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Original Communications.

GASOLINE AS A SURGICAL DETERGENT.*

BY BRUCE L. RIORDAN, M.D., TORONTO.

In introducing the subject of gasoline as a surgical detergent I will make the statement that I believe that the subject of detergents in surgical work has not been given the attention which it deserves from the general body of medical and surgical practitioners.

Dungleson's Medical Dictionary defines detergents, abstergents or abluents as medicines which possess the power to deterge or cleanse parts, such as wounds, ulcers, etc., and in these days of asepsis and antisepsis detergents should occupy a very prominent place. The old saying that "Cleanliness is next to godliness," has been found by experience to be a truism. So many of the ills to which we are subject, both surgically and medically, are preventable diseases, and preventable by perfect cleanliness. I wish to present to your notice to-day a new surgical detergent, although a detergent which has been in use for years in the arts. I speak of gasoline—commercial gasoline. It can be had wherever surgeons are found, and has the advantage of being inexpensive, and, being a distilled product, is sterile in itself. Gasoline is a product of the fractional distillation of crude petroleum. On distilling this body, the first distillate consists principally of rhigoline; the second is gasoline, which passes over at between 60 and 90 per cent. The average yield is about 1½ to 2 per cent.; refined naphtha, 10 per cent.; benzine, 4 per cent.; kerosene, 55 per cent.; lubricating oil, 17½ per cent.; paraffin, 2 per cent.

* Read at meeting of International Association of Railway Surgeons, Detroit.

Gasoline consists of the lighter boiling liquid members of the $C_n H_{2n+2}$ or paraffin series. It dissolves fats and oils. Its principal use is as a cleansing agent.

I have been using gasoline for the past four years in cleansing the field of operation, in cleansing traumatic wounds, and in the subsequent dressings of all classes of wounds—not using water or other lotions or solutions—and can now recommend to the members of this Association a trial of this common detergent in their ordinary surgical work.

I was led to use gasoline first for the purpose of cleansing from injured parts what railway employees call black oil. We all know how black and grimy are the hands of railway employees engaged in shop work and about locomotives. While working in their ordinary occupation an accident occurs—fingers are crushed, for instance. The injured person comes under the surgeon's care. The surgeon's first duty is to see that the injured parts and the surrounding tissues are thoroughly and surgically deterged or made surgically clean.

Soap and warm water with a brush has been the usual means employed, also ether, alcohol, etc. I found the process to be slow, painful, and not always thorough, as we understand surgical cleanliness, and the idea of using gasoline as a detergent readily suggested itself, as this substance has been used for years to cleanse grease stains from clothing, gloves, etc.

I find that it does not irritate fresh wounds or granulating surfaces any more than water does. It is best applied by taking an ordinary wipe, made of cotton batting or sterilized gauze, and wiping the parts which it is desired to cleanse. The gasoline immediately evaporates and leaves the surface dry and perfectly free from grease. This will be found an advantage where sectional strapping by adhesive plaster is to be used, as the plaster adheres much more firmly when the skin is free from any oily substance.

My results, as far as early healing and absence of infection are concerned, have been most satisfactory, and include the treatment of all classes of wounds, and I cannot too strongly recommend to the members of this Association gasoline as the best surgical detergent.

I am indebted to my friend, Dr. Goldie, of Toronto, who is a practical bacteriologist, for the following notes on gasoline as a detergent and antiseptic. He says: "I have carried out in part the experiments in regard to the detergent and antiseptic properties of commercial gasoline. Weighed scrapings from the same arm from areas roughly two square inches were plated out, after washing with soap and water for five minutes and after scrubbing with gasoline for two minutes, also without any preparation.

"Unsterilized skin gave 173 colonies; soap and water, 20 colonies; gasoline, 2 minutes' scrubbing, 16 colonies.

"Scrapings from skin, scraped with soap and water, then dressed with 1 to 60 carbolic acid over night gave for same weight of scrapings, 22 colonies.

"Gasoline poured on skin without rubbing gave 84 colonies. Repeated with scrubbing with cotton wipe, gasoline gave only gave 7 colonies.

"Staphylococcus pyogenes aureus smeared on the skin as a film remain alive at the end of two minutes exposed to gasoline.

"I shall continue the experiments more fully and let you have report at early date."

This report corroborates my claim, that gasoline is a valuable detergent, and may yet be found to be antiseptic.

I need hardly caution the members of this Association about the dangers of gasoline, but would just remind them that it is very inflammable. It should not be used carelessly about an exposed light. If it gets into cavities, such as the ears or eyes, it is irritating just as chloroform or ether is. If applied to a surface where it can rapidly evaporate it gives a cooling, pleasant sensation.

In subsequent dressing of wounds you may find the dressings adherent about line of incision or suture. Squeeze a few drops of gasoline on the adherent dressing and you will find that it can be readily detached.

If you want to remove sutures from wound and they are masked by iodoform powder and exudations from wound, gasoline on a wipe applied gently will clear your field. Gasoline dissolves iodoform and the exudation from wounds and then immediately evaporates, leaving a clean and dry surface. You can readily find your sutures and remove them.

Microscopic appearance of skin after scrubbing with soap and water, and after wiping off the skin with gasoline, showed that the cleansing effect of gasoline went much deeper and cleaned out the mouths of hair follicles, sebaceous glands and sweat ducts much more perfectly than scrubbing with soap and water could do.

POSTERIOR POSITIONS OF THE OCCIPUT.

BY K. C. McILWRAITH, M.B. (TOR.),

Demonstrator of Obstetrics in the University of Toronto.

In spite of the forces which tend to bring about the O. L. A. position at the brim, the occiput, in a certain proportion of cases, is directed posteriorly; and in a great majority of these cases the back is to the right. The head descends into the cavity in this position, and when the occiput reaches the pelvic floor it is rotated to the front in accordance with the law of internal rotation that "that part of the fetus which touches the pelvic floor first is rotated to the front." Rotation thus occurs late in labor, and, as it is through three-eighths of a circle instead of through one-eighth, as in anterior positions of the occiput, labor in this position is always tedious. In order that rotation may take place at all good flexion is necessary (unless the pelvis is very large or the head very small), because, as the occiput rotates from the rear to the front it is obvious that at some time during the process the long diameter of the head must be in the transverse diameter of the cavity. This diameter is about $4\frac{1}{2}$ inches in the dried pelvis, and with the soft parts in place is rather less. With good flexion the diameter of the fetal head engaging in it would be the sub-occipito bregmatic— $3\frac{3}{4}$ inches. With poor flexion it would be the occipito-frontal— $4\frac{1}{2}$ inches, which could not pass the transverse. Under these circumstances the occiput is rotated still further to the rear under the influence of the inclined planes of the bony pelvis, and the head has to be delivered in the occipito-posterior position. It is of these cases in particular that I wish to speak. Many minor measures have been recommended in treatment, most of them useless. There are two main lines of treatment to-day: (1) Leaving the case to nature as long as we can, and delivering with the forceps if rotation does not take place; (2) Manual rotation of the occiput to the front. Hitherto I have pursued the former of these courses, but further experience leads me to prefer the latter, because (1) labor is nearly always long and exhausting; (2) a much greater degree of force is required to deliver with the forceps in this than in anterior positions of the occiput; (3) the forceps are very apt to slip—all three of which factors tend to kill the child and injure the mother. I think a large part of the danger to the child is due to the pressing of the forehead against the symphysis, a danger which is increased by the fact that in this position the forceps tends to undue flexion. If they must be used they should be of the axis-traction pattern, and one should draw slightly posterior to the ordinary axis of traction.

Some men claim that they can place one or two fingers behind the ear of the fetus, and by simple pressure there push the occiput round. The cases in which this can be done are, in all probability, those cases in which nature would do the rotation herself, and not much is gained. The first essential for true manual rotation is a *certain* diagnosis of the position before the head has become immovably fixed at the brim. O. D. P. should be suspected whenever abdominal palpation shows that the back is to the right, progress slow in spite of good pains, and the fetal heart abnormally hard to hear. Under these conditions as soon as the os is dilatable the patient should be placed under chloroform, the hand passed into the vagina and the position determined with certainty. If the occiput be posterior the os should be dilated if necessary, and the head pushed above the brim and rotated to the front by the internal hand, the shoulders being pushed round at the same time by the external hand. Forceps should then be applied and delivery proceeded with. As prolapse of the cord may occur, it is advisable that the patient should be placed in the Sims' position with the hips slightly elevated, or in the Trendelenberg position.

USE OF ERGOT IN OBSTETRIC PRACTICE.

BY CHAS. J. C. O. HASTINGS, M.D., L.R.C.P.I., TORONTO.

Before considering the advisability or non-advisability of using a drug, we must first make ourselves perfectly familiar with its therapeutic action, which, in this instance, gives us a wide range of reference, including, as it does, all authorities on therapeutics and obstetrics. Now, for over a century, which constitutes the therapeutic age of ergot, all recognized authorities on this subject agree that ergot has a specific action on the unstripped muscular fibres of the body, and that it consequently produces a tonic contraction of the uterus. This opinion never has been questioned by any authority. Then passing on to the field of obstetrics, in briefly interviewing some of the leading authorities, we glean the following:

Herman,¹ in speaking of this drug, says that there is one drug, and one only, which produces uterine contraction and retraction, and that is ergot. But in the worst cases we cannot wait for the absorption of ergot, for even when injected under the skin there is still time for fatal hemorrhage before its action on the uterine muscle begins. Ergot is invaluable, but its chief uses are (*a*) as a prophylactic, given immediately after the birth

of the child, and (b) after bleeding has stopped to make tonic the contractions produced by other means.

Cazeaux and Tarnier,² in speaking of the use of ergot, say that the method they have employed for years, is to administer a full dose of ergot immediately after the birth of the child, this being followed by the best results.

Paul F. Munde, of New York,³ in referring to the hygiene of the puerperal state, says that he has frequently expressed clots the size of a fist from a uterus three or four hours after labor. But this, he goes on to say, was at a time when I was not in the habit of giving ergot simultaneously with the delivery of the head, as I now do.

Jewett,⁴ in the "American Text-book of Obstetrics," strongly advises the use of ergot after the uterus is emptied, as it is perfectly harmless; it limits the danger of hemorrhage, and by diminishing the blood supply it promotes involution. It closes the gates against infection, guards against the retention of blood-clot in the uterine cavity, and therefore lessens the tendency to after-pains, and to putrid accumulation in the uterus.

Garrigues,⁵ in his article on the Prevention of Puerperal Infection, says: "Contraction and involution being great preventives of puerperal infection, a drachm of fluid extract of ergot should be given three times a day till an ounce is given."

Barton Cook Hirst,⁶ in his valuable "Text-book of Obstetrics," in view of the uncertainty of the occurrence of hemorrhage in the third stage of labor, advises a drachm dose of ergot to be administered as soon as the child is born.

Again, in referring to *post-partum* hemorrhage,⁷ he says this may occur after any labor. Measures to prevent it consequently form part of the routine management of labor, as already described. If any of the predisposing causes of uterine relaxation exist during labor, additional precautions should be taken, and as soon as the presenting part emerges from the vulva, a syringe-ful of the fluid extract of ergot should be injected into the thigh of the patient.

Lusk,⁸ in referring to the use of ergot in parturition, expresses himself as follows: "The only imperative exhibition of ergot is presented by the occurrence of *post-partum* hemorrhage resulting from uterine atony. The unyielding, tetanic, uterine contraction which it produces, acts most beneficently in occluding the orifices of the vessels."

Dr. Routh,⁹ in his paper read before the B.M.A., in 1896, spoke of one of the causes of secondary p.p. hemorrhage, being the administering of ergot causing spasm of the internal sphincter resulting in retention of clots and severe internal hemorrhage, yet in his treatment of secondary p.p. hemorrhage, in the same paper, he recommends the hypodermic injection of

ergot and emptying of the uterus. Probably he holds the homeopathic view, "*Similia similibus curantur.*"

Ergot has been accused of producing hour-glass contraction. I have been a faithful disciple of the users of ergot. I have had two cases of hour-glass contraction, a little less than one-fifth of one per cent., and in these cases ergot was not given, so personally I can't endorse that objection.

Ergot has also been accused of producing after-pains. Now, if we consider for a moment the principal cause of after-pains we can readily see the fallacy of this.

Dr. More-Madden,¹⁰ obstetrician to the Matre Hospital, Dublin, in his able paper read before the Obstetrical section of the Royal Academy of Medicine, Dublin, in May, 1897, in which he gives a wide range of use to ergot in obstetrics, strongly recommends it as a prophylactic of p.p. pains. The late Dr. T. Beaty,¹¹ of the Dublin School of Midwifery, strongly recommended ergot in the prophylaxis and treatment of after-pains. Cazeaux and Tarnier strongly recommend ergot as a preventive of after-pains. So, to say the least of it, there is a difference of opinion even on this point.

But, Mr. President, there is an objection to the use of ergot, and that is, that it is a drug over which we have no control after it is administered; in from fifteen to twenty minutes its action begins, and it attains its maximum intensity in about one-half hour, and this lasts for about one and a half hours. And this is positive, as sure as we give ergot so sure will we get tonic contraction of the uterus, so that the whole question of when to use ergot simmers down to this, "When is it safe and desirable to have tonic contraction of the uterus?" Can we safely give it before the birth of the child? I never do, yet some very eminent authorities think it safe, provided that the uterus is dilated or dilatable sufficiently to apply the forceps, and you have a normal vertex presentation, and there is positively no obstruction or impediment to deliver other than inertia; but as Barns puts it, "This postulate is not always easily obtained. Then woe to the mother if any obstacle should delay the passage of the child, and woe to the child if it be not quickly born." We have in quinine a very good substitute for ergot in the second or first stage, as it simply intensifies the natural pains.

For twelve years I have made a routine practice of giving a full dose of ergot immediately after the birth of the child, and leave a dose for the nurse to give in two hours. For this treatment I am indebted to Cazeaux and Tarnier, of Paris, and Paul F. Munde, of New York. While the vast majority of recognized authorities recommend it most highly as a preventive of p.p. hemorrhage, yet they advise it not to be given

till the uterus is emptied. Now note the inconsistency of this: they give the ergot after the afterbirth is expelled, and then wait for twenty or thirty minutes for its action; in the meantime the woman may be flooding to death. We must always remember that we must give our drug twenty or thirty minutes before we want its action; we must give it then immediately that the child is born, and in fifteen or twenty minutes we will begin to expel our placenta by Crede's method, and in half an hour when the drug will have had time to reach its maximum intensity our uterus ought to be empty.

My object in this routine treatment is, that in securing tonic contraction I prevent p.p. hemorrhage and close up the channels for septic absorption.

Dr. Lomby Athill recommends the use of ergot in small doses combined with strychnine for some time before labor in those cases in which you have a history of p.p. hemorrhage, and has had very gratifying results from this form of treatment.

