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CONTENTS.

ORIGINAL COMMUNICATION.	
Clinical Lecture at the Pennsylvania Hospital, Philadelphia.....	361
PROGRESS OF SCIENCE.	
On the Treatment of Acute Rheumatism.....	363
On Anesthetics.....	364
The Curability of Consumption.....	367
Therapeutics of Cholera Infantum.....	369
Notes of Four Cases of Varicose Veins Treated with Hamamelis.....	370
A Case of Obstinate Hiccough relieved by Nitro-Glycerin.....	371
Pothenill on Hepatic Disorders.....	372
On the Therapeutic Value of the Chloride of Calcium.....	372
Iodised Phenol in the Treatment of Whooping-Cough.....	373

The Treatment of Acute Laryngitis.....	373
Brief Notes on the Treatment of Acute Coryza.....	374
The Elements of Prognosis in Bright's Disease.....	375
Treatment of Abortion at the Fourth or Fifth Month, with retained Placenta.....	376
On Some New Medicaments.....	377
How to Treat Wounds of the Fingers.....	377
Cancer of the Uterus.....	378
Case of Caesarean Section after Death of Mother—Living Child Removed.....	379
A New Method of Reducing Dislocations of the Hip.....	379
The Treatment of Ascithis.....	380
Jaundice and Pain in Biliary Colic.....	380
Leucorrhœal Discharge from Itoller-Skating.....	380

Santonine in Amenorrhœa and Dysmenorrhœa.....	381
Belladonna and Iodide of Potassium.....	381
Vinegar in Puerperal Hemorrhage.....	381
Soothing Application in Neuralgia.....	381
Transmission of Pithitis between Man and Wife.....	381
Delacour's Lip Salve.....	381
Hæmorrhoids.....	381
A Mixture for Whooping-cough.....	382
Vomiting of Pregnancy.....	382

EDITORIAL.

The Origin of the Epidemic.....	382
Bovine-Vaccine Points.....	383
Lactopeptine.....	383
Personal.....	384
Reviews.....	384

Original Communications.

CLINICAL LECTURE, AT THE PENNSYLVANIA HOSPITAL, PHILADELPHIA.

By THOMAS G. MORTON, M.D.

Reported for the *Canada Medical Record* by
Dr. J. F. Edwards.

MUSCULAR ATROPHY FROM INFLAMMATION OF NERVES.

I have before spoken to the class about the changes that will take place in a part consequent upon inflammation and secondary changes in the nerves of such part. If a nerve be injured or from any cause inflamed, it will become sclerosed; even if the inflammation originate in a branch or a filament of the main nerve it will extend up to it, and the nerve, as I say, becoming sclerosed, the nutritive life of the part will be interfered with, and it will atrophy, so that after an injury to a nerve there will always ensue more or less atrophy. It is of practical importance for you to remember this, for it may help you out of a scrape. It will sometimes happen that, after you have operated upon a child for club-foot, this atrophy, the cause of which has been congenital, or at least has arisen from what I have already told you, will cause the parents to claim that you have cut or injured some nerve or some part that you ought not to have cut, and you may be bothered with a suit for malpractice. The small branches, as I have said, may influence the main nerve, and, though the synovitis (which may have been the original cause of the trouble) may be well, still the sclerosis will go on. We have such a case before us. This young man has had a synovitis, there can be no doubt of this,

for you see the swelling and tumefaction about the knee, while there is luxation forwards of the femur or backwards of the tibia, whichever you may choose. As a result you see how this limb has atrophied. Some might claim that this atrophy was due to want of use, but such is not the case, a very slight amount of the atrophy might possibly be due to this cause, but the young man has been able to walk about all the time, so that his leg has been exercised and we must therefore look beyond disuse for the cause of the atrophy, and this atrophy, just as in the wasting of club-foot, will be permanent; the atrophied limb will never catch up to the other one, there will always be a marked difference. You will always find the limb, and the foot itself, from an inch and a-half to an inch and three-quarters shorter in the clubbed side than on the other. Some have claimed that congenital club-foot is due to intra-uterine pressure, but this is an error; it is caused, just as is the acquired disease, by the nervous changes already referred to. To return to the case before us, I introduce a probe into this fistula, and find dead bone at the bottom; now this fistula will never heal so long as the dead bone, or indeed any other foreign body, remains at the bottom of it; such fistulas will sometimes persist for forty or fifty years unless the cause be removed. In some cases the process of separation by nature is so slow that in order to aid her we would be compelled to make such a large wound that we are compelled, by prudence, to let it alone and wait for the slow process of nature. I will now apply the Esmarch bandage and see what it is best to do. I must be very cautious in this case, for the fistula is in the close vicinity of the femoral artery. The

finger is the best probe, and when I have insinuated my finger down to the bone, if I find the necrosis near the other side from that in which the fistula is, I will consider the advisability of removing the sequestrum from a counter-opening on the other side, which would insure better drainage. In such a case as this, if you could absolutely promise the patient that he would recover, it would be the better plan to amputate, because an artificial limb would be much more useful than this crippled member can ever be; but the risk would be great, and we would not be justified in taking it. When I try to introduce my finger, I find considerable difficulty for, as is often the case, the tissues about a fistula have become very dense. Now I find a large piece of bone loose, and I can readily remove it without making any new incision. The operation, as you see, has been bloodless, but, now, when I remove the Esmarch, considerable hemorrhage occurs; the granulations covering the bone are very exuberant, and they bleed almost as would an artery. This is a good sign, for it shows that there is a good blood supply to the part, that will favor the reparative process; it is readily controlled by a bandage from below up the limb and elevation.

GUNSHOT INJURY—AMPUTATION.

Six weeks ago, this man, who is 30 years old, was loading a gun, when it discharged prematurely, driving a portion of the ram-rod into his hand. The presence of this foreign body was not suspected at the time, but two weeks later it was found and removed. Free drainage was procured, but the injury to the deeper structure had been very severe; the wrist joint was opened; the carpus destroyed, and even the ulnar was involved. Abscesses formed and the pus burrowed along the flexor-tendons, causing abscesses in the fingers and it also extended up the arm. There has been so much disorganization that we have decided to amputate, because we cannot hope to save the hand. When I merely shake the hand you can hear the carpus rattle. Necrosis of the bones of the wrist is very unsatisfactory to treat without operation; with the ankle it is different, because there are less bones, they are larger and there is more nutrition; while in the wrist, the bones are smaller and less abundantly nourished. Such a case, if it healed at all, would leave a stiff and useless hand, but it would be much more likely to destroy the patient by exhaustion from repeated suppuration. When

to amputate is a question to decide. If it is performed within twenty-four hours after the injury it is a primary operation; at any subsequent time, it is secondary. After the receipt of the injury there is a condition of shock, when the thermometer will pursue a zig-zag course for some time, as one abscess after another forms and opens, the system being impressed by the pus formation, and relief produced by its evacuation. After three or four weeks the system becomes habituated to the discharge, the condition becomes chronic, the functions were in a fair condition, and it is now a favorable time to operate. If it be postponed, the patient is liable to become exhausted, colliquative diarrhoea may set in, and the result prove disastrous. When this man first came in his temperature was 104°. During the course of the abscesses it varied from 98 to 103°, and now, for a week, it has been nearly normal. This shows a good indication for the operation, and if we postpone it longer the pus may extend up the arm, form more abscesses, and necrosis of the radius may be added to that which we already have. Now, as to the site of operation. In this point we must be guided by the disease, and in this case I think the best point will be just below the middle of the fore-arm. Now we have a variety of methods of operation to select from: the circular; the oval; transfixion and Teale's. It will be best to make our flaps so that the scar will be on the under surface. We need not here fear retraction of the flaps, as in primary operations, because the exudation has so consolidated the parts that much of the elasticity has been lost. In this case I will not use the Esmarch, because such great pressure might crush the blood-vessels near the seat of the injury and interfere with the nutrition in the flaps; therefore I will preferably use a tourniquet. On the posterior surface of the arm I will make a long, rectangular Teale flap. Always try to have the larger vessels of the limb in the shorter flap. Now there is a triangular space on the under surface of the arm where there has been a loss of tissue, but, rather than disarticulate at the elbow, I will excise this denuded piece and stitch the edges together. You will always have more hemorrhage in secondary than in primary operations, because the small vessels which, ordinarily, are hardly perceptible, have, in the progress of the disease, become dilated, and they have also lost much of their contractility.

So that here you see we have considerable hemorrhage; that from the smaller vessels can be

readily controlled by towels soaked in very hot water—almost scalding hot. We used to use cold water for this purpose, but I derive quicker results from the use of very hot water.

Progress of Science.

ON THE TREATMENT OF ACUTE RHEUMATISM.

Dr. W. R. Thomas spoke thus before the British Medical Association :

“Our knowledge of the treatment of acute rheumatism is making rapid strides day by day ; but still we frequently meet with cases which are most unsatisfactory to treat, because, I believe, our knowledge is in its infancy. In medicine, we are all apt naturally to follow fashion. Certain remedies are recommended highly, and we are inclined to take it that all cases of rheumatism can be cured by the same remedy. Given a case of acute rheumatism, all we have to do is to give salicylic acid, or bicarbonate of potash, or nitrate of potash, or a certain other remedy at the time recommended, and attend to the ordinary directions given as to diet and hygiene, and the patient gradually, or often rapidly, is sure to improve. That is what we expect. Now I have tried each of the remedies recommended on a large scale in both hospital and in private practice, and have come to the conclusion, after noticing carefully, and I think without prejudice, the effect of each one, that there is no one grand remedy for the disease we call acute rheumatism. The bicarbonate of potash, which has always been a favorite remedy of mine, I have seen act like a charm ; so also have I the nitrate of potash ; and then again, other cases I have met with where the remedy has entirely failed to have any effect whatever upon the disease. During recent years I have given, time after time, salicylic acid in large and in small doses, and have been delighted at the immediate good effect, thinking that, at last, we had met with a certain remedy ; then again, other cases have occurred where the salicylate of soda has had no appreciable good effect whatever, even when given in large doses, until certain symptoms were produced by the medicine.

“I do not think the remedies in these cases are at all at fault. When we prescribe a certain medicine in a certain case, we find that the patient derives immediate and surprising benefit ; and then we give the same remedy in another case, which to us appears to be similar, and are surprised at the patient not receiving any benefit whatever. Now, why should this occur ? Simply, I believe, because we have separate and distinct varieties of rheumatism, each one of which requires a treatment of its own. In one case, the salicylate will act well ; in another, it will not have any effect at all.

“In hospital practice, we naturally attribute all the improvement that take place after admission to the medicine which has been prescribed. A patient is admitted ; his temperature may be very high, his pulse very frequent, and the joint-signs may be severe ; in two days he is in a comparative state of comfort. In many of these cases, no doubt the removal of a patient from a miserable hovel in a back lane, where the surroundings are of the worst kind, to a comfortable bed in a well ventilated ward, where cleanliness is predominant, where warmth, proper food, and constant nursing are supplied, may have much to do with the rapid improvement which has taken place ; and I do not think that we are justified in attributing all the improvement which takes place—at all events, during the first few days—to the medicines prescribed.

“In practice I generally find that we have at least three distinct varieties of rheumatism :

“1. The sthenic.

“2. The asthenic.

“3. That variety caused and preceded by other diseases, as gonorrhœa, scarlet fever, etc.

“The first kind I have generally found among the well-to-do classes ; sometimes among the poorer. The patient, perhaps a commercial traveller or merchant, has always been exceedingly well, and until lately has enjoyed very good health. For some months he has suffered from dyspeptic and hepatic derangements ; his urine has generally been very high colored, and a large amount of sediment has been noticed daily in it. He has complained of frequent headache, back-ache, and aching of limbs. He is florid, and probably very stout, and has found that he has not been able to go through the same amount of work as he formerly could. Evidently he has eaten and drunk more than his body has been able to use and burn up daily ; and the several excreting organs, having had too much work thrown on them for a considerable time, are not now able to perform their functions properly.

“I shall not deal with the pathology of rheumatism at all ; but in this patient there is a tendency to inflammation of certain tissues ; and to the accompanying fever. He now sleeps in a damp bed, or catches cold in some way, and now comes on the attack. These are the cases where salicylic acid, salicylate of soda, and the bicarbonate of potash are beneficial. Of the two, I am inclined to think that I have seen more benefit derived from the salicylate than from the bicarbonate ; but I frequently begin by giving the salicylates, and then go on with the potash. Attention to little details we all find in rheumatism, as in all other complaints, of great importance ; for instance, covering the whole of the front of the chest with a layer of cotton wadding has often, I am sure, prevented an attack of pericarditis from coming on, and I found a night-shirt of very thin wool very useful, as these patients, perspiring much, are very apt to catch cold ; in fact, I now recommend all

my rheumatic patients to wear it regularly, and many have been very thankful for the advice. With regard to the joints, I have found wrapping the affected bones in cotton-wool all that is, as a rule, necessary, but when pain has been very excruciating, hot fomentations, with solution of belladonna sprinkled on the flannel next to the skin, have given relief. For pericarditis, my patients have generally seemed to be relieved by turpentine-stupes, followed by linseed-poultices; but unless it seem to be severe, I think it is advisable not take away the cotton-wadding or to apply anything else, for I feel sure that the less these patients are exposed the better. If possible, I avoid giving anything to procure sleep, but, when obliged to do so, I find our old friend Dover's powder the best. These patients generally require something to act upon their chylopoietic viscera; and I must say that I find nothing equal to five grains of pilula hydrargyri, followed by haustus albus, which draught has often to be repeated. As to diet there is nothing better for them than milk; and when the fever begins to subside, we can afford to be more generous.

