on the adjacent skin, it will often, after a while, set up an artificial eczema, which is very annoying to a patient.—*Med. & Surg. Reporter.*

STANDARD DISINFECTANTS.

Disinfection of Excreta, etc.—The infectious character of the dejections of patients suffering from cholera and from typhoid fever is well established; and this is true of mild cases and of the earliest stages of these diseases as well as of severe and fatal cases. It is probable that epidemic dysentery, tuberculosis, and perhaps diphtheria, yellow fever, scarlet fever, and typhus fever may also be transmitted by means of the alvine discharges of the sick. It is therefore of the first importance that these should be disinfected. In cholera, diphtheria, yellow fever, and scarlet fever, all vomited material should also be looked upon as infectious. And in tuberculosis, diphtheria, scarlet fever, and infectious pneumonia, the sputa of the sick should be disinfected or destroyed by fire. It seems advisable also to treat the urine of patients sick with an infectious disease with one of the disinfecting solutions below recommended.

Chloride of lime, or bleaching powder, is, perhaps, entitled to the first place for disinfecting excreta, on account of the rapidity of its action. The following standard solution is recommended:

STANDARD SOLUTION No. 1.

Dissolve chloride of lime of the best quality in

soft water, in the proportion of four ounces to the gallon.

Use one pint of this solution for the disinfection of each discharge in cholera, typhoid fever, etc. Mix well, and leave in vessel for at least ten minutes before throwing into privy-vault or water-closet. The same directions apply for the disinfection of vomited matters. Infected sputum should be discharged directly into a cup half full of the solution.

STANDARD SOLUTION NO. 2.

Dissolve corrosive sublimate and permanganate of potash in soft water, in the proportion of two drachms of each salt to the gallon.

This is to be used for the same purposes and in the same way as Standard Solution No. 1. It is equally effective, but it is necessary to leave it for a longer time in contact with the material to be disinfected—at least an hour. The only advantage which this solution has over the chloride of lime solution consists in the fact that it is odorless, while the odor of chlorine in the sick-room is considered by some persons objectionable. The cost is about the same. It must be remembered that this solution is highly poisonous. It is proper, also, to call attention to the fact that *it will injure lead pipes if passed through them in considerable quantities.*

STANDARD SOLUTION NO. 3.

To one part of Labarraque's Solution (liquor sodæ chlorinatæ) add five parts of soft water.

This solution is more expensive than the solution of chloride of lime, and has no special advantages for the purposes mentioned. It may, however be used in the same manner as recommended for Standard Solution No. 1.

The following powder is also recommended for the disinfection of excreta in the sick-room and of privy-vaults, etc. :

DISINFECTING AND ANTISEPTIC POWDER.

One pound of chloride of lime ; one ounce of corrosive sublimate ; nine pounds of plaster of Paris. Pulverize the corrosive sublimate and mix thoroughly with the plaster of Paris. Then add the chloride of lime and mix well. Pack in paste-board boxes or in wooden casks. Keep dry.

As an antiseptic and deodorizer this powder is to be sprinkled upon the surface of excreta, etc.

To disinfect excreta in the sick-room, cover the entire surface with a thin layer of the powder—one-fourth inch in thickness—and if the material is not liquid pour on sufficient water to cover it.

Disinfection of the Person.—The surface of the body of a sick person, or of his attendants, when soiled with infectious discharges, should be at once cleansed with a suitable disinfecting agent. For this, Standard Solution No. 3 may be used.

In diseases like small-pox and scarlet fever, in which the infectious agent is given off from the en-

tire surface of the body, occasional ablutions with Labarraque's Solution, diluted with twenty parts of water, will be more suitable than the strong solution above recommended.

In all infectious diseases the surface of the body of the dead should be thoroughly washed with one of the standard solutions above recommended, and then enveloped in a sheet saturated with the same.

Disinfection of Clothing.—Boiling for half an hour will destroy the vitality of all known disease germs, and there is no better way of disinfecting clothing or bedding which can be washed than to put it through the ordinary operations of the laundry. No delay should occur, however, between the time of removing soiled clothing from the person or bed of the sick and its immersion in boiling water, or in one of the following solutions ; and no article should be permitted to leave the infected room until so treated.

STANDARD SOLUTION NO. 4.

Dissolve corrosive sublimate in water in the proportion of four ounces to the gallon, and add one drachm of permanganate of potash to each gallon to give color to the solution.

One fluidounce of this standard solution to the gallon of water will make a suitable solution for the disinfection of clothing. The articles to be disinfected must be thoroughly soaked with the disinfecting solution and left in it for at least two hours, after which they may be wrung out and sent to the wash.

Solutions of corrosive sublimate should not be placed in metal receptacles, for the salt is decomposed and the mercury precipitated by contact with copper, lead, or tin. A wooden tub or earthen crock is a suitable receptacle for such solutions.

Clothing may also be disinfected by immersion for two hours in a solution made by diluting Standard Solution No. 1 with nine parts of water—one gallon in ten. This solution is preferable for general use, especially during the prevalence of epidemics, on account of the possibility of accidents from the poisonous nature of Standard Solution No. 4. When diluted as directed this solution may, however, be used without danger from poisoning through the medium of clothing immersed in it, or by absorption through the hands in washing. A poisonous dose could scarcely be swallowed by mistake, owing to the metallic taste of the solution, and the considerable quantity which would be required to produce a fatal effect—at least half a pint.

Clothing and bedding which cannot be washed, may be disinfected by exposure to dry heat in a properly constructed disinfecting chamber for three or four hours. A temperature of 230° F. should be maintained during this time, and the clothing must be freely exposed—*i. e.*, hot folded or arranged in piles or bundles, for the penetrating power of dry heat is very slight.

The limitations with reference to the use of dry heat as a disinfectant are stated in a "Preliminary Report of the Committee on Disinfectants," published in the *Medical News*, March 14, 1885.

The temperature above mentioned will not destroy the *spores* of bacilli—*e. g.*, of the anthrax bacillus, but is effective for the destruction of all disease germs which do not form spores; and there is good reason to believe that this list includes small-pox, cholera, yellow fever, diphtheria, erysipelas, puerperal fever, and scarlet fever (?) Moist heat is far more effective, and it is demonstrated that ten minutes exposure to steam, at a temperature of 230 F., will destroy all known disease germs, including the most refractory spores.

In the absence of a suitable disinfecting chamber, it will be necessary to burn infected clothing and bedding, the value of which would be destroyed by immersion in boiling water, or in one of the disinfecting solutions recommended.

Disinfection of the Sick-room.—In the sick-room no disinfectant can take the place of free ventilation and cleanliness. It is an axiom in sanitary science that *it is impracticable to disinfect an occupied apartment*; for the reason that disease germs are not destroyed by the presence in the atmosphere of any known disinfectant in respirable quantity. Bad odors may be neutralized, but this does not constitute disinfection in the sense in which the term is here used. These bad odors are, for the most part, an indication of want of cleanliness, or of proper ventilation; and it is better to turn contaminated air out of the window, or up the chimney, than to attempt to purify it by the use of volatile chemical agents, such as carbolic acid, chlorine, etc., which are all more or less offensive to the sick, and are useless so far as disinfection—properly so-called—is concerned.

When an apartment which has been occupied by a person sick with an infectious disease is vacated, it should be disinfected. But it is hardly worth while to attempt to disinfect the atmosphere of such an apartment, for this will escape through an open window and be replaced by fresh air from without while preparations are being made to disinfect it. Moreover, experience shows that the infecting power of such an atmosphere is quickly lost by dilution, or by the destruction of floating disease germs through contact with oxygen, and that even small-pox and scarlet fever are not transmitted to any great distance through the atmosphere; while cholera, typhoid fever, and yellow fever are rarely, if ever, contracted by contact with the sick, or by respiring the atmosphere of the apartments occupied by them.

The object of disinfection in the sick-room is, mainly, the destruction of infectious material attached to surfaces, or deposited upon window-ledges, in crevices, etc. If the room has been properly cleansed and ventilated while still occu-

ried by the sick person, and especially if it was stripped of carpets and unnecessary furniture at the outset of his attack, the difficulties of disinfection will be greatly reduced.

All surfaces should be thoroughly washed with a solution of corrosive sublimate of the strength of one part in 1000 parts of water, which may be conveniently made by adding four ounces of Standard Solution No. 4 to the gallon, or one pint to four gallons of water. The walls and ceiling, if plastered, should be whitewashed with a lime wash containing the same proportion of corrosive sublimate, or they may be brushed over with the aqueous solution. Especial care must be taken to wash away all dust from window-ledges and other places where it may have settled, and to cleanse thoroughly crevices and out-of-the-way places. After this application of the disinfecting solution, and an interval of twenty-four hours or longer for free ventilation, the floors and wood-work should be well scrubbed with soap and hot water, and this should be followed by a second more prolonged exposure to fresh air, admitted through open doors and windows.

Many sanitary authorities consider it necessary to insist upon fumigation with sulphurous acid gas—produced by combustion of sulphur—for the disinfection of the sick-room. As an additional precaution, this is to be recommended, especially for rooms which have been occupied by patients with small-pox, scarlet fever, diphtheria, typhus fever, and yellow fever. It should precede the washing of surfaces and free ventilation above recommended. But fumigation with sulphurous acid gas alone, as commonly practised, cannot be relied upon for the disinfection of the sick-room and its contents, including bedding, furniture, infected clothing, etc., as is popularly believed. And a misplaced confidence in this mode of disinfection is likely to lead to a neglect of the more important measures which have been recommended. In the absence of moisture the disinfecting power of sulphurous acid gas is very limited, and under no circumstances can it be relied upon for the destruction of spores. But exposure to this agent in sufficient quantity, and for a considerable time, especially in the presence of moisture, is destructive of disease germs, in the absence of spores. It is essential, however, that the germs to be destroyed shall be very freely exposed to the disinfecting agent, which has but slight penetrating power.

To secure any results of value, it will be necessary to close the apartment to be disinfected as completely as possible by stopping all apertures through which the gas might escape, and to burn not less than three pounds of sulphur for each thousand cubic feet of air-space in the room. To secure complete combustion of the sulphur it should be placed, in powder or in small fragments, in a shallow iron pan, which

should be set upon a couple of bricks in a tub partly filled with water, to guard against fire. The sulphur should be thoroughly moistened with alcohol before igniting it.

Disinfection of Privy-vaults, Cesspools, etc.—When the excreta—not previously disinfected—of patients with cholera or typhoid fever, have been thrown into a privy-vault this is infected, and disinfection should be resorted to as soon as the fact is discovered, or whenever there is reasonable suspicion that such is the case. It will be advisable to take the same precautions with reference to privy-vaults into which the excreta of yellow fever patients have been thrown, although we do not definitely know that this is infectious material. Disinfection may be accomplished either with corrosive sublimate, or with chloride of lime. The amount used must be proportioned to the amount of material to be disinfected.

Use one pound of corrosive sublimate for every five hundred pounds—estimated—of fecal matter contained in the vault, or one pound of chloride of lime to every thirty pounds.