Conclusions—(1) That the use of ergot is always attended with more or less danger with the fetus *in utero*; (2) That it should be given twenty minutes before you require its action; (3) That it should always be given to secure tonic contraction.

Now you will naturally ask the question, "Why, in the face of all this, do we occasionally have a physician condemn the use of ergot?" The only explanation I can give is that there is probably no other drug, of which there are so few *reliable preparations* as ergot. For years I have limited myself to Squibs' Fl. Ext. and P. D. & Co.'s Normal liquid, and ergot aseptic, (P. D. & Co.), for *hypodermic* use.

I think, therefore, we should consider well before allowing ourselves to be carried away with novel ideas. Would it not be better for us to accept Paul's advice to the Thessalonians, to "Prove all things, and hold fast that which is good"?

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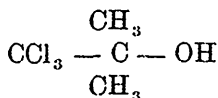
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NOTES ON CHLORETONE.

BY R. D. RUDOLF, M.D. (EDIN.), M.R.C.P. (LOND.), TORONTO.

Chloretone is described as "a beautiful white crystalline compound of camphoraceous odor and taste, soluble to the extent of 1 per cent. in warm water, 15 per cent. in glycerine, and 150 per cent. in alcohol; permanent in constitution whether as crystal or solution" ¹.

"It has, according to Willgerodt, the following formula:



and is formed when caustic potash is slowly added to equal parts of chloroform and acetone" ².

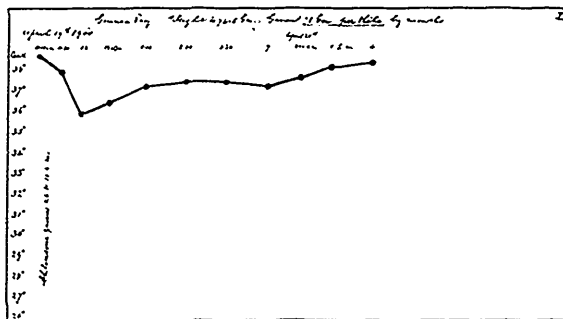


CHART 1.

The drug has been recommended for use in a variety of different ways, but chiefly (1) as a local anesthetic, (2) as an antiseptic, (3) as a hypnotic and possible general anesthetic. The chief advantage which has been claimed for the drug over those already in use for these purposes is its great safety.

Having used the drug somewhat extensively in experimental work in Physiological Department of Toronto University, we give here such results of this work as may seem to be of general interest.

1. We have not specially investigated the local anesthetic effects of the drug, but several casual observations would suggest that it is far inferior to cocaine in this respect. In guinea pigs, in which intra-peritoneal injections of the saturated warm aqueous solution had been made, the small parietal abdominal wound remained sensitive during the hours that the

experiments lasted, although it had been freely bathed with the solution. In stronger solutions made with ether, it seems to have given satisfaction in dentistry⁴, and the small quantities used here would probably be perfectly safe.

2. The antiseptic power of the drug is said to be considerable. We have not tested it in this direction.

3. As regards the hypnotic effect, it is hard to test this in animals with certainty, but undoubtedly a certain amount of drowsiness and hebetude is produced with moderate doses, increasing as the dose is increased, to deep torpor.

Houghton and Aldrich found that .2 gm. per kilo of body weight produced complete anesthesia in dogs, but results show that a somewhat larger dose than this is required for this purpose, but that about .275 produces a perfect anesthesia for experimental purposes. The pulse respiration and blood pressure remain good for hours, and the animal is completely insen-

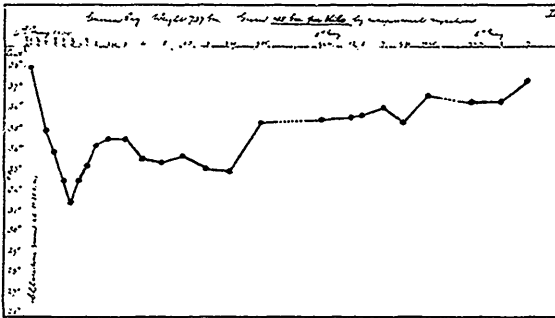


CHART 2.

sible to pain. But it does not recover. After many hours, during which the body temperature has been steadily falling (we will refer to this point below), the pulse and respiration become very slow, the blood pressure falls and the animal dies of heart failure. (Charts 5 and 6.)

A curious point to be noticed here, however, is, that if the administration of chloretone be preceded by that of chloroform, a smaller dose of the former seems to be sufficient to keep up the anesthesia. As low a dose as .15 gm. per kilo of body weight produced anesthesia, while .2 gm. did not do so when no chloroform was used. This peculiarity may account for the different results obtained by different observers.

If a dose, even insufficient to produce anesthesia, *e.g.*, .2 gm. per kilo, is given to a dog, the animal exhibits a considerable fall in body temperature. (Chart 5.) He is drowsy, and when roused, staggers and falls, and this inco-ordination of movement

lasts for two or even three days. This last effect would be an objectionable one if the drug were used in medical practice for its general effect. Dr. W. M. Donald, of Detroit, records a case⁵ where a man (whose weight is not mentioned) took 120 grains of the drug in 24 hours. He slept heavily for days, passing his feces and urine at times involuntarily. When partially recovered he showed the impairment of co-ordination "so that he was with difficulty prevented from falling," which our dogs and guinea-pigs exhibited under similar circumstances. He was never completely anaesthetised even with such a dose as he could always be roused.

The lowering of the temperature of the body was so constant a result of the drug that we paid special attention to the point and the following are notes of some experiments illustrating this effect:

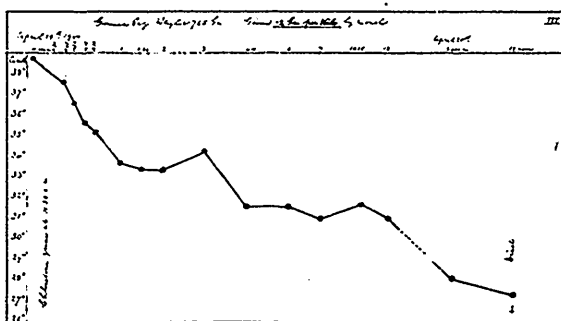


CHART 3.

1. A guinea-pig was given by the mouth .1 gm. per kilo (of body weight) of chloretone in warm aqueous solution. No anesthesia was induced, but a fall of about 3 degrees Cent. occurred. (Chart 1.)

2. A guinea-pig was given .15 gm. per kilo (of body weight) intra-peritoneally. In 2 hours his temperature had fallen some 6 degrees Cent. He was stupid, but not anaesthetised. After that the temperature gradually rose, but the animal was not quite normal for several days. (Chart 2.)

3. Then a guinea-pig was given .2 gm. per kilo by the mouth. The temperature fell steadily and he died about 24 hours later with a temperature below 27.4 Cent. He was sensible to pain almost to the end. (Chart 3.)

4. The same dose as in Exper. 3, but intra-peritoneally. The temperature fell with greater celerity, and in 4 hours was down to 27.4 C. The animal died 10 hours after the administration. He was not anaesthetised although in a state of hebetude. (Chart 4.)

5. A dose was given .2 gm. of chloretone by the mouth after the administration of chloroform. He showed great drowsiness for a few hours but no anesthesia (always resenting the introduction of the thermometer per rectum). During recovery he showed much inco-ordination of movement. The temperature fell some 5 degrees Cent. The room was at 61 degrees Fahr. (Chart 5.)

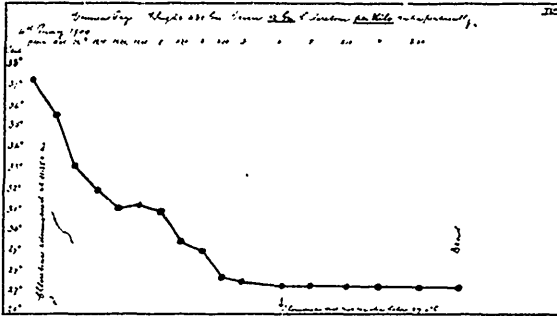


CHART 4.

6. Chart 5 illustrates the point that there is not a great difference between a dose of chloretone which produces only slight effects and one which is fatal. In this experiment 1½ gm. of the drug caused little fall in temperature, and no anesthesia; 2 gm. produced profound depression of temperature, perfect anesthesia and eventual death with fall in pressure of blood and slow pulse and respiration.

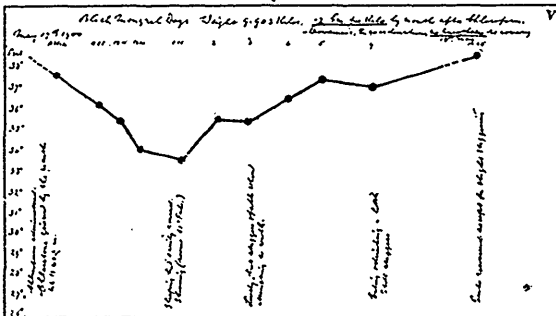


CHART 5.

It was found that by keeping the animal very warm the fall in temperature could be partially limited and they did not become so stupid.

(We have not settled exactly how low the temperature does fall as a result of chloretone, as in the experiments the thermometer used did not register below 27.4 degrees C.)

Many drugs produce a fall in the normal temperature. Thus the administration of chloroform in production of ordinary anesthesia produces a fall of .5 C. in man. If chloroform is slowly administered to animals for a long period, then the temperature may be lowered to 30 degrees C., and this without anesthesia³. In chloral poisoning it may fall to 33 degrees C., and lastly, Kembel states that in alcoholic poisoning the temperature per rectum may reach the low point of 24 degrees C. if the poisoned individual is lying out in the cold. The records in our experiments were made in a room at about 55 to 65 degrees Fahr.

To summarize our results :

1. Chloretone would seem, as has been found by Houghton and Aldrich, to be an ideal general anesthetic for physiological

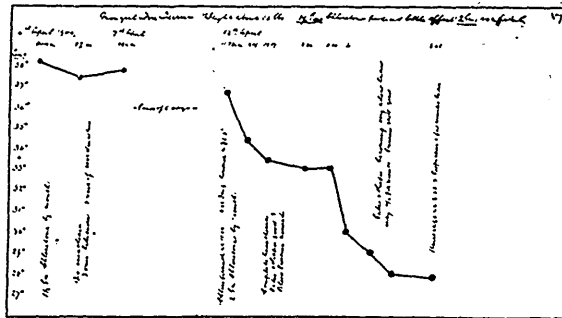


CHART 6.

work. Then we think there might be some doubt about the recovery of the animals, however, and this would limit its use to where recovery is not desired. The preliminary use of chloroform or ether might be used here, but this increases the risk, of course.

2. It has little or no effect upon the pulse, respiration and blood pressure for hours, but eventually, if the dose be large enough, these become depressed and the animal dies, the heart stopping before the respiration.

3. Chloretone has a most marked and profoundly depressing effect upon the body temperature, lowering this more than any other drug with which we are acquainted, with the possible exception of alcohol. This depressing effect is evident before the animal is even drowsy, and is in ratio to the dose given. It may be partially prevented by keeping the animal very warm.

4. Any drug which can exert such an effect on the total heat of the body is one which requires to be used with great caution in medical practice. This is doubly important as the drug is very slowly got rid of, and we know of no antidote, with the exception, perhaps, of external warmth.

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**AN APPRECIATION OF PRYOR'S METHOD FOR
REMOVAL OF FIBROID UTERUS BY THE
ABDOMEN, WITH REPORT OF TEN
SUCCESSIVE SUCCESSFUL CASES.***

BY A. LAPTHORN SMITH, B.A., M.D., M.R.C.S. (ENG.),

Fellow of the American and British Gynecological Societies; Professor of Clinical Gynecology in Bishop's University; Gynecologist to the Montreal Dispensary; Consulting Gynecologist to the Women's Hospital; Surgeon-in-Chief of the Samaritan Free Hospital for Women; Surgeon to the Western Hospital, Montreal, Canada.

Twenty years ago he was strongly opposed to the operative treatment of fibroids on account of the high mortality then prevailing among the best operators. Ten years ago he became a strong advocate of Apostoli's method of treatment by electricity, by which he has cured the hemorrhage permanently in sixty-three out of a hundred and two cases in ten years. Eight years ago Price lowered the mortality enough to induce him to operate in certain cases with the *serre-nœud*. Baer further reduced the mortality, and he adopted his method and operated oftener. Three years ago Pryor perfected an ideal method which had almost no mortality, and which he (Lapthorn Smith) had adopted, and to which he gave the preference over all other treatment in every case of fibroid suffering enough to consult him. He claimed that he had acted consistently throughout, being guided by the one test question, "What is the mortality?" In his last ten successive cases, seven last year and three this year, all had recovered. Therefore the operation is now almost devoid of danger while it was absolutely effective. Pryor's method is by far the best, and to it was due, he believes, his absence of mortality in these ten cases. The great advan-

*Read before the American Gynecological Society at Washington, May 1st, 1900.

tage of Pryor's method is that we begin on easy side, and after securely tying the ovarian round ligament and uterine arteries, and separating the bladder, we cut across the cervix and roll the tumor out, thus obtaining plenty of room to tie the arteries from below upwards. Another great advantage of this method is that there is much less danger of injuring the ureters. This accident is most likely to happen on the most difficult side, that is, the side where the tumor fills all the space between the uterus and the wall of the pelvis. But it is precisely on this side that the tumor is dragged away from the ureter while it is being rolled out, and by the time that it becomes necessary to cut anything on that side, the ureter is at least two inches away and quite out of danger. Doyen's method has this advantage on both sides, because he pulls the tumor off the bladder and ureters, and from the first he is getting further and further away from the bladder and ureters. But Doyen's method has the great objection of opening the vagina and thereby increasing time of anesthesia, loss of blood and risk of infection, besides the anesthetic one of shortening the vagina. The author lays even greater stress than Pryor does upon the importance of feeling for each individual artery and tying it before cutting it, and then putting a second ligature on it as the first one may loosen after the tension of the tumor has been removed. He also strongly advises chromicised catgut prepared by the operator himself, or else Red Cross cumol catgut prepared by Johnston, of New Brunswick, N.J., which he has found reliable. Besides the six principal arteries there are two small arteries which require tying on each side of the cervix. There is no need of disinfecting the stump beyond wiping away the little plug of mucus: but the cervix should be hollowed out so as to make an anterior and posterior flap which are securely brought together before sewing up the peritoneum. The omentum, if long enough, should be brought down to meet this line of suture, thereby preventing the intestines from sticking to it or to the abdominal incision. The author is opposed to leaving the ovaries and tubes, although he admits that in young women by so doing it diminishes the discomforts of the premature menopause. But in the majority of cases the appendages are diseased, and we run the risk of the whole success of the operation being marred by leaving the organs which sooner or later will cause more symptoms than did the fibroid itself. His experience of leaving in ovaries or parts of ovaries has been most unfortunate, having received no thanks for his conscientious endeavors but a great deal of blame for having failed to cure the pain, which in the patient's estimation was more important than the tumor.