"The asthenic patient is thin, pale and weak to begin with, from some cause or other; perhaps an over-worked and over-anxious young man, who in his desire to get on in the world has always neglected himself, and has taken his meals (and of them but little) irregularly; or a young mother, with one or two children, living on little else than tea. These patients have the same local signs and the same fever as the other patient had; but although there is the same tendency to inflammation of certain tissues, and the same fever, the tendency has, I believe, been produced by different causes entirely; and to obviate this tendency, or to remove the cause, we must, I think, adopt a very different mode of general treatment from what we do in the other class. These patients require plenty of support from the beginning, and we cannot give anything better than milk to begin with. Soon this patient will require beef-tea and other foods. As an internal remedy, I think we have none to equal quinine, giving from the beginning. Occasionally we may have to give other remedies when called for, but quinine is the remedy upon which we have to depend; and later on, I invariably find that the addition of iron to the mixture is beneficial. The same local treatment is required in these cases as in the other. As aperients, colocynth and aloes are preferable to the mercurial and haustus albus.

"My object in speaking to-day is to express my candid opinion that we should not treat all cases alike, but first of all should take in to consideration the class of the patient we have to treat, and then to decide what remedy or treatment to choose.—In one case it may be potash or salicylate, in other quinine. Of course, the treatment of rheumatism following other diseases will be different, as such will have to be taken into consideration."

ON ANESTHETICS.

In a paper read at a meeting of the British Medical Association by John Chiene, Esq., Professor of Surgery in the University of Edinburgh, he says:

The present outcry against chloroform is the result of an imperfect understanding of its physiological action; the proper method of administration; the dangers which may accompany its use, and their treatment.

Proper method of administration. Simple means are the best. A towel or handkerchief is better than any apparatus. If any apparatus is used, then the administrator trusts to the apparatus; the only sure trust is knowledge of the action of the drug, its dangers and their treatment. It is a matter of no importance how much is poured on the towel, except as a matter of economy; what has to be carefully attended to is the effect of the drug upon the patient. The administrator has to give his entire attention to the effect of the drug; The administrator must have his catch-forceps attached to his coat, and have confidence in himself.

In hospital practice, for the last eighteen months I have used Allis's ether-inhaler. By it chloroform is saved, and it is a convenient method of administration. As a rule I think the patient drops more quickly under the influence of the drug.

The administrator must watch the breathing and the appearance of the patient. The sense of feeling with the hand between the towel and the mouth is the best guide to the breathing. The heaving of the chest is also to be watched. The heaving of the abdominal walls is deceptive, as this may be due to contractions of the diaphragm, which may continue for some time without any air entering and being expelled from the chest. Voluntary stoppage of the breathing frequently occurs early in the administration. Experience will soon enable the administrator to understand this, and to distinguish it from stoppage of respiration due to the action of the drug on the nervous centers which govern the muscles of respiration. The sense of hearing may also assist in enabling the administrator to judge of the breathing. In antiseptic surgery the use of the steam-spray, accompanied by a hissing noise interferes with the sense of hearing; in such cases the surgeon must trust to the senses of touch and sight. If the breathing becomes shallow or irregular, accompanied by gasping or sighing, then the towel must be at once removed from the patient's face. When the breathing becomes deeply stertorous, then the patient has, as a rule, had sufficient; the towel must be at once removed. Stertorous breathing is not in itself an evidence of danger.

The appearance of the patient's face is also to be watched. As long as the lips are red, the blood is being properly aerated, the circulation and the heart's action are unaffected. If the patient become livid or unnaturally pallid then there is danger.

Tell the patient that he is to take long breaths. Give the drug slowly at first, in order to prevent a choking sensation. Do not let the towel rest on the face, because it is apt to cause blistering. After a time the patient struggles involuntarily. Do not fight with him; guide his movements; and as the drug takes effect, they will soon subside.

How are you to know when the patient has had enough? There are three signs, all of which should be made use of.

1. By touching the conjunctiva. If the patient do not contract his orbicularis palpebrarum, then he is generally sufficiently under the influence. Sometimes, however, this is not a certain sign. The action on the nervous centers is progressive; although sufficient for an operation in the region of the eye, the drug may not yet have affected the whole of the spinal cord and reflex action in the limbs may not be abolished.

2. Muscular relaxation, judged of by raising the arm and seeing if it fall heavily by the side.

3. Local sensibility at the seat of the operation. This is to be estimated by the surgeon pinching the part to be operated on with a pair of artery-forceps.

These three signs are all useful, and experience will enable the administrator to estimate their proper value in each case. Take away the towel the moment the patient is under the influence. A very common mistake is to suppose that, if the patient be breathing, then all is right. When the breathing stops then the patient is on the point of death.

No attention is to be paid to the pulse; it is the last thing that stops. When the stoppage of the heart's action is due to the drug, then the patient is dead. Fortunately, the poison is a volatile one; and if, from ignorance, too much has been given, interfering with the action of the heart, either directly by acting on the nervous centers which govern the heart's action, or indirectly by stoppage of the circulation, the heart may recover itself if the patient be kept alive by artificial respiration until the poison, in consequence of its volatility, is dissipated.

The administrator has to devote his attention to other things; and, if he attend to the pulse, he can not pay sufficient attention to the more important signs—important because they occur earlier in the administration. Attention to the pulse by a second person is not necessary, because the signs which I have already given will be quite sufficient to prevent danger. There is a division of responsibility. Assistance is apt to make the administrator trust to his assistant, and not to be sufficiently watchful himself of the other signs which guide him in the administration. It is not necessary to use the stethoscope in order to test the propriety of giving chloroform. If there be heart disease; or weak action of the organ, then these are the very cases in which chloroform is most useful, because they are most liable to the occurrence of shock, which

the drug prevents by abrogating sensibility.

The dangers which may accompany its use and their treatment. We must always be prepared for these. They may occur in any case, because the drug acts with much greater rapidity in some cases than in others, and we can never in any case foretell how rapidly the drug may act. The frontier-line between the abolition of sensation, voluntary motion, and reflex action, and stoppage of the circulation and heart's action, is often very indistinctly marked. In old people this is the case; to them, the drug must be administered with the greatest caution.

[I have occasionally seen troublesome symptoms in young children; and, while I say that in old people the drug must be given with the greatest caution, I do not wish it to be understood that children can take it without risk.]

We may reach the dangerous effects earlier in some than in others; hence the great care necessary in every case. The order in which the effects take place is the same in all. This must be distinctly understood.

These dangers may be classed under four heads:

1. *The tongue falling back* and closing the glottis, in consequence of paralysis of the muscles which hold the tongue forward. The signs of this are lividity of the face and shallow breathing, as the air does not enter and leave the chest in sufficient quantity. The patient is in the same state as if a piece of meat had stuck in his pharynx, closing his glottis. The piece of meat is his tongue.

2. *The glottis closing*, due to paralysis of the intrinsic muscles of the larynx. The signs of this are lividity and a crowing sound, as heard in a case of croup, acute laryngitis, or laryngismus stridulus.

3. *Fainting*. This is due to an imperfect supply of blood to the brain, the result of either the sitting posture during administration, as the dentist's chair, or to a naturally weak heart in the aged or prematurely aged person. The sign of this is unnatural pallor of the face, judged of more especially by the paleness of the lips. The faintness may be due also (at the commencement of the administration) to fear on the part of the patient. It may also be due to any cause which may give rise to faintness in general. In this case, the chloroform has nothing whatever to do with the faintness; it may be associated with, but in no way due to, the chloroform. The faintness may also be due to want of confidence on the part of the administrator. He fears the drug, from ignorance of its physiological action. He commences the operation before the patient is sufficiently under the influence. The patient is then in a condition which renders him most liable to shock. He is unable to brace himself up to bear the pain; his nervous centers are in a semi-paralyzed condition. The unfortunate result may follow, namely, imperfection or stoppage of the heart's action, followed by syncope,

4. *Vomiting.* This is only dangerous if there be food on the stomach. The food passes into the pharynx, and may pass through the semi-paralyzed larynx, and cause suffocation by passing into the bronchi. If the stomach be empty, this danger can not occur.

The treatment of these dangers is as follows :

1. *The tongue falling back.* The head is to be turned on one side, in order that, by its weight, the tongue may pass to one side, and the opening of the glottis may be free for the entrance and exit of air. If this do not at once effect the object, then the tongue must be removed from its dangerous position, and for the same reason that, if a person be choking from a piece of meat lying on his glottis, the proper treatment is to remove the obstruction. The best way to do this is to seize the tongue with the catch-forceps and pull it forward so that the tip of the tongue appears between the teeth.

2. *The closure of the glottis, due to paralysis of the intrinsic muscles of the pharynx.* The remedy for this danger the tongue must be pulled forcibly out of the mouth. By so doing, the epiglottis is pulled forward by stretching the ligaments which unite it to the tongue; the epiglottis, passing forward, stretches the aryteno-epiglottidean ligament, and separation of the vocal cords follows. The action here is purely mechanical, and was first explained to me by Dr. John Wyllie, who first described this effect of forcible traction on the tongue. This can be verified on the dead subject.

[From further experience, I am inclined to lay greater stress now than I did in 1876 on the view of Lister, published in Holmes's System of Surgery; namely, that the forcibly pulling forward of the tongue acts reflexly, stimulating the respiratory centers. I can not, however, lay altogether aside the mechanical theory described in the text. Lister's theory has strong corroboration in what I have seen of Mr. Joseph Bell's practice in the Royal Infirmary here. In case of shallow respiration with or without lividity, in which the forcible pulling forward of the tongue has no immediate effect, he at once pushes his finger into the glottis; here the action, undoubtedly most beneficial, is two-fold, mechanical in opening the glottis, but mainly, as Mr. Bell holds, and I think truly, by irritating an excessively sensitive surface, and in this way reflexly stimulating the respiratory and cardiac centers.]

If these two dangers, the tongue falling back and closure of the glottis, be not treated at once, the result is that respiration does not proceed, the blood is improperly aerated, the lungs become gorged, the heart becomes gorged, and the result is, stoppage of the heart's action. If a rabbit be killed with chloroform and the chest opened, the heart will be found to be gorged with blood, and the contractions of the heart will be in abeyance; prick the heart with a needle, allow some blood to escape, and the contractions of the heart are re-established. This experiment seems to show that

if, by striking the chest and by artificial respiration the action of the heart be not quickly re-established then bleeding from the external jugular vein should at once be resorted to. I have never yet required to have recourse to this remedy, artificial respiration having been sufficient. It must be remembered that it should never occur unless by a fault on the part of the administrator in not using at once the proper remedies—either removal of the tongue, if it be acting as a mechanical obstacle to the admission of air, or forcible traction of the organ if the obstruction be in the larynx itself in consequence of paralysis of the intrinsic muscles of the organ.

3. *Fainting.* The treatment is preventive and curative.

a. *Preventive.* Never give chloroform in the sitting posture. Never commence any operation, however trivial, until the patient is fully under the influence of the drug; it is far better not to give chloroform at all than to use it imperfectly.

b. *Curative.* If it occur as a result of a weak heart, or in consequence of an excessive loss of blood during the operation, or as a coincidence during the administration of the drug, then the head must be at once placed at a lower level than the body, the arms and legs must be raised to the vertical, or the patient may be held up by the heels, as recommended by M. Nélaton. The effect in all these ways is attained of restoring a sufficient supply of blood to the brain.

The good effects of Nélaton's practice are, in my opinion, of a twofold nature; first, by restoring the proper supply of blood to the brain in the most efficient and quickest manner; second, in many of the cases the danger may have been at the opening of the glottis, due to obstruction by the tongue; inverting the patient will at once remedy this by causing the tongue to fall forward. It will also be useful in cases in which blood, in operations about the mouth and nasal cavities, has passed into the bronchi, or in cases in which vomited matter has passed into the larynx, the foreign body being removed by inversion, as Brunel removed the half-sovereign from his bronchial tubes. The frequency with which Nélaton's practice has been attended by good results in cases of apparent death from chloroform, seems to show that inversion may act in this twofold manner, because obstruction of the glottis is a much more frequent danger in the administration of chloroform than faintness, which, as far as my experience shows, is comparatively rare.

4. *Vomiting.* Do not give any solid food for four hours before the operation. In railway accidents and other sudden injuries in which it is necessary to give chloroform, the greatest care must be taken; if vomiting occur during the administration, turn the patient on his side, in order to allow the vomited matter to escape from the mouth, and prevent any regurgitation into the bronchial tubes. In such cases, the administration of chloroform should be abstained from until the stomach is empty.

When the act of vomiting takes place, the stomach being empty, then the administration of more chloroform is required in order to stop the abnormal contractions of the muscular walls of the stomach. There is in such a case no danger from vomited matter passing into the larynx.