Standard Solution No. 4, diluted with three parts of water, may be used. It should be applied—the diluted solution—in the proportion of one gallon to every four gallons—estimated—of the contents of the vault.

If chloride of lime is to be used, one gallon of Standard Solution No. 1 will be required for every gallon—estimated—of the material to be disinfected.

All exposed portions of the vault, and the wood-work above it, should be thoroughly washed down with the disinfecting solution.

To keep a privy-vault disinfected during the progress of an epidemic, sprinkle chloride of lime freely over the surface of its contents daily. Or, if the odor of chlorine is objectionable, apply daily four or five gallons of Standard Solution No. 2, which should be made up by the barrel, and kept in a convenient location, for this purpose.

Disinfection of Ingesta.—It is well established that cholera and typhoid fever are very frequently, and perhaps usually, transmitted through the medium of infected water or articles of food, and especially milk. Fortunately we have a simple means at hand for disinfecting such infected fluids. This consists in the application of heat. *The boiling temperature maintained for half-an-hour kills all known disease germs.* So far as the germs of cholera, yellow fever, and diphtheria are concerned, there is good reason to believe that a temperature considerably below the boiling point of water will destroy them. But, in order to keep on the safe side, it is best not to trust anything short of the boiling point (212° F.) when the object in view is to disinfect food or drink which is open to the suspicion of containing the germs of an infectious disease.

During the prevalence of an epidemic of cholera it is well to boil all water for drinking purposes. After boiling, the water may be filtered, if necessary, to remove sediment, and then cooled with pure ice, if desired.

A sheet of filtering paper, such as druggists use, and a glass or tin funnel, furnish the best means for filtering water on a small scale for drinking purposes. A fresh sheet of paper is to be used each day.—*Med. News.*

A NEW TREATMENT OF SCIATICA.

Every physician in general practice must have at different times realized how unsatisfactory are all the modes of treating sciatica. Anodynes have failed, or are required in doses so large and frequent as to be a source of danger to the patient. All the machinery of the revulsive medication, from rubefacient terebinthine liniments to linear vesication, the actual cautery, or punctiform (Paquelin) cauterizations, have been brought to bear upon the suffering member. Electricity in all its forms has been tried and frequently proved disappointing. Local anodynes (solutions of menthol, belladonna, ether spray, chloroform) may have rendered some fleeting service. The general tone of the organism has been fortified by quinine, and the quality of the blood improved by iron and cod-liver oil, but the vitality of the *locus minoris resistentiæ* (that "greatest and worst nerve of the body," as we have heard patients say) still remains depressed. Anti-rheumatics have been tried from salicylate of sodium to colchicum and iodide of potassium, all to the point of tolerance, but all to little effect. Nerve-stretching remains, but that somewhat delicate and difficult operation has been reserved as a last resort. In view, then, of the want of success which has attended the old methods, a new method of treatment which promises comfort to physician and patient will be welcomed.

Devobe has lately proposed refrigeration by chloride of methyl in sciatica, as a medication of singular efficacy. This substance, which is obtained by distilling together methyl alcohol, sodium chlorate, and sulphuric acid, is a colorless gas, slightly soluble in water, with sweetened taste and odor; when projected on a part of the body from a suitable siphon bottle, it is attended with the production of intense cold, followed by intense smarting, and if the action be sufficiently prolonged, considerable erythema and even vesication. The benefit which is claimed from this remedy would seem to be due not so much to the refrigerant as to the subsequent counter-irritant and vesicant effect. Devobe, in a late number of the *Bulletin Général de Thérapeutique*, thus explains the principle and *modus operandi* of his method:—

"When we employ revulsion under any form

whatever (vesication, punctiform cauterization, etc.) for a neuralgic affection, we act on certain of the sensory extremities of the painful nerve, but we respect a far greater number of these nerve terminations because it is not possible to multiply to any great extent our vesicatories and cautery points. A process of revulsion which may be extended to the totality of the member innervated by the affected nerve will be then of far greater efficacy. This process I have realized in employing, as a revulsive, *congelation*. To this end I have had recourse to chloride of methyl, which is readily obtainable in commerce, and with which you may produce a speedy refrigeration. I practise with this agent, using for the purpose a siphon bottle furnished with suitable stop-cock and beak, pulverizations along the diseased nerve, directing the spray especially upon the *points douloureux*. This spraying ought not to last longer than a few minutes. It is much less disagreeable than the actual cautery, and (what is more important) *it is followed by instantaneous relief of pain*. I have by this means cured patients who long had been sufferers, and who had obtained only partial relief from other revulsives. Ordinarily one *séance* suffices to cause the pain to completely disappear; sometimes, nevertheless, a second *séance* is necessary; but always after the first *séance* the pains are considerably lessened. When you prolong the spraying a little too long, you produce vesication. Although this is an accident of little importance, I think it better to guard against it, and as a precautionary guide, I habitually consult the feelings of the patient; when they tell me that the sensations which they experience resemble the pain which the punctiform cautery would occasion, I cease the pulverization."

This mode of treatment was lately discussed at a meeting of the Academy of Medicine. Desnos reported four cases of sciatica in which this method was tried; in three it was completely successful. The spraying from a siphon bottle was performed with great precautions, occupying only a few seconds. Rendu has found that a liability to the production of eschars follows the careless or too free use of this new medication: nevertheless, in one or two stubborn instances the most gratifying amelioration, and even cure, resulted. Bucquoi finds the methyl chloride a revulsive rather than an anodyne; in one rebellious case in his practice it was signally beneficial. Sevestre claims to have cured one inveterate case of sciatica after daily applications for two months of the methyl spray. Legroux has also found spraying with this substance useful in the intercostal neuralgias of tuberculosis. Robin, in December, obtained a striking cure by this means, in a patient forty years of age who had for six months suffered from sciatica with atrophy of the limbs; he was cured after two applications of the methyl, which were followed by vesication and intense pigmentation of

the congealed region. Letulle has treated two patients by the same process; the one was affected with sciatica from neuritis, and was completely cured; the other, who was suffering from Pott's disease, complained constantly of diffuse lumbar pains, and derived the greatest benefit from the methyl-chloride spray.

It is to be hoped that the favorable experiences of these French practitioners with this new remedy may be followed by equally good results in this country, and that this painful, inveterate malady may become less of an opprobrium to medicine and surgery.—*Boston Med. Journal*.

HEAT AS A DISINFECTANT.

Dr. George H. Rohe gives the following in the *Medical News* regarding dry heat as a disinfectant: The first accurate observations on the disinfecting power of dry heat were made by Henry, of Manchester, in 1831. (Quoted in E. Vallin: *Traité des désinfectants*, Paris, 1882, p. 226). Henry exposed (fresh?) vaccine virus to temperatures varying from 50° to 82° Cent. (122°–180° Fahr.) for two, three, and four hours, and secured complete disinfection, none of the specimens of vaccine thus exposed producing vaccinia when subsequently inoculated. Exposure for three hours to a temperature of 49° C. (120 F.) failed to disinfect. No contra experiments with non-disinfected virus was made by this observer.

E. B. Baxter *Report Medical Officer of Privy Council*, etc., N. S., No. vi., p. 216) exposed dry vaccine to a temperature of from 90°–95° C. (194°–203° F.) for thirty minutes. Disinfection was complete. Vaccination with disinfected virus was unsuccessful. Contra inoculations with non-disinfected virus were successful.

Koch and Wolfhügel (*Mitt. a. d. Kais. Gesundheitsamte*, Bd. I.) experimented with a large number of pathogenic and non-pathogenic organisms. A temperature varying from 78°–123° C. (172°–253° F.) maintained for one hour and a-half (over 212° F. for an hour) sufficed to kill micrococcus prodigiosus and the bacilli of septicæmia of mice and rabbits, but failed to destroy the spores of bacillus anthracis and of various non-pathogenic bacteria and fungi. Micrococci and bacilli containing no spores, and spores of mould fungi, were completely killed by one and a-half hour's exposure to a temperature of from 120°–128° C. (248°–262° F.); but spores of *B. subtilis*, *B. anthracis*, and of a bacillus growing upon potato, resisted a second heating to the same temperature for a similar length of time.

These authors further experimented upon a number of organisms disposed in various ways in the disinfecting chamber, so as to approach in a measure the conditions of practical disinfection. Some of the articles were placed in coat pockets,

others rolled up in balls of cotton, oakum, blankets, or soiled clothing, making packages of different thickness and density. The organisms consisted of micrococcus prodigiosus, micrococcus of blue pus, bacillus anthracis, and bacilli found in garden soil. With each package was placed a registering thermometer to indicate the highest temperature reached during the experiment. The temperature in the chamber varied from 133° to 156° C. (271°–313° F.), and the exposure was continued for three hours and ten minutes. The temperatures in the different packages varied from 74.5° C. (167° F.) to 121.5° C. (251° F.). In none of the packages were the spore-bearing organisms destroyed. In a small iron vessel hanging free in the chamber and containing specimens of the same organisms, a temperature of 139.5° C. (283° F.) was indicated by the thermometer. Here complete disinfection had taken place.

Another series of observations with the temperature in the chamber varying from 131°–140° C. (267°–284° F.), and exposure continuing for three hours, resulted as follows: The organisms (micrococcus prodigiosus, spores of bacillus anthracis, and of bacilli of garden soil) and registering thermometers were enclosed in packages of clothing, bedding, and rolls of blankets. Complete destruction of the spore-bearing organisms did not follow unless the temperature of 139° C. (282° F.) had been reached. In one large package consisting of nineteen blankets, thoroughly dried and rolled up, the heat did not penetrate to the interior in a sufficiently high degree to destroy the vitality of micrococcus prodigiosus even.

He submits the following conclusions:

1. A temperature of 100° C. (212° F., dry heat), maintained for one hour and a-half, will destroy bacteria which do not contain spores.
2. Spores of mould-fungi require for their destruction in hot air, a temperature of from 110°–115° C. (230°–230° F.) maintained for one hour and a-half.
3. Bacillus spores require for their destruction in hot air a temperature of 140° C. (284° F.), maintained for three hours.
4. In dry air the heat penetrates objects so slowly that small packages, such as a pillow or small bundle of clothing, are not disinfected after an exposure of from three to four hours, to a temperature of 140° C. (284° F.).
5. Exposure to a temperature of 140° C. (284° F.) in dry air for a period of three hours injures most objects requiring disinfection (clothing, bedding, etc.) to a greater or less degree.

MARTIN'S METHOD OF TREATMENT OF SYNOVITIS, ESPECIALLY OF THE KNEE-JOINT.—During the past thirty-one years over four hundred cases of synovitis of the knee and its sequelæ, of every

form and degree of severity, in every variety of diathesis and complication, however chronic or acute, have been treated by the use of the pure rubber or "Martin" bandage—applied to the limb from the foot to above the knee. The joint is previously strapped from three inches above to a corresponding point below the patella, with non-irritating rubber plaster. This strapping is not applied for the ordinary reasons, but to obviate, or at least mitigate, a troublesome chafing of the skin in the popliteal space, from walking exercise while the bandage is on the limb. One such strapping will remain *in situ* for four or five weeks, and in a very large proportion of cases has not to be repeated. The plaster, however, must be perfectly non-irritating. The bandage should be applied as tightly as the patient can wear it with comfort. There is no danger of the circulation by following this rule, as no dangerous constriction of the limb could be endured without pain and discomfort. The bandage thus applied should be worn in general for from four to six weeks, according to the severity of the case, day and night; and, after that, during the day only, or while in the upright position, for from four to eight weeks longer. Many patients prefer to wear them a good deal longer, to prevent any possible return of trouble, but this is in general not at all necessary.