He was also opposed to myomectomy; the operation was

quite as dangerous as hysterectomy; there was very seldom any reason for it, most of the women who have fibroids being either unmarried or at an age too advanced to raise children to advantage or having passed the child-bearing age. After submitting to such a serious operation the patient has a right to be guaranteed against a second or third one in the same disease. So many women have been disappointed by these operations—incomplete or so-called conservative operations—that their friends who really could be cured by an operation hesitate to undergo it. He would make an exception, of course, in case of there being apparently only a single polypus, no matter how large, or a single pediculated tumor.

He held the opinion that all fibroid uteri should be removed as soon as discovered, because the woman with a fibroid is liable not only to the hemorrhage which may not be great, but to the reflex disturbances of digestion and circulation. Besides every day it grows, its removal is becoming more dangerous and the chances of its becoming malignant are greater.

He was opposed to a preliminary curetting because it was unnecessary, and second, because when done it was seldom done effectually. Having examined fibroid uteri immediately after removal which had been curetted just before, he had found only about a twentieth part of the uterine mucosa removed.

He was strongly opposed to morcellement, which is not to be compared with Pryor's method. It is more dangerous, much more difficult, and keeps the patient a much longer time under the anesthetic. The operation is carried on in the dark, and the ureters are frequently wounded with complications such as adhesions of the vermiform appendix, and tears of the intestine which are easily dealt with by the abdomen, and the patient in the Trendelenburg posture, are almost impossible to manage when working from the vagina. Moreover, nearly all women with fibroids are nulliparous and the vagina is consequently narrow; they are nearly all elderly and the passage is consequently inextensible. No more suitable class of patients could therefore be chosen for this most difficult vaginal work. The author strongly advises the closure of the abdomen with through and through silkworm gut sutures left for three, or better still, four weeks. If not tied too tightly, and if dressed with boracic acid in abundance, the one dressing, or at most two, will suffice from the beginning of the case. Besides they can be passed very quickly and thus save ten minutes in the duration of the anesthesia.

Montreal, April 24th, 1900.

Society Reports.

PATHOLOGICAL SOCIETY.

JANUARY 27TH, 1900.

Dr. J. J. MacKenzie in the chair.

Present: Drs. Peters, Primrose, Rudolf, Carveth, Goldie, Parsons, Bruce, Cameron, Wilson, Silverthorne, Tanner.

Minutes taken as read.

Dr. Clarence Starr was elected a member of the Society.

Moved by Dr. Primrose—That a committee composed of the President, Drs. Anderson, Amyot, Primrose and Parsons be appointed to obtain information regarding the Study of Pathological Material in Asylums as elsewhere provided for, and to draft a resolution calling the attention of the Government to the necessity of similar work in Ontario. Carried.

General Cystic Degeneration of Kidney.

Dr. Parsons read a paper and presented specimen.

Discussion.—Drs. Goldie, MacKenzie, Rudolf.

Tuberculosis of Testes and Epididymis.—DR. BRUCE.

In one the seminal vesicle was large and nodular, the other normal. Patient was twenty-six years of age. The disease was of nine or ten months' duration. A discharging sinus has been present for six weeks. There was no evidence of tuberculosis elsewhere. There were no bladder symptoms. Left seminal vesicle was large and hard.

Rodent Ulcer, etc.

Dr. Tanner showed slides of rodent ulcer, endothelioma, carcinoma of suprarenal capsule, carcinoma of wall of cardiac ventricle.

Pathological specimens were shown by Dr. H. B. Anderson and Mr. J. J. Walker:

- (a) Double meningocele in a calf.
- (b) Osteo-sarcoma of the pelvis of a sow.
- (c) Sarcoma of penis of a bull.

Dr. Amyot:

- (a) Sarcomatosis of peritoneum.
- (b) Imperforate anus in a puppy.

The meeting then adjourned.

H. C. PARSONS,

Recording Secretary.

MEETING, MARCH 31ST, 1900.

Dr. J. J. MacKenzie in the chair.

Present: Drs. Greig, Fotheringham, Goldie, Parsons, Peters, Primrose, Rudolf, King, Peplar, Anderson, Oldright, Hamilton Wishart, Thistle, Bruce, Silverthorne.

Visitor: Dr. Taylor.

Called to order 9.15.

Minutes taken as read.

Cancer of Stomach.—DR. ANDERSON.

The wall was greatly involved. At cardiac orifice was a pedunculated mass having a valve action preventing vomiting.

Dr. Rudolf: Is valve condition rare? Said that physical examination suggested stricture of œsophagus.

Dr. King: Was there hemorrhage following pressing of tube?

Dr. Anderson: There was much blood found in stomach. The stools showed no blood, *post-mortem*.

Dr. Goldie: Was there history of tarry stools? Asks why with so great original growth was there only one metastasis in the liver.

Dr. Peplar: No other organs affected?

Dr. Anderson: Glands at head of pancreas were enlarged. Pancreas not involved.

Dr. Hamilton: Regarding examination of stomach contents. hydrochloric acid may be absent from many other causes than cancer. Lactic acid more often found where there is pyloric obstruction.

Dr. MacKenzie, speaking of the oppler-boaz bacillus, said that perhaps too much stress is laid upon one organism. Many others may produce lactic acid as well.

Lithopædion.—DR. TAYLOR.

It is not a very complete history. On February 15th, last, called to see woman dying with great emaciation; pulse 130, respiration rapid, edema of legs and abdomen, and vomiting.

The previous history is as follows:

In 1892 sudden hemorrhage from uterus, pelvic pains, face blue and cyanotic. It was thought to be ptomaine poisoning, and thought child was dead. Abdominal section a day or so later; nothing was removed. A mass was felt in the pelvis; it was not removed. Patient left hospital seven weeks later.

In February, 1893, an abscess formed in the groin. Good health later, but pelvic pain and difficult urination. Two years later great flatulence and distension. An incision was made and intestinal contents escaped, also pus and a mass was found in left flank.

Post-mortem.—This mass was found in Douglas' pouch bound to sacrum. The cord, about twelve inches long, ran to right iliac fossa, and was there fixed in a fibroid tissue. Melanotic sarcoma was found in liver and lungs; one tuberculous knee. Two sinuses over sacrum; abscess in groin connected with hip; a hernia at umbilicus, adherent to skin. The appendix was at the umbilicus.

Dr. A. B. Anderson discussing Dr. Taylor's specimen said: Lithopedion is a rare condition. Thoma states that an embryo retained either in the uterus or in the abdominal cavity may undergo this change. Three classes are described: 1. Where only the membranes are calcified. In such cases the fetus is readily taken out. 2. The membranes become adherent to the surface of the fetus, with calcification. In this case no separation between fetus and membrane is possible. 3. The fetus may escape from the membranes with calcification of the outer layers of the fetus. This patient died of pneumonia.

Dr. Fotheringham, discussing Dr. Taylor's Lithopedion, drew attention to Kùeben Meister's statement in *Archiv. f. Gynæk.*, quoted by Hirst, in his Text-book of Obstetrics, to the effect: (a) That the pregnancy resulting in lithopedion is always abdominal or at least tubal with rupture. (b) That the deposit of lime (usually phosphate or carbonate) occurs usually in the membranes, and in the parts of the fetus in contact with it. (c) It may arise in the *vernix caseosa*—though we would suppose that an abdominal pregnancy, in which the fetus was old enough to show the *vernix caseosa*, must be even more rare than lithopedion. The specimen seems to bear clear evidence that the membranes were first calcified. Most of the really fetal structure apart from the skeleton being absent, apparently having been absorbed.

Dr. J. J. MacKenzie and Dr. R. W. Rudolf reported the results of three experiments upon rabbits, along the lines of Lack's experiments. In two rabbits the left ovary was cut open and scraped, the scrapings being distributed over the mesentery and peritoneal surfaces; the third rabbit was inoculated intraperitoneally and in the anterior chamber of the eye. One rabbit was killed after six months, the other two at five months and a half. All the animals were healthy when killed, and showed nothing which could be construed as malignant new growth.

Dr. Lock's experiment was founded on his theory that cancer is due to growth of animal epithelium in a lymphatic space where it is extraneous.

He sowed an emulsion of one of the ovaries in the peritoneal cavity and fourteen months later the animal died filled with cancer. He repeated the experiment in a number of rabbits but has not reported since. Possibly the cancer was an accident

Tubercular Epididymis.—DR. GREIG.

Abscesses were present. Tuberculosis was formally thought primary in epididymis. Now thought secondary to some lesion in the body. There was tuberculosis of the lung in this case.

Dr. Goldie: It was said that typical tuberculosis is not seen in epididymis and cord. In one case, however, he did find real caseous nodules with typical cellular elements. Tubercle bacilli well shown.

Dr. Greig: In the right testicle there was no sign of tuberculosis, nor in bladder or vesicle. On examination as to origin, he thinks it was secondary to the lung. There was history of injury to this testicle, also the abscesses suggested tuberculosis.

Dr. Silverthorne: Showed stomach from case of carbolic acid poisoning; suicide. Fluid in stomach, whiteish, odor very strong. Bowels also affected, no perforation.

The meeting then adjourned.

MEETING, APRIL 28TH.

Meeting called to order 9 p.m. In the absence of the president and vice-president, Dr. King moved, seconded by Dr. Oldright, that Dr. Meyers take the chair.

Present were Drs. Meyers, Goldie, Anderson, Oldright, King, Silverthorne, Parsons.

Drs. Thistle and Goldie presented notes and specimens of the case of initial stenosis.

Dr. E. E. King and Dr. Silverthorne presented two cases of cancer of the prostate gland and a case of hypertrophy of the middle lobe of the gland.

Rodent Ulcers.—DR. GOLDIE.

These specimens of rodent ulcer are of most interest from a teaching standpoint. The specimens comprising the whole face.

They present all the typical appearances of rodent ulcer, both macroscopically and microscopically.

The origin is apparently in the hair follicles, the cells are small, alveoli in the one specimen, being well marked, while in the other it is with difficulty that one can tell the epithelial cells from the proliferating connective tissue cells immediately around.

The vessels show marked changes, endarteritis and hyaline degeneration.

Dr. Anderson discussing Dr. Goldie's specimens of rodent ulcer, spoke of a peculiar feature in one specimen. The very

marked endarteritis which might be important in helping to explain the ulceration in these cases. In both cases the tumor evidently arises from the epithelium of the hair follicles, though rodent ulcers may originate from the epithelium of the sebaceous glands or sudoriferous glands as well.

Dr. Silverthorne showed specimen of tumor from palm of hand, size of hen's egg, first noticed after injury (a bruise) three years ago. The patient was a female, 53 years of age, the mass reached the size of large marble in a short time and remained this size until about three months ago, when it became very tender and painful and rapidly grew to present size. The tumor was situated in the ulnar side of the palm.

The tumor was somewhat movable, the smooth skin was closely attached to it and very tender. It was soft and apparently fluctuated and on this account was cut into, but it was found to be a solid tumor and was subsequently removed. It appeared to be distinctly encapsuled and was removed without any special difficulty except for considerable adhesions at the posterior part. In sections the tumour appears to be a myxofibroma in some places very cellular, and with thin-walled bloodvessels. On this account it suggests the possibility of beginning sarcomatous degeneration.

Tumor of Occipital lobe. Fibro-Sarcoma of Right lobe of Cerebellum-Hydrocephalus.—DRS. ANDERSON AND FOTHERINGHAM.

Discussed by Drs. Myers, Goldie, King, Parsons.

A Case of Cerebral Tumor.

Mrs. W., aged 66. Family history—unimportant; all long-lived; no history of any neurotic or chronic nervous troubles.

Personal history—very meagre. Was thrown from a horse when a girl at school and had eye and side of head injured, which side I could not find out. Had a "stroke" (cerebral hemorrhage) at age of 28, followed by paralysis of leg, just after birth of first child, and was for a long time unable to walk:

Present illness—Twelve years before this date prolonged business worry and reverses, with bad conduct on the part of husband who became addicted to drink, caused a sudden accession of mental derangement, which was only slight, but had existed in the form at least of eccentricity for some years. From this time she declined to go to church or otherwise appear in public, and gradually lost interest in domestic affairs, etc., though she would do some housework at times. She developed also wild delusions of persecution, acting very capriciously towards visitors and friends, some days very pleasant, next day refusing to speak to them on the ground that they were there spying on her, etc. To one daughter she conceived

a violent aversion and at times used very bad language to her, such as the friends could not imagine that she had ever heard. Delusions of sight, too, were present, as, for instance, that she saw friends from the window who had been long dead or who were not in town at all at the time.

In November, '98, she had a period of unconsciousness, preceded by a few days of sleeplessness and mental excitement, violent language, etc. There were twelve such periods, about one each month, till her death in Nov., 1899. The unconsciousness lasted usually two or three days, sometimes more, was accompanied by stertorous breathing, absence of patellar reflex, paralysis of sphincters and deep coma. She had no squint or ocular symptoms. The muscular paralysis seemed more profound on left side. She was distinctly not hemiplegic. This condition slowly passed off, leaving her in the interval with amnesic aphasia, a paretic condition of muscular system and marked mental hebetude. Each successive period of coma left her more markedly aphasic, torpid, and incapable of walking, till she finally died in one of the attacks.

The description of the specimen I leave to Dr. Anderson who did the *post mortem* examination.

Microscopically it is a beautiful specimen of endothelioma.

I apologize for the crudity of my clinical report, but direct attention to the absence of the three classical symptoms of cerebral tumor, vomiting, optic neuritis and headache. The absence of convulsion is readily understood from the location of the growth.

REGULAR MEETING, MAY 26TH.

Dr. J. J. MacKenzie in chair.

Present—Drs. King, Silverthorne, Rudolf, Oldright, Parsons.

Dr. Struthers, of Sudbury—Minutes taken as read.

Duofinal Ulcer from Burn.—DR. OLDRIGHT.

Dr. Silverthorne gave *post mortem* report. Discussed by Drs. MacKenzie, Rudolf and Parsons.

Fatal Gunshot Wound.*—DRS. KING AND SILVERTHORNE.

Election of Officers.—President, Dr. Silverthorne; Executive Committee, Drs. Amyot, Rudolf, Parsons, King.

Meeting then adjourned.

H. C. PARSONS,

Recording Secretary.

* A full report of this case will be published in July issue.

Editorials.

CANADIAN SUMMER RESORTS.