The dangers which accompany its abuse and their treatment. If an overdose of chloroform be administered—and it must be remembered that some patients are very susceptible to the action of the drug—the nervous centers which rule the muscles of respiration are poisoned; then the treatment required is to pull the tongue forward, in order to allow air to enter or leave the chest by artificial respiration. It is a volatile poison, and perseverance in artificial respiration must be continued until the volatile poison passes away. A case recorded by Dr. J. J. Brown, in the *Edinburgh Medical Journal* (Nov., 1874) well illustrates this important fact. By artificial respiration, kept up continuously for two hours and three quarters, he saved a patient in whom complete paralysis of the respiratory ganglia had occurred, but the cardiac ganglia were unaffected. The case also shows that the respiratory ganglia are poisoned before the cardiac ganglia. When the overdose is excessive, then the heart's action is interfered with; by artificial respiration, striking the chest-wall with a wet towel, and the use of the galvanic battery, it must, if possible, be restored.

THE CURABILITY OF CONSUMPTION.

In an article on pulmonary phthisis in the *Medical Record*, of the 21st ult., Dr. J. Milner Fothergill, of London, makes the somewhat startling assertion, based on an experience of ten years in a chest-hospital, that the disease is far from being necessarily fatal. Under fairly favorable circumstances, he holds, a rally may be made in the large bulk of cases, which may lead to recovery. This is glad tidings, and a detail of the means through which this consummation may be reached will be eagerly read. It is customary in acquainting the patient of the fact that he has consumption to do so in a tone and manner calculated to shut out from him the faintest ray of hope. Treatment, moreover, is usually undertaken with a view to euthanasia, rather than with a hope to snatch the brand from the burning. If, therefore, Dr. Fothergill has put in our power to tell the consumptive that the odds are in favor of his outliving his disease he will prove to have been one of the greatest of the benefactors of this and succeeding ages. He does not propose anything particularly new in the way of treatment, nor does he vaunt any specific. His common-sense application of means already familiar will, however, commend themselves to the attention of the profession.

The line of attack advised in incipient cases is to improve the general condition, in which improvement the new growth have its share. To

check the body expenditure and to increase the body income are our aims. All out-goings must be stopped. This is the first step. If a woman, attend to any leucorrhœa at once. Many a good line of attack has failed, many a woman sunk into her grave who might have been rescued, if only that out-going had been attended to. If the catamenial loss be heavy, put an arresting finger upon it by some ergot, sulphuric acid, and sulphate of magnesia, commencing with this two days before the appearance of the flux, and continuing it during the flow, reverting to the usual treatment on its completion. Then, is there diarrhœa? If so, attend to it. Milk and farinaceous matters are indicated (no meat-broths, no beef-tea—"giving the patient a stone when he asks for bread"—unless some farina be added). Then for medicine some astringent preparation of iron may be given in the day, and a pill of sulphate of copper (gr. $\frac{1}{4}$ - $\frac{1}{2}$) with opium (gr. $1-1\frac{1}{2}$) at bed-time. If there be both diarrhœa and night-sweats this pill will often "kill two birds with one stone."

If there be night-sweats, arrest them at once, or as soon as may be. Sweat is an excretion, and is highly charged with blood-salts. Consequently, profuse sweats are most exhausting. Check them, and the appetite returns, and between the two the patient does well. Prof. Sidney Ringer, F.R.S., has laid the phthisical world under a deep debt of gratitude by pointing out the potency of belladonna in the matter of hydrosis. The best preparation is atropine, not only because it is tasteless, but because we know exactly what we are doing when using it. But to secure its good effects it must be pushed. Its effects upon the pupil is nothing. Indeed, in a very extensive use of belladonna the pupil has rarely been affected. (The effect upon the pupil is a bug-bear which ought to be buried). Dry throat and dim eyesight are discomforts, but unless severe they need not disturb the treatment. There is a wide gulf between these and any real danger. The very lowest dose is $\frac{1}{15}$ of a grain. If this does not achieve the desired end, then $\frac{1}{10}$. If that is insufficient, then $\frac{1}{5}$. If that fails—which it rarely does—one must begin to look seriously at the case. When this dose is reached, and yet the sweats continue, Dr. F. adopts the plan of an Old New York quack, of which Lewis Sayre told him, viz., to sponge the paper over with hot vinegar ($\frac{1}{2}$ pint) with a teaspoonful of cayenne in it. This is not at all disagreeable, and is effective. If the combined measures fail, the patient's case is hopeless, but his physician's conscience is clear.

Perhaps the patient's rest is broken by cough. Dr. F. recommends the following combination in such cases: Morphine, (gr. $\frac{1}{2}$), atropine (gr. $\frac{1}{10}$), with pil. galban. co. or "pil. al. et myrrh.," as the case may require. This is a pill which has done him yeoman service in his warfare with phthisis. It has found its way into the Brompton Hospital, and more recently into Squire's *Companion to the Pharmacopœia*. It will, he thinks, find its way

before long into every consumption hospital in the world. This action of carbonic acid upon the sweat-glands has led Dr. Lauder Brunton to advocate strychnine (a potent stimulant to the respiratory centre) in the night-sweats of phthisis. No doubt it is useful. Dr. F.'s practice is to give it in the day-medicine. His favorite mixture at the hospital consists of liquor strychnine (4 minims), acid. phosph. dil. (15 minims), tincture capsici (4 minims), in infus. gent. (3 dr.), *ter in die*. This forms a capital tonic. Some quinine or sulphate of magnesia (or soda) may be added as required.

One of the rules which have formed themselves in his mind is to give acids when the tongue is clean or coated. When the tongue is bare, raw, or irritable, then alkalis are indicated as am. carb. (gr. 2 to 5), tinct. nuc. vom. (10 minims) in inf. gent. (1 ounce), *ter in die*.

On such a line of treatment the patient usually improves. The night-sweats cease, the appetite returns, the cachectic look departs, and the patient feels much better. The improvement is maintained, and soon iron and arsenic can be added to the strychnine, and cod-liver oil to the dietary (but cod-liver oil is not the best form of fat, nor yet the most palatable, though it is the most digestible. Some forms of fat in an emulsified state are now on the market which possess many advantages over cod-liver oil). Iron is a good haemic.

Arsenic is an alterative and a tonic greatly believed in by many good observers in lung-consolidation. If the patient can be induced to take fat in any form the healthy tissues can be built up. Very commonly the affected area is found to shrink, and air to pass into it. In a few months, in many cases, it is scarcely possible to detect any change in the lung. The threatened danger has passed away!

All along in the treatment advocated the matter of improving the condition has never been lost sight of for a moment. If the patient can get away to a dry soil and a bracing locality, all the better for him or her.

Another common patient is the person who has chronic phthisis with cavities. Such patient is always spare and badly nourished at the best; and when any intercurrent ailment still further lowers the general condition the lung trouble is aggravated. (And one matter has forced itself upon his attention, viz., that wherever there is old lung-consolidation any disturbance in the liver sets up irritation in this consolidated patch with resultant cough. And this cough, which is intractable to ordinary cough-medicines, is relieved by acting upon the liver.) The appetite has fallen off and the nutrition is impaired; and then the special danger in phthisis is set up. Very often the tongue is raw, or beef-steak, or patchy. Here attention to the *prime vie* (as our grandfathers phrased it) is imperative. The patient must be sent to bed, to reduce the body expenditure to the minimum. The medicine must be bismuth, with alkalis; and the food, milk

with malt extract, or a malt preparation with Mellin's food, in small quantities at a time, oft-repeated. No solid particle in the stomach to vex and irritate the sensitive (because ill-fed) mucous membrane. Even an alkali—like carbonate of magnesia—may be required to neutralize acidity and prevent too firm curdling of the milk: as much as will lay on a sixpence to half pint of milk is usually sufficient. Having got the assimilating processes into good working order, the tonic may be given. "The more haste the less speed" is especially true of the treatment of phthisis; and the desire to push on with tonics and good food sadly too often defeats its own end. Sometimes a masterly inactivity is the wisest practice. A clear head and a firm will are often required to curb the desire of the patient (and still more the patient's friends) to be getting on. Back-cast after back-cast teach a painful lesson to the medical man, and involve the patient in acute danger. If the pressure put on a young medical attendant is becoming more than he can bear, let him call in an older head to help.

The chief thing to avoid is morphia tinctures for the cough. An opiate to procure sleep may be essential and unavoidable; but sedatives in the day are dangerous. They give relief from the cough but too commonly they give permanent relief by death. Opium lays its palsyng hand upon the assimilative organs, and destroys the appetite. Its evil effects seem most distinctly felt by the liver. When an opiate is indicated at night it should be combined with ipecac to antagonize its effect upon the liver, and with aloes and myrrh pill to correct its actions upon the bowels. Opium strikes directly at the assimilation which is the cardinal matter in the treatment of phthisis. The patient most certain to die, the case least amenable to any treatment, is that one whose wasting progresses steadily, and where the lungs are only affected quite late on—indeed, a brief while before the final change sets in.

As to other means of allaying the cough than opiates, inhalations of steam are often serviceable. Friar's balsam, iodine, carbolic acid, terepene, eucalyptus, all are good as additions to steam. Where there is a cavity with ragged walls smelling offensively, a respirator with cotton wool charged with carbolic acid is indicated.

Then, as to the other means of feeding the patient, there are injunctions of oil, often of service, especially with young subjects. Nutritious enemata have only lately suggested themselves: but in one case of a medical man steadily wasting an enema of cod-liver oil (emulsified by a drop of bile) and milk in equal quantities is being tried. Such enema night and morning, while in the recumbent posture, would be readily retained. When the temperature mounts up, and especially when the skin is also moist (the usual state in hectic fever connected with phthisis), Dr. F.'s plan is to give quinine (gr. 2 to 5) with tincture of digitalis (10 to 15 minims) and dilute phosphoric acid (15 minims,) thrice daily. The effect is very satisfac-

tory usually. Where a severe racking cough is present, shaking the poor sufferer terribly, it may be necessary to give opiates; but, in the author's experience, such cough is very rarely found with pulmonary phthisis.

The treatment of hæmoptysis is quiet; no movement, no talking. When it arises from the bursting of an aneurismal sac in a cavity, or from an ulcerating process eating into a blood-vessel and opening a communication between the vessel and an open air-tube, syncope alone is likely to arrest it. In congestion of the lung it is often an excellent form of local bleeding. Men of old bled for its relief; now free purgation with mineral salts is in vogue. For small recurrent hæmoptyses the best treatment is to keep the bowels open. Ice, ergot, and dilute sulphuric acid may also be tried; probably they will do no harm. It is a bad plan to feed up a case of recurrent hemorrhage; it only fills the vessels rapidly, to end in more bleeding.

Finally, the management of phthisis pulmonalis, whether the less grave or the more serious conditions, is a good test of the knowledge, skill and tact of the practitioner, who must, like a competent soldier, be able alike to plan a campaign or execute a sudden change of front in an emergency. That is, he must be able to lay down a persisting plan of treatment, and promptly change his plan to meet some intercurrent conditions, as hæmoptysis or acute gastric disturbance.—*Med. Age.*

THERAPEUTICS OF CHOLERA INFANTUM.

Looking over the mortality-records of children, especially in the larger cities of the moderate and warm zones, with the view of ascertaining the principal etiological factors, the frightful ravages of cholera infantum seem inexplicable in view of its generally acknowledged causative factors. It is apparently in vain that the light of hygienic and sanitary knowledge is persistently, with word and letter, thrown into the dwellings of the poor, the gospel of fresh air and pure water will apparently never enter the crowded tenement-houses, and the high mortality-rate of children during the summer months remains stationary. It is unfair to blame the medical guardians of the community for the meagre results of their curative efforts, as long as even the most ordinary prophylactic measures are systematically ignored, if not ridiculed, by the ignorant portion of the poor public.

We present to our readers in the following a full abstract of a classical essay by Dr. Baginsky, of Berlin, treating of the prophylaxis and therapeutics of cholera infantum.*

The prophylaxis is to begin with the most careful notation of every dyspeptic disturbance during

the summer, especially in such children which probably some weeks previously suffered from a dyspeptic catarrh or have just been weaned. The dyspeptic catarrh may or may not be dependent upon dentition, at any rate, it is to be regarded as a serious morbid condition. The foolish view of many mothers, and—it is to be regretted—also of physicians, that diarrhœa in children comes from the teeth, and consequently requires no astringent or any other treatment, slays annually thousands of young children.

If the catarrh, in spite of strict diet and appropriate remedies, cannot be mastered even after a complete change of nutrition, the child is to be sent to the country under careful medical attendance.

The therapeutics of the affection will vary according to the stage of the latter in which the treatment is begun, and may either be the attack itself or the so-called period of reaction.

The treatment of the choleraic paroxysm is intended (*a*) to check the hyper-excretion, (*b*) to revive the cardiac power, and thus protect the system against the danger of collapse. To satisfy both indications is only possible in the beginning; later, during the stage of existing weakness, the second object engages exclusively the medical attendant. The question whether medicines, which, like opium, subdue the violent intestinal peristalsis, are proper, is to be answered in the affirmative, but only conditionally. Opium is for children of a very tender age a highly dangerous drug; its action is often unquestionably favorable, but is surely harmful where it does no good. Its applicability, then, must be determined by the peculiarities of each single case. If the child is very restless, or if constant whining, violent movements, and expressions of pain when the abdomen is touched, point to abdominal colic, opium has to be resorted to, and is best given in combination with an antiferment, such as calomel, iodoform, resorcine, or bismuth. The tincture of opium is to be given in doses of 2 to 3 drops, the extract in correspondingly smaller doses; Dover's powder and hydropathic applications usually act very well. The more quiet and apathic a child is from the beginning, the softer and flabbier the abdomen, the more the diarrhœa, as it were, passes off insensibly, the less appropriate is opium, the greater the danger to hasten the lethal exit through sopor and somnolence.

