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NOTES OF FIVE CASES OF PHLEGMASIA DOLENS—WITH TREATMENT.*

BY J. M'WILLIAM, M.D., THAMESFORD, ONT.

In speaking of the progress of Phlegmasia Dolens, Playfair says: "After the acute stage has lasted for a week or a fortnight, the constitutional disturbance becomes less marked, and the pulse and temperature fall, the pain abates, and the swelling and tension of the limb now begin to diminish, and absorption commences. This is invariably a slow process; it is always many weeks, and it may be many months before the effusion has disappeared."

In speaking of the treatment, he says: "What has been said of the pathology of the affection, tends to the conclusion that active treatment of any kind, in the hope of curing the disease, is likely to be useless; our chief reliance must be on time and perfect rest," etc.

It is in view of these statements that the following notes are submitted to the Association:

Mrs. S., confined June 10th, 1887, labor protracted and terminated by forceps, considerable *post-partum* hæmorrhage. Did fairly well till June 18th, eight days after confinement, when she had a chill, followed by fever and sweating; for this quin. sulph. was prescribed. On June 22nd, twelve days after confinement, she began to complain of pain in left knee and groin; temperature 102.5°, pulse 106, also more or less stiffness and pain in all the extremities. In the previous April she had suffered from a mild attack of acute inflammatory rheumatism, which yielded promptly to soda salicylate. Her own impression was that she was now attacked in the same way, and had

*Read before the Ontario Med. Association, June, 1891.

a return of her rheumatism. I was in doubt myself as to the exact nature of the trouble, though some tenderness in the iliac veins, and also in the popliteal spaces, made me suspect that phlegmasia dolens was the trouble. I ordered a cathartic of magnes. sulph. and infusion of senna, as the bowels were constipated, and soda salicylate in the following prescription:—

R—Acid. salicylic, ʒ iij.
Sodæ bicarb., ʒ ij.
Aquæ, ad., ʒ̄ vj.M

Sig.—Two teaspoonfuls in water every three hours till sweating freely, then every four or six hours.

June 23—Pain not any worse, swelling in whole left thigh, and distinct tenderness along course of femoral vein, also pain in calf, which was slightly swollen; pulse 90, temperature 100° F. The disease was now undoubtedly phlegmasia dolens and not rheumatism; sweating very profusely; ordered the salicylate every six hours.

June 25—General condition much the same; the limb more swollen, tender and red along course of large veins; ordered salicylate every three hours, as it seemed to be controlling the pain and fever. Right limb showing signs of the disease.

June 26-28.—Continued much the same, except that swelling was less. Fever gone in the mornings, pulse 70° to 80°; salicylate continued at greater or less intervals as the sweating was more or less profuse.

June 29.—Patient was decidedly worse, swelling and pain had set in more severely in right calf and thigh. Temperature 103.4°, pulse 115; swelling, pain and tenderness in left limb abated. From this I judged that the salicylate might be doing some good, and continued it every three hours till profuse sweating or head symptoms supervened, when the time between the doses was lengthened to four or six hours.

June 30—July 3.—The symptoms in the left limb had nearly disappeared, nothing but stiffness remaining. The right limb, the second one attacked, was also much improved, no pain of any account being present except when the limb was moved. The characteristic white color was never so marked in this limb as in the first.

July 6.—The fourteenth day of the disease, the patient was much improved, some stiffness

still in limbs, but swelling and pain all gone; some tenderness along iliac veins and in popliteal spaces; appetite fair, tongue cleaning. In the meantime the salicylate had been discontinued and tonics substituted for it, and on July 12th, twenty days after the beginning of the disease all trace of it had disappeared, and the patient was able to be about the house and do her own housework.

CASE II.—Mrs. C., confined July 11th, 1887; confinement normal, terminated naturally in six hours; no hæmorrhage; patient very weak and extremely anæmic.

Six days after confinement phlegmasia dolens set in, and during the next three days both limbs developed all the characteristic signs of phlegmasia dolens; pain was extreme. In addition to means for relieving the pain, soda salicylate was given as in the former case. This the stomach, not good to begin with, bore for three days when it had to be stopped; twenty-four hours after stopping it the pain and tenderness became more intense, and the amount of morphine taken produced retention of the urine. On the sixth day the salicylate was again prescribed and given in cold tea, and less morphine was given. This was followed in six hours with profuse diaphoresis with much abatement in the pain, lowering of the fever, and a decided improvement in the pulse. Three days after this, on the ninth day of the disease, the patient was very weak; retention again came on, though the febrile symptoms were much abated and pain much less, the swelling and tenderness also being less marked. Consultation was suggested, and the consulting physician thought that the salicylate had had a sufficient trial, and that it would be unwise to follow it up in the weakened condition of the patient, suggested ammonia and digitalis instead of continuing local treatment the same. Two days after this, the eleventh day of the disease, the patient's stomach had improved somewhat, but the limbs were more painful and tender along the course of the veins. Salicylate was again prescribed with a more or less complete fall in the temperature, and great cessation of the pain within six hours. This was continued as the stomach would bear it, till August 2nd, the fifteenth day of the disease, when all fever having disappeared, and very little pain being complained of, this was replaced by tonics of iron, quinine, etc.