The popular holiday season in Canada appears to be during the hot summer months. This is due largely to the fact that this is vacation time in all our schools and colleges. It frequently happens that families going away in good health return with more or less sickness. Fortunately both the public and the profession have learned that in a large proportion of such cases there is sufficient reason for the bad results. The sanitary conditions in many summer resorts has been so bad that it was really dangerous to go near them. As far as Toronto is concerned the Muskoka district is probably the most popular place for a summer outing. When only a very limited number visited the wilds of Muskoka sanitary precautions were scarcely thought of at all. Before many years the number of visitors increased so greatly that many of the hotels and boarding houses were overcrowded during the hot weather, and it was found that in some at least a very unsanitary condition existed.

Dr. Bryce, the Secretary of the Provincial Board of Health, has devoted a great deal of attention to this matter during the last few years; and, as a consequence, there is a great improvement from a sanitary point of view throughout the whole district. We fear, however, that there is still room for improvement in many places, and it is well for physicians to bear this in mind when giving advice to their patients about these matters.

There is always a certain element of danger where a number of families live in a group of houses, unless certain precautions are taken. We think the system carried out at DeGrassi Point on Lake Simcoe is about as nearly perfect as possible. Certain rules are laid down regulating the manner of erecting buildings, as to draining, plumbing, etc. All refuse is collected and destroyed each day. This is not left to the individuals occupying the houses, but to a committee legally endowed with power to compel the observance of the existing regulations. The collection and destruction of the waste material from all the

dwellings are all done by a person or persons acting for this committee. A system such as this, properly carried out by a person or persons endowed with the proper authority, is about the best that can be devised.

ONTARIO MEDICAL ASSOCIATION.

Wednesday and Thursday, June 6th and 7th, are the dates of the twentieth annual meeting of the Ontario Medical Association. For months past the committees have given every effort to make this year's meeting a great success.

The appended provisional programme has been sent to all the practitioners in the Province, with the desire that it may arouse an interest in many who are entitled to the privileges of the Association, but of which they have never availed themselves. The discussions will be of unusual interest, and the papers to be read are on subjects such as should call forth free discussion.

At the meeting in 1898 it was decided that an association dinner be held on the evening of the first day, instead of the luncheon formerly given on the second day. The Committee on Arrangements have made excellent preparation for this, and it is hoped that everyone attending the meeting will do his part toward making this function an unqualified success. As stated in the provisional programme, convention rates may be procured from the railways.

PROVISIONAL PROGRAMME.

Medicine—"The Future of Therapy." Lewellys F. Barker, Johns Hopkins Hospital, Baltimore. Followed by A. McPhedran, Toronto; James Third, Kingston, and J. L. Davison, Toronto.

Surgery—"Appendicitis, Its Recognition and Operative Interference." Luke Teskey, Toronto. Followed by L. C. Prevost, Ottawa; J. F. W. Ross, Toronto; Ingersoll Olmsted, Hamilton, and H. A. Bruce, Toronto.

"Inter-Provincial Medical Registration." To be introduced by J. Arthur Williams, Ingersoll. Followed by T. G. Roddick, M.P., Montreal; John Herald, Kingston, and J. P. Armour, St. Catharines.

"Army Medical Arrangements for the War in South Africa," J. T. Fotheringham, Toronto. Followed by Wm. Nattress, Toronto; F. LeM. Grasset, and George A. Peters, Toronto.

"The Medical Aspect of the Transvaal War." G. Sterling Ryerson, Toronto.

(a) "Total Removal of Vas Deferens and Vesiculæ Seminales for Tuberculosis." (b) "Traumatic Ventral Hernia." J. Alexander Hutchison, Montreal.

"Removal of Tubercular Testicle, Vas Deferens and Vesiculæ Seminales at one sitting, Transplantation of Ureters into Rectum by extra peritoneal method.—Further Report of Case, with Exhibition of Patient." G. A. Peters, Toronto.

- "Carcinoma of the Uterus." John W. S. McCullough, Alliston.
- "Cancer of the Rectum." Illustration by lantern slides. Edmund E. King, Toronto.
- "The Adaptation of Patient to Climate in Cases of Phthisis. N. A. Powell, Toronto.
- "The Use of Morphia in Puerperal Eclampsia." David Hoig, Oshawa.
- "The Aetiology of Acute Rheumatism." H. B. Anderson, Toronto.
- "Two Forms of Puerperal Infection." K. C. McIlwraith, Toronto.
- "Differential Diagnosis between Pneumonia and Pleurisy with effusion." H. H. Oldright, St. Catharines.
- "Erythema Bullosum." Graham Chambers, Toronto.
- "Observations upon Blood Pressure." Illustrated by lantern slides. R. D. Rudolf, Toronto.
- "An Unusual Case of Crossed Paralysis." D. Campbell Meyers, Toronto.
- "Beds: Their Proper Construction and Care, from the Doctor's Standpoint." George H. Carveth, Toronto.
- "Artificial Feeding of Infants." C. Sears McKee, Toronto.
- "Exploratory Incision in Obscure Brain Lesions, and Some Points in the Surgical Treatment of Meningocele." L. W. Cockburn, Hamilton.
- "The Removal of Septal Spurs.—A Note upon the Use of Carnalt Jones' Spokeshave." D. J. Gibb Wishart, Toronto.
- "Extensive Necrosis of Skull." Presentation of Patient and Photographs. William Oldright, Toronto.
- "Vaccination as it is To-day." H. R. Franks, Brantford.
- "The Treatment of Squint from the Standpoint of the Family Physician." J. F. Duncan, Toronto.
- (a) "Acute Suppuration of Mastoid Cells." (b) Chronic Suppuration of Maxillary Antrum and Anterior Ethmoidal Cells of Thirty Years' Duration." Percy G. Goldsmith, Belleville.
- "Nasal and Post-Nasal Synechiae." J. Price Brown, Toronto.
- "Aneurism of the Heart with Specimen." W. B. Thistle, Toronto.

Personals.

Charles H. Doherty (Trin. '00) has been appointed Superintendent of the Nelson (B.C.) General Hospital.

Dr. J. H. Cotton, of Toronto, left his home, May 29th, on a visit to New York, Philadelphia and Baltimore.

Thos. H. Middleton, M.B. (Tor. '92), house surgeon Toronto General Hospital, '92-3, practising in Owen Sound, '93-9, taking a post-graduate course in England during the past year, has successfully qualified for the double qualification (Physicians and Surgeons), London, England.

Donald Jno. Armour, B.A. (Tor. '91), M.B. (Tor. '94), house surgeon Toronto General Hospital '94-5, M.R.C.P.(Lond.) '97, has recently passed the examination for the Fellowship of the Royal College of Surgeons (F.R.C.S.Eng.). During the last ten years he has been demonstrator of Anatomy, University College, London.

Progress of Medical Science.

MEDICINE.

IN CHARGE OF W. H. B. AIKINS, J. FERGUSON, T. McMAHON, H. J. HAMILTON,
AND INGERSOLL OLMSTED.

Thyroid Gland Extract in Obesity.

Dr. J. N. Love, of St. Louis (*Jour. Amer. Med. Association* for April 21st), reports his experience in the treatment of obesity, especially in children, by the administration of thyroid gland extract. He holds that there is a defective condition of metabolism greatly benefited by the extract. When the treatment is commenced it is well to avoid causing too much headache and nervousness. The combination of moderate doses of strychnia aids the action of the gland extract. There is a reduction of the fat and an increase in muscle. These obese children become brighter and more disposed to romp and play. In one case the reduction in weight was from 131 lbs. to 106 lbs., with distinct improvement in health. The treatment should be continued until the tendency to obesity is controlled.

Tricuspid Regurgitation.

Dr. W. C. Huntington, of Howell, Mich., in *Medical Age* for April 25th, has some useful observations on the above subject. He contends that if a tricuspid murmur can be heard, there is disease of these valves, as the safety valve regurgitation never causes a murmur. The opinion is advanced that this form of valvular disease is more frequent than any form of heart disease. Further, it is claimed that if there be no disease of the left side of the heart or kidneys, there is rarely or never dropsy. Tricuspid regurgitation causes anemia of the lungs and enlargement of the portal circulation with enlargement of the liver. There are increased arterial tension and renal activity. The other secretions are dried up somewhat, and the action of the skin and bowels lessened, giving rise to constipation and piles. As the lungs are anemic, the dyspnea of tricuspid regurgitation is generally relieved by the recumbent position. There is malnutrition and loss of weight. The apex impulse is well marked at the xiphoid cartilage. When the displacement has become greatest, the murmur can be heard on both sides of the lower end of the sternum as a distinct rasping sound. When dilatation commences, the murmur becomes less distinct, and disappears altogether when it becomes advanced. There is usually

no irregularity of pulse, though a little rapid. The abdomen is usually tympanitic and the epigastrium tender. The appetite keeps up a fair average. The shortness of breath is not specially affected by going up stairs, as in the case of mental insufficiency. The treatment is along the lines of careful feeding on digestible and nutritious diet. *Digitalis* does not agree well with these cases, as there is already too high a degree of arterial tension. Emphysema adds much to the distress of these cases, and may be secondary to the heart trouble, and require special attention. Over-exercise is injurious, but on the other hand, a sedentary life is even worse. Drugs that strengthen the heart, on the one hand, and lower the arterial, on the other, are indicated.

Intestinal Antisepsis in Typhoid Fever.

Dr. J. M. Anders, of Philadelphia, in *Therapeutic Gazette* for April 25th, makes the observation that typhoid fever is not a disease of the intestinal tract. Intestinal remedies hold a subordinate place as compared with the judicious use of baths, nourishment and stimulants. The antiseptic treatment of typhoid fever has no claims to be ranked as specific. It would be futile to attempt to direct antiseptic remedies against the bacillus of Eberth or its toxins. The functions of the liver are poorly performed during the disease, and there is defective secretion of hydrochloric acid. These defects, together with the over-feeding of the patients, often give rise to considerable tympanitis. In many cases small doses of calomel at the commencement of the disease does much good by acting on these secretions and removing undigested food. After a very careful trial of the various intestinal antiseptics, the conclusion is reached that it is impossible to obtain or maintain an antiseptic condition of the intestinal tract, or to inhibit the activity of the bacilli. It is impossible to destroy the germs in the walls of the ileum, many of them having gained the circulation and adjacent glands. During the course of the disease, other germs found in the intestinal canal may take on special activity and cause harm through their toxins. The removal of these toxins is helpful to the patients. For this purpose there is nothing better than plenty of water. Its free use cleanses the gastrointestinal tract, and aids the stimulation of the toxins both by the skin and kidneys. A moderate amount of constipation is favorable to the patient. In such a condition there is less meteorism than in cases with moderate diarrhea. For this constipation laxatives are not employed, except calomel at the early stage. Large soap-sud enemata are used instead, and with better results than those obtained from laxatives. At a late stage of the disease it sometimes takes on an intermittent

form. In such cases the administration of saline laxatives in divided doses until they act has a very good effect. Thus it will be seen that intestinal antiseptics have a limited sphere in the treatment of typhoid fever.

Bradycardia.

Dr. R. F. Chase (*Bost. Med. and Surg. Jour.*). The conditions in which bradycardia occurs are of interest, and are well given by Riegel in his classification, which is the one most generally accepted. It is as follows:

1. Physiological bradycardia.
2. Pathological bradycardia.

Physiological bradycardia includes those cases due to physiological conditions only. Probably Napoleon's case is the best known example of this type. The condition is reported to have been observed in entire families. It occurs in the puerperal state at full term, abortions and premature labors; also in fasting and other conditions. In any case of slow pulse an extended observation may be necessary to determine its class.

Pathological bradycardia embraces all cases not physiological. It occurs in the following conditions:

1. Convalescence from acute fevers, such as pneumonia, typhoid fever, erysipelas, scarlatina, diphtheria, acute rheumatism, and the like. It is mostly seen in young persons in whom the fever has run a normal course. Hibbard concludes that its presence in young children with diphtheria is a sign of serious heart trouble. According to Atkinson and others, it is met with in the beginning of acute rheumatism as well as in convalescence.
2. Diseases of the digestive system: Acute, chronic and nervous dyspepsia, ulcer and cancer of stomach, and esophageal affections.
3. Respiratory diseases: Emphysema, bronchitis, pleuritis and laryngeal affections.
4. Circulatory disturbances: Myocarditis, fatty degeneration of heart, pericarditis and arteriosclerosis; not common in valvular diseases.
5. Diseases of the urinary organs: Nephritis and cystitis.
6. Toxic agents: Uremia, lead, alcohol, tea, coffee, tobacco and certain drugs.
7. Constitutional disorders: Anemia, chlorosis and diabetes.
8. Diseases of the nervous system: Epilepsy, apoplexy, cerebral tumors, medulla affections, injury to cervical cord, meningitis, mania, melancholia, and the like.
9. Various other affections, as skin diseases, affections of the sexual organs, sunstroke, etc.

After giving these divisions and subdivisions, Riegei feels that there are still cases which may not properly come under this grouping, and mentions, as an example, those cases in old persons in whom some affection of the heart or blood vessels, most probably due to old age, is the cause of the slow pulse. Again, of the 94 cases by Prentiss, in 35 no cause is assigned for the slow pulse. This is of particular significance, for the reason that every writer has probably done his utmost to ascertain the cause.

Cause.—The immediate cause of bradycardia may be due to (a) a condition of the nerve centres producing either irritation of the pneumogastric or paralysis of the sympathetic (accelerator) nerves of the heart; (b) a condition of the sympathetic nerves paralyzing them; (c) or to some condition of the cardiac ganglia, in which the influence of the pneumogastric preponderates; (d) or a condition of the heart muscle whereby it fails to respond to the normal stimulus; (e) or to poisons acting either on the nerve centres or endings.

Pathology.—Our knowledge of the physiology of bradycardia is limited, and the same is true of the pathology; at the same time, regarding the pathological causes of bradycardia, we are not lacking in theories.

Treatment.—It is evident that many cases require no treatment, the removal of the cause effecting a cure. In those cases where the patient suffers from the result of a slow pulse, and in which life may be threatened, rest and certain drugs seem indicated. Strychnia, atropia and nitroglycerin are most commonly used, but in the majority of cases without any beneficial effect.

In conclusion, the author says that if the reader's attention has been directed to the following points, the object of his paper is attained:

1. A pulse rate under 60, which is synchronous with the heart's systole, constitutes a bradycardia, according to Grob.
2. The condition, all classes considered, is of common occurrence.
3. It is much more common in males than in females.
4. There are three types of bradycardia, as classified according to their clinical aspects.
5. The class termed idiopathic bradycardia, on account of its usual fatal termination, must not in any case be passed by as a mere curiosity.—*The Post-Graduate.*

Non-Diabetic Glycosuria.

Dr. Robert Loundly, of Birmingham (*Brit. Med. Jour.* for April 24th), discusses the different varieties of glycosuria not of that type regarded as diabetic. These cases are not very num-

erous, but they are of importance. The method of testing the urine in these cases of pseudo-glycosuria is to boil a few drops of the urine in a drachm of Fehling's solution.