When the bandages are thus applied, great comfort and support are at once experienced, and with these much increased capacity to use the joint. Very soon it becomes evident that absorption of effused fluid, and of the interstitial deposits in the tissues of the synovial sac, and of the other tissues about the joint, is going on; and, in a space of time too short to be credible to those who have not accurately pursued the practice, and carefully and repeatedly observed the fact, the enlarged and weakened articulation is restored to the normal size, and if not immediately to its original strength, to a far greater capacity for use, and eventually to a perfect restoration in all respects.

In cases where the amount of fluid effusion within the sac is small, or where the thickening of the sac is the principal element of the case, these results may be always looked for with certainty and rapidity. Sometimes, however, when the amount of fluid effusion is very large, the use of the bandage *alone* (although of the greatest value as a palliative, by strengthening the joint, and permitting painless use of the limb) will produce *complete* absorption of the fluid very slowly, if at all. The existence of these exceptional obstinate cases induced my father, some twelve years ago, to add to the use of the bandage a preceding thorough aspiration of the sac, all the other points of treatment being exactly as before described. This was done at first only in exceptionally obstinate cases, in which the effusion within the synovial sac was large, but the operation was gradually found to be

entirely free from danger, and latterly aspiration has been practiced in all cases in which, being chronic, the synovial effusion is of any considerable amount, and even in the most acute cases in which rapid effusion produces great distention and consequent pain.

The results of my father's experience are summed up in the following statements :

1. In the last twelve years over two hundred cases of synovitis of the knee, and its sequelæ, have been treated by aspiration with a single strapping of the joint, and subsequent use of the bandage.

2. In these cases the knee-joint has been punctured over four hundred times.

3. In all these cases, with the exception of a very few, and these only in the early stages of treatment, the patient was not only permitted, but obliged to take a daily and considerable amount of walking exercise.

4. In not a single instance has there been failure of absolute and entire cure, requiring, in one case, seventeen weeks, but in no other more than eleven weeks.

5. Although no antiseptic measure, beyond perfect cleanliness of the aspirating needle, was employed, in not one instance has any ill symptom followed the operation. When the needle is withdrawn, the puncture is at once covered securely with adhesive plaster.

Sir Benjamin Brodie long ago declared most emphatically, that when the synovial sac is distended with fluid, it can be punctured, and the effusion drawn off with perfect safety. He does not by any means regard this as a help in treatment, however, as he says the fluid will accumulate again, and in a few hours the joint will be as much distended as before. The originality and value of my father's method of treatment lies in successfully demonstrating the fact that thorough aspiration of the knee-joint, followed by proper use of the rubber bandage, gives us a complete and satisfactory method of cure even in the worst cases of synovitis. By the firm and equable pressure of the rubber bandage, the re-accumulation of fluid is checked. If there is any return of the fluid at all, it is in very much diminished quantity, and a second, or perhaps in severe cases a third, aspiration of the joint is all that is ever required. One great advantage of it is to explode the idea that perfect rest of the joint is the only way to hope for a cure. The patient is emphatically *not* to be confined to bed, or, worse still, to a fixed splint. When the joint is strengthened by a properly applied rubber bandage, exercise is a very great and important adjunct in the treatment. This very day I have visited a lady who passed last summer in Switzerland. While there she was attacked with synovitis of the left knee, with a large amount of effusion into the sac. She was kept in bed,

with the limb placed on a fixed splint and continually poulticed. After sweltering through the hot weather with the limb swathed in many thicknesses of cotton wadding, at the expiration of two months the splint was removed, and—she has come home with a joint almost immovable! I am sure that had this case been treated by prompt aspiration of the sac, and the proper use of the rubber bandage, a perfect and rapid cure would have resulted without a week's confinement of the patient to her bed.—*Medical Record.*

AMPUTATIONS AND EXCISIONS.—Speaking of amputations, Mr. Banks, of Liverpool, *Med. Record* (N.Y.) naively remarks that for his part he only knows and only teaches two things about them, viz., to make one flap longer than the other and to saw the bone as low down as possible. I may remark that the size of the flaps is a question on which surgeons differ greatly. Many British surgeons are now in favor of having two flaps of nearly equal size. The "circular" method has also many advocates.

In amputating through the femur for disease of the knee-joint it is difficult, says Mr. Banks, to see any use in keeping the patella. Sawing off its cartilaginous surface and then trying to make it stick on to the cut end of the femur may afford an operator of a mechanical turn of mind some amusement, but nothing more. It is not the patella we want, but the hard skin over it.

In describing a case of double amputation for railway injuries, Mr. Banks alludes to rapidity of operating as an element in prognosis. In this case the patient, a boy of ten years of age, had fallen from a train and lay in a tunnel all night in severe wintry weather. He was apparently dead when brought to the hospital, but some signs of life appeared after a time. Subcutaneous injections of ether were given him (two of thirty minims each) and "he was placed on a mattress opposite a large fire and literally cooked into life again." Reaction had fairly set in by the evening. He was then taken into the theatre, "the smallest whiff of ether" was given him, while the two injured limbs were removed "with all the rapidity possible." Rough dressings of lint soaked in carbolic oil were applied, and the patient "was again in the ward on the mattress before the fire in less than fifteen minutes from the time of his removal." Space fails me to give the full history of this most interesting case, but I may say that the patient was attacked with "surgical scarlet fever," the urine became albuminous, the flaps opened up and refused to heal, and the bones protruded. The patient eventually recovered, a result largely due, Mr. Banks believes, to the speed with which the operations on him were performed. He remarks that in these days of anæsthetics the surgeon is apt to proceed too deliberately, forgetting that the patient, though not suffer-

ing pain is suffering shock—that “every minute of anæsthesia, every fresh incision, every lost teaspoonful of blood,” lessens his chance of recovery. Mr. Banks goes so far as to say that in a thigh amputation for smash, the fact of the patient being on the table twenty minutes in one case, or forty-five in another, makes all the difference “between his crossing the bar and sticking on it.” In the case just alluded to, the warm fire, subcutaneous injections of ether, the selection of ether as an anæsthetic, and the careful use of antiseptics, all no doubt aided in procuring the favorable result.

Mr. Banks is a warm advocate of ether as an anæsthetic, and even goes so far as to say, “To-day it has elbowed chloroform out of the field.” This may be so in Liverpool; it certainly is not so in London. Chloroform is still largely used both in hospital and private practice. The A.C.E. mixture is becoming more generally used also. Local anæsthesia is becoming more largely employed. Ether-spray, or ice and salt, is much more often made use of for minor operations than formerly. The introduction of cocaine has stimulated investigators to try and discover some other local anæsthetic agent. Mr. Banks recognizes two objections to ether. One, the danger of excessive secretion of mucus in bronchitic patients; the other, its failure to thoroughly control muscular action even after feeling is abolished.

Mr. Banks has some very thoughtful remarks to make on the subject of excisions. At the International Medical Congress in London (1881) Mr. Howard Marsh ignored statistics and pointed out that excision belongs to the same class of treatment as amputation. It is giving up the attempt to cure the disease. To this view Mr. Banks cordially assents. Far better than advocating early excision is it, he says, to devote ourselves to teaching the early recognition of hip and joint disease. “The children of rich people,” he says, “don’t have their hips and knees excised. Why not? Because the articular mischief is promptly found out, and skillfully and patiently treated.” Joint diseases are so prevalent in the cold and damp climate of Liverpool, that Mr. Banks’ opinion is worth hearing at any rate. I may remark that the Clinical Society’s report (1881) on excision of the hip-joint, showed a mortality of thirty-five per cent. in cases of excision as against thirty in cases of supuration treated by rest and extension.

Mr. Banks says the following is his teaching to students: “In children up to fifteen years of age, if you get a case of knee or hip disease from its commencement, make up your mind to save the limb. You ought to save it. Between fifteen and twenty-five, failure is to be looked for very often, and then you may excise. Don’t operate until your art is exhausted—only don’t wait until your patient is exhausted. Fortunately after twenty-five or thirty, joint mischief is not common; but

at that age whatever you may do with the hip, do not excise the knee, if your patient will let you amputate.”

Mr. Banks says that his impression of excision of the knee-joint after thirty years of age is that it is, as a rule, disastrous, and that many a life has been lost to save a leg. On this question many surgeons will be disposed to join issue with Mr. Banks, but one remark that he makes is certainly worth remembering. It is that a workingman does not usually do a stroke of work on an excised knee-joint under eighteen months or two years; after amputation he is at work in from four to six months on a sound stump.

CASE OF CÆSAREAN SECTION PERFORMED BY THE PATIENT HERSELF.—The following remarkable case was related by Dr. von Guggenberg, and the patient exhibited, at the last annual meeting of Bohemian physicians at Tetschen. On September 28, 1876, he was summoned at two in the morning to see a woman, who was said to have cut open her abdomen. He found the patient lying in a miserable house, on a wretched and dirty bed, exhausted and bloodless, and only capable of making affirmative and negative signs. On removing a dirty petticoat which covered her, an incised wound was seen on the right side of the abdomen, passing downward and inward, from which a somewhat large coil of intestine protruded, the greater part of which, covered with dried blood, rested upon a dirty blood-soaked straw sack. Hæmorrhage seemed to have ceased from every part of the wound, and the uterus was contracted to the size of a child’s head. A fully developed, but dead, male child lay between the patient’s knees. Clean linen was procured from a neighboring house, and, with a piece soaked in oil, the protruded intestines were carefully wiped and returned, and the wound sewed up, the peritoneum being included with the skin. The incision was about three and a half inches long, and slightly S-shaped. It was dressed with a five-per-cent carbolic solution, fixed with strapping, and the abdomen was carefully bandaged. By the afternoon, the patient was able to speak, and next day the history was taken. She had had seven children previously, four of whom had been born without medical assistance, two with forceps, and one after craniotomy. The pains began between September 24th and 25th, ceased in the afternoon, and came on again on September 26th, when the midwife stated that she felt the presenting head on vaginal examination. On September 27th, convulsions came on, according to the patient’s account, accompanied by agonizing pain and great distension of the abdomen, the movements of the child ceasing. The pain and distension became so severe that the patient determined to perform Cæsarean section, of which she had heard. She therefore took a razor and divid-

ed the skin slowly; she then made a second and a third incision; and finding the child not yet appearing, made another cut, which caused a large jet of blood to escape, and exposed the placenta; this she removed. One foot of the child came into view, which she seized and pulled upon until the whole of the body came through the wound, the head requiring the exertion of all her force. She divided the umbilical cord, laid the child (which she believed to be dead) beside her on the bed, and threw the placenta on the floor. She had passed neither urine nor feces since September 24th. The progress of the case was very good; urine was passed on the afternoon of September 28th, but the first stool not till October 2d. The pulse reached one hundred and twenty on the day after the operation, but was never again so frequent; the temperature is stated to have been not very high; and, although there was a considerable amount of exudation from the wound, it had united by October 3d. The patient soon returned to work, and has been ever since in perfect health.—*British Medical Journal*.