The antiferments assist likewise the stoppage of the diarrhœa by eliminating the fermentation of the ingested matters which produced the heightened peristalsis. These remedies may also be employed alone without opium; our expectations though, in this case, must be moderate. Astringents, both the metallic and vegetable ones, are decidedly contraindicated during the choleraic attack, though they are very valuable in the secondary catarrhs.

Rectal washes, consisting of large quantities of lukewarm water, are more effective than generally

* This essay forms the third series of Baginsky's work, entitled "Practical Contributions to the Therapeutics of Diseases of Children." The first series treats of pneumonia and pleurisy, the second of rachitis.

understood. If, in spite of all instituted measures of relief, the collapse progresses, the extremities grow cold and the skin pale, the fontanelles recede and the face assumes what is known as the hippocratic expression, medicines intended to stop the diarrhoea are no longer appropriate; true stimulants are then called for. The dietetic means, such as black, strong coffee and alcoholic stimulants (such as cognac, champagne, and genuine port wine), will also revive the flagging vitality. Small quantities are to be administered in short intervals, from a few drops to a teaspoonful, according to the age of the child. Wine is best given by itself, cognac with soda-water (cold), coffee best warm, and only if vomited, cold. Among all eligible medicines camphor, benzoic acid, liquor ammonii anisati or liquor ammonii succinii deserve the preference. The following may be given every two hours in children of $\frac{1}{2}$ to 2 years:

R Camphoræ tritæ,
Acidi benzoici, aa 0.03-0.05 grm. ($\frac{1}{2}$ - $\frac{3}{4}$ grain);
Sacchari lactis, 0.5. grm. (7 $\frac{1}{2}$ grains).

Or the following:

R Liquor ammonii succinii, 1-2 pts. per 100;
One teaspoonful every half-hour.

Unfortunately, all medicines are very liable to be vomited up in this, and, in fact, in all infantile affections; under these circumstances hypodermic medication should unhesitatingly be resorted to: acetic or sulphuric ether, in doses of 2 to 5 drops, or the tincture of musk recommending itself best. All are well borne, and act, often with surprising promptness, in raising the arterial wave and stimulating the great nervous centres.

During the height of the collapse, marked by diarrhoea and vomiting, food (including even the mother's breast) is of course wholly interdicted. To quench the great existing thirst, seltzer-water, with wine or cognac (cold) or coffee, is to be freely given. Warming bottles are to be placed to the feet and cold compresses every half-hour to the abdomen as long as any algidity is absent. Is it advisable to bathe children during the paroxysm? Some authors praise baths, both cold and warm, though the former are scarcely advisable. Warm baths, especially when combined with chloride of sodium or calamus, are said to be of advantage, though Baginsky has never obtained any palpable benefit from them. The same is true of mustard-poultices and mustard-baths, though both should be tried, as, besides being harmless, they may at least cause a momentary improvement of the child's condition.

The period of reaction requires a novel and equally careful attention to the patient. The condition known as hydrocephaloid is here well to be separated from the so-called typhoid state. Hydrocephaloid manifests itself as a uniformly advancing phase of constitutional failing, and calls for a protracted mildly stimulating treatment. This is best initiated with either the mother's milk or ice-cold cow's milk, or Biedert's food. The

child is now to be kept warm by warm compresses to the abdomen and even to the head; internally (in addition to the above-stated excitants) wine or coffee are to be given. Complications, such as bronchial irritation, abscess, or albuminuria, of course require the ordinary special attention.

In the typhoid state of cholera infantum lukewarm baths or lukewarm applications to thorax and abdomen are especially indicated when the respiratory tract has been attacked. Senega and the liquor ammonii anisati will then act much better than ipecac, which is rather apt to heighten the already existing inclination to vomit.

The cornea and conjunctiva usually do not obtain the degree of attention to which these important structures are entitled. The eye is to be repeatedly moistened with lukewarm water or covered with a cloth saturated with greatly diluted chlorine-water.

NOTES OF FOUR CASES OF VARICOSE VEINS TREATED WITH HAMAMELIS.

BY E. F. NICHOLLS, M.D.

In April, 1883, I read in the *Philadelphia Medical Times*, No. 402, an article by Dr. J. H. Musser on "The Treatment of Varicose Veins with Hamamelis." A few days after I read this article, Mrs. W., a married woman, age 35, called at my office on account of swelling and varicose veins of the left leg. On examination, I found the left leg considerably swollen, with here and there large dark spots, which on pressure were quite soft and somewhat tender. These spots were as large as eggs, and situated on the inner aspect of the calf. The right leg was all right. Mrs. W. was three and a half months pregnant with her fourth child. She had always experienced trouble with the veins of her left leg while pregnant, beginning about the third month of pregnancy, and continuing till delivery. In her former pregnancies her leg had been treated by bandaging, which afforded some relief, but her distress was so great that at times she was compelled to seek relief by lying down. I concluded to try the hamamelis and ordered to take one teaspoonful ext. hamamelis four times a day in a wineglassful of water. She began to improve at once, and continued to take the drug till delivered. Her leg gave her no trouble, the swelling and varicose veins disappearing altogether. Mrs. W. is again pregnant, and the varicose veins appeared again at the usual time. She is now taking hamamelis with success.

The second case is a young colored man, age 30; has had varicose veins for two years. He got some relief from bandaging, but relief was only temporary. Last November he came to my office with a ruptured vein, considerable oozing of blood. Put on a compress and ordered hamamelis, teaspoonful every three hours. Saw him next day, took off compress, no bleeding. Con-

tinued hamamelis. Did not see him again for two months, when he reported at my office well. I have seen him several times since, and he has no return of his varicose veins.

The third case was a woman, age 50 years; was a washerwoman; had had varicose veins for a long time; did not remember when they first came; was treated by adhesive strips and bandage, but always returned after the bandages were left off for a short time. I gave her hamamelis, two teaspoonfuls three times a day in water. She got entirely well in two months, and has remained so ever since.

The fourth case, a woman, age 47 years, sent for me May 10, 1883. I found her sitting in a chair, bent forward till her face was between her knees, her hands clasped firmly together, her legs stuck out in front, covered with wet cloths. I do not think I ever saw in my life such a picture of utter hopelessness as this patient. When I approached her, she looked up, and in the most piteous voice exclaimed, "For God's sake, can you do anything for me?" On examining her legs, I found the cause of all her troubles: both legs were a mass of ulcers from the knees to the ankles. From ulcers was oozing a clear fluid, which soon turned the cloths black. Situated a little behind the knee were several bunches of varicose veins. I thought I had found the original trouble. On inquiry, she said at first, some five years ago, her leg was full of large veins and considerably swelled, and the ulcers came afterwards. I put her on extract of hamamelis, a teaspoonful every three hours, and told her to keep cloths wet with hamamelis applied to the leg. She recovered in two months and all she has left to remind her of her former trouble is considerable discoloration on the anterior aspect of her legs. She walks all about the city, experiencing no trouble whatever.

The extract of hamamelis used in all my cases was procured at Bullock & Crenshaw's.

In conclusion, I would say that I consider hamamelis almost a specific in varicose veins from almost any cause. I did not find it disagree in any way with my patients. It is not at all unpleasant to the taste.—*Philadelphia Medical Times.*

A CASE OF OBSTINATE HICCOUGH RELIEVED BY NITRO-GLYCERIN.

Dr. O. T. Schultz reports in the *American Practitioner* for September, 1885, a case of a miller, aged 58, affected with fibroid phthisis, in whom the severity of the cough had apparently brought on several very violent attacks of angina pectoris. The attacks had been rapidly relieved by morphine. During the excessive heat of the last weeks of July, hiccough set in, which continued with moderate severity for three days before Dr. Schultz was called in. Chloroform administered internally gave temporary relief but at the end of two days his seizures had increased in number and severity, and were

attended by occasional attacks of dyspnea. Morphine and atropine only produced relief when the narcotic action was at its height, while it gave rise to a condition resembling alcoholic intoxication, to sleeplessness, and to an increase of the chronic gastric catarrh which also complicated the case. On the sixth day strychnine was given, and the morphine limited to half a grain at bedtime. On the eighth day, there being no improvement, electricity was added. Galvanization of the phrenics and of the epigastric region gave no relief. A powerful induced current applied to the epigastrium and along the costal region of the diaphragm broke up the spasms after five minutes. There was complete absence of hiccough for half an hour after each sitting, the attacks being less violent and less long in the intervals between the *sittings*. Improvement, however, did not last long. On the ninth day potassium bromid., gr. xxx, and strychnine, gr. 1-80, were given every third hour. Only very transient relief was afforded by this combination, the hiccough being not quite so severe for a short time after the prescription had been taken. The next night was almost one constant hiccough, and on the morning of the tenth day the induced current failed to interrupt the attacks.

The patient's condition now became very critical. There was only very rarely a cessation of the spasms, day and night. The appetite had improved since stopping the morphine, but the food taken was ejected as soon as it was swallowed. There was exquisite tenderness along the line of attachment of the diaphragm, and soreness and burning in the whole chest. When he coughed, long and distressing spasms of the thoracic respiratory muscles would set in. He was worn out, and entirely despondent. The temperature was normal and the pulse 100. The bowels were kept freely open with calomel, senna and salts.

Thinking that the causes which had given rise to the former attacks of angina pectoris might be identical with those which originated and kept up the present singultus, and knowing what an excellent remedy nitro-glycerin is for the former form of spasm, Dr. Schultz concluded to try this drug in the case. One drop of a one per cent. solution was given at 8 A.M. of the tenth day, and repeated at 9 A.M. A moderate degree of bursting headache set in immediately on swallowing the dose, the hiccough became easier and rarer, and by 9.30 o'clock had ceased entirely. The medicine was continued every two hours. At 2 P.M., after drinking a glass of iced milk, the spasms again appeared, but yielded quickly to a new dose. During the afternoon and the night there was only an occasional hiccough, but on the eleventh day a short attack appeared at 2 and 6 P.M. The medicine was steadily continued. The spasmodic movements now ceased entirely. On the twelfth day an occasional dose of the nitro glycerin was exhibited and a tonic of iron, muriatic acid, quinine, and nuxvomica begun; on the next day the former was dropped entirely.

FOTHERGILL ON HEPATIC DISORDERS.

The functions of the liver and kidneys are closely linked together; and in those derangements where the urine has a thick sediment and the bowels are disordered, the old-fashioned doctor who shook his head and oracularly uttered, "Liver!" was not such a fool as it has recently been the rule to regard him. First cut down the amount of albuminoids eaten or drank, in order to reduce the demand upon the liver; then sweep away the waste from the blood by a pill at bedtime:

- Pulv. pip. nig grs. ij.
- Pil. col. comp grs.

and in the morning:

- Sodæ pot. tart..... ʒ j.
- Sodæ sulphatis..... ʒ ss.
- Tinct. zingiberis..... ʒ ss.
- Inf. gentian..... ʒ j.

with an equal quantity of boiling water, so as to make the draught as hot as can comfortably be borne. Let this be done twice or thrice a week, till the tongue is clean. When that is done, give the

- Sodæ sulphat..... ʒ j
- Sod. et pot. tart..... ʒ ss.
- Tinct. nuc. vom..... gtt. vj.
- Inf. cascariellæ ʒ j.

Ter in die before meals, and the pill twice a week.

If there be general asthenia, do not proceed to give iron until the tongue is thoroughly clean, the water clear, and the appetite good; and then commence with two or three drops of the dialyzed iron once a day, after food. In other cases, where there is only slight constipation, with deposits in the urine, especially after meals, give the old-fashioned dinner pill:

- Pulv. ipecac..... grs. j.
- Pulv. capsici..... grs. ss.
- Ext. cinchonæ..... grs. ij.
- Pil. a. et myrrh..... grs. j.

every day after dinner. It will be found very efficacious. If this dinner pill does not act sufficiently, give the morning laxative twice or thrice a week, so long as the bowels require it. Then as to the union of laxatives with tonics, it is well often to combine these two agents. In convalescence, tonics never act genially, if there be not at the same time time regular and sufficient action of the bowels; so, and sulphate of magnesia or sulphate of soda to the tonic.—

- Mag. sulphate..... grs. xx.
- vel soda sulpha..... ʒ j.
- Quin. sulph..... grs. j.
- Ac. phosp., dil..... m. xv.
- Inf. gentian..... ʒ j.

Ter in die before meals, and ten minims of dialyzed iron after dinner, daily, will usually give good results; or,

- Mag. sulphat..... ʒ j.
- Tinct. fer. mur..... m. x.
- Liq. strychnia..... m. iv.
- Inf. quass..... ʒ j.

Ter in die; forms a less expensive tonic, of much utility.

But in this use of laxatives, with occasional mercurials, avoid the pitfall of letting the patient eat with unlicensed abandon.