First, there is that form known as the alimentary. By giving the healthy person 300 to 500 grains of the syrup of grape sugar temporary glycosuria can be induced.

Another form of glycosuria is that caused by the abuse of alcohol. The presence of the sugar in the urine may be intermittent or permanent so long as the over-use continues. There is usually indications of the indigestion in these cases. The sugar disappears with the adoption of temperate habits.

In cases of chronic hepatitis there may be sugar in the urine. In some of these cases there was the history of biliary colic. In some of the instances there was the possibility that the derangement of the liver was due to drinking habits.

In chronic gastritis, glycosuria may be met with. There may be some common connecting link in all those cases mentioned under the headings of alcohol, hepatic and gastric. It is most likely that cause will be found in the liver.

In neurasthenia glycosuria of temporary character is sometimes met with. In these cases no other cause can be discovered for the presence of the sugar. Some writers regard glycosuria as very frequent in neurasthenia, passing off as the patients gain their health.

In the old a senile type of glycosuria is frequently found. This must be regarded as an evidence of the breaking up of the system, and a restricted diet must be ordered with much care.

In the above forms of glycosuria there is an absence of the symptoms of diabetes. In these cases there need be few restrictions placed upon the diet, other than as required to meet indications such as the over-use of alcohol, sugar, or indigestible foods. Very little drug treatment is called for.

Diet in Typhoid Fever.

While we are anxious to urge a more liberal feeding in typhoid fever and other prolonged and exhausting febrile diseases, we are not advocates of the reckless administration of food in these conditions; but we are firmly convinced that a patient will generally resist the virulence of the disease better, maintain his strength, and have a more rapid convalescence when he is not confined strictly to a milk diet. The question of dietetics in typhoid fever is much like every other therapeutic question in the sense that the patient fares best when the physician does not adhere to any routine plan of treatment, but fits his drugs, his bathing and his feeding to the needs of the case.—*Therapeutic Gazette.*

Treatment of Pneumonia.

At the Congress of Internal Medicine, Koranyi, of Buda Pesth, read an interesting paper on the treatment of acute inflammation of the lungs. In his preliminary remarks he suggested that the simple croupous inflammation of the lung should be distinguished from the asthenic form of inflammation.

This distinction is indicated etiologically from streptococci pneumonia, which anatomically is cellular pneumonia. That Fraenkel's diplococcus lanceolatus and the streptococcus give different results according to intensity is an admission of two forms. He considered this diagnosis of a primary fibrinous asthenic pneumonia as important in the treatment.

Recent pathology had taught us to be careful in examining the blood in pneumonic cases before we attempt treatment with serum, as it is first necessary to know exactly the bacteria present, and the amount of toxin operating. The serum treatment had not on the whole been a success. In examining the blood, leucocytosis is often found in pneumonia, and this led to the theory of treatment with pilocarpin, antipyrin, antifebrin, nuclein and Hydropathy, which he considered unsound. His own examination of the blood consisted in estimating the sp. g. the amount of chlorides and the freezing point of the fluid which is usually higher than in other conditions. To restore a normal state it is necessary to drive a stream of oxygen through it to relieve the chlorine-saturated serum. This form of treatment is also practised by Powell, Grey and others.

Bleeding is anti-pneumonic treatment, and need not be mentioned. There is a combination of bleeding and injecting a NaCl solution that seems reasonable where "ischemia" on the left side of the heart is relieved; at the same time, the diuresis is increased that washes off a large quantity of the toxic agent. In the treatment of pneumonia digitalis, antipyretics, alcohol, opium, ice, and a few others of this class were very questionable. In conclusion, he thought that each case required special treatment according to the symptoms. He firmly believed in the efficacy of baths, but thought there was no specific treatment.

In the discussion Mulier produced the statistics of the army for the last 20 years in Prussia, Saxony and Wurtemberg. During the whole 20 years there were 85,000 pneumonic cases recorded or an average of 4,100. When calculated according to the strength of the army the average was 12.7 per 1,000, which at the most averages only 6.8 per 1,000.

This happy result has undoubtedly been brought about by the sanitary condition of the barracks, and a more healthy state of the recruits. The mortality of these pneumonic cases

at the present time is 106 per annum, making it 15 per cent. of the total death-rate. If phthisis be excluded it will be reduced to 4 per cent. There is no particular form of treatment laid down for the army physician.

According to the case-book the average period for each soldier in hospital is four weeks. Jurgensen maintained that the hydropathic treatment was the most rational and efficacious as it supported the strength of the weak heart and relieved the temperature.

Remf strongly advocated the normal solution of sodium chloride in supporting the weak heart of pneumonia and improving the fluidity of the blood as well as encouraging diuresis. Rosenstein recommended an accurate percussion of the cardiac area, and as soon as the dulness had extended over the left and was approaching the right lung, accompanied with a frequent pulse, which was a dangerous prognosis, right side irritants should be commenced.

Smith loudly warned against the use of alcohol, as it endangered the life of the patient by producing cardiac dilatation. Paessler condemned the use of chloral hydrate as a sedative, as it caused vascular paralysis and increased the operation of the pneumococci by their accumulation in the vessels. Schultze thought that alcohol in drunkards would often be found useful. He recommended analeptics, coffee and camphor, but digitalis he had no faith in.

Naunyn was in favor of expectorants, particularly potassium iodide. Ergotin was an excellent remedy against collapse as it produced a higher pressure in the vessels.

Lenhartz thought that pneumonic patients did not die of heart and nerve enfeebleness alone, but of bacteriemia. The examination of the blood was of considerable prognostic value. Digitalis, in his mind, was the best tonic for the heart, as after 40 years of age the elasticity of the cardiac muscles was reduced.

Nothnagel recommended the hydropathic treatment, but for medicine he had no prompt remedy. Senator advised the use of alkaline mineral waters, or alkali hydrochloric, because they hastened the afflux in the bronchi.—Vienna correspondent *Medical Press and Circular*.

SURGERY.

IN CHARGE OF EDMUND E. KING, HERBERT A. BRUCE AND L. M. SWEETNAM.

Some Surgical Aspects of Vomiting.

The *Brit. Med. Jour.* for March 24th contains a paper by Mr. William H. Bennett which calls for some comment. After pointing out that in some instances the broncho-pneumonia which follows the administration of an anesthetic is due to the entry of vomited matter into the lungs, he rightly insists that the stomach should be empty before producing anesthesia, and this is all the more imperative in cases of fecal vomiting, because, apart from the risk of the vomited matter entering the lungs, it is in the highest degree desirable that any poisonous fecal matter in the stomach should be washed out.

But when Mr. Bennett attempts to differentiate between fecal vomiting that will get well without operation by "the casting off of the complaint" in the vomited matter, and cases of fecal vomiting that will end fatally if not operated on, we do not hesitate to say that he is unintentionally doing grievous harm by lending his name to such pernicious doctrine. Several cases are quoted in which recovery without operation took place after large quantities of fecal matter had been vomited, and in each of these Mr. Bennett noted that there was absence of progressive distension of the abdomen. Reasoning from these and probably from other unrecorded cases, he is of opinion "that in abdominal disease or injury, feculent vomiting, even when persistent, is no positive indication for surgical interference unless it is accompanied by increasing abdominal distension."

No one will doubt the accuracy of Mr. Bennett's observation, nor the significance of progressive abdominal distension, but are we to wait in every case of persistent fecal vomiting until it is evident that the abdomen is becoming extended?

For years, in season and out of season, surgeons have been insisting on the importance of early operation in cases of intestinal obstruction before the system becomes poisoned by the horribly offensive and highly toxic intestinal contents, and with emphasis we would add before the intestinal muscular tissue has become paralyzed and progressive distension of the abdomen becomes possible. Whatever value lies in Mr. Bennett's observation, it can only be applicable to abdominal cases, such as those of incarcerated feces, or impacted gall-stones, where the diagnosis does not preclude a cure by natural means; and we prefer to think that Mr. Bennett had these cases, and not "all cases abdominal disease and injury" in his mind at the time he wrote his article; and we hope he will seek an early opportunity

of amending a statement which, coming from so distinguished and well-known a source, cannot fail to do much mischief.

NOTE.—The above comments by Mr. Priestly Leech in the *Quarterly Med. Jour.* are, in our opinion, so appropriate that we reprint them without further comment.

Recent Investigations in Diabetes Mellitus in Children.

Bogoros is not able to furnish an exact definition of diabetes mellitus in children, since it has been proven that they can, under certain circumstances, excrete a considerable quantity of sugar in the urine without having diabetes mellitus. Bogoros states that experiments have shown that the liver, the pancreas, some parts of the nervous system, central and peripheral, the kidneys too, play an important part in the process of providing the tissues of the human organism with sugar. Thus, Seegen regarded the liver as the source from which the sugar in the circulation always comes; because, an hour after the *functional exclusion* of the liver, the blood is almost free of sugar. Tangl and Horiey, after the ligature of three intestinal arteries, found a considerable diminution of the sugar in the blood. As for the pancreas, the experiments of Mehring, Minkowski and de Dominicis are well known. These experiments proved that after the extirpation of the pancreas, sugar appears in the urine. Cavazzani, by stimulating the celiac plexus, was able to increase the elimination of sugar. Leven was able to do the same, by stimulating the peripheral extremity of the vagus. Morat and Dufourt had a similar result, by stimulating the splanchnic nerves.

It is clear then, that under the name of diabetes mellitus, are comprised many different diseases, which have one symptom in common, the presence of sugar in the urine. One of these forms is the diabetes mellitus of children. This disease is not very frequent in children. In pediatric literature different cases have been described, and from these we must infer that diabetes increases progressively from the first year of life. There have been related 13 cases in children under one year. The diagnostic difficulties, perhaps, may have an influence on the variety of the disease. Rungo relates a case in a newborn child. The diagnosis of diabetes mellitus in infancy is based on the existence of grape-sugar in the urine. We must never forget, however, that in infants reductive matters, as well as sugar, are not infrequently to be found in the urine. The experiments of Gros have shown that lactose is found in the urine of infants, especially when they are suffering from digestive disturbances.

Whenever we have to examine the urine only in small portions we ought to take that which is passed late in the day.

Von Noorden says that we must not limit the examination to the urine of the morning hours, or else we run the risk that many cases of diabetes will be overlooked. Posner, Epskin and others give the same warning. The prognosis is unfavorable according to Semtor, Stern, Kulz, Wegeli and Muller. Out of 500 cases of infantile diabetes on record, only 30 were cured; and of these 5 had a relapse. The appearance of *acetone* is a sign of a fatal ending; so also is rapid emaciation and the appearance of casts in the urine during and after the coma.—Translated from *Giornale Internazionale delle Scienze Mediche*, by HARLEY SMITH.

Cancer.

In anatomically impossible cases I do not think it is justifiable to refuse to operate in some fashion, if, after knowing the truth as to the hopelessness of the condition, a patient demands that an operation be done. In these cases the psychological effect of even an imperfect, partial removal of the offensive cancer sometimes is very beneficial, and puts off for months the inevitable morphine syringe, which we are compelled to use during the last weeks.—A. C. BERNAYS, *Philadelphia Med. Jour.*

Fractures of the Bones of the Leg.

Of 232 fractures of the bones of the leg, 41 were simple fractures of the bones of the leg, 41 were simple fractures of the tibia, 53 were simple fractures of both bones of the leg, 24 were simple fractures of the fibula, 14 were Pott's fracture of the fibula, 17 were compound fractures of the tibia, 7 were compound fractures of the fibula, 71 were compound fractures of both bones, 2 were simple fractures of both bones of both legs, and 3 were compound fractures of both bones of both legs.—*N. Y. Med. Record.*

Treatment of Scarlatinal Nephritis, by DR. ZIEMSSSEN.

We must first be convinced of this important fact, that the inflamed glands must not be excited in their functions. We can, however, produce free action of the skin, to relieve the kidneys. We can thus eliminate not only the water, but also the excrementitious substances of the urine. Of all the diaphoretic methods that which is most to be commended in grave nephritis is the *hot bath*, followed by wrapping up the patient in woollen coverings. Ziemssen declares that a long experience warrants him in recommending highly hot baths or baths progressively heated. The bath is heated according to Liebermeister's method. This consists in heating the bath by pouring into it hot water while the patient is in the bath, until the water is heated to 38° or even 42° C. After the bath the patient

is rolled in woollen coverings. The bath must last one or two hours, for not in less time does transpiration become free. Twenty years' experience, says Ziemssen, makes me consider Liebermeister's method as the best, in the different forms of renal dropsy. It is especially applicable to patients who cannot sit up. It is to be observed that the hot bath given every day produces only a slight action of the skin the first and second day, but that on the third day the transpiration becomes abundant. In serious cases of nephritis, where anuria is present and uremic symptoms threaten, the use of pilocarpine is indicated, in addition to the hot baths. Throughout the whole course of scarlatinal nephritis, milk renders excellent service, both as food and as medicine. Digitalis is also useful, and sometimes acetate of potash and ammonia. If a uremic condition does not exist it is well to abstain from drugs altogether. It goes without saying that during convalescence, when the disturbances of urinary secretion and especially the albuminuria have ceased, we must avoid with the greatest care everything that may bring on an excitement of the kidneys, such as alcohol, blisters and chills. If circumstances permit it is well to wear wool next to the skin and to live in a warm climate during severe weather.—Translated from *Journal de Médecine de Paris*, by HARLEY SMITH.

Sequelæ to Herniotomy.

(1) The wound may not unite by first intention, and if the sac has been very adherent the disturbance of the cellular tissue may cause some sloughing. In such cases the wound should be reopened and stuffed with iodoform gauze. (2) Diffuse general peritonitis may set in; this is known by the persistence of the vomiting, the continuance of the pain, distention, and tenderness of the abdomen, with elevation of temperature. This may be due to leakage from a perforation, to a gangrenous condition of the gut, or to the introduction of septic matter from without at the time of perforation, as in any other abdominal section. Immediate laparotomy should be done. (3) The reduced gut, which has been returned as suspicious, may become gangrenous and obstruction of the bowel may still continue. If this condition be suspected, the abdomen should be opened and the gangrenous bowel sought for, and either resected or incised, and kept outside the abdomen with the object of forming an artificial anus. (4) The bowel may not be gangrenous, yet be so injured that it may not be able to resume its proper functions, and the patient may die in consequence if not relieved by a laparotomy. (5) The bowel may be temporarily paralyzed by local inflammation so as not to be able immediately to resume its functions, though after some days it may recover completely

its normal condition. In such cases there is obstinate constipation, without vomiting or other signs of peritonitis. (6) Cases of acute mania have followed the operation for strangulated hernia, some of which have proved fatal.—SHEPHERD, "American Text-Book of Surgery."—*N.Y. Med. Record.*

Intestinal Perforation in Typhoid.