TREATMENT OF GONORRHOEA—In the early treatment of gonorrhœa, Prof. Gross condemns the use of injections. His plan is as follows: If possible, put the patient to bed; give him at the outset a purge, by administering Epsom and Rochelle salts, each \mathfrak{z} ij, in lemon syrup. Allow no meat or any stimulating articles of diet, etc. Malt liquors do more harm than alcoholic, so interdict both. No tea or coffee, but give him milk, eggs and some oysters, etc. Three times daily he is to hold the penis in a cup of hot water—quite hot. Keep the organ there for five minutes at a time, then wipe it gently each time.

The internal treatment will be by the "antimonial and saline mixture":—

R. Antimonii et potassii tartrat., gr. \mathfrak{r}°
 Magnesii sulphatis, \mathfrak{D} ij
 Morphinæ sulphatis, gr. \mathfrak{r}°
 Tinct. aconiti radicis, gtt. j
 Liquor. potassii citrat., \mathfrak{f} \mathfrak{z} ss
 Olei limonis, gtt. ss
 Elixir. simplicis, \mathfrak{f} \mathfrak{z} ss. M.

SIG.—Ter die.

By this treatment the urine will be rendered bland and unirritating. Should the urine persist in "scalding," then add to the above prescription gtt. x tinct. cannabis indicæ. To prevent or cure chordee, order at night a suppository of—

R. Extract. opii,
 Camphoræ, aa gr. iij.

In the course of four or five days the discharge from the urethra will look more like laudable pus; then order an injection:—

R. Hydrargyri chloridi corrosivi, gr. ij
 Aquæ destillat., O j.

SIG.—With syringe that holds an ounce, inject into the urethra—having first "flushed" the canal several times by voiding urine—and retain the fluid for five minutes.

Internally, a useful combination is that used at the out-door department at the hospital, and consisting of—

R. Cubebæ, \mathfrak{z} ij
 Alum. pulv., \mathfrak{z} j. M.

SIG.—Of this take a heaping teaspoonful in a tumbler of water ter die; the dose to be increased.

Should the discharge per urethram still persist, use an injection of—

R. Liquor. plumbi subacetatis, \mathfrak{f} \mathfrak{z} j
 Aquæ, \mathfrak{f} \mathfrak{z} x. M.

Or—

R. Plumbi acetatis, gr. ij
 Zinci sulphat., gr. iij
 Aquæ, \mathfrak{f} \mathfrak{z} j. M.

Or—

R. Acidi tannici, gr. ij
 Aquæ, \mathfrak{f} \mathfrak{z} j. M.

—*Coll. and Clin. Record*.

MONSEL'S IRON IN DIARRHOEA.—Dr. E. T. Williams (*Boston Med. and Surg. Journal*), says: "Ever since I began practice in 1868 I have been looking for a really satisfactory astringent in chronic catarrh of the bowels. There is, as everyone knows, a class of cases where the ordinary vegetable astringents fail to act, or at least act too feebly to do real good. The intestinal lining is in an ulcerous, or quasi-ulcerous, condition, and requires the potent action of a mineral astringent to treat it, as in cases of external ulcer. The acetate of lead is one of the best remedies in these cases, but cannot be safely given for any great length of time. Oxide of zinc in pill form is safe and efficient, but with children, who must take it in powder, often vomits and gripes. Sulphate of copper and nitrate of silver are still harsher, and for children quite out of the question. Subnitrate of bismuth is worse.

"I began trying, in 1876, at the Seashore Home, iron alum (the officinal sulphate of iron and ammonia). I found it better than anything I had previously tried, and have used it freely ever since. It is not quite so well borne by the stomach as lead and bismuth, but far better than zinc or copper. The dose for a child is from one to three grains; for adults, from three to ten. At the Seashore Home we make powders containing one grain of the salt to a twelfth of a grain of opium, giving one or more for a dose according to the age of the child. For adults the pill form is of course preferable. I have had the best results from its use.

"Last summer I began using Monsel's salt in

its place, both in public and private practice. This I did from my experience of its great efficiency as a styptic, and a presumption that it might do equally well in diarrhoea, and have found it even better than iron alum. I have tried it only in the dry form, manufactured by Squibb under the name of pulvis ferri subsulphatis. In this State it is not official, though it is precisely the same as the official liquid ferri subsulphatis evaporated to dryness. It may be given in the same doses and in the same way as iron alum."

POPLITEAL ANEURISM SIMULATING SARCOMA.—The diagnosis of popliteal aneurism is not generally a matter of great difficulty, still some of the cases of aneurism simulate other diseases so closely that mistakes are occasionally made. Many able surgeons have opened aneurisms, supposing them to be abscesses, and others again have tied the femoral artery for malignant growths, mistaking them for aneurisms. There are not a few cases recorded where an old consolidated aneurism has been mistaken for a sarcomatous tumor. In the January issue of the American Journal of the Medical Sciences Dr. Francis J. Shepherd, of Montreal, reports an obscure and instructive case of popliteal aneurism, which was under observation for several weeks, and in which there was a total absence of aneurismal symptoms, and the rational symptoms pointed to sarcoma, either of the periosteum or the parts about an old popliteal aneurism, for which the patient had been successfully treated some years before. Amputation was performed, and an examination of the tumor showed it to be solid throughout and composed of fibrin, solidified *en masse*. The orifice of the aneurism was at the distal end of the tumor, and the blood therefore flowed from below up, with, of course, a lessened stream; the circulation, owing to the obliteration of the femoral above the tumor, being carried on by collateral branches. As there was no cavity in the tumor the absence of pulsation and bruit is explained. As there was not a single symptom which pointed to aneurism an accurate diagnosis seems to have been impossible.—*Louisville Med. News*.

THE THERAPEUTIC VALUE OF MILK.—In *L'Union Medicale du Canada*, Dr. H. E. Desrosiers has a very interesting lecture on the above subject. Milk may be used constitutionally and locally. Internally, it is, first of all, a very valuable restorative. It is an article of diet that can be borne when everything else is rejected; and in general the patients like it. It may be used in all diseases characterised by anæmia, debility and asthenia. Among the diseases in which it is most commonly used may be mentioned, idiopathic anæmia, chlorosis, convalescence from debilitating diseases, inflammations and febrile affections, in cachexias,

etc. M. Dujardin-Beaumez insists upon a milk diet in tuberculosis.

In the above diseases, a milk diet need not always be prescribed to the exclusion of other food. Milk is expressly indicated in the treatment of certain special diseases, such as irritative dyspepsia, gastric catarrh, gastric ulcer, cancer of the stomach, chronic intestinal indigestion, chronic diarrhoea, especially in children; in acute and chronic nephritis, diabetes mellitus, cystitis (especially chronic), gout, aneurism, and organic disease of the heart. In regard to the last, milk is used with most benefit in the period of non-compensation (the *adynamic* period of Peter). Milk has no appreciable effect in affections with compensatory hypertrophy. The intravenous injection of milk has been proposed in profound anæmia, following hemorrhage, etc.; this treatment has met with a certain degree of success in the hands of most observers.

Locally warm milk is a good gargle in acute pharyngitis and tonsillitis. It has also been recommended in diphtheria.

Sometimes skim-milk is preferred by the patients; and it even seems to be better than pure milk in interstitial nephritis. Skim-milk seems easier to digest in gastro-intestinal disorders. It has been employed with success to reduce obesity. Tyson says that it is better than any other article of diet in glycosuria.

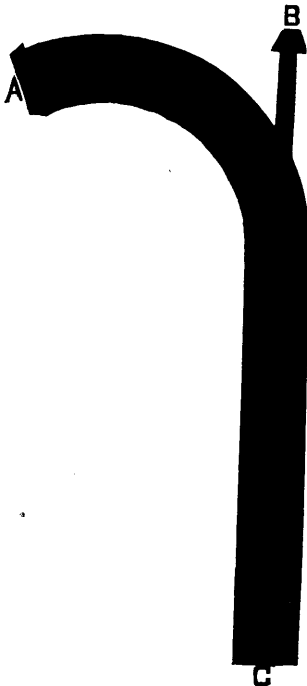
Buttermilk, too, has its adherents; and it seems preferable to pure milk in the treatment of the gastro-intestinal disturbances above mentioned.—*N. O. Med. and Surg. Jour.*

NEW OPERATION FOR RUPTURED PERINEUM.—Dr. A. C. Post read a brief paper on this subject before the N. Y. Academy of Medicine. He said that the operation had not been performed a sufficient number of times to entitle it to be regarded as established, but in the three cases in which he had performed it the result had been so satisfactory as to lead him to recommend it to the profession as worthy of trial. The operation was simpler in execution than the one ordinarily performed, and he thought it secured a more solid perineal body, and it also had the advantage that there was no loss of substance in its performance, and consequently it might be easily repeated if for any reason the first operation should fail.

An incision was made each side of the vagina to the depth of fifteen or twenty millimetres. The incisions met in front in a manner to divide the parts into an upper and lower segment. The upper segments were turned up and formed the floor of the vagina, and were secured in position by a row of catgut sutures passed, not through the skin, but through the subcutaneous cellular tissue so as to turn the edges of the skin upward to form a ridge on the floor of the vagina. A second row of sutures, of silver wire, were passed from either side

through the deepest part of the incisions, where the upper and lower segments met. The ends of these sutures were passed through glass beads and perforated shot, and after the flaps were brought into close contact the shot were compressed. The inferior edges were united by fine sutures, and an iodoform dressing was then applied. The integument on the inner side of the thighs should be protected from pressure by the shot and beads. The patient should be allowed to urinate without the use of the catheter, and the parts be washed afterwards with a solution of mercuric bichloride. The sutures might be removed at the end of ten days or a fortnight.—*Med. Times.*

A NEW ABDOMINAL DRAINAGE TUBE.—Dr. H. Marion Sims describes the following new abdominal drainage tube in the *N. Y. Medical Journal*: "It acted so nicely and drained the pelvis so well that he wished to call the attention of the medical profession to it. It consists of a large and a small tube made of hard rubber. The smaller tube is inside of the larger one, running along the posterior wall, and terminating about an eighth of an inch from the bottom. The large



tube is perforated on the sides and curved on the top, so that, when in the abdominal wound, the top of the tube projects nearly over the symphysis pubis. The smaller tube is for the purpose of washing out the peritoneal cavity, the water being thrown in at the bottom of the cavity instead of at the top, as in most draining-tubes. He attaches a

small rubber tube at B, and forces the water to the bottom of the tube C with a Davidson's syringe. At the mouth of the tube A he attaches a large rubber tube, and, while washing out, the water runs into a bed-pan or any convenient vessel placed in the bed. Where drainage is constant and very profuse, the rubber tube can be long enough to hang over the side of the bed into some vessel placed there. By having the smaller, or washing-tube project through the dressing on the wound, the pelvic cavity can be washed out without removing the dressing, which will remain dry and clean.