Now, in conclusion, let me tell the student to strive to see what are the indications for treatment what in this case, calls most imperiously for attention. He is taught too exclusively, at present, to look at disease from a deadhouse point of view. To make a diagnosis which would be corroborated in the deadhouse is the great matter! Yes, so it is at a medical school; but in practice for yourself, remember that a living, grateful patient, who has got well under your care, is worth far, far more to you than any amount of accurate diagnosis—which, so far as other persons and their opinions are concerned, is as voiceless to further your interests as the tombstones in the churchyard which mark your failures.—*Indian Med. Jour.*

ON THE THERAPEUTIC VALUE OF THE CHLORIDE OF CALCIUM.

Dr. R. W. Crighton, M. D., England, writes in *Fractitioner*, concerning the chloride of calcium in the following positive terms:

In suitable cases I know of no other therapeutic agent that will produce the same good results. And, among these, first in glandular enlargements of the neck in children, where the glands seem massed together, and are almost of stony hardness, and in which both iodine and cod-liver oil have failed to reduce the bulk.

After some weeks' patient use of the chloride, with careful attention to diet and general hygiene, there seldom fail to be noticed a softening and separation of the individual glands, and generally, in a few months, such a reduction in size, or complete disappearance in milder cases, as to warrant the term *cure* being applied to the case. On the discontinuance of the remedy, however, an increase of size often takes place, necessitating its continuance at intervals for a year or more.

I have found the chloride of calcium equally efficacious in cases where suppuration had occurred—in fact, one of the earliest cases which I treated thus was that of a lady aged forty, who, from childhood, had scarcely ever been many months free from suppuration of some of the cervical glands. These had generally been incised, and cod-liver oil and the preparations of iodine almost constantly taken. She had been under my care for several years with this unsatisfactory result, when, in May, 1878, she was treated with doses of chloride of calcium thrice daily. In less than three months all suppuration had ceased, and the enlarged glands had become much reduced in size. I ordered her to continue the medicine at intervals; and, much to my delight, learned from her several years afterward, when attending her for some abdominal affection, that there had been

no suppuration in the interval, and that, on observing any increase in size of the neck, she invariably had recourse to it. In tabes mesenterica the good effects are striking and lasting, if the disease is not too far advanced.

In pulmonary phthisis I have not found the chloride so useful as I had been led to expect from the reports of Drs. Wood, Sanders, and others, and should recommend its employment in those cases only where there is evidence of the bronchial glands being decidedly enlarged.

In scrofulous caries I have witnessed quite as remarkable results from the prolonged use of the remedy as in scrofulous enlargements of cervical and other glands.

Valuable as iodine and cod-liver oil are in many cases of the large class of diseases comprehended in the term "scrofulous diathesis," I yet claim for the chloride of calcium, in certain instances, a special therapeutic power which neither of them possesses, and, in all cases of this diathesis, the merit of a valuable *alternative* remedy.

I prescribe the crystallized chloride of calcium, as the anhydrous salt forms a turbid solution and has an unpleasant taste. The recognized dose is from ten to twenty grains, or even more; but I have generally given a smaller one—one, two, or three grains for young children, and rarely over twelve or fifteen for adults. The formula is five ounces of the crystallized salt in fluid twelve ounces of syrup. The dose of this solution has varied from minims v to minims xl, according to age and other circumstances. I give it in milk after meals.

IODISED PHENOL IN THE TREATMENT OF WHOOPING-COUGH.

Rothe (*Memorabilien*) announces his continued satisfaction with carbolic acid as a remedy for whooping-cough, after fifteen years' experience with it. The formula employed is as follows:

Carbolic acid,	} each.....	7½ grains.
Alcohol,		
Tincture of iodine.....		5 drops.
Peppermint water.....		750 grains.
Tincture of belladonna		15 "
Syrup of diacodium.....		150 "

A teaspoonful is to be given every two hours, the administration being continued until the paroxysms entirely disappear.

ASTHMA.—

Tinct. lobellia.....	oz. j.
Ammon. iodidi.....	dr. ij.
Ammon. bromidi.....	dr. ij.
Syr. tolu	oz. ij.

M. Sig.—A teaspoonful every one, two, three or four hours.

Dr. Bartholow says the above gives relief in a few minutes, and sometimes the relief is permanent.

SKULLCAP FOR ENURESIS is highly recommended by Dr. Wimermark in the *New York Record*. For a child of twelve years he gives one teaspoonful of the fluid extract. t. i. d.

COUGH MIXTURE.—(Cook County Hospital, Chicago.)

Morphiæ sulph.....	gr. i.
Tr. aconite.....	gtt. xvi.
Potass. nitrate.....	dr. j.
Acid hydrobrom., dil.....	gtt. xvi.
Syr. ipecac.....	dr. ij.
Syr. scilla.....	dr. vi.
Water.....	q. s. ad. oz. ij.

Teaspoonful every three or four hours.

CHRONIC DYSENTERY.—(*Ibid.*)

Morphiæ sulph.....	gr. j.
Ferri sulph.....	gr. xvi.
Sulph. acid. dil.....	dr. ss.
Magnesiæ sulph.....	oz. ss.
Water.....	q. s. ad. oz. ij.

SAGE'S CATARRH REMEDY.—

R. Hydrastis canadensis.....	grs. v.
Indigo.....	grs. ss.
Camphoræ pulv.	
Acid. carbolic.....	aa grs. ij.
Sodii chlorid	grs. l.

Powder the camphor by means of a drop of alcohol, and mix with the salt previously reduced to a moderately fine powder; rub the indigo and carbolic acid together, mix with the salt and camphor, and lastly add the powdered hydrastis, and intimately mix, without much pressure, in a mortar. —*Chicago Med. Times.*

THE TREATMENT OF ACUTE LARYNGITIS.

Dr. John M. Keating tells us in the *Archives of Pediatrics* that he has frequently found the following treatment very efficacious:

"In conjunction with a hot foot-bath, the temperature of the water as hot as the hand can bear with comfort, and the feet afterwards wrapped in flannel or Canton-flannel night-drawers with the feet of extra length, and sewed up at the extremities, he prescribes the following in a half tumblerful of water: ℞i. Tinct. aconii. rad. gtt. iij.; spts. ætheris nit. dulc., ʒj.; syr. scillæ co., ʒj. This is given in frequently-repeated dessert spoonful doses throughout the night. A soft handkerchief wrung with ice-cold water and surrounded by a silk one or a piece of flannel is applied.

If the cough continues, and becomes bronchial it is well to produce a certain amount of counter-irritation of the chest. Ordinary camphorated oil is about the best. In addition to the ipecac, we should recommend small doses of castor oil, the object being to relieve the congestion of the bronchial mucous membrane by acting on the intestinal mucous membrane."

BRIEF NOTES ON THE TREATMENT OF ACUTE CORYZA.

By SOLOMON SOLIS-COHEN, A.M., M.D.

Chief Clinical Assistant, Out-patient Laryngological Department, Jefferson Medical College Hospital. Read before the Philadelphia Laryngological Society.

It is related of a celebrated French physician that, when asked how he treated a cold in the head, he replied, "With contempt." That some colds may be safely treated in this manner, universal experience will testify. That many attacks of acute coryza cause pain and distress sufficient to demand the best efforts of the physician for their relief must be not alone within the observation, but among the personal experiences of all. The writer has had occasion to test the methods here related upon his own person, and can, therefore, speak with a realizing sense of the relief afforded from annoying symptoms. The property possessed by belladonna, of checking secretion from mucous surfaces, long ago suggested the employment of this drug in acute coryza. I have however, been unable to find any reference to it in the treatises of Mackenzie or Bosworth, the most recent works published in the vernacular upon the special subject of diseases of the upper air passages.

Dr. Beverley Robinson,* of New York, speaks highly of the local use of a powder of belladonna leaves, morphine sulphate, and acacia, but does not mention the internal administration of the drug. J. Solis-Cohen † alludes favorably to the use of the tincture of belladonna in doses of twenty minims. M. Gentilhomme ‡ reports that he has succeeded in arresting the disease in several bad cases, attended with abundant secretion, fever, and embarrassment of respiration, by the use of atropine sulphate in doses of one-half milligramme given at the commencement of the inflammatory period. My own experience with atropine has been equally fortunate. It must be given early in the attack, and when so given is veritably abortive in nine cases out of ten. I have tried several methods of administration, employing granules and triturates of $\frac{1}{100}$ gr. and $\frac{1}{200}$ gr., and a solution of one grain of the salt to the ounce of water, of which the usual dose is four minims (gr. $\frac{1}{20}$). The latter method is preferable with patients upon whose discretion we can fully rely, and to whom we feel no hesitation in entrusting a prescription for a poisonous drug. With other individuals it is safer practice to hand the patient three or four triturates or granules of the dose desired, writing explicit directions as to their use upon the envelope containing them. The manner of using the remedy which has proved most efficacious is to

administer $\frac{1}{100}$ grain at the first interview (if this be on the first or second day of the attack), and to repeat the dose in four hours, provided there be no dryness of the throat. The rule for the third dose is the same; dryness of the throat or dilatation of the pupils being the indication to stop the remedy.

When a case is seen during the first twenty-four hours, two doses will often bring the affection under such complete control that the patient does not resort to any further medication. Secretion of thick, yellowish mucus, requiring the occasional use of handkerchief, will, however, usually persist for about a week, but there is, ordinarily, no embarrassment to breathing. Sometimes it is necessary to repeat the dosage in the same manner on the following day, the indication being renewal of watery discharge, suffusion of the eyes, and more or less "stuffiness" of the nose. In order to secure the full therapeutic benefit of the atropine in severe cases, it must be pushed until the physiological effect is produced; that is, dryness of the throat and dilatation of the pupil. One patient complained of the former symptom, that it was worse than the disease. In one case, $\frac{1}{10}$ gr. of pilocarpine hydrochlorate was administered by the mouth, with the effect of relieving the unpleasant sensations. Ordinarily, however, the dryness is readily overcome by allowing a few pellets of ice to melt in the mouth, or by rinsing the mouth from time to time with cold water.

More recently the effect of cocaine in emptying the engorged venous sinuses of the nasal mucous membrane, first prominently called to professional attention by Dr. Bosworth,* has led to its employment in the treatment of acute coryza. While the relief is almost immediate, even in cases where there has been great obstruction to breathing, the effect passes away in from two to three hours, and the drug is too expensive to use as often as may be necessary. I have found the fluid extract of erythroxyton to be equally efficacious, if instilled into the nose in sufficient quantity. The alcohol of the fluid extract is, however, objectionable, producing considerable smarting. An effusion can be made of equal strength † by the addition of a small quantity of glycerine, and by this means we get rid of all unpleasant effects not inseparable from the drug. The employment of a preparation of coca will give excellent results in connection with the atropine treatment. The patient is given a glass "dropper" slightly curved at the end, such as is used by oculists, and instructed to flood the nose with the infusion of coca whenever it becomes "stopped up." He is directed to draw the medicine back into the throat, in order to make sure of reaching the posterior ends of the turbinated bodies.

* *Medical Record* (New York) November 15th, 1884.

† This objection, in the interval between the reading and the publication of this paper, has been obviated.

‡ Mr. Stedem, of Philadelphia, makes an infusion of coca, two grains to the minim. I am indebted to Dr. Jurist for a specimen of this preparation.

* A Practical Treatise on Nasal Catarrh, New York, 1880, p. 600.

† Diseases of the Throat and Nasal Passages. Second Edition. New York, 1879, page 336.

‡ *Union Medicale*, September 4, 1883; *Medical and Surgical Report*, December 15, 1883, p. 66.

While not denying the advantage of the good old methods of treating acute coryza with Dover's powder, foot-baths, etc., I am convinced that the plan above described, namely, small doses of atropine pushed to the point of physiological effect, with local use of cocaine or infusion of coca, will be found the most convenient and effective for the majority of cases. Like everything else, even quinine, it will sometimes fail. In one case of acute coryza I tried pilocarpine, producing but slight perspiration, but apparently curing the cold. As my experience is limited to this one case, which may be an example of *post hoc*, and not *propter hoc*, I do not claim anything for the treatment. In all cases, however treated, a brisk saline cathartic administered at the outset is found of the greatest advantage.

Where cases are seen too late to employ atropine with advantage, good results have sometimes been obtained from ammonium salicylate in doses of ten to fifteen grains, repeated every second hour until *timidus curium* is produced. Salicin Salicylic acid, and sodium salicylate have not seemed to be equally efficacious with the ammonium salt.

In a few cases of influenza, in which the coryza, has been quite severe, in some of which there has been much conjunctival distress, and in all of which headache and lassitude have been marked, though the febrile symptoms have been mild, cinchonidine salicylate has apparently been of great benefit, while the infusion of erythroxyton has been of inestimable value in relieving the distress occasioned by the nasal symptoms.—*College and Clin. Record.*

THE ELEMENTS OF PROGNOSIS IN BRIGHT'S DISEASE.

Dr. Austin Flint read a paper with this title before the Medical Society of the County of New York (*N. Y. Med. Jour.*, December 5). In the popular mind the name Bright's disease at the present time had a prophetic import not unlike that of a verdict of conviction after a trial for life. It was regarded as a hopelessly fatal malady. This prevailing impression reflected the views of the medical profession, that a fatal termination would invariably take place, sooner or later. This view accorded with our pathological knowledge and clinical experience. But the scope of prognosis was not limited to recovery from the disease. A disease might involve more or less irremediable damage to important organs, but, after having progressed to a certain extent, the damage might not become greater, and the remaining healthy portion of organs might be sufficient for all purposes of life and a perfect state of health. Again, a disease might be progressive, but so slow as not to be opposed to long life and general good health. But in chronic disease the danger to health might depend upon associated affections, or chronic disease might be tolerated, provided the conditions were favorable; otherwise it would prove fatal.