Operate unless the patient is moribund or not likely to stand the shock. Suture by the insertion of a series of fine sutures, after Lembert's method; free the peritoneum of all contamination; close partially, leaving in a gauze drain down to the region of sutures.—WARING.

Surgical Hints.

Never use morphine before anesthesia in patients who are in a state of stupor or traumatic shock. In these the drug has a distinct tendency to increase these conditions.

Never have any more assistants at an operation than are absolutely necessary. They are apt to get into each other's way, and the more people help you, the greater the difficulty of securing asepsis.

Excepting in emergency cases, every patient about to be operated on is entitled to as careful an examination as if he were applying for life insurance, and to treatment before the operation for any complicating condition.

There are certain patients in whom it is very desirable that they shall make no violent movements while they are being anesthetized, as for instance in certain fractures. In these cases a full dose of morphine an hour before the anesthesia will contribute a great deal to secure a quiet etherization.

When using cocaine hypodermically, it is seldom necessary to use a solution stronger than one per cent., and then always have the patient in a recumbent position. The danger of cocaine lies in the possibility of syncope from failure of the heart's action, and lying down is the best preventive.

When operating, never put too many instruments in one tray, as it becomes more difficult to find just what you want. It is best to have several small trays, and to put the cutting instruments in one, the artery forceps in another, and the special instruments required in the particular operation you are doing in a third.

During the removal of tumors having many attachments, it is a good principle to free first all the points that are easily detached, and to pediculate the tumor, as it were, where it is most

difficult to free it. This will usually result in the largest vessels being included in the pedicle, so that with your ligature or clamp you may safely secure the most dangerous region, and cut above it without danger.

In old ovarian lesions, it is often a fact that the patients show a decided insufficiency in the secretion of urea. It is well to subject such patients to preliminary treatment for this condition, for two reasons: The first is, that if the proper treatment increases the excretion of urea the patient will have a better chance of recovering from the operation; and the second is, that if the patient's urine shows no improvement, the prognosis is rendered more serious, and forewarned is forearmed.—*International Jour. of Surgery.*

Never prolong the anesthetic state beyond the minimum time for careful and accurate technique.

THERAPEUTICS.

IN CHARGE OF GRAHAM CHAMBERS AND J. T. FOTHERINGHAM.

The Diet in Dilatation of the Stomach.

Albu (*Deutsche Med. Woch.*) deprecates the practice, which has been set down first by von Swieten, and then faithfully recommended by various authorities and taken in by the profession at large, of keeping patients with dilated stomach on dry diet. Von Mering has demonstrated that the healthy gastric surface is possessed of a limited power of absorption, while Moritz, on the other hand, has shown that fluid food leaves the stomach sooner than soft diet; and again, mushy food enters the intestinal tract earlier than solid diet. The whole question of diet in gastrectasia therefore hinges upon the condition of the gastric motor functions, and should be regulated, not according to the existing anatomical lesion, but to the derangement of physiological efficiency. It seems, therefore, indicated to substitute, instead of the irrational dry diet, such a line of foods as will pass in the quickest, easiest, and most complete manner into the intestinal tract, as had been previously recommended by Liebermeister, Pick, Fleiner, and Kussmaul. The possible objection that fluid diet is to be deprecated on account of its reduced nutritive value holds good for water and thin soups. Milk, however, offers an ideal means of nutrition, and should be used in all possible combinations, especially with eggs and some of the artificial albumins (nutrose, plasmon, etc.), which, to the advantage of easy

solubility, join that of being capable of intestinal absorption. The finer vegetables—spinach, green peas and carrots in purée form, asparagus, cauliflower, baked apples—are to be recommended. Meat should be finely chopped. Calf-brains and sweetbreads, fowl (excepting geese), and white dry fish meats may be tried. Avoid beef, pork and game. Of pastry, nothing but light cakes and rusks should be allowed. The necessity of toasting bread hinges upon the dry diet fallacy and may be disregarded. Butter should be used in small quantities (not over one ounce a day). It may be advisable to follow thorough lavage of the stomach with the ingestion through the stomach-tube of an appropriate nutrient mixture.—*Medical Age*.

Disinfection by Formaldehyde.

Gorini (*Il Policlinico*), has made a series of experiments on the disinfection of surroundings by means of formaldehyde. The author found it a particularly useful disinfectant for large unfurnished rooms or places with a considerable unbroken surface. It is not advisable where there is much furniture or many crevices, owing to its small penetrating power. It is useful where the infective material is likely to be widely distributed. As to the dosage, good results were obtained by two grammes of formaldehyde to the cubic centimeter, used for twenty-four hours. The organism chosen as a test was the staphylococcus aureus.—*Medical Age*.

Treatment of Gonorrhœal Epididymitis with Salicylates.

Bettmann (*Munch. Med. Woch.*), treats this affection with a mixture of one part of pure methyl salicylate and two parts of olive oil applied to the scrotum and protected by gutta-percha paper and a suspensory bandage. The dressings are changed every two hours, and that the salicylic acid is absorbed is proven by the urine showing reaction of the salicylates after the application with the preparation. The objective course of epididymitis is not markedly influenced by this treatment, but there is a prompt relief from pain.—*Medical Age*.

The Anesthetic uses of Chloride of Ethyl.

Bloch (*Revue de Chirurgie*), believes that by means of chloride of ethyl, occasionally preceded by a few whiffs of chloroform, general anesthesia may be in the main dispensed with in major operations. He has operated in all on over 1200 cases, nearly one-half of them under ethyl chloride alone. In using the chloride of ethyl it is applied directly along the line of proposed incision, and the cut is made when the skin turns suddenly white and hard. Anesthesia will not, however, be

produced in inflamed tissues, unless the scalpel is so sharp that it can be driven through the frozen skin without making appreciable pressure. Bloch has operated upon sixteen cases of hernia, three tracheotomies, six colostomies, and one enterostomy under ethyl chloride alone. In his combined method the patient is first given about 15 to 30 drops of chloroform and allowed to inhale this for perhaps about two minutes. He then becomes drowsy or quite asleep. The tissues are then frozen and incised. If the patient experiences pain a little more chloroform is given. The healthy peritoneum can be incised but not pulled upon without giving pain. During the suturing of wounds there is usually some suffering. Rarely more than one to two teaspoonfuls of chloroform is required.—*Therapeutic Gazette*.

The Treatment of Atonic Ulcers by hot Irrigations.

Kindler (*Centralblatt f. Chirurgie*), treated, and with excellent results, a series of chronic ulcers by daily irrigations of two liters of water as hot as could be borne, flowing with a drop of six feet. These irrigations were repeated two or three times a day, and were followed by a dry rubbing with powdered iodoform or dermatol. He noted that chronic leg ulcers, perforating lesions of tabes, the slow and progressive erosions of tertiary syphilis, and phagadenic chancroids, were thus cured in a very short time.—*Therapeutic Gazette*.

The Value of Carbolic Acid as a Disinfectant in Surgical Practice.

Minervini (*Centralblatt f. Chirurgie*), noting that though carbolic acid is little used in large clinics and hospital practice it is very commonly employed by physicians in their private work, and is relied upon by them as an efficient germicide, conducted a careful study for the purpose of determining the true worth of this medium to the surgeon. He observed that solutions of ordinary strength were absolutely unable to disinfect either catgut or silk, and inclines to the belief that the drug is of little service, in so far as its use for the preparation of surgical materials or the cleansing of the hands is concerned.—*Therapeutic Gazette*.

Hyoscine Hydrobromate in Chorea.

Hyoscine hydrobromate has been tried by A. C. Rendle, of Madras, India (*Brit. Med. Jour.*), on a bad case of chorea in a youth of 16 years. He was thin and anemic; the temperature was slightly raised; the tongue was dry and coated with a brownish fur; the pulse was weak and the respirations irregular; there were constant involuntary movements. Albu-

min was present in his urine. Potassium bromide, chloral hydrate, and increasing doses of arsenic gave no relief. He was very restless at night, and morphine eased him slightly. Hyoscine hydrobromate doses of $\frac{1}{240}$ of a grain was injected hypodermically twice a day. On the day following the first injection there was marked improvement in the choreal movements. The dose was increased to $\frac{1}{100}$ of a grain and given three times a day. In a week the movements had almost entirely ceased. The hydrobromate was then discontinued and the arsenic treatment resumed. The patient made an excellent recovery. Chorea is an extremely fatal disease in India.—*Alienist and Neurologist.*

Chrysarobin a Specific for Warts.

Dr. G. M. Fitz calls attention to the excellent results which are obtained in the treatment of warts by solutions of chrysarobin. He first pares down the wart until there is rather profuse bleeding, and then applies a 10 per cent. solution of the drug, the vehicle being either ether or the ordinary gutta-percha solution. As a matter of fact, chrysarobin is by no means the only effectual means of dealing with these often refractory conditions of epithelial hypertrophy. The essential part of the treatment is unquestionably the removal of the thickened epithelium. When this has been done the application of chromic acid or a collodion solution of salicylic acid will, in most cases, cause the disappearance of the growths within a few days.—*Med. Press.*

The Treatment of Scabies.

Sherwell (*Journal of Cutaneous and Genito-Urinary Diseases*) states that for twenty-five of the now nearly thirty years of his active dermatological practice he has used the method of treatment which he describes, and that many of his colleagues and most of his students do the same. This treatment consists in the use of the washed flowers of sulphur, and is the cleanest, least disagreeable, and altogether the most efficient method at our command. The patient is directed to take a bath; using a little sand soap over the tougher portions, except in the case of infants. The body and limbs are rubbed lightly with a little of the sulphur powder. A half-teaspoonful is more than enough for each individual. The bed-linen and underclothing of all kinds are changed, and between the sheets or the coverings that comes next the person in bed a half-teaspoonful of sulphur is sprinkled. One of the sheets is lifted and a light blow given, which causes enough disturbance of the air to disseminate the powder over the whole internal surface. By repeating this application to the bed every other

or every third night, by bathing, and changing clothes in about the same way and at about the same interval for a week, a cure is effected in ordinary cases.

The male acarus is not a burrower. At the time the female has proruptured into the external world from below the epiderm, the male is either dead or certainly functionless.

Few cases or case groups last over the ninth day under this treatment.—*Therapeutic Gazette*.

Simple Catarrhal Conjunctivitis.

℞ Acidi boricī	gr. 40.
Sodii chloridi	gr. 6.
Aq. camphoræ,	
Aq. dest	āā ℥ 2.

M. Sig.: Apply as lotion to eye every two hours.—*Jour. Amer. Med. Assn.*

Dyspepsia and Gastro-Enteritis.

℞ Creosote (beechwood)	gtt. iij.
Alcohol	℥ xv.
Powd. acacia	℥ iiss.
Syr.	℥ j.
Aq. aurantii flor. fl	℥ iiss.
Aq., q. s. ad fl	℥ iij.

M. Sig.: A teaspoonful for children, a tablespoonful for adults, t. i. d., before meals.—*Zangger, Phila. Med. Jour.*

Angioma.

Blaschko (*Munchener medicinische Wochenschrift, Lyon medical*) recommends the following formula:

℞ Perchloride of iron.	
Chloride of zinc	āā gr. 15.
Hydrochloride of cocaine	gr. 1½.
Aq. dest	gr. 150.

M. Sig.: From half to a whole Pravaz syringe-ful to be injected every two or three days.—*N. Y. Med. Jour.*

Pain and Tenesmus of Dysenteric Diarrhea.

Taylor and Wells recommend the following analgesic suppositories:

℞ Cocain. hydrochlorate	gr. j.
Aq. ext. of ergot	gr. xij.
Aristol	gr. v.
Cocoa butter to make twelve suppositories.	

Sig.: One to be applied every hour or longer.—*Columbus Med. Jour.*

Sycosis of the Beard.

℞ Sulphur	ʒ ij.
Ol. rose	ʒ v.
Vaseline	ʒ j.

M. Sig.: Use locally, after removing loose hairs.—*Medical Summary.*

Urethral Inflammation and Ovarian Pain.

E. A. Ferrea, of San Francisco, Cal., contributes the following formula to the *Medical Summary* as one which has given satisfactory results :

℞ Potass. citrate	ʒ j.
Sodii bicarb.	ʒ ij.
Fl. ext. buchu	ʒ iv.
Fl. ext. corn-silk	ʒ ij.
Fl. ext. henbane	ʒ j.
Fl. ext. saw palmetto	ʒ j.
Decoct. dog-grass	q.s. ad ʒ viij.

M. Sig.: Teaspoonful every three hours.—*Jour. Amer. Med. Assn.*

OBSTETRICS AND GYNECOLOGY.

IN CHARGE OF ADAM H. WRIGHT, JAMES F. W. ROSS, ALBERT A. MACDONALD,
H. C. SCADDING AND K. C. McILWRAITH.

Puerperal Pyelo-Nephritis.

Vinay and Cade (*L'Obstetrique*, May 15th, 1899) report nine cases of this complication of pregnancy. The recognition of this accident is comparatively recent, because it has been confounded with cystitis. Compression of the ureters by the gravid uterus has long been known as an occasional determining cause of eclampsia, but it was not until the publication of Kruse's thesis (Wurzburg, 1889) that the profession was made aware of a special form of pyelo-nephritis in the pregnant. Three years later Reblaud reported the first compendious study of this affection, and since that time a number of important papers have appeared on the subject, including several theses.

The affection cannot be said to be of frequent occurrence, but is far from being a rarity. The nine cases of the authors occurred at the Hotel-Dieu Maternity since 1893. It may occur at any time after the fourth month. The etiology appears to be obscure, and many apparent contributory factors have been claimed without any proof. The immediate cause often appears to be in some way connected with pressure on

the ureters by the gravid uterus, and the right ureter is much more subject to this accident than the left, but this anatomical fact entirely fails to explain the origin of the disease, and is no more than an occasional contributory factor. Compression to some degree is far more frequent than is the disease in question. The latter is undoubtedly in some way dependent upon the presence of pathogenic bacteria, and there appears to be little doubt that the bacillus coli is found more frequently in the urine of these patients than any other germ, although the streptococcus has also appeared to be pathogenic in these cases. Reblaud believes that the bacillus coli reaches the urine of the pregnant woman through the intestines, and Bué claims that purgatives cut short the pyelo-nephritis.

The symptoms are obscure in but a few recorded cases. As a rule, the patient is stricken with grave manifestations, consisting of chills, fever, rapid pulse, malaise; and, in general, the clinical picture of a severe acute disease. Of symptoms especially referable to the disease, there are scanty dark-colored urine, which is albuminous, and within a few days purulent, with the usual picture of the urine of pyelitis associated with nephritis. The amount of urine is about one litre in 24 hours.

Examination reveals a normal condition of the bladder, as the tenesmus and incessant desire to urinate are not present, and there is no tenderness on pressure. On the contrary, exploration of the kidney reveals marked tenderness. The other viscera, as a rule, present nothing abnormal.