CHLORAL HYDRATE AS AN ANTISEPTIC.—Dr. Warner of Worcester, in a communication to the *Boston Medical and Surgical Journal*, states, that, during the last ten years, he has used a solution of chloral (three to five grains to the ounce) as almost his only dressing, and has found it acts admirably; as, while it is inodorous itself, it removes the factor of purulent discharges effectually. It is cheap, and simple in its application, and, causing no stain, can be sprinkled freely about. It seems also to act as a local sedative, often so relieving pain of a recent injury or operation as to render resort to an opiate unnecessary. During the treatment of large suppurating wounds, it keeps the air of a ward or room pure; while there is no danger from its absorption, and the comfort from a light compress moistened in the solution is very great. Somewhat frequent changes are required to prevent the compress from becoming dry and sticky, and secure perfect cleanliness. It acts as a perfect germicide, rendering spraying quite unnecessary. In a solution in warm water, the hands of the operator, instruments, sponges, etc., are cleansed. Dr. Warner speaks of his experience of its employment in various operations producing large surfaces, and greatly prefers it to carbolic acid and other antiseptics. Chloral may also be used with cosmoline or glycerine in the same proportions, if there is any reason to prefer this form of preparation.—*Pop. Science News.*

HOW TO TREAT THE ATTACHMENTS OF UTERINE TUMORS.—Dr. Thomas Keith, (*Brit. Med. Journal*) says: I have no one way in dealing with the attachments of uterine tumors. At present each case must be a law unto itself, and of this part of the operation there is much to be learned. A few of the simpler cases may be treated extra-peritoneally. Generally the broad ligament must be left inside, and sometimes the whole attachment, when there is much enucleation, must be so treated. Sometimes the treatment may be entirely intra-peritoneal by means of Kœberlé's *serre-neud*, or it may be half intra- and half extra-peritoneal. These cases require much care in the after dressing, though the convalescence is much shorter than

when the whole is left outside. I am hopeful that the cautery will yet be the safest and best of all the methods of dealing with some of these tumors. The more I use it in ovariectomy the more I like it. It is simply perfect, and its employment seems to me "a higher exercise of our art" than the ligature, which, apart from the chances of hemorrhage, embraces ten times the amount of tissue that is really necessary. That a more perfect way will soon be found I have little doubt. This will do as much for uterine tumors as Baker Brown's intraperitoneal method has done for ovariectomy ever since 1864.

EXTIRPATION, BY LAPAROTOMY, OF A HYDATID CYST OF THE LIVER.—Dr. Gutierrez reports this curious case in *El Dictamen (Le Progrès Medical)*. A boy, 8 years of age, suffered from a tumor situated in the right iliac fossa and as large as a foetal head. Capillary puncture gave a clear fluid containing numerous hooklets, which were insignificant. It having been decided to extirpate the tumor, the right side of the abdomen was opened by an oblique incision, and the tumor dissected from its adhesions to the epiploon, of which a portion was also removed to avoid its mortification. After opening the cysts, which had increased rapidly in size after the exploratory puncture, there was discharged with the fluid the great pouch or hydatid, which had as its external envelope the thickened capsule of Glisson, which the hydatid had by degrees disengaged from the external surface of the liver until it had lodged in the iliac fossa; the operator extirpated the fibrous envelope from its hepatic attachment to prevent any suppuration that might compromise the result of such a brilliant operation. He then applied three sets of sutures, very fine catgut, including first the peritoneum, then the divided muscles, and, finally, the skin, using Lister's dressings. There was not the slightest trace of peritonitis, but reaction from the effects of the operation was slow; the wound healed perfectly, however, and digestion was normal.—*Fourn. Am. Med. Association.*

CORROSIVE SUBLIMATE AND GLYCERINE IN EPITHELIOMA OF THE CERVIX UTERI.—D. Biddle in the *Brit. Med. Journal* says: There are few things in the way of palliative treatment that have given me greater satisfaction than the use, in a case of epithelioma of the cervix uteri, of a lotion, or injection, containing one-fourth of a grain of corrosive sublimate, and half an ounce of glycerine, to a pint of water. Before using it, a patient of mine had, for seven or eight months, been subject to paroxysms of agonising pain, and to frequent hæmorrhages, which were occasionally profuse. Immediately upon its employment, and for the last three months of her life, hæmorrhage became merely nominal; and, instead of agonising pain,

there was simply the distress consequent upon irritation (by the tumor) of the bowel and bladder, the latter of which became perforated a week before death. I attribute the beneficial change to the very marked reduction in the amount of infiltration. The lotion was used continuously, with very few exceptions, twice a day during the three months, and I shall certainly adopt the same treatment in the next case I have, even before recovery is despaired of. In the case referred to, it was not tried until the curative effects of chromic acid had been tried in vain.

CARBONATE OF AMMONIA IN SCARLET FEVER.—Dr. A. W. Jackson, of Brooklyn, writes calling attention to the treatment of scarlatina first brought prominently into notice by Dr. Peart, of England. This consists in the administration of from three to seven grains of carbonate of ammonia every hour for the first day, and then at longer intervals. Purgatives are to be avoided during the early stages of the disease. The writer states that he has had occasion to test this mode of treatment, and can endorse it heartily. In addition he employs the fluid extract of eucalyptus internally and as a gargle. When there is much exudation a mixture of carbolic acid and iodine in glycerine is painted over the parts. In too rapid recession of the rash, Dr. Jackson applies cloths dipped in thick mustard water, or wraps the child in blankets wrung out in hot water.—*The Medical Record.*

TREATMENT OF ZONA.—Dr. Fabre recommends the following treatment of zona: In the beginning of the disease, mild purgatives may be necessary. These should be followed by general sedatives, such as opium, belladonna, and ether, to diminish the pain. Locally, anodyne liniments may be applied and the diseased parts dusted with subnitrate of bismuth or oxide of zinc. If the vesicles are fresh and transparent, they may be aborted by covering them with collodion; but if they have been present four or five days, application of collodion will have no good effect; but, on the contrary, they will suppurate beneath it. The neuralgia which persists after the cure of the eruption should be treated by hypodermic injection of morphine or atropine, and arsenious acid in doses of from $\frac{1}{10}$ th to $\frac{1}{8}$ th of a grain be administered internally.—*L'Union Médicale*, Feb. 26, 1885.—*Med. News.*

ANTISEPTIC SILK.—Freeman uses Chinese twist which has rendered a septic by boiling for ten minutes in a two-per-cent. solution of chromic acid, and then soaking for twelve hours in a one-per-cent. solution of the same. He states that the sutures may be left *in situ* for three weeks without the occurrence of either suppuration or softening of the silk. Silk thus prepared is especially useful in operations about the genital organs in women as well as in laparotomy.—*N. Y. Med. Journal.*

THE CANADA LANCET.

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The LANCET has the largest circulation of any Medical Journal in Canada, comprising four-fifths of the entire Medical Profession.

THE USES OF IODOFORM.

Among German surgeons iodoform is more extensively used than any other antiseptic in the treatment of wounds. This substance, while less likely to be followed by toxic effects than carbolic acid, is not entirely free from danger. But whilst its careless use may occasion unpleasant symptoms, one very excellent feature in its favor is its freedom from irritating qualities. It may be applied directly to extensive raw surfaces, or dusted into large abscess cavities, without any fear of provoking irritation, and it is only when used in excessive quantities that danger from poisoning may be apprehended. Unlike carbolic acid, it does not increase the amount of serum from a wound.

The utility and general applicability of iodoform is much impaired by the fact that it is insoluble in water. It cannot therefore be used for irrigation, washing, cleansing, disinfecting instruments and the like. It is soluble in ether, collodion and glycerine in the proportion of about one part to ten of either menstruum, and these solutions may be used for dressing wounds. In the treatment of wounds it is generally used, however, in the form of powder, or gauze in which the meshes are thoroughly impregnated with iodoform by dusting and rubbing with the hands. An ointment of varying strength is also frequently used in the treatment of ulcers. Iodoform has been in use for several years past in the Toronto General Hospital in the treatment of chancroid and syphilitic ulcers, chronic

ulcers, compound fractures and all unhealthy wounds, and the results have been most satisfactory.

Iodoform is used largely by Billroth and others in the Vienna clinics. Iodoform gauze is the favorite application after operations, especially about the face and throat, in compound fractures and resection of joints. Billroth claims that iodoform possesses anti-tuberculous properties in addition to its antiseptic qualities, and consequently employs it freely in all joint diseases of a scrofulous character. After resecting and removing all diseased bone, the cavity is packed with iodoform gauze. The gauze is used in the same way in the treatment of compound fractures and abscess cavities. Strips of the gauze are packed in alongside the fragments of bone, and in abscess cavities, until the space is completely filled, and over this is placed layers of iodoform gauze and this dressing allowed to remain for several days.

One very effectual method of applying iodoform to an ulcer or wound is by atomization, by means of a spray producer, of an ethereal solution made by dissolving one part of iodoform in from seven to ten parts of ether. Evaporation of the ether takes place in a few minutes, leaving a thin film of iodoform evenly distributed on the surface of the wound. Another very convenient method, when it is desirable to introduce it into a sinus, or abscess cavity, is to inject a solution of one part of iodoform to ten of glycerine, after the cavity has been well washed out. Gynæcologists have for some years past been in the habit of using iodoform as an antiseptic coating for uterine tents, also in cases of endometritis, puerperal septicæmia, and as a palliative and to correct the fœtor of the discharges in cancer of the uterus and rectum. It is not only valuable in removing the fœtor, but also in alleviating the pain and suffering in these distressing affections.

The internal use of iodoform is somewhat limited. Within the past year or two it has been used in the treatment of secondary and tertiary syphilis, when iodide of potassium could not well be borne. We have in our own experience seen some benefit derived from its internal administration in chronic ulcer of the stomach. It has also been used with indifferent success in chronic diseases of the lungs. The dose is from one-half to three grains in the form of a pill.

RESORCINE IN WHOOPING-COUGH.

This remedy has been extensively employed during the last year in the treatment of whooping-cough, with more or less success. Dr. Moncorvo, of Rio de Janeiro, was among the first to bring the treatment into general notice. He strongly advocates the topical employment of resorcine in the strength of one per cent, applied by a fine pencil-brush to the larynx. He gives fourteen instructive cases, of various degrees of severity and duration, in which this remedy was found by him highly serviceable. He gives the following conclusions:

1. That whooping-cough—whose nature, up to a very recent period, has been subjected to the most diverse interpretations, in relation to its genesis—may, to-day, according to the latest microscopic researches, be included in the class of parasitic diseases.

2. That the disease appears attributable to the presence of micrococci which multiply prodigiously in the hyperglottic vicinity of the larynx, infiltrating its epithelial cells, which appear to be the predilective seat of their development.