Was the disease acute or chronic? Assuming the existence of acute Bright's disease, experience taught that, exclusive of the important concomitant affections, it did not end fatally as a rule, and did not result in any permanent renal lesion. In other words, the acute was not followed by the chronic disease; but exceptionally it ended fatally or in the chronic form. In some cases the acute disease was not marked; it continued for some time and ended in recovery. Here he would substitute for the word acute, subacute. In some cases the question would arise, whether the disease was subacute or chronic; and the diagnosis could only be definitely settled in favor of the subacute form by the disappearance of every evidence of renal disease after some weeks, and the recovery of health.

The author then considered some of the elements of prognosis in cases of chronic Bright's disease. What were some of the conditions requisite for latency? 1. The kidneys must not be damaged beyond a certain degree. 2. The important organs of the body, other than the kidneys, must be capable of performing their respective functions satisfactorily. 3. The laws of health relating to alimentation, exercise, etc., must be observed. Suppose these conditions to be fulfilled, and a lesion of the kidneys to exist which diminished their functional ability one-half, and the disease was not progressive; life and health would be compatible with the existence of chronic Bright's disease for an indefinite period. In order that chronic Bright's disease should be well tolerated, the treatment should relate to accessory conditions required for bringing about toleration, those conditions relating to other organs of the body and to general hygiene. The kidneys in this condition were incapable of meeting an additional demand on their functions. Should the patient fail to observe the accessory conditions mentioned, the inefficiency of the kidneys would become manifest in headache, misty vision, nausea in the morning, impairment of the appetite, and general debility. Examine the urine in such a case, and evidence would be found of chronic Bright's disease which had probably existed for years, the progress of the renal affection at length rendering the organs incapable of performing their functions properly, which caused attention to be directed to the state of the kidneys. It was important, in determining whether the kidneys eliminated excrementitious matters sufficiently not to endanger the health, to make a thorough examination of the urine, not alone with regard to the presence of albumen and casts, but also as to the amount of urine eliminated daily, its specific gravity, and the proportion of the salts. The quantity of the urine might be increased while the specific gravity was so low as to involve great danger from uræmic toxæmia. Suppose the examination of the urine in a case of chronic Bright's disease showed renal æquacy; how should that fact influence the treatment? In this way, that diuretics, sudorific and hydra-

gogue cathartics, would not be indicated; indeed inasmuch as their influence was debilitating and opposed to the accessory conditions for health just mentioned, they were contra-indicated. Was the degree of renal adequacy, as determined by an examination of the urine, reliable in judging of the absence of danger from toxæmia? This question was to be answered in the negative. In some cases of Bright's disease the quantity of the urine was decreased for a long period without serious consequences. The explanation lay in the fact that the excrementitious matter was eliminated vicariously, or its effects upon the system were counteracted by other agents. On the other hand, slight inadequacy, without vicarious elimination and counteracting agents, sometimes led to serious consequences. The prognosis after coma was always grave, yet we meet with cases repeatedly in which life was preserved for a long time. Of acute pulmonary œdema the same might be said as of uræmic coma. In his experience the most serious consequence of Bright's disease was dyspnoea, or renal asthma, apparently due to toxic effects upon the respiratory center. He had never known such a case to end in recovery, but he had known life to be prolonged for several years after dyspnoea from pulmonary œdema occurring in the course of chronic Bright's disease.

Recapitulating, Dr. Flint said that subacute diffuse nephritis, having the same seat and characters as acute Bright's disease, exclusive of acuteness, occurred not only after scarlet fever and other fevers, but irrespective of these; and when it occurred as a primary affection, or in connection with other diseases, it was liable to be overlooked, or, if recognized, to be mistaken for the chronic form. Further, acute or subacute diffuse nephritis not infrequently occurred as an intercurrent affection in the course of chronic Bright's disease, and rendered the prognosis temporarily more serious. The disappearance of symptoms and the presence of health did not necessarily indicate that the chronic disease was not still in existence. Again, a susceptibility to the causes of inflammation of the uriniferous tubules, irrespective of the existence of chronic Bright's disease, was to be recognized as an individual peculiarity.

TREATMENT OF ABORTION AT THE FOURTH OR FIFTH MONTH, WITH RETAINED PLACENTA.

Dr. G. R. Southwick of Boston, (in the *Am. Jour. Obs.*) gives us a very interesting paper on this subject in which he points out the change in the medical fraternity during the last few years on this subject from the expectant treatment to the radical plan of dilating the cervix and removing the secundines immediately, and very pertinently puts the query as to whether or not the pendulum of progress might not have swung too far to the opposite side from the old but easy expectant idea. He says when the labor takes place at full

term the uterus contracts away from the placenta, which is a more contractile body, and thus separation takes place. The uterine muscular tissue continuing in this contracted state constricts the sinuses and hemorrhage is prevented. Thrombi form back of these constrictions and when the uterus partially relaxes in twenty-four hours, serve to plug the vessels and in turn also prevent hemorrhage. But when abortion takes place in the middle of gestation, the muscular tissue of the uterus has not reached that degree of development, and becomes ready for the metamorphosis which takes place at full term. The surface contraction is less in proportion, *i. e.*, there is less contraction to the square inch of surface, and consequently separation of the placenta is less likely to follow, both for this reason and on account of its firm attachment. Thrombi therefore do not form so rapidly, and hemorrhage is liable to ensue though not so severe as under similar circumstance at term.

In some rare cases small portions of adherent placenta become organized and a fibroid polypus hydatidiform mole develops. In nature's method of removal the blood-vessels are closed behind the adherent portions, the placental tissue gradually disintegrates and is cast off; here another element must be considered—the danger of septicæmia.

Retention of a part or the whole of the placenta is, therefore, liable to give rise to one of the following complications:

1. Hemorrhage, either immediately and profuse or remote, and become continuous in small quantities.
2. Septicæmia.
3. Some intra-uterine growth.

The aim of treatment is to prevent or forestall them, and may be active or conservative. Active treatment consists in the immediate removal of the secundines in every case, either by the finger, placental forceps, or curette. There is good reason to fear the results of traumatism, as inflammation of the uterus and cellular tissue, or even perforation of the uterus, especially when performed by an unskillful hand, which is not infrequently the case. Very often the removal of placental tissue is tedious and accompanied with considerable hemorrhage.

If no urgent symptoms be present the Doctor thinks it is well to see what conservative treatment will do, or plug the vagina for a few hours, and often on removal of the tampon the retained secundines are easily delivered.

It sounds very easy to read that, to remove the placenta, the uterus is to be pressed down in the pelvis with one hand externally while the forefinger of the other enters the uterine cavity, passes up over one side of the placenta and down on the other so as to hook it down and extract it from the uterus, but it is a very different thing to do it.

The pelvic tissues being tender and painful, the abdominal walls being quite thick, the uterus being high up, and the os contracted and small, the operator's fingers being short, or, when the uterine cavity is reached, the attached placental tissue

being high up in one horn of the uterus, extremely slippery and persists in gliding from beneath the finger, and yet does not come away, any or all of these complications, soon exhaust the Doctor's strength, the patient's good nature and forbearance, and lays the foundation for pelvic inflammation, besides endangering the patient to the introduction of septic germs during the process of this manipulation.

But if any of the three complications mentioned above should ensue, then of course there would be no alternative other than active interference and emptying the uterine cavity.

To prevent hemorrhage he suggests the tampon as temporary means, as, after the most careful plugging, the plug becomes compressed and blood escapes around it as before. It is important to remember that no portion of the tampon should protrude between the labia, as it would almost certainly be forced out by muscular action. The plug may extend into the cervix. It serves the double purpose of promoting uterine contractions and expulsion of the secundines, as well as temporary control of hemorrhage; and avoids the necessity of radical measures unless symptoms of sepsis ensue.

The next danger, and the most to be dreaded, is septicæmia. As this most probably is a result of the introduction of septic germs from without in some manner, by the hands, or instruments or air, it goes without saying that the physician should never attend such cases immediately after visiting a case of scarlatina or other zymotic diseases without the most rigid antiseptic precautions. When symptoms of septic infection present themselves, they should be treated the same as septic fever from any other origin; rigid cleanliness by intra-uterine douche, control of temperature, etc.

The third complication is so rare it only needs to be referred to as a sequela and treated as an independent subsequent incident, when menorrhagia and metrorrhagia require the use of the curette, placental forceps or sometimes the ecraseur.

ON SOME NEW MEDICAMENTS.

At the recent meeting of the Society of the Medical Staff of the Royal Charité Hospital, Prof. Senator gave a summary of newly-discovered medicaments, reported in the *Berl. Klin. Wochenschrift*. He drew a comparison between the innumerable medicines as such and their value as medicaments, and pointed out that, although the advance made with regard to specific medicines for directly curing diseases was small, yet great progress has been made with regard to those which act symptomatically. This, he said, was of great value, for by their means the pains of many incurable diseases can now be diminished, and troublesome and threatening symptoms in curable diseases can be prevented or removed. Dr. Senator then gave a brief account of his own experiences

of some exotic medicaments, that have as yet received little attention in Germany. Of purgatives, he mentioned tincture of cascara sagrada, euonymin, and trisin. The tincture of cascara sagrada he considers a non-irritant and very certain remedy. One great advantage it possesses is that it can be taken for a long time without disadvantage. Dr. Senator prefers it to senna, because it is effective in smaller doses. With regard to euonymin, Dr. Senator refers to Rutherford's valuable experiments on its physiological effects, and mentions that it is used both as an aperient and as a cholagogue; but as a cholagogue he says it is difficult to form an opinion. At any rate, it is a certain and very drastic remedy, and for this reason cannot be taken continuously for a long period. From his own experience, Dr. Senator said he had nothing to communicate about trisin, but he considered there was not much reason for introducing it. He then mentioned two narcotics, extract of piscidia erythrina and hydrochlorate of cocaine. The extract of piscidia erythrina, recommended since 1845 in America as soporific, he has found very useful for neuralgic pains in the head, given in an evening in doses of about four and a half to eight grains. Hydrochlorate of cocaine he had applied with success to the mucous membrane of the urethra and the rectum, especially in connection with diseases of the bladder. As a remedy against the immoderate perspiration of phthisical patients, Senator mentioned picrotoxin, which he tried on the recommendation of Dr. W. Murrell. He had tried it in forty cases, in two-thirds of them with success. On the whole it was found to be almost as certain a remedy, as atropin or agaricin. Agaricin was used in the Giessen clinic as a substitute for atropin in 1883, and found to be preferable to the latter in this respect, that it could be used for a longer time.

HOW TO TREAT WOUNDS OF THE FINGERS.

Every physician, no doubt, feels satisfied that he knows perfectly well how to treat finger wounds, yet Dr. John Kent Spender seems to think that he knows enough original about the subject to warrant him in publishing an article in the *British Medico-Chirurgical Journal* for June. He believes in properly dressing such wounds, and then *letting them alone*, and the prime element in his proper dressing is the *absolute exclusion* of air. To illustrate his method, he relates the case of a man whose third and little fingers were cut by machinery; the last phalanx of the third finger was almost separated. The flow of blood was checked with circular pledgets of lint; next he fastened the arm and hand to a board, and suspended the whole limb in a sling; and the last step of these preliminary proceedings was to send the patient home to recover from the shock, with the help of warm food and a little sleep. Four

hours afterwards he visited him, and dressed the injured fingers in the following way :

Firstly, the pledgets of lint, stiffened with dry blood, were soaked in water and gently removed. No foreign body of any kind was found. The fingers were thoroughly cleansed, the nearly separated portions were brought into juxtaposition and retained *in situ* while a circlet of boric lint was applied. Each finger was laid upon a bed of absorbent cotton-wool tissue, which just met on the dorsal side ; then a lilliputian bandage of thin, soft calico was put around, with moderate pressure, and the turns of bandage were brushed over with the gum acacia mucilage of the British Pharmacopoeia. Finally, each finger was put into a cradle of gummed paper, which was moulded while soft, and then dried in the gradual heat of an oven. These light and simple shields kept the fingers apart, and guarded them from further accident.

The wounded fingers were not undressed until eleven days had elapsed from the date of the accident; and when exposed to view the healing was found to be complete, and the fingers were of their natural size (though of course a little shorter than before the injury). The tender cicatrices were protected for a few more days with ordinary plaster, and the work was finished.—*Med. and Surg. Rep.*

CANCER OF THE UTERUS.

The following is taken from a clinical lecture by William Goodell, M.D., published in the *Medical Bulletin*, August, 1885. The patient was thirty-nine years of age, and had five children, the youngest eleven years of age.

There are three forms of cancer which may attack the uterus: scirrhus, epithelioma, and encephaloid, but there is no doubt that they merge one into the other. The practical question is not so much, is the tumor scirrhus, epithelioma, or encephaloid cancer, as it is a question whether or not the growth is malignant. There is only one thing about this differentiation, and that is that epithelioma is more amenable to treatment than either of the other forms. In the vast majority of cases when cancer attacks the uterus it takes the form of epithelioma. There are some cases which seem to begin as scirrhus, and ultimately break down into the epithelial form.