The disease usually pursues a rapid course, but resolution is not complete until the period of pregnancy has terminated, while relapses are of frequent occurrence. The disease occasionally returns with each succeeding pregnancy.

With regard to prognosis, fatalities are extremely rare, despite the severity of the symptoms. Delivery always exerts a favorable influence upon the disease, and hence those cases which develop late in the pregnancy tend to experience a more clear-cut recovery. There appears to be no evidence that the fetus is in any way compromised by the disease.

It is evident from what has been said that diagnosis is not usually difficult. Certain conditions like right salpingitis and appendicitis may require to be excluded. If the physician is himself a good microscopist, or has access to one, the diagnosis ought to be made without the least trouble.

The two indications for treatment are to ease the pain by rest in bed, and sedatives, and to disinfect the urinary tract. Vesicants should not be used, but morphine is not contra-indicated. The milk diet should be insisted upon, as in eclampsia. Intestinal antisepsis is imperatively demanded, and the authors recommend benzo-naphthol for this purpose.

Artificial delivery might be theoretically indicated in very severe cases, but, as death, convulsions, etc., have not thus far been recorded as accidents in this disease, one should think twice before deciding on this step.

Golden Rules of Obstetric Practice.

When abortion is inevitable, plug the vagina with strips of gauze or some clean, soft material, and wait six or eight hours. You will often find the ovum in the vagina on removing the gauze. If not, plug again and wait.

If any part of the ovum or decidua remains in the uterus, clean it out at once with the finger or curette, not hesitating to give an anesthetic if any difficulty is met with.

If there is a rise in pulse rate and temperature, and the vaginal secretion is foul, give an anesthetic, dilate the cervix, empty the uterus, scrape it clean, no matter what stage the process of abortion has reached.

In other words, use artificial dilatation, followed by emptying and cleaning out the uterus in threatened, incomplete and complete abortion alike, whenever the uterine cavity becomes the source of septic intoxication. FOTHERGILL.

A Mixture for Preventing Abortion.

Bossi, of Genoa, recommends the following mixture:

℞ Fluid extract of hydrastis,	}	each, 10 parts;
Fluid extract of hama-		
melis,		
Fluid extract of viburnum		
prunifolium,		
Tincture of piscidia,		
Laudanum.....	2	"

M. S.: Ninety drops, in half a glass of water, three times a day.—*N. Y. Med. Jour.*

"Tired Ovaries and a Hungry Womb."

We learn from the *British Medical Journal* for June 17th that the midwives of Manchester and the region round that city have formed a society and issued a volume of *Transactions*. From this volume our contemporary gives several specimens. In one of them, from a paper entitled Malthusianism, or Tired Ovaries, the author states that the forty-year-old virgin is rarely healthy, and the same is true of the married woman who resolves to have no more than one or two children—they are both afflicted with "tired ovaries," from constant ovulation and "a hungry womb."—*N. Y. Med. Jour.*

Typhoid Fever Complicating Pregnancy.

Although all infectious diseases are more serious when they occur during the pregnant or puerperal period, typhoid fever is one of those most likely to endanger the life of the fetus. Abortion or premature labor is produced in the majority of cases. According to Hare ("Medical Complications and Sequelæ of Typhoid Fever") the frequency of abortion is about 56 per cent. Other authorities give even a higher percentage of interruptions of pregnancy. Hirst states that 65 per cent. of typhoid fever cases, complicated by pregnancy, result in abortion or premature labor. The direct causes of the abortion may be either the continued high temperature, hemorrhage in the endometrium or membranes of the developing ovum, or the depressed condition of the mother with asphyxiation of the child. Typhoid may affect the fetus *in utero* and yet the child survive. The fact that the fetus may become infected by the transmission of germs of typhoid through the placenta, has been conclusively demonstrated by Giglio (*Centralblatt für Gynäkologie*, 1890, No. 46). One particularly interesting illustration of this fact reported by Eberth (*Centralblatt für Bakteriologie und Parasitenkunde*, May 13th, 1890) is the case of a woman who suffered from typhoid in the fifth month of pregnancy, and miscarried; and in the cardiac and splenic blood of the fetus the specific bacillus was found. Many recent observers have confirmed the statement made by Mossé and Fraenkel, in their report upon the agglutination test in the placental blood, made to the Société Médicale des Hôpitaux, that the Widal test can be obtained from the placenta, and that it is also possible to obtain it from the milk of the mother and the blood of the fetus even many days after parturition.

The maternal mortality in these cases ranges from 17 per cent. to 19 per cent., and although typhoid is not common in pregnancy, it is sufficiently so to make its study important. The majority of authorities do not agree with Cazeaux in the belief that typhoid, so far from being influenced unfavorably by the puerperal state, is even less grave than in the ordinary conditions of life. During the recent epidemic which disgraced the municipality of Philadelphia, many cases occurred during pregnancy and were carefully studied. In those instances in which the fetus survives it may be seriously affected by the prolonged infectious disease, idiocy having been noted in a considerable number of cases. The diagnosis presents no special difficulty if the physician has the advantage of seeing the patient early, although often when the miscarriage or premature labor occurs before the physician is summoned or the temperature recorded, some difficulty may be experienced. W. R. Wilson has called attention to the striking analogy

between puerperal septicemia and certain cases of typhoid fever. Both diseases present the common evidences of a septic infectious fever; both are likely to be characterized by abdominal symptoms and to show certain signs of nervous exhaustion, chief of which is delirium. Tympany, diarrhea, and splenic enlargement may also be present in both. The septic diarrhea which is often associated with the delirium and abdominal tenderness in septicemia, may make the differential diagnosis between the two conditions difficult and confusing. The points which aid in diagnosis are: The history of the case, the slowly developing prodromal stage, and the presence of the rose-colored spots. The characteristic temperature, the comparatively slow pulse with the added confirmation of the Widal test, will indicate enteric fever. The importance of the latter means of corroborating the clinical evidences of typhoid in any given case cannot be overestimated.

The treatment of typhoid complicating pregnancy does not differ materially from that employed in the non-pregnant woman. The controlling of the temperature and the maintenance of the patient's strength are the two chief considerations. No fear need be felt regarding the use of the cold bath or pack for the relief of the pyrexia, for it will not be the use of these methods, but the continued high temperature, which will be the cause of abortion or premature labor. The premature ending of gestation is far more likely to be produced by the pyrexia than by the energetic application of cold for the reduction of the fever. If abortion occurs, care must be exercised to prevent the retention of the secundines in the uterus and to produce subsequent involution which is apt to be tardy in such a state of impaired vitality.—*Phil. Med. Jour.*

Use of Normal Salines.

This subject has become such an important one, that Dr. J. D. Bovee's article, in the *American Journal of Obstetrics*, is very welcome. He gives the following as important points when the solution is given intra-venously, or by injection into the tissues:

1. The apparatus must be sterile.
2. The solution must be sterile.
3. It should reach the tissues at a temperature of 105° to 120° F. This is important as the stimulating properties of the high temperature are needed, and particularly in shock, renal insufficiency, uremia, eclampsia, and sepsis, as the skin must act strongly as an emunctory.
4. As a rule, one ounce per minute is the maximum quantity that can be safely introduced into the veins or subcutaneous tissue.

5. The tension of the arteries is the criterion as to the amount of the solution to be employed, though this does not hold good in sepsis. K. C. M.

Immediate Repair of Cervix.

The New York Obstetrical Society has published its "Transactions for the Year 1898-99." Many interesting subjects have been discussed, and amongst them the question of "Immediate Repair of the Cervix." On this question Dr. Thomas says: "The attempts which I have made towards repairing the cervix immediately after labor have taught me that it is extremely difficult to do. In support of this opinion I was rather pleased, not long ago, in looking over a work in gynecology by a member of this society, to see the statement made that, from a gynecological point of view, the procedure was not advised, on account of the difficulty in bringing the parts into proper apposition, owing to their extreme distortion at this time." This, we believe, to be correct. Our own practice is not to examine the cervix immediately after labor unless called upon to do so by hemorrhage, hemorrhage also being the only indication for immediate repair. K. C. M.

Plugging of the Uterus in Abortion.

Dr. J. Keogh Murphy (*Treatment*, December 28th, 1899), in a thesis for the M.D. degree of the University of Cambridge, says:

"I would venture to put forward what I consider to be safe rules for the employment of plugging: 1. Plugging may be considered to be good treatment—indeed, the best—in cases of inevitable abortion, where the hemorrhage is very serious, and the os contracted so that neither a finger nor the curette can be passed into the uterine cavity. 2. In such cases plugging should only be used as a means of stimulating uterine contractions so as to obtain sufficient dilatation of the cervix to be able to empty the uterus. 3. Under no circumstances should plugging be used in incomplete abortion.

"Plugging, indeed, in cases of abortion only finds its place in the first three months of pregnancy; here the hemorrhage may be very alarming before there is any dilatation of the os—indeed, I consider the earlier the pregnancy, the graver the hemorrhage is likely to be. After the third month the hemorrhage is not likely to be severe before the os is sufficiently dilated to allow the finger to be introduced.

"I consider, even in the early months of pregnancy, the cases where plugging is really needed are very rare indeed. To illustrate from my own cases: out of nearly four hundred cases I only had to plug the vagina three times, and in one of these

it was quite unnecessary; but I had no curette with me at the time, and the woman had lost a very great quantity of blood. Most certainly, when used, plugging *was* effectual; it completely controlled the hemorrhage, and after the plug was removed the os was found to be sufficiently dilated.

"The advantages of plugging, to my mind, are: 1. That it is not a safe operation unless done with great cleanliness, and aseptic materials, the great pressure around the cervix causing ready absorption of septic material. 2. If it is to be effectual, it is a very painful operation, necessitating an anesthetic. 3. It is a temporary, not a final, measure, requiring to be repeated perhaps indefinitely.

"To shortly enumerate the routine of the operation itself which should be followed: A vaginal douche should always be given, the vulva being first cleansed with soap and water. The bladder and rectum should be always emptied before plugging. A speculum is really never needed, two fingers of one hand pressing down the perineum being much better, a speculum giving rise to difficulty in withdrawal and loosening of the plug. If possible, plug round the cervix with gauze, but for the vagina I would strongly recommend small balls of absorbent wool wrung out in an antiseptic, preferably lysol; the kit¹ of lint soaked in oil and fastened together by strings, recommended by some authors—a wonderful and fearsome device—should be eschewed.

"The plug should always be removed in twelve hours at the longest, and the vagina douched again after removal, care being taken to see that no plug is left behind in the fornices. For this reason I advise a single piece of gauze round the cervix. In such cases the use of the catheter will seldom be required owing to the preceding loss of blood. If plugging be done at all, it should be thoroughly done; it is not easy to err on the score of tightness, short of actual violence. The necessarily large consumption of cotton wool should not be feared, remembering that a plug to be of any use at all must not only fill but distend the vagina and press up the uterus."

The author then recommends boldly emptying the uterus by the finger or by the curette as soon as the cervix is sufficiently dilated to do so. This he believes to be the correct treatment in all cases, and he would even recommend it to be done in all cases where hemorrhage, even though slight, continues, for here we may be certain that the abortion is incomplete.

The author submits the following conclusions: 1. Plugging in early abortion is rarely necessary, and when employed should be used only with the definite hope of dilating the cervix. 2. Ergot and other drugs should not be used unless the case is complete, and they will then be unnecessary. 3. In about five

per cent. of all cases (twenty to four hundred) operative removal of the ovum must be undertaken. He would advocate the early and thorough treatment of inevitable and incomplete abortions, as well as the entire safety of the treatment.—*N. Y. Med. Jour.*

Treatment of the Navel.

The chief principles to be observed in the treatment of the navel following birth are, according to A. Ahlfeld (*Centralbl. f. Gyn.*, Nor. 13, p. 337), shortening of the cord to the recognized minimum, touching up the stump and vicinity of the navel with 95 per cent. alcohol, then placing a layer of sterilized cotton which is to remain on for five or six days, only being removed in case of its becoming moist with urine. Especially may it be noted that after the birth of the child the cord is to be cut about 3 to 4 inches from the navel, after carefully tying it off with linen tape. Then, after the bath, the secondary shortening is to be performed. This consists in tying off the cord about two-fifths of an inch from the navel and a little beyond this the cut is made. Now the aforementioned moistening with alcohol is to be done and the sterile cotton wrapped over it. The author never uses silk ligatures for tying off the cord, as it frequently happens that a hematoma of the cord follows a too tightly applied silk thread. The suggestion that a cautery-scissors be used to cut off the cord about one-half inch from the child's abdomen, Ahlfeld scores as being too dangerous in its application.—*Medical News.*

Dr. W. E. Gimby, of Chesley, and Dr. J. H. Gimby, of Bedford, sailed on the 12th ult., per Dominion Line for Liverpool. They purpose spending a few months in post-graduate work in Europe.

We are pleased to announce that Dr. J. T. Duncan of this city, will, in association with Dr. G. S. Ryerson, have charge of the department of ophthalmology.

Book Reviews.

The Pathology and Surgical Treatment of Tumors. By N. SENN, M.D., Ph.D., LL.D., Professor of Surgery, Rush Medical College, in affiliation with the University of Chicago; Professor of Surgery, Chicago Polyclinic; Attending Surgeon to the Presbyterian Hospital; Surgeon-in-Chief, St. Joseph's Hospital, Chicago. Second edition, revised. 16mo. 718 pages. Illustrated by 478 engravings and 12 full-page plates in colors. Philadelphia: W. B. Saunders. 1900. Toronto: J. A. Carveth & Co. Price, cloth, \$5.00; half morocco or sheep, \$6.00.

This is an old friend, brushed up and brought up to date. Many new illustrations have been introduced, as also "a new section on Sarcoma of the Decidua," and an account of recent work by Roncali, of Rome, and others in the investigation of the subject of the parasitic origin of malignant tumors.

To those of us who have had the pleasure and advantage of seeing and listening to Dr. Senn in his large and instructive clinic, the book brings back many pleasant and profitable reminiscences, and we wish to congratulate him and to again thank him for the opportunities just alluded to.

We congratulate the publishers also on the re-publication of this outcome of Dr. Senn's laborious and painstaking work, and also upon the handsome appearance of this and the former edition.

One more personal remark and we are done. It is a pleasure, from a social standpoint, to remember that some of the finishing touches were given to the first edition by Dr. Senn whilst on a holiday (?) tour in Toronto and other parts of the Dominion.

The Anatomy of the Brain. A Text-book for Medical Students. By RICHARD H. WHITEHEAD, M.D., Professor of Anatomy in the University of North Carolina. Illustrated with forty-one engravings, 6¼ x 9½ inches. Pages v.-96. Extra vellum cloth, \$1.00, net. The F. A. Davis Co., Publishers, 1914-16 Cherry Street, Philadelphia, Pa.