3. That resorcine, applied to the laryngeal mucous membrane, caused, in all the cases in which it was employed, rapid decrease of the number of paroxysms, moderation of their intensity, and finally recovery in a short period of time, without the aid of any other medication.

Dr. Moncorvo says that resorcine, owing to its less caustic action, and the absence of disagreeable taste and odor, is far preferable to carbolic acid. He has administered it internally to children, even the newly born, suffering under diarrhœa and dysentery. He advises that strict attention be given to the quality, so as to secure the article in purity; and he recommends that prepared by Monnet, of Geneva, which is of notable whiteness, and in the form of silvery bright crystalline needles. It is extremely soluble in water. Dr. M. recommends the topical application with the fine pencil-brush, to be repeated every two hours. The first applications, he says, sometimes exacerbate the coughing fits, but this irritation ceases in two or three days. In twenty cases treated by him, he was not disappointed in his expectation in a single instance; and some of them had been very obstinate, or even dangerously complicated, as with hereditary

syphilis, threatened hydrocephalus, pulmonary tuberculosis, intermittent fever, etc.

Resorcine, in its source, being a congener of carbolic acid, no doubt acts in a similar manner as a parasiticide. Dr. Moncorvo states that he has, by numerous microscopic examinations of sputa expectorated by his patients laboring under whooping-cough, verified the statements made by Letzerich, Henke, Steiner, Hagenbush, and other writers, as to the parasitic character or complications of the disease. The treatment advocated by him is, therefore, free from all insinuation of empiricism, and, as the article is not expensive, it will no doubt be largely sought after.

MALPRACTICE SUITS IN FRANCE.

The Paris correspondent of the *British Medical Journal*, for February 7th, gives an account of an interesting suit for malpractice in which an action was brought by an *officier de santé* against M. Trélat, Professor at the Ecole de Médecine, and M. Delens, of the St. Antoine Hospital. M. Bouyer, the plaintiff, stated his case as follows: In the act of nailing down a box in May, 1883, he slightly injured the left forefinger. He sent for M. Piogey, his neighbor. M. Delens and M. Trélat were called in by M. Piogey, and the plaintiff complained that a number of operations were performed on him, and that he was conducted to a *maison de santé*, and that M. Delens applied undiluted alcohol to his bleeding wound; that drainage-tubes were applied, and camphor-dressings bandaged on. After six weeks of daily agony, he left the *maison de santé* with a deformed hand. M. Bouyer accused MM. Delens, Trélat, and Piogey of having treated and tortured him against his will, of having injured him by unskillful treatment, and named his damages at 20,000 francs (\$4,000). M. Piogey declared that the plaintiff had a deep wound in the left forefinger, which required constant care day and night; symptoms of septicæmia soon appeared, and it was necessary to call in surgical assistance; very serious lymphangitis had set in, and several collections of pus had formed. The patient expressed gratitude for the care taken of him, and never opposed any part of the treatment, otherwise his wishes would have been considered. M. Trélat accepted the responsibility of having M. Bouyer removed to a *maison de santé*;

his condition required it; he was in an almost hopeless condition, and could not otherwise have had the necessary attention given him. M. Bcuyer, the plaintiff, was condemned to pay damages of 3,000 francs (\$600), to each of the three defendants. A few such verdicts in Canada would be hailed with delight by the profession, and would most effectually put a stop to much vexatious litigation.

MEDICAL EXAMINATIONS.—The following is a list of the successful candidates in the various Universities and Colleges in Canada, so far as we have received returns.

COLLEGE OF PHYSICIANS AND SURGEONS, ONT.—
FINAL—J. A. Burgess, A. F. Baumann, C. H. Britton, J. D. Courtenay, T. C. Cowan, Margaret A. Corlis, F. W. Cane, H. C. Cunningham, J. A. Couch, F. Campbell, P. E. Doolittle, J. R. Dales, P. A. Dewar, A. W. Dwyer, W. Ewing, D. D. Ellis, D. W. Eberts, J. Ferguson, H. B. Ford, A. Graham, W. J. Gunne, W. S. Harrison, H. J. Hamilton, A. R. Harvie, J. H. Howell, H. H. Hawley, A. R. Hanks, F. Harkin, D. O. R. Jones, J. H. Knight, A. B. Kinsley, C. A. Krick, W. A. Kyle, R. J. Lockhart, W. V. Lynch, A. T. Little, R. Lucy, H. D. Leitch, F. G. Lundy, D. J. Minchin, L. J. Mothersill, J. Marty, W. J. Mitchell, D. C. McLaren, M. C. McGannon, N. McCormack, G. A. Peters, J. J. Paul, W. T. Parry, J. E. Pickard, G. F. Palmer, J. A. Rutherford, H. G. Roberts, Helen E. Reynolds, D. G. Russell, C. F. Snelgrove, J. N. Simmons, A. M. Shaver, S. Scott, J. G. Sutherland, C. E. Stacey, J. A. Stirling, E. A. C. Smith, Wm. Spankie, L. W. Thompson, O. Totten, C. Trow, A. Trudel, J. A. Watson, W. H. Wright, D. J. G. Wishart, E. G. Wood, G. Veitch.

PRIMARY—J. V. Anglin, A. F. Baumann, G. M. Brodie, W. C. Beeman, H. E. Burdett, F. Campbell, Margaret A. Corlis, J. Casselman, J. B. Caruthers, C. R. Charteris, W. F. Cale, G. R. Cruikshank, J. F. Campbell, C. R. Cuthbertson, S. S. Cornell, C. Collins, J. M. Conerty, H. E. Drummond, W. G. Dow, W. Dow, M. L. Dixon, D. Dunton, A. A. Dame, A. Ego, J. H. Eastwood, A. B. Eadie, W. Ewing, J. M. Fraser, E. J. Free, W. H. Fox, Ada A. Funnell, J. M. Forster, D. E. Foley, J. W. Fraser, A. W. Gardner, J. Guinane, W. R. Gillespie, H. P. H. Galloway, T. D. Galligan, W. Giles, W. D. Green, W. J. Glassford, M. J. Glass, D. M. Gordon, J. H. Hoover, W. B. Hopkins, Geo. Hunt, J. W. Hart, C. W. Haentschell, F. C. Heath, J. E. Hanna, A. Hotson, J. A. Harvie, J. H. Hamilton, D. Johnston, M. James, M. J. Keane, D. Kester, W. J. Logie, F. G. Lundy, M. J. Mullock, D. E. Mundell, J. C. Moffatt, C. F. Moore, J. Macoun, W. J. Mitchell, J.

C. McCabe, D. C. McLaren, J. C. McAllister, T. McEwen, D. McEdwards, H. A. McCallum, E. McLaughlin, A. F. McVety, J. McLurg, Alice McLaughlin, O. G. Niemeier, W. R. Nichols, T. H. Orton, I. Olmsted, Annie L. Pickering, T. S. Philp, A. B. Riddell, H. G. Roberts, D. Sinclair, E. A. C. Smith, W. Spankie, W. R. Shaw, R. S. Smith, W. O. Stewart, C. R. Staples, J. M. Shaw, H. C. Scadding, D. Storms, J. P. Shaw, J. J. Soden, A. F. Tracey, A. B. Thompson, J. A. Tuck, J. D. Thorburn, A. Trudel, S. West, R. West, W. R. Walters, F. Woodhull, E. J. Watts, R. J. Wilson, E. W. Wright, A. F. Woodward, E. G. Wood, A. E. Yelland.

TRINITY UNIVERSITY, TORONTO.—M.D., C.M.—
J. R. Logan (*Gold Medal*), H. H. Hawley (*Silver Medal*), A. M. Shaver, N. Allan, S. Scott, A. Graham, D. C. Throop, C. E. Stacey, W. V. Lynch, H. D. Leitch, C. F. Snelgrove, A. F. Little, F. Campbell, A. Hanks, P. A. Dewar, F. C. Hood, J. Lindsay (*Honors*). R. J. Lockhart, R. Lucy, J. G. Harper, H. G. Roberts, T. S. Farrar, D. O. R. Jones, C. Trow, A. H. Edmison, J. N. Simmons, P. E. Doolittle, W. J. Gunne, H. W. Hoover, O. Totten, J. J. Paul, J. A. Watson, H. S. Bingham, J. A. Couch, J. Ferguson, W. H. Pepler, A. F. Baumann, L. W. Thompson, A. T. Woodward, F. G. Lundy, H. J. Caldwell, J. Evans, G. Leitch, R. A. Barber, J. G. White, S. A. Metherell (M. B.), G. J. Charlesworth, J. E. Jenner, R. M. Fairchild, H. Hislop, and J. D. Wilson.

PRIMARY.—J. R. Logan, H. H. Hawley, John McLurg, James McLurg, J. Hamilton, W. R. Nichols, J. M. Thompson, D. McLaughlin, A. E. Yelland, H. Campbell, C. K. Staples, J. E. Midgley, B. Hawke, C. E. Thompson, J. C. Moffatt, D. McEdwards, J. W. Hart, T. S. Philp, T. Primmer, W. F. Graham, W. Panson, M. Maxwell, W. H. Mackay, J. P. Shaw, D. A. Kidd, H. R. McCullough, W. A. Fish, (*Honors*). F. G. Lundy, A. J. Stevenson, W. Giles, H. C. Philips, J. S. Patterson, J. H. Hoover, O. G. Niemeier, F. E. Luke, J. A. Tuck, D. M. Gordon, J. J. Sodon, C. A. Toole, D. Thompson, J. C. C. Grasett, S. H. Irwin, D. Kester, H. Blair, J. W. Shillington, T. Wilson, G. Gordon, S. T. Bell, R. A. Barber, J. B. Reid, H. S. Bingham, H. J. Caldwell, J. G. White.

MCGILL UNIVERSITY, MONTREAL.—M.D., C.M.,
 E. G. Wood, *Holmes Gold Medal*; S. Gustin, *Prizeman*; F. G. Finlay, H. T. Hurdmann, M. C. McGannon, T. A. Baird, J. Elder, D. W. Eberts, *Honors*. R. H. Arthur, J. H. B. Allan, F. N. Burrows, Geo. O. Cassidy, W. S. Daly, D. Corson, J. H. Darey, H. Dazé, W. W. Doherty, F. McD. Harkin, E. O. Hallet, A. E. Hanna, A. C. Hawkins, R. T. Irvine, H. D. Johnson, W. H. Klock, J. W. McMeekin, N. McCormack, H. J. McDonald, D.