There are certain popular fallacies about cancer of the uterus. One is that it is always accompanied with pain. Carcinoma of the neck of the womb does not always produce more pain than most women experience at each period. It is only when the disease advances toward the internal os that pain is felt. When it ascends and invades the cavity of the womb the woman's sufferings are very great. You see in our practice in the dispensary the same thing. We hook tenacula into the cervix and apply powerful caustics without eliciting any sign of pain. Under some circumstances, just as cartilage, which

is normally insensible, may become excessively tender, so the cervix of the womb will, under certain circumstances, become very sensitive, and the slightest touch will cause the patient to flinch; but, as a rule, in cancer limited to the neck of the womb there is no pain. There may be leucorrhœa and that will certainly be if there is an open sore. This is a very common delusion. Old physicians have said to me, "O, no, doctor, it cannot be a cancer, there has been no pain." The idea of cancer is associated in their minds with lancinating pain, which cuts like a knife. When carcinoma invades external portions of the body which are well supplied with nerves, these pains are present. The sensitive portion of the womb begins at the internal os, and the lining membrane is very sensitive.

Another fallacy is that there is, in every instance, the cancerous cachexia. This is a great mistake. My impression is that one-half of the cases which come to me do not present the cancerous cachexia. Instead of being lean, bony, and scrawny, with the leaden hue of the countenance, many of these cases present a buxom appearance, with rosy cheeks. It is my experience that such cases are less amenable to treatment, and operation is less liable to be followed by temporary benefit, than in those cases which present the appearance of the patient before us. In our patient, if the disease were limited to the cervix, I should expect that the operation would do a great deal of good.

Again, cancer may exist without bleeding. Before ulceration occurs it is not present, and even in the vegetating form it may be absent, although there is usually some discharge. This discharge need not be offensive, and this is another point which it is well to bear in mind.

I wish now to give you a little history of this case. She comes from a distance, and was brought here by her husband in great distress of mind. She had been told that she had a cancer. My own rule, to which exceptions are very rare, is never to tell a woman that she has a cancer. I speak of it as a bad ulceration. Many of my patients have known in their hearts that they have a cancer, and know that I know it, and yet the word "cancer" never passes our lips. Many women say to me, "Now, Doctor, if I have a cancer do not tell me." I advise you to adopt the rule which I follow. I do not want you to lie about it, but never tell a woman that she has a cancer if you can get out of it.

This woman came in a very painful state of mind. As a drowning man will grasp a straw, so she was willing to embrace anything that would do her good. She tells me that she has five children and cannot bear to think of leaving them. I said to her, "While I cannot cure you, I may be able to do something which will do you a great deal of good." She jumped at the idea, and I have not disillusionized her. She thinks that I am going to do more than I can do.

When I examined her, I found a great excavation. What I thought of doing was to scrape off the vegetations, and, if I dared, cover the part with nitric acid, but a symptom has appeared which shows that the disease has attacked the bladder, and I can do nothing for her. Three days ago she began to pass blood from the bladder. The urine does not trickle into the vagina, because there is no opening as yet, but the disease has involved the bladder, and in the course of a few days the tissue will break down, and there will be produced a vesico-vaginal fistula, through which the urine will trickle into the vagina.

There is still one other thing. That woman has not long to live. Her sufferings will, I think, be excruciating. She ought to have as much opium or morphia as will make her comfortable. Some would object to this, saying that she would get into the opium habit. She will not live long enough to contract the habit. I say let us make the last end of her life as comfortable and peaceful as we can. Give her opium in any form or amount that she chooses to take it, exercising a little restriction in the beginning.—*Med. Journal.*

CASE OF CÆSAREAN SECTION AFTER DEATH OF MOTHER—LIVING CHILD REMOVED.

By J. MACK HAYS, M.D., OXFORD, N.C.

A short while after 8 o'clock on the evening of the 3rd of October I was hastily summoned to the wife of Mr. C., living seven miles distant. On reaching the house I was informed that the patient was too far gone for me to do her any good. The following history was briefly given me: about four hours previously Mrs. C. was in the yard looking after her domestic affairs and enjoying, apparently, her ordinary good health, when she was suddenly attacked with a violent headache and sent for her husband at the mill, a hundred yards distant. When he reached the house she told him to send at once for the doctor, as she felt very sick and her head hurt her terribly; then, throwing her hand to the back of her head, fell on the bed with the exclamation, "I can't stand it!" She was speechless from that moment, vomited frequently for some little time, several times threw her left hand to her head, and sank rapidly into the condition in which I found her. She was evidently suffering from an extensive cerebral apoplexy, presenting the following symptoms: Complete motor and sensory paralysis of left side of face and right side of body, both pupils widely dilated and totally insensible to a bright light; very slow, stertorous breathing and "drawing in of the paralyzed cheek with inspiration and its puffing out with a sort of explosion in expiration;" pulse rapid and barely perceptible; face pallid. A sharp pinch on the non-paralyzed arm produced no evidence of sensation, nor did the hypodermics of whiskey which I administered as a forlorn hope. The patient was

rapidly approaching her end, and was eight and one-half months advanced in pregnancy. I satisfied myself from the husband that the child was probably alive, as he had heard his wife speak of having felt motion the same day. I then laid the case clearly before the husband, telling him that while one life was fast passing away, another was at stake which might be saved even after the mother had breathed her last. He told me to do as I thought best. Accordingly I made the necessary preparations, and, after all evidences of life had disappeared in the mother, and the bystanders sent out of the room, I proceeded without delay with the operation. With one stroke of my scalpel I incised the skin and subcutaneous tissues from the umbilicus nearly to the symphysis pubis; two incisions more, through the linea alba and peritoneum, exposed the uterus to full view; through it I next made an opening as low down as possible and of sufficient size to admit my two fingers, at the same time liberating the liquor amni. Using my fingers as a director I slit up the uterus to the placenta, which I easily detached. The body of the child was now fully exposed, lying in the second cranial position. I lifted it from the uterus, and by exerting some little force to overcome the suction brought to bear upon the head, removed a living male child from its dead mother. The cord was tied and cut as usual. The operation was attended with very slight loss of blood, and that of a dark venous character.

The unusual shape of the child's head, born without any pressure having been made upon it, was quite noticeable.

The child is being fed on fresh cow's milk, diluted and sweetened, and at the present writing (October 15th) stands a fair chance of being raised.

A NEW METHOD OF REDUCING DISLOCATIONS OF THE HIP.

(Dr. J. S. ALLEN in the *Annals of Surgery.*)

An anæsthetic having been administered to the extent of producing complete muscular relaxation, the surgeon stands over the recumbent patient, flexes the leg upon the thigh, and the thigh to a right angle with the body, brings the patient's foot between his legs so that the dorsum of the foot rests upon the operator's nates, and then the surgeon, passing his right arm beneath the flexed knee, lifts the hips of the patient well from the bed or floor, and holds them thus suspended for a short time; the head of the femur will quickly be drawn back into its socket. The weight of the hips and opposite leg rotates the body outwards, producing just sufficient abduction and extension to draw the head of the femur quietly through the slit in the capsular ligament, and direct it into the acetabulum.

The present writer can bear witness to the efficiency of this method, having practised it successfully on the 4th of May, 1885, in a case which had resisted the usual method of reduction.

THE TREATMENT OF ASTHMA.

By DR. PAUL RODET.

Translated from *L'Abeille Méd.* by F. R. CAMPBELL, M.D.

I. TREATMENT OF THE ATTACK.—The principal indication is to relieve the dyspnoea. For this purpose, the following remedies may be employed, given in the order of their efficiency:

(a) *Injections of Morphine.*—These rapidly relieve the attack and produce a quiet sleep, but it is necessary to gradually increase the dose. It should be used with great caution, for fear of inducing morphinism.

(b) *Inhalation of Iodide of Ethyl.*—Direct the patient to pour ten or twelve drops on a handkerchief and inhale slowly. This drug rapidly relieves an attack, sometimes instantaneously. These inhalations are much to be preferred to those of ether or chloroform, which usually fail.

(c) *Ammoniacal Vapor.*—This produces a sedative effect by exciting an excessive secretion in the nose and throat. Many patients are relieved in this way.

It has also been proposed to touch the pharynx with a strong solution of ammonia. A certain amount of inflammation with an abundant secretion is thus produced. This method of treatment sometimes affords excellent results.

(d) *The Inhalation of Medicated Fumigations.*—These act upon the bronchial mucous membrane. Nitre papers burned in a saucer near the patient, are much employed. The leaves of acrid narcotic plants, such as stramonium, belladonna, may be smoked in cigarettes alone, or with a small quantity of nitre. Cigarettes made of belladonna leaves, containing arsenic, are also prescribed. These means are beneficial only for a limited time.

2. TREATMENT OF THE DISEASE.—Seek out the causes which produce the attack, with a view to changing the occupation or surroundings of the patient, if necessary. The medical treatment will vary, according to the variety of asthma.

(a) *Catarrhal Asthma.*—Avoid cold; treat the laryngitis and bronchitis by ordinary methods, emollient drinks, ipecac and opium, and cutaneous revulsion. If the asthma is not of long standing, Hardy recommends the application, on the chest and arms, of a vesicatory or rubefacient. Tincture of lobelia, thirty to sixty drops a day, is considered an excellent remedy by the Germans.

The waters of Royat or Cauterets and a winter residence in the south, at the seaside, may be tried.

(b) *Nervous Asthma.*—Bromide and, above all, iodide of potassium produce excellent effects, although we do not know the rationale of this treatment.

Unroasted coffee, a tablespoonful to be infused in a cup of water over night, and taken at one dose in the morning for several months, may be tried.

Compressed air is an excellent remedy. The same results may sometimes be obtained by playing the cornet or blowing a trumpet, thus producing a distension of the bronchia. Gymnastic

exercise of the upper extremities should be ordered for those of sedentary habits. Hydropathic treatment may be employed with patients who do not cough.

(c) *Herpetic Asthma.*—That is, cases in which the asthma alternates with attacks of skin disease. Employ the hygienic and therapeutic remedies mentioned above, and, in addition to these, arsenic. Counter-irritants, where the eczema has disappeared, Mont Dore water to be preferred to those of Bourboule, which are better for the scrofulous.—*Buffalo Med. Journal.*

JAUNDICE AND PAIN IN BILIARY COLIC.

Dr. Lawson Tait, in the *Lancet*, discusses the reason why, during the passage of gall-stones, there is frequently no jaundice. In fifteen cases of cholecystotomy he found no history of jaundice, and Dr. Tait has found that the occurrence of jaundice, either in the skin or in the urine, during and after the passage of gall-stones, is of extreme rarity, and not, as has been believed, common. Dr. Tait seeks for an explanation of this fact in the following anatomical conditions of the cystic and common ducts. The common duct is not so long (three inches) as most text-books assert, and is much less rigid and more easily dilatable than the cystic duct, which is larger than most of the text-books describe it, viz., one inch. Hence we can understand how a stone, if not of very great size, will cause intolerable agony while passing through the unyielding cystic duct, and without a trace of jaundice ensuing, the gall-bladder alone being its propellent force; but the moment it enters the common duct the extending impulse will be increased by the influence of the whole excreting force of the liver, so that its passage through the common duct is more rapid. The chief symptom, then, that of pain, is due to the slow passage of the calculus through the unyielding cystic duct, while its rapid passage through the easily distended and much larger common duct gives no time, in the majority of instances, for the production of jaundice, which only takes place after long-continued obstruction of this, the common duct.

LEUCORRHEAL DISCHARGE FROM ROLLER-SKATING.

Dr. Von Klein in the *Boston Medical and Surgical Journal*, writes that he has found in a number of instances leucorrhœal discharges produced in young girls by the excessive exercise consequent upon the practice of roller-skating. He adds that he has reason to believe that the practice of roller-skating is injurious to young females by reason of the excessive movements of the lower extremities, and of the pelvic organs, including the walls of the vagina.—From the *Weekly Medical Review.*

SANTONINE IN AMENORRHOEA AND
DYSMENORRHOEA.

Dr. J. Cheron in the same journal recommends santonine in certain cases of amenorrhœa and dysmenorrhœa, especially if combined with adynamia, anemia and chlorosis attending the onset of the menses at puberty. Santonine as an anthelmintic acts by causing a lively peristaltic action of the intestines, through which the worms are expelled. The author therefore compares its action to ergot, like which it acts upon the vascular system. It is consequently indicated in certain forms of chronic congestion where the amenorrhœa or dysmenorrhœa is of a passive, adynamic type, where it not only relieves the utero-ovarian congestion but also improves the nutrition. For it has been shown that whilst ergot nauseates the stomach, santonine improves the digestion. He prescribes two grams, to be divided into forty pills, of which two are taken before each meal (about one and a half grains at a dose), or it may be given in a mixture of alcohol (to dissolve the santonine) and syrup, each tablespoonful containing 0.65 grams (one grain). One to two tablespoonfuls before each meal.

BELLADONNA AND IODIDE OF POTASSIUM.

The fact that belladonna produces dryness of the throat, nose and mouth has induced Dr. Aubut to try it rather empirically to combat certain disagreeable effects of iodide of potash, and he has published his results in the *Lyon Medical*. In three cases of naso-pharyngeal intolerance of the iodide a mixture of belladonna with iodide of potassium has given good results. He had also the same success in a young man suffering from acute iodism, in whom he made this symptom disappear by preceding the administration of iodide of potassium by the extract of belladonna. The dose was two pills of five centigrams each of the extract per day, one in the morning and the other at night. In one of the cases he was able to suspend the use of belladonna after some days, continuing the administration of iodide of potassium alone, without producing any intolerance.