This is a neat, concise little work which we feel sure will be highly appreciated by "medical students," including those like ourselves, who have been long enough in practice to need brushing up. To such it will be found a most useful, convenient, and suitable "handy book," printed on good paper, with clear engravings and type.

A Hand-book for Nurses. By J. K. WATSON, M.D. (Edin.), late House Surgeon, Essex and Colchester Hospital; Assistant House Surgeon, Sheffield Royal Infirmary and Sheffield Royal Hospital. American Edition, under the supervision of A. A. STEVENS, A.M., M.D., Professor of Pathology in the Woman's Medical College of Pennsylvania; Lecturer on Physical Diagnosis in the University of Pennsylvania; Physician to St. Agnes' Hospital, Philadelphia. Philadelphia; W. B. Saunders. 1900. Toronto: J. A. Carveth & Co. 413 pages. 72 illustrations. Price, cloth, \$1.50.

On perusing this work we were struck with the characteristic which we afterwards found announced in the preface, that it is the endeavor of the author "to supply in one volume that information which so many nurses at the present time are trying to extract from various medical works. . . . The subject of nursing *per se* has been confined to one chapter." Various points of anatomy, physiology, therapeutics and hygiene are sketched in a manner suitable for the informing of the nurse. We would have liked to see more information given on matters hygienic; and we do not exactly understand what the author means when discussing the question whether 2,000 or "1,200 cubic feet of air are required for each patient in a ward." Does he mean air space? We would also point out that the temperature of 60° may suit in England, but it is too low for our wards on this continent. We take this opportunity of saying also that we think the writers of our profession ought to try and guard the "well of English undefiled," and not slip into such colloquialisms as "learnt" for "learned."

It must not be thought, however, from our trying to stir the author and others up to greater care that we do not appreciate the work, which we think will be a most useful addition to the nurse's library.

Practical Manual of Diseases of Women and Uterine Therapeutics for Students and Practitioners. By H. McNAUGH-
TON-JONES, M.D., M.Ch., Master of Obstetrics (Honoris
Causa) Royal University of Ireland, President of the British
Gynecological Society, etc. Eighth edition, revised and
enlarged, with 640 illustrations and 28 plates. Price, 18s.
net. London: Bailliere, Tindall & Cox., 20 and 21 Wil-
liam Street, Strand, 1900.

The author in his preface refers in detail to certain advances in gynecology during the past few years, especially as to operative procedures. In consequence of such advances, and

on account of clearer views with reference to vexed questions, pathological and clinical, he has found it necessary to completely re-arrange, in great part re-write, and considerably modify former editions of the work. This eighth edition is therefore, practically a new book.

In the first place he gives a summary of clinical hints together with anatomical facts, which have a bearing on gynecological practice. This combination of the clinical with the anatomical makes the chapter very interesting. He then explains the proper method of making a systematic and careful examination when such is actually required, giving illustrations of all the instruments, tables, etc., that are required. Then follows a chapter on asepsis and antisepsis, in which he explains the terms, and describes his methods, referring at the same time to the views and methods of several authorities in Europe and America. After describing some minor gynecological operations he takes up disorders of menstruation, uterine displacements, uterine reflexes, inflammation of the uterine tissues, perimetritic inflammation, pelvic hemorrhages, uterine neoplasms of all kinds, together with the operative procedures to the methods of treatment. He then treats the affections of the other organs which are of interest to the modern gynecologist. The book is written in a clear style, and is quite up to date in all respects. It will be found useful and interesting to both students and practitioners of medicine.

The International Text-Book of Surgery. By British and American authors. Edited by J. COLLINS WARREN, M.D., LL.D., Professor of Surgery in Harvard Medical School, Surgeon to the Massachusetts General Hospital; and A. PEARCE GOULD, M.S., F.R.C.S., Surgeon to Middlesex Hospital, Lecturer on Practical Surgery and Teacher of Operative Surgery Middlesex Hospital Medical School, Member of the Court of Examiners of the Royal College of Surgeons, England. Philadelphia: W. B. Saunders; Toronto: J. A. Carveth & Co. 1900. Vol. II., 16mo, 1072 pages, 471 engravings and 8 colored full-page plates. Cloth, \$5.00; sheep or half morocco, \$6.00.

We pointed out in our last issue some of the pleasing features of this international work.

This second volume keeps up our high opinion of the work as a most valuable collection of surgical essays by various masters, both English and American. Amongst the contributors will be found the names of some whom we have gladly welcomed and heard at several of our annual gatherings in Canada, and also that of one of our fellow-citizens. The following is the

list: Robert W. Abbe, William T. Bull, James Cantlie, William Bruce Clarke, William B. Coley, E. Treacher Collins, H. Holbrook Curtis, John B. Deaver, Christian Fenger, A. Pearce Gould, M. L. Harris, Rudolph Matas, Andrew J. McCosh, J. Ewing Mears, Robert W. Parker, James J. Putnam, W. P. Dandridge John W. Elliot, W. H. Forwood, J. Orne Green, Ferdinand Henrotin, Charles McBurney, Lewis S. McMurry, John Murray, George A. Peters, A. W. Mayo Robson, William L. Rodman, H. Tuholske, J. Collins Warren, Charles A. Siegfried, Weller Van Hook.

A Practical Treatise on the Sexual Disorders of the Male and Female. New (2nd) edition. By ROBERT W. TAYLOR, M.D., Clinical Professor of Venereal Diseases in the College of Physicians and Surgeons, New York. In one handsome octavo volume of 435 pages, with 91 illustrations, and 13 plates, in colors and monochrome. Cloth, \$3.00 net. Philadelphia and New York; Lea Brothers & Co.

Nordrach at Home; or, Hygienic Treatment of Consumption. Adapted to English home life. By J. J. LUCAS, B.A., M.R.C.S. Bristol: J. W. Arrowsmith. London: Simpkin, Marshall & Co.

This little volume of 60 pp. gives much useful information. It is specially intended for the general reader, but there are points in it of no little interest for the medical reader. It would be well if such a little book had an extensive sale among the community. At this time when the public is being aroused to the importance, both of the prevention of tuberculosis and its sanitary management at home, such a book is bound to do good.

The American Year-Book of Medicine and Surgery. Under the general editorial charge of GEORGE M. GOULD, M.D.

This volume consists of 650 octavo pages. The subjects reviewed are: "General Medicine," by Drs. Stengal and Edsall; "Pediatrics," by Drs. Starr and Hand; "Pathology," by Dr. Riesman; "Nervous and Mental Diseases," by Dr. Church; "Cutaneous Medicine and Syphilis," by Drs. Duhring and Hartzell; "Materia Medica and Therapeutics," by Drs. Wilcox and Stevens; "Physiology," by Dr. Stewart; "Legal Medicine," by Dr. Wyatt Johnston; "Public Hygiene and Preventive Medicine," by Dr. Abbott, and "Physiological Chemistry," by Drs. Jones and Hunt.

This work appears annually, and with its companion volume on surgery gives a very full account of the year's progress in medicine and surgery. The several sections are well written. The best in medical literature has been placed under tribute for the material from which the present volume has been made. This becomes apparent on reading the work.

Dr. Gould has performed his share of the work well. To those who desire a year-book it would be difficult to imagine a more complete one than the present work. Throughout its pages there are a number of very excellent illustrations.

The work is published in the well-known attractive form of W. B. Saunders, of Philadelphia. J. A. Carveth & Co. are the Toronto agents. The price per volume is \$3.00, in cloth.

Proceedings of the Davenport Academy of Natural Science.
Vol. VII. 1897-1899.

This volume is published at the expense of the Putnam Memorial Fund. The articles are of considerable interest and high merit. The volume is well illustrated. The frontispiece is a beautiful photogravure of the late Charles Edwin Putnam. Those engaged in the study of general science will find this and the previous volumes of much value. The price, in paper, is \$4.00, and can be obtained through Prof. W. H. Barris, Davenport, Iowa.

Mr. W. B. Saunders wishes to announce the final accomplishment of a step that he has long had in mind. Feeling that the growth of the business to its present large proportions has been due, not alone to his own exertions, but quite as much to the efficient co-operation of a number of his employees, he has decided to give recognition to such service by associating with himself in business, under the firm name of W. B. Saunders & Company, Mr. F. L. Hopkins, manager of the Subscription Department, and Mr. T. F. Dagny, manager of the Publication Department. These gentlemen have been connected with the establishment almost from its inception, and to their capable management of their respective departments Mr. Saunders attributes much of the success that has attended his efforts. Mr. Saunders believes that this action will strengthen the position of the house in the eyes of the medical profession, as it will secure a permanence of organization that will ensure the perpetuation of the business. Besides this, it will obviate the disadvantages incident to a large business that rests entirely upon the shoulders of one person, by permanently attaching to the house those whose ability and experience have contributed

in bringing the business to its present state of prosperity. The Subscription and Publication departments will be conducted as heretofore. The Trade Book department will be under the management of Mr. W. D. Watson, whose connection with the house has extended over the past eight years, and who has demonstrated his ability to manage that department with efficiency and success.

Selections.

THE TREATMENT OF GONORRHEA BY METHYLENE BLUE.—Specifics for gonorrhœa are nearly as plentiful as panacœa for tuberculosis and meet with about an equal measure of success. This, however, would not justify a refusal to take cognizance of plausible suggestions for treatment, indeed the very futility of existing methods of treatment constitutes, on the contrary, a reason why we should be on the *qui vive* for useful suggestions. The latest departure is the use of methylene blue internally and as an injection. This anilin compound is reputed to exert a specific influence on the gonococcus, but it is also fatal to the various pyogenic bacteria of mixed infections. In an interesting article, embodying considerable personal experience with the drug, Dr. O'Neill, of New York, describes the method which he has found to answer best. He does not say much in favor of urethral injections of this agent which are inconvenient on account of its marked staining properties, but he advocates its internal administration in four one-grain doses daily. The formula which experience has shown to be safe and serviceable, is as follows: Methylene blue, 1 gr. ; oil of nutmeg, 1 gtt. ; oil of sandalwood, 2 gtt. ; put up in gelatine capsules. It is claimed that by this method a cure may be effected within a fortnight, or even less, but we are not in a position to affirm that equally good results will be obtained under different climatic conditions, for many of these rapid "cures" seem to fail when transplanted to our latitude.—*Medical Press and Circular*.

URIC ACID AND ITS ELIMINATION.—Editorially (*The Medical Brief*, February, 1900) this vital subject is ably considered. Investigation strengthens the belief that eating too much meat is responsible for the formation of uric acid in disease-producing quantities. To dispose of meat satisfactorily gastric digestion must be active, the constitution well supplied with fluids and the organs more or less actively engaged in growth and development. These conditions cease to exist when adult life

is reached and the requirements of the constitution are chiefly for food to supply energy, heat and vital stimulus. At this period in life a small amount of meat or other albuminous food will suffice, especially in torpid systems or persons of sedentary habits. The symptoms caused by an excess of uric acid depend upon the degree of saturation and whether these morbid products are circulating in the blood or are precipitated in the tissues or joints. The susceptibility of the various organs and the constitution of the individual also help to determine the symptoms; one person may have asthma, another an irritable bladder, and another sick headache or rheumatism. In the treatment diet is highly important. Meat once a day is often enough. Fresh fruit, especially apples, should be eaten in abundance. Tomatoes are excellent, so is asparagus. Baked bananas and well-done rice are excellent substitutes for meat. Pure honey is always allowable. In uncomplicated cases lithiated hydrangea will be the only remedy needed in addition to dietetic reform and plenty of water.—*Ex.*

Miscellaneous.

DON'T ANSWER IMPERTINENT QUESTIONS.—Impertinent questions are to be met with firm and dignified politeness. Any question about another's personal affairs, about the price of one's clothing, the amount of one's earnings, the reasons one has for entirely private conduct, is impertinent. Would I answer such questions? Not at all. Usually, by a little tact, one can settle such questioners. If there is no other way, I counsel a plain but courteous sincerity—a simple refusal to answer. One may just say: "Pardon me, I prefer not to give any information whatever on this matter."—MARGARET E. SANGSTER in the *April Ladies' Home Journal*.

L'HOMME A LA FOURCHETTE.—Lausseur, the man whose name has been immortalized in connection with the fact that he was the patient from whose stomach Labbé, the great French surgeon, first performed gastrotomy for the removal of a fork, has just died, twenty-five years after the operation. *L'homme a la fourchette* created an immense sensation at the time, as it was the first occasion on which a foreign body had been removed from the stomach by a surgical procedure. Inasmuch as the operation really consisted in cutting down on an abscess in the region of the umbilicus, and the removal of the fork, which was projecting into the wound, it was not strictly speaking, gastrotomy.—*Medical Press and Circular*.

Gunshot Wounds with Mauser Bullets.

From the accounts published of the wounds inflicted on our troops by the Mauser bullets it may be inferred that it is, so to speak, a humane bullet, usually occasioning but little pain or hemorrhage in traversing the body and limbs of the soldier. This may be adduced in its favor in contrast with the vastly more destructive effect of the old spherical bullet of bygone wars, or the big Snider bullet of more recent times. The special features of the Mauser bullet wound probably owe their character to its greater velocity and smaller diameter than the other projectiles, with consequently less strain upon the tissues through which it passes. There may be a modulus of elasticity inherent in the human tissues, which is exceeded by the passage through them of the more slowly moving and more bulky old round bullet, which causes them to give way and be torn and disrupted from their connections beyond the immediate track of the projectile. This collateral action would give rise to extreme pain, and cause laceration of blood vessels and nerves beyond those actually cut by the foreign body in its track. On the other hand, the swifter, less bulky and more pointed bullet would probably glide through the tissues under the modulus of their inherent elasticity, thus leaving them in a condition to close again after the passage of the projectile, and so sealing up the track from bleeding. This unimpaired elasticity would allow the nerves and blood vessels to resume their normal positions without being torn or overstretched, and would account for the diminution of pain and hemorrhage following wounds by the Mauser and similar gunshot missiles. The aseptic character of these rifle wounds may possibly be explained by there being less air and *débris* driven in front of the pointed and narrower bullet. Waves of air are seen in instantaneous photographs to precede the missile like a buffer, and the wave of air following the base of the ball would in a great part be shut off by the sphincter action of the elasticity of the penetrated tissues. Under the above circumstances grave shock to the system would be minimized in consequence of the lightning-like transit of the bullet through the body, provided it does not endanger the integrity of nerves or blood-vessels.—*Medical Press.*

“What happens to be the matter with your father?” inquired the doctor, as he hastily put his clothes on.

“He’s got the lumbago,” replied the boy. “I think that’s what maw says it is.”

“Pain in the small of the back, I presume,” said the doctor.

“No, sir; he hain’t got no small of the back. My paw weighs 28½ pounds.”—*Charlotte Medical Journal.*