L. McMillan, F. H. Powell, G. F. Palmer, A. Robertson, J. L. Shibley, D. G. Wishart, J. A. K. Wilson.

PRIMARY.—H. A. Lafleur, *Sutherland Gold Medal*; E. J. Evans, *Prizeman*; J. A. A. Kelly, D. L. Ross, E. H. P. Blackader, R. A. Kennedy, L. F. Ross, T. J. Haythorne, R. C. Kirkpatrick, W. Hall, and J. M. Fraser, *Honors*. P. Aylen, C. W. Boggs, S. W. Boone, A. W. Campbell, L. H. Carter, W. Cattanach, A. MacD. Cowie, D. McG. DeCow, H. Dazé, J. A. Dickson, E. H. Earl, W. E. Ellis, W. D. Ferguson, E. W. Fillmore, J. D. Flagg, A. W. Gardner, W. C. Haentschell, A. L. Hamer, J. W. Johnson, A. C. Leslie, W. F. Loucks, D. D. McDonald, G. A. McMillan, V. H. Morgan, T. J. Norman, L. E. M. Pomeroy, A. Poole, E. Reavely, G. C. Richardson, D. J. Scully, D. Sinclair, G. C. Stephen, P. H. Warneford, E. P. Williams, J. F. Williams, A. A. Young.

Botany Prize.—T. A. Clouston. *Practical Anatomy*.—1st year, W. J. Bradley; 2nd year, H. A. Lafleur. *Clinical Medicine*.—H. S. Birkett.

TRINITY MEDICAL COLLEGE, TORONTO—*Fellowship Degree*.—H. H. Hawley, *Gold Medal*; J. R. Logan, *1st Silver Medal*, A. M. Shaver, *2nd Silver Medal*.—D. C. Throop, C. F. Snellgrove, S. Scott, A. T. Little, *Honors*. N. Allan, A. Buemann, H. S. Bingman, J. A. Couch, F. Campbell, H. J. Caldwell, P. E. Doolittle, P. A. Dewar, A. H. Edmiston, T. S. Farrar, A. Graham, H. W. Hoover, E. C. Hood, A. R. Hanks, D. O. R. Jones, R. Lucy, H. D. Leitch, W. V. Lynch, J. Lindsay, R. J. Lockhart, J. J. Paul, W. H. Pepler, H. G. Roberts, C. E. Stacey, J. N. Simmons, O. Totten, J. Watson.

Primary.—H. H. Hawley, J. Hamilton, J. R. Logan, Jas. McLurg, W. R. Nichols, J. M. Thompson, *Honors*. H. Blair, S. T. Bell, R. H. Barber, H. S. Bingham, T. F. Campbell, H. J. Caldwell, W. A. Fish, W. Giles, W. F. Graham, D. M. Gordon, G. Gordon, J. C. C. Grasett, B. Hawke, J. H. Hoover, J. W. Hart, D. Kester, D. C. Kidd, F. G. Lundy, D. McLaughlin, J. E. Midgely, J. C. Moffatt, D. McEdward, M. MacDowell, H. R. McCullough, O. G. Niemeier, G. S. Paterson, H. C. Phillips, T. S. Philp, T. Primmer, J. B. Reid, J. W. Shillington, C. R. Staples, A. J. Stevenson, J. P. Shaw, J. J. Soden, J. A. Tuck, C. E. Thompson, C. A. Toole, D. S. Thompson, T. Wilson, A. E. Yelland.

Scholarships.—First, 1st year's scholarship, G. H. Fere; second, 1st year's scholarship, W. S. Cummings; second year scholarship, John McLurg; third year scholarship, W. H. McKague. Upwards of 80 candidates successfully passed the first year's examination.

QUEEN'S UNIVERSITY, KINGSTON—*M. D.*—W. Spankie, B. A., and H. C. Cunningham, equal.

Gold and Silver Medals.—T. A. Bertram, C. W. D. Clarke, Mrs. Corlis, H. G. Dawson, A. W. Dwyer, H. B. Ford, E. Hooper, W. A. Kyle, Helen E. Reynolds, H. Ray, D. G. Russell, J. A. Stirling.

Intermediate Examination.—T. A. Beeman, H. Burdett, Joseph Casselman, C. Collins, N. Coy, A. A. Dame, Miss A. E. Dickson, M. L. Dixon, F. D. Gulligan, G. C. Jack, A. Jamieson, W. M. Mather, P. J. Mellow, E. J. McArdle, E. McLaughlin, A. F. McVity, Miss M. Oliver, T. B. Smith, D. Storms, E. W. Wright. **Primary and Intermediate.**—F. Bruce, J. M. Conerty, S. Cornell, J. G. Creeggan, B.A.; E. J. Donovan, D. E. Foley, F. C. Heath, B.A.; J. J. Lane, D. E. Mundell, J. Mundell, J. M. Shaw. **Hospital Surgeons.**—M. L. Dixon and D. E. Mundell. **Demonstrators of Anatomy.**—E. W. Wright and J. V. Anglin.

VICTORIA UNIVERSITY—*M. D. C. M.*—J. Barber, A. W. Bigelow, J. A. Burgess, J. R. Dales, J. S. Freebourne, W. A. Goodall, S. M. Hay, A. R. Harvie, L. L. Hooper, H. J. Hamilton, C. J. C. O. Hastings, A. B. Knisley, E. E. King, J. Marty, W. C. McKinnon, H. McGillivray, J. E. Pickard, W. T. Parry, D. Pool, P. P. Park, J. A. Rutherford, J. G. Sutherland, L. G. Smith, W. T. Teasdale, T. Verner, D. M. Williams, H. A. Wright, H. A. Wright, W. H. Wright, G. Simenton.

Primary.—G. M. Brodie, D. B. Cruikshank, J. Caven, F. Campbell, E. Campbell, J. A. Carbert, C. R. Charteris, A. E. Collins, C. R. Cuthbertson, W. G. Dow, W. Dow, D. Dunton, W. H. Fox, E. J. Free, W. G. Glasford, P. H. Galloway, W. R. Gillespie, A. O. Hastings, W. B. Hopkins, R. Hillier, G. Hunt, S. J. Jones, J. Leeming, J. M. McCallum, C. F. Moore, T. M. McFaul, C. F. Nairn, J. F. Orr, J. Rea, P. J. Rice, W. R. Shaw, J. C. Smith, W. B. Thistle, A. F. Tracey, J. C. Vrooman, R. J. Wilson, S. West.

ONTARIO MEDICAL ASSOCIATION.—We desire to draw special attention to the meeting of the Ontario Association, which will be held in London, Ont., on the 3rd and 4th of June. A number of interesting and valuable papers have been promised and every effort is being made by our brethren in London to make the meeting a success, and from what we know of the Western men, we feel assured that nothing will be left undone that can contribute in any way to make the meeting in every respect a success. It will be remembered that this year a new departure will be inaugurated. Instead of the annual reports on medicine, surgery, and obstetrics, the chairmen of the committees respectively will open the discussion on specified subjects, as follows: Medicine,—Dr. Tye, of

Chatham, Diphtheria; Surgery.—Dr. Powell, of Edgar, Plaster Splints; Obstetrics.—Dr. Temple, of Toronto, Intra-Uterine Medication. The usual certificates will be issued by the Secretary entitling members to reduced rates by the different railroad lines. We trust that there will be a full attendance of members.

ONTARIO MEDICAL COUNCIL ELECTIONS.—The elections for representatives to the Ontario Medical Council takes place on the 26th inst. Candidates for the Territorial Divisions must receive the nomination of, at least, ten registered practitioners resident in such Division, and forward the same to the Returning Officer for the Division on the 5th of May. Voting papers will be issued by the Registrar on the 12th inst. Among the candidates recently brought forward may be mentioned Dr. Jas. Russell, of Binbrook, for the "Burlington and Home" Division, Dr. McDonald, of Hamilton, having retired. Dr. Russell has received a numerous signed requisition, and his election may be safely counted upon. Dr. Orr, of Maple, has also received a large requisition to become a candidate for the King's and Queen's Division, and intends to contest the seat with the old member, Dr. Allison.

ANÆSTHESIA BY THE MIXED METHOD.—This method of producing anæsthesia has been highly spoken of by many leading surgeons. It consists in the administration of a hypodermic injection of morphine and atropine prior to the inhalation of ether or chloroform. The stage of excitement is very slight, anæsthesia occurs more rapidly and the patient rarely vomits. A large dose of bromide of potassium on the evening and morning before the operation, has been found to bring about similar results, and is worthy of further trial. In a few cases in which we have tried it, the good effect has been very wonderful.

APPOINTMENTS *Re* NORTH-WEST REBELLION.—Dr. Bergin, (M.P.) has been appointed Surgeon-General, and Dr. Roddick, of Montreal, Deputy Surgeon-General; Hon. Dr. Sullivan, Purveyor-General; Dr. Orton, M.P., Brigade Surgeon.

HOSPITAL AND AMBULANCE CORPS.—C. M. Douglas, Surgeon-General; Dr. Bell, of Montreal; Dr. A. Graveley, of Cornwall, Ont.; Dr. J. Reddick, of Winchester, Ont.; Dr. E. Hooper, of

Kingston, Ont.; Dr. F. H. Powell, of Ottawa, Ont.; Surgeons. FIELD HOSPITAL, No. 4.—Dr. H. Casgrain, of Windsor, Ont.; Surgeon-Major, Dr. R. Tracey, of Belleville, Ont.; Dr. N. O. Walker, of Toronto, Ont.; Dr. Francis Murray, of Montreal, Que.; Dr. Cloutier, of St. Arsene, Que.; Dr. Phillippe Pelletier, of Quebec; Surgeons. Dr. Nattress, Surgeon-in-Chief of the Red Cross Corps. Along with these, a staff of medical men, medical students and dressers have gone to the front.

Dr. E. Allen has been appointed Surgeon to the 30th Wellington Battalion of Rifles, and Dr. W. H. Johnson, Assistant Surgeon.

MERCURY AND IRON.—We have seen it stated that iron given with mercury would prevent salivation from the latter. We have tried it many times, giving it in small doses for a long time, without salivating our patients. How much this result depends on the iron given with the mercury we cannot say, but it is a fair presumption that the iron has some effect in preventing the bad effects often accompanying fractional doses of mercury long continued, especially when it is necessary to continue its use for the cure of syphilis.

The *London Medical Times* considers the following the most unfortunate *lapsus calami* which has come under its observation for a long time. The hero of the young lady novelist has succeeded with great difficulty in saving the heroine from falling down the precipitous side of a mountain on which they have lost their way. The heroine has fainted and is apparently lifeless. But to his intense delight the gentleman discovers that the heart still beats "by the pulse in her femoral artery."

DOBELL'S SOLUTION.—The following, which is a very pleasant, soothing, cleansing, and disinfectant wash, is especially recommended in the local treatment of catarrh, laryngitis, &c. :—

℞ Acid carbol.		3ss.
Sod. bicarb,		
Sod. bibor,	aa.	ʒj.
Glycerini,		ʒj.
Aquam,	ad.	Oj. M.

SIG.—Apply with a nasal syringe or by insufflation.

COMPOUND FERRIC MIXTURE.—The following which is an excellent tonic and hæmatic, is said to

be used in the Charing Cross Hospital, London, Eng. :—

℞ Ferri sulph.	grs. xx.
Potas carb.	grs. xxiv.
Sachar, alb.	grs. xlvij.
Aq. cinnam.	ʒiv.
Aq. puræ.	ad. ʒviii.

SIG.—One to two tablespoonfuls three times a day.