VINEGAR IN PUERPERAL HEMORRHAGE.

The editor of the *Revue des Maladies des Femmes* states that it has accidentally been discovered that a large glass of vinegar given as a drink to a woman attacked with puerperal hemorrhage produced immediate contraction of the uterus, and may therefore be employed when ergot is not at hand. Doctor Grigg, acting upon this suggestion, has recommended the use of vinegar to several midwives. He considers it a specific which is of immense value, especially to physicians in country practice.

SOOTHING APPLICATION IN NEURALGIA.

Mayet has presented, before the Société de Thérapeutique, the following formula for a very neat and compact local application for use in neuralgic affections:

Chloral hydrate.....	5 parts.
Crystallized menthol.....	5 "
Cacao butter	10 "
Spermaceti	20 "

These constituents are mixed into a paste, which is divided into pieces about two-fifths of an inch square, and weighing about thirty grains.

Chloral thus applied in cacao butter has no local irritative effect. The part affected is to be gently rubbed with one of the squares, which is then allowed to melt at the most painful point.—*Journal de Médecine de Paris*.

TRANSMISSION OF PHTHISIS BETWEEN
MAN AND WIFE.

Revue de Med. Prof. Potain presents an array of cases to prove this possibility. In each case the subject of contagion was from a healthy family, doubtful cases being excluded, as also where other causes than contagion might explain the disease. Transmission can take place, without pregnancy or other debilitating cause.

I feel sure that it will soon be the general practice of physicians to warn the husband, for example, to occupy a different apartment from a tubercular wife. When the bacterial craze has subsided we will not be so apt to remember this caution.

DELACOUR'S LIP SALVE.

The following is said to be the formula for Delacour's lip salve, a famous French remedy for chapped and cracked lips, sore nipples, etc.: Powdered nutgalls, pomegranate bark, and sumac, of each, 1 drachm; myrtle leaves and sulphate of zinc, of each, 30 grains; wax, spermaceti and oil of sweet almonds, of each, 1 ounce; virgin's milk (dilute tincture of benzoin), 2 drachms; balsam of mecca, 12 drops; unguentum rosarum, 4 ounces; perfume to suit the taste.—*I bid*.

HÆMORRHOIDS.

Duval gives, in the *Centralblatt fuer die gesammte Therapie*, the following formula for an application to hæmorrhoids:

℞ Unguenti camphorati.....	5	1
Pulveris galliarum.....	grns.	15
Plumbi acetatis.....	"	15
Extracti belladonnæ	"	8; Mix.

Sig.—Rub on the hæmorrhoids four times a day.

A MIXTURE FOR WHOOPING-COUGH.

A contributor to *Un. Med.* prescribes the following formula :

Tincture of belladonna..... 5 drachms
 Tincture of valerian, } each, 75 grains.
 Tincture of digitalis, }

For a child two years old, begin with five drops daily ; increase the amount by five drops each day until it reaches thirty drops. The initial dose and the increment are ten and fifteen drops, respectively, for children between two and five years old and for patients who are still older. If the valerian is not well borne, tincture of musk may be used instead. Where nervous and spasmodic symptoms predominate, the author resorts to chloroform, giving to children between two and five years old from six to thirty drops daily, in two ounces of gum julep.

VOMITING OF PREGNANCY.

The latest remedy for the obstinate vomiting of pregnancy is the hydrochlorate of cocaine. Dr. Holtz (*Algem. Med. Wochenschr.*) says that in a case where, everything having failed, he had determined to produce abortion, but at the last moment, thought of cocaine, he gave the patient 10 drops of a 3 per cent. solution, and had the satisfaction of finding the vomiting under control. —*Nat. Druggist.*

THE CANADA MEDICAL RECORD

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THE ORIGIN OF THE EPIDEMIC.

The sub-committee appointed by the Civic Health Board to enquire into the origin of the late small-pox epidemic have submitted their report. This report consists of replies to certain questions put to persons known to have been connected in some way with the outbreak. From them we learn that previous to the beginning of 1885 there had been no small-pox in Montreal for several years,

and that the disease may be definitely traced from one, and perhaps two sources, and from one patient to another until the sequence of cases becomes lost in the widespread contagion of the early summer.

The lay statements in this connection are fairly unanimous, but it must be a matter of regret to the profession to learn that the stories of the two medical men who ought to know most about the matter—Drs. Hingston and Rodger—differ entirely and radically on important questions of fact. In the absence of evidence it is not our intention to take either one side or the other of this unfortunate controversy.

Dr. Hingston's letter—not embodied in the committee's report—is largely a reply to Dr. Rodger's statements, and we leave it to the professional friends of both these gentlemen to draw their own conclusions from these published letters.—To those who have not had an opportunity of seeing them, and in fairness to Dr. Rodger, it must be plainly stated here that he informed Dr. Hingston of his belief that the case he (Dr. H.) was asked to admit to the hospital was one of variola, that he knew that the patient Longley, a Pullman car conductor on the Grand Trunk Railway, had been exposed to the disease in Chicago ; that he reported the case to the Health Authorities as a case of small-pox ; that the case had been diagnosed independently in the Montreal General Hospital as small-pox, and that it ultimately turned out to be one of small-pox. Notwithstanding this, the impression is abroad that in the first days of Longley's stay in the Hotel Dieu, the medical men in attendance were generally of the opinion that he was the subject of not variola but varicella: We are not in a position to say whether this impression is correctly founded or not, but whatever may have been the understanding, or misunderstanding, as to the conduct of the case, it may, without fear of contradiction, be asserted that there was inexcusable carelessness displayed in the lack of proper isolation of the patient. We understand that students and other physicians were allowed to see Longley, and Dr. Hingston himself says that another man was allowed to remain in the wards because, forsooth ! he wasn't afraid of the disease ! No wonder the disease shortly afterwards breaks out in another ward, a medical student takes it ; friends of patients who visit the Hotel Dieu get it, and soon the whole Hospital becomes infected.

Dr. Hingston emphasizes the fact that he had a care of ventilation in the ward, but the subject

of isolation, in the scientific sense, is entirely ignored. We do not believe that it was carried out. Shortly after this general infection of the Hotel Dieu it was not only considered inexpedient to admit any more patients, but it was also decided to close the institution and to send to their homes those who had previously been under treatment. The result of this determination upon the part of the Hotel Dieu authorities may easily be anticipated; each patient discharged from the Hospital—all impregnated as it was with small-pox contagion—formed a local infecting centre for the propagation of the disease. Had the management of the Hospital put their heads together to determine in what way they could most expeditiously and most thoroughly spread variola throughout this city, they could hardly have hit upon a more effective plan. Instead of vaccinating and quarantining the whole institution they deliberately allowed to go by default the only chance that was left of preventing the further spread of the disease.

It would almost seem as if the enquiry into the origin of the epidemic has served the purpose of averting criticism from the Civic Government. Why was there no permanent small-pox hospital ready for the reception of such patients as Longley and Shattuck? Why was no public vaccination done for a year and a half before the outbreak? Why should there have been any difficulty in getting the Civic Hospital opened?

And the answer to these questions is, that the chief officials of the Sanitary Department were grossly incompetent to deal with the matter of the public health, and because our city council, actuated by petty notions of false economy, refused the necessary funds. Nor, later on, did they grasp the situation, but palliated and procrastinated until the golden opportunity was lost forever.

Montreal has had a bitter experience, and it remains to be seen whether in the future a better record will be shown. Let us hope, with Dr. Hingston, "that it will never again happen in the history of the city that a patient stricken with small-pox will be driven round from pillar to post in the vain search of some place where he can be treated and cared for without endangering the public safety."

BOVINE-VACCINE POINTS.

Messrs. John Wyeth & Brother, of Philadelphia, the well-known pharmacists, have quite re-

cently established a vaccine farm in Chester County, a short distance from that city. The land is undulating, well adapted to grazing, and contains several hundred acres, well watered and wooded. The buildings are all arranged on the latest scientific principles, and the animals and the inoculations have been placed under the immediate charge of Dr. W. L. Zuill, Professor in the Veterinary Department of the University of Pennsylvania. The virus with which the Messrs. Wyeth have started their inoculations was obtained from the Vaccine Bureau, under the auspices of the Belgian Government, in the City of Brussels. The high standing which the firm of John Wyeth & Brother have with the profession in the Dominion of Canada will at once commend to them the vaccine which they produce. The Davis & Lawrence Co. of Montreal are the agents for Canada.

We observe that Dr. Piffard has retired from his editorial connection with the *Journal of Cutaneous and Venereal Diseases*. The Journal will be continued under the sole editorial charge of Dr. P. A. Morrow. We may remind our readers that this is the only publication in the English language devoted to Skin and Venereal Diseases, and during the three years of its existence it has won for itself a high reputation for scientific excellence as well as practical utility. In addition to presenting all that is new and valuable in these special departments, the colored lithographs and wood engravings with which the original articles are illustrated are worth more than the price of subscription.

Judging from the handsome appearance of the January number, which is enriched by an admirable chromo-lithograph and a number of well-executed woodcuts, and the eminently practical character of its contents, this high standard will be maintained in the future.

LACTOPEPTINE.

We have used this article extensively for some years in cases of indigestion, and can recommend it as a very valuable remedy. Being a compound of the five active agents which are contained in the process of digestion, it cannot fail to aid the system in preparing the food for assimilation. It is an invaluable remedy in the summer diarrhoea of

children. In this disease, owing to the great impairment of the vital forces, and feeble powers of the digestive tract, food frequently irritates and increases the difficulty. For such cases we know of no agent in the *Materia Medica* as reliable as Lactopeptine.

PERSONAL.

Dr. Ebbitts, for nearly a year past one of the Resident Assistant Surgeons at the Montreal General Hospital, has received the appointment of Medical Superintendent of the Winnipeg General Hospital, and left the middle of January to enter upon his duties.

Dr. Peter McLaren (M.D., McGill, 1872) was in Montreal the first week in January. Dr McLaren still is located at Ormstown, P.Q.

Dr. Wells of Quebec has been appointed by the Local Government a member of the Central Board of Health, in the place of Dr. Marsden, deceased.

Dr. J. B. Lawford (M.D., McGill, 1879) passed in November last the final examination for the Fellowship of the Royal College of Surgeons of England.

Dr. Wm. Stephen (M.D., McGill, 1882) has left Montreal to practice in Rosana, Argentine Republic.

Dr. Chandler (M.D., Bishop's, 1880, and Gold Medalist) is a rapidly-rising Ophthalmic Surgeon in Boston, Mass., U. S.

Dr. Heber Bishop (M.D., Bishop's, 1883) is practising in Boston, U. S. His address is Hoffman House.

Dr. Gustin, one of the Resident Assistants at the Montreal General Hospital, has resigned and left for the Western States.

Dr. Robertson and Dr. Corson have been appointed Resident Assistants at the Montreal General Hospital.

REVIEWS.

A Reference Hand-Book of the Medical Science: Being a complete and convenient work of reference for information upon topics belonging to the entire range of scientific and practical medicine, and consisting of a series of concise essays and brief paragraphs arranged in the alphabetical order of the topics of which they treat, prepared by writers who are experts in their respective departments. Illustrated by chromo-lithographs and fine wood engravings. Edited by ALBERT H. BUCK, M.D., New York

City. Vol. I. New York: William Wood & Co., 1885.

This is the first volume of a series of eight, which is to comprise the set, and a very large and well-stocked book it is of over eight hundred pages. It is gotten up in the style of an Encyclopedia, and the title-page, which we have given in full, gives a very excellent idea of the character of the work. The undertaking is a gigantic one, and the Editor has a heavy task before him, of which he gives good evidence in the present volume of being well able to deal. We have read carefully a few of the principal articles, and are pleased with the style and the conciseness with which important material facts are given. Some may possibly think that some things might with advantage have been omitted—but, upon the whole, the bulk of the contents are entitled to a place in such a book. The engravings are very fine, the chromo-lithographs (several in number) beautiful, the type clear, the paper and the printing not to be excelled. The fact that several Canadian writers contribute to this, and are to contribute to subsequent volumes, will perhaps give it more than usual interest to the bulk of the profession in the Dominion, while to some the fact that they have nearly all been selected from Montreal will not be a point which will commend it to their favor. Personally, we think the Publishers, have made a mistake in not securing the services of men from various parts of the Dominion. Montreal has medical talent and good writers beyond doubt, but when the writers selected in the United States are from so many varied points, it was a mistake to make one city in Canada the source from which to draw its Canadian material.

A Treatise on Diphtheria Historically and Practically Considered, Including Croup and Tracheotomy. By A. SAUNÉ, Docteur en Médecin Ancien des Hôpitaux de Paris, Chevalier de la Légion d'Honneur, etc., etc., translated, annotated and the Surgical Anatomy added, with a full-page colored plate and thirty-six illustrations by Henry Z. Gill, A.M., M.D., LL.D., Professor of Operative and Clinical Surgery in the Medical Department of the University of Worcester, Cleveland, Ohio.

The firm of J. H. Chambers & Co., of St. Louis, Mo., have the above work in press, and will in a few weeks issue it to the profession. We have reason to believe it will be a valuable addition to our literature of these subjects.