THE DYSPNŒA OF BRIGHT'S DISEASE.—In a paper read before the Canada Medical Association by Dr. Howard, of Montreal (*Can. Med. & Surg. Jour.*), on the varieties of dyspnœa met with in Bright's disease, he illustrated the following points: (1) That marked dyspnœa may occur in Bright's disease not due to gross lesions in the lungs, pleura, or heart, such as inflammation or œdema of the lungs, hydrothorax, or pleurisy with effusion, endocarditis, or valvular disease. (2) That it may be continuous dyspnœa, or of a paroxysmal character, resembling ordinary spasmodic asthma; and that these types may occur in the same case, although in his experience, the continued variety is more frequent than the asthmatic. (3) That these forms of dyspnœa may occur as the prominent symptoms of renal disease, and their origin may escape recognition if the urine be not carefully examined, as well as the heart and pulse. (4) That Cheyne-Stokes respiration is often a symptom of Bright's disease, and that it obtains in both acute parenchymatous and in chronic interstitial nephritis. (5) That while usually an evidence that the fatal issue is near at hand, it may occur in a chronic form, and may occur for weeks, perhaps even for years. (6) That these several forms of dyspnœa just mentioned are very probably due to that defective renal elimination called uræmia. (7) That in the acute forms of Bright's disease, serious or fatal dyspnœa sometimes, but rarely, occurs in connection with effusion into the submucous membrane of the larynx (œdema glottidis).

LOCAL APPLICATION FOR PILES.

℞ Pul. opii.	
“ Aloes	aa grs. v.
Ext. Hamamelis,	ʒj.
Cosmoline,	ʒj. M.

SIG.—Sponge the parts with warm water and apply after each defecation.

PARALDEHYDE IN DELIRIUM TREMENS.—This new remedy has been found successful in the treatment of delirium tremens, after the failure of potassium bromide, valerian, hyoscyamus and morphine to produce sleep. This agent is claimed to be a hypnotic, producing a perfectly natural sleep of from two to six hours' duration, from which the patient awakens without any sense of distress, headache, dulness or nausea. It may be administered in the form of an elixir, two drachms of the drug being dissolved in an ounce of simple elixir and a tablespoonful administered, to be repeated when necessary.

BRITISH DIPLOMAS.—Drs. Davidson and Furrer, (Trinity), have been admitted to the M.R.C.S., Eng. Dr. W. A. Goodall (Toronto) has obtained the License of the King's and Queen's College of Physicians, Dublin.

We are very much pained to learn of the death of Private Ferguson, son of Dr. R. B. Ferguson, of Winnipeg, in the Fish Creek battle. The Dr. has our deepest sympathies in his severe family affliction.

CORONER.—Dr. J. M. Cotton has been appointed coroner for the County of York, Ont., and Dr. G. Schmidt for the County of Waterloo.

The death of Dr. Jas. L. Little, of New York, is recorded in our American exchanges.

Notes, Queries and Replies.

To the Editor of the "CANADA LANCET."

SIR.—If your correspondent, who asks for experience regarding the use of picrotoxine as a remedy for sweating in phthisis, will refer to McKesson & Robbins "Formula Book," he will find some remarks which influenced me in selecting this drug. I have employed it in cases of sweating from various causes and am very much pleased with the result.

Yours truly,

J. H. BURNS, M. D.

Toronto, March 31st, 1885.

To the Editor of the CANADA LANCET.

SIR,—The following question was given at the late Council examination: What poison can a woman take to poison her child, without injuring herself, through her milk, and how can you detect

it by *post mortem* examination of child after death?
Will some one please answer in next LANCET?

Yours respectfully,

L. J. MOTHERSILL.

Tuscarora, April 28, 1885.

Books and Pamphlets.

INSANITY AND ALLIED NEUROSES; PRACTICAL AND CLINICAL, by George H. Savage, M.D., M.R., C.P. Physician and Superintendent of Bethlehem Royal Hospital, &c. Published by Henry Lea's Son & Co., Philadelphia.

The American reproducers of this work have probably long ago learned the fact that a large book is, in the eye of the student of any branch of medicine, a large evil. They have therefore contrived to squeeze into this unpretending little octavo, on fine paper and in clear type, a quantity of most instructive solid matter, which might not inexcusably have been made to fill one of twice the size. Never has it been our good fortune to rise from the perusal of any work on insanity with more thorough gratification than we have realized throughout all its pages. It was our intention to present to the readers of the LANCET some extracts from which they might be enabled to form an anticipative opinion of the real merits of the book; and with this view we made notings of such passages as appeared to us most saliently instructive, but before we had got over half the pages, these markings had become so numerous that we have reluctantly felt constrained to relinquish our purpose.

The book is presented as a "Manual for Practitioners and Students." Every practitioner of medicine is, or ought to be, a student of insanity; therefore it would not have at all derogated from the dignity of the former to have passed them over unnamed. It is sincerely to be hoped that those of ripe knowledge and prolonged observance will not allow themselves to be distanced in the field of alienism by their juniors. A little money devoted to the purchase, and a very little daily time to the study of Dr Savage's plain and modest treatise, will not fail to prove profitable investments. But whatever may be the appreciation in which it may be held by the general profession, it is sure to be highly valued by the entire body of

alienistic and neuropathic specialists. Every man who has had any lengthened experience in psychiatry, and has loved his work, will feel, in reading Dr. Savage's graphic and succinct description of cases, as if he had been erewhile walking arm in arm with the author, for years, through the wards of his own asylum; and the retired veteran will have displayed before him a living panorama of mental scenes and shadings, which must revive his remembrance of many anxious and many pleasant days in his past life,—scenes and shadings which lapse of years may have begun to enshroud in the gloom of clouded remembrance, but whose reproduction he will contemplate with a kindred gratification to that of the tired pilgrim on his return to his youthful home.

We cannot but commend Dr. Savage's book to every member of the medical profession, and to every student who aspires to the possession of a sound practical knowledge of mental disorders. It is quite probable that if more attention were given to this department of medical science, the public would be relieved from witnessing many of those scenes of professional conflict in courts of law, which are the opprobria of our profession.

THE POPULAR SCIENCE MONTHLY FOR MAY, 1885.
New York: D. Appleton & Co. Fifty cents a number, \$5 a year.

The first paper, "Our Recent Debts to Vivisection," by William W. Keen, M. D., is a graphic account of the benefits that have been conferred upon humanity during the last quarter of a century, by means of experiments on animals. There is no strained construction in the argument, and the numerous examples given cannot easily be explained away. Dr. Max von Pettenkofer's valuable and timely papers on "Cholera" end in this number, with the fourth of the series, which is mainly devoted to the subject of prevention. "A Scientific View of the Coal Question," by G. Gore; and "Training in Ethical Science," by Mr. H. H. Curtis, are able articles. "The Nervous System and Consciousness," by Professor W. R. Benedict, illustrated, and "Arctic Exploration and its Object," by Dr. Franz Boas, are both good papers in their respective departments. There is also an article by Professor Tyndall, describing the patient labor, the ingenious methods, and the grand results of "Pasteur's Researches in Germ-Life."

THE EAR, Its Anatomy, Physiology and Diseases, a Practical Treatise for the use of Medical Students and Practitioners. By Chas. H. Burnett, A.M., M.D., Professor of Otolaryngology in the Philadelphia Polyclinic and College for Graduates in Medicine, etc. With 100 illustrations. Second edition, revised and rewritten. Philadelphia: Lea Bros. & Co. Toronto: Williamson & Co.

The above work will be cordially received by the profession, especially those members who have become acquainted with the author through a perusal of the first edition, or in attendance upon his lectures on this subject. His style is clear and concise, and his methods attractive. The work of revision has been carefully done, and much new matter, rendered necessary by the progress of the science, has been added. The author in the outset gives a description of the anatomy of the parts, which is followed up by a description of the instruments used, and how to handle them, and concludes with a clinical history of the various diseases and their appropriate treatment. The work will be found very useful to those desirous of acquiring a knowledge of the diseases of the ear.

THE SCIENCE AND ART OF SURGERY. By John Eric Erichsen, F. R. S., LL. D., F. R. C. S., Emeritus Professor of Surgery in University College, etc. Eighth Edition Revised and Edited by M. Beck, M. B., Lond., F. R. C. S., Eng. Prof. of Clinical Surgery in University College, London. With 984 Engravings on Wood. Vol. II. Philadelphia: Lea Bros. & Co. Toronto: Hart & Co.

We have already noticed with comments the first volume of this classic work on surgery, and it only remains at present to notice the issue of the second volume. It embraces a consideration of those affections, not included in the first volume, and contains an appendix on corrosive sublimate as an antiseptic. We cannot speak too highly of this excellent work. It represents the most advanced and settled views in regard to the science of surgery, and will ever be found a faithful guide and counsellor in practice.

KIRKE'S HAND-BOOK OF PHYSIOLOGY. By W. Marrant Baker, F. R. C. S. Lecturer on Physiology at St. Bartholomew's Hospital; and Vincent D. Harris, M. D., London, Demonstrator of Physiology at St. Bartholomew's Hospital. Eleventh edition with nearly 500 illustrations. Vols. I. and II. New York: Wm. Wood & Co. The above work constitutes the February and

March Nos., of Wood's Library of Standard Medical Authors, and will no doubt be hailed with satisfaction by the subscribers to this "Library." Kirke's Physiology is so well known to the profession that an extended notice would be quite superfluous; the fact that it has reached the eleventh volume speaks for itself. All the recent advances in the science have been incorporated in the work so as to bring it fully abreast of the times.

AN INTRODUCTION TO PATHOLOGY AND MORBID ANATOMY. By T. Henry Greene, M.D., Lond., F. R. C. P., Lecturer on Pathology at Charing Cross Medical School. Fifth American and sixth revised and enlarged English edition, with one hundred and fifty engravings. Philadelphia: Lea Bros. & Co. Toronto: Williamson & Co.

This able and instructive work is well known to the profession, and the edition before us fairly represents the status of this important branch of medical study. It is a lamentable fact that too little attention is paid to pathology and its sister science physiology by the majority of medical practitioners on this side of the Atlantic. A careful perusal of such a work as this, however, cannot fail to arouse an interest in the study of this much-neglected branch of medical science.

BERLIN AS A MEDICAL CENTRE, by H. R. Bigelow, M.D., Washington, D.C.

The above work will be issued by the New England Publishing Co., Sandy Hook, Conn., during the month of May. It will be a complete and accurate medical guide to Berlin, giving instructions in reference to board, clinics, lectures, expenses, etc., and all information that will be necessary for the medical student abroad. The price will be \$2.

Births, Marriages and Deaths.

On the 15th ult., J. T. Small, M.D., M.R.C.S. Eng., of Toronto, aged 63 years.

On the 29th March, D. A. Livingstone, M.D., of St. Chrysostome, Que., aged 30 years.

On the 10th ult., J. McCurdy, M.D., of Chatham, N.B., aged 42 years.

On the 11th ult., D. Burnet, M.D., of Cobourg, aged 40 years.

On the 23rd March Dr. Thomas Tanner, M.D., of Holstein Ont., aged 64 years.