This patient made a very slow recovery, owing to the previous existing anæmia, but by August 9th was able to be about the house and take charge of her household duties, though not able to do heavy work. The swelling, pain and tenderness in the limbs had almost entirely disappeared.

CASE III.—Mrs. C., confined April 1st, 1888. Labor normal, patient delicate and weak, but did fairly well till April 12th, when phlegmasia dolens set in in the left limb, with the usual symptoms of the disease. Soda salicylate and morphine were prescribed internally, while anodyne lotions and warm stupes were applied externally.

April 19.—Eighth day of the disease, pain and tenderness has greatly left the left limb, and the swelling is much reduced, but the disease is beginning to appear in the right limb. The temperature and pulse are higher than for the last three days. The salicylate, which had been lessened for several days, was now given again in full doses every three hours.

April 25.—The thirteenth day of the disease, pain almost entirely ceased in both limbs, some tenderness in both calves, and considerable swelling, more in the left, the one first attacked. The patient was now put on beef, iron and wine, and other tonics, and was about the house at work with no symptoms of the disease on May 11th, twenty-six days after the onset of the disease.

CASE IV.—Ella R., aged 16, unmarried, confined January 11th, 1889. Labor protracted, terminated by forceps twenty-four hours after it had set in. Fourteen days after delivery her father came to see me, and told me his daughter had been taken two days before with a high fever, and great pain in her left thigh which was now much swollen and very tender. I gave her father a bottle of soda salicylate and anodyne liniment, and ordered warm poultices to the affected parts, also a dose of black draught to move the bowels. I was unable to see her for forty-eight hours after the above treatment was begun. I found her then with a pulse of 144, temperature 101.5°, and a most typical case of phlegmasia dolens as far as the appearance of the limbs showed. A mixture of digitalis and ammonia was added, and the salicylate continued every six hours. The symptoms gradually abated until the 11th of February, or seventeen days after the treatment

was begun, all pain and most of the swelling and tenderness had disappeared, and the patient was able to sit up and be dressed, and was married on that day. In this, as in the other cases, tonics were given for a time, but the limb had completely recovered its functions and appearance, within three weeks after the onset of the disease.

CASE V.—Mrs. D., delivered of twins April 23rd, 1889, version being performed for the delivery of the second child by the attending physician, much hæmorrhage, patient very weak. Phlegmasia dolens set in eleven days after confinement, not severe, but both limbs were affected. The same course of treatment was pursued as in the other cases, with the result that on May 15th, eleven days after the disease set in, all trouble with the limbs had disappeared, and the patient though weak, was able to be up and about the house.

From the foregoing cases I would infer :

First—That we have in salicylate of soda a remedy that does modify the disease to a very great extent. I think I may fairly claim that it obviates almost entirely the tendency of the disease to become chronic.

Second—That to obtain this result, the drug has to be pushed to get its full physiological action, and persevered in for at least six or eight days.

Third—That the reason the drug does not seem to act with such promptitude as it does in rheumatism is :

(a) That the subjects of phlegmasia dolens were very anæmic and weak, and consequently bad subjects for the exhibition of such a drug as soda salicylate.

(b) That in phlegmasia dolens we have an inflamed condition of veins to overcome as well as a morbid condition of the blood.

Fourth—That the treatment of phlegmasia dolens by soda salicylate rests on as reasonable grounds as that of acute rheumatism. As, if we grant that rheumatism is due to the blood sepsis, arising from the presence of a special germ in the organism, and that soda salicylate is a potent remedy, and more or less effectual antidote for that condition, it is not unreasonable to suppose that it would be quite as effectual in the treatment of phlegmasia dolens. For without claiming any necessary relation between the two diseases, they seem to have some points in common, as for

example, the condition of anæmia, and the excess of fibrin in the blood that exists in the majority of cases, the proneness of each to become chronic, and, lastly, should the result of my experience be borne out by further clinical observations, we will have another striking similarity, in that both diseases are beneficially affected by the action of the same drug, soda salicylate.

NOTES OF CASES.*

BY ALFRED J. HORSEY, M.D., M.C.R.S., E., OTTAWA, ONT.

TRACHOMATOUS KERATITIS, (OR PANNUS SARCOMATOSA.)

James H., aged 24 years, a well nourished and robust young man from the country, kindly referred to me by Dr. Rogers, consulted me on account of failure of sight and soreness in his left eye, which had been steadily growing worse since February last. His vision in this the left eye = only $\frac{6}{30}$ or $\frac{20}{100}$, the second line of Snelling's wall type, while his right vision = $\frac{6}{6}$, or the last line. The upper lid was thickened, drooped, and moved sluggishly over the upper half of the globe. Involving both conjunctiva and cornea, and extending over the pupillary margin was a thickened network of vessels and membrane, giving the eye a reddened and inflammatory appearance, known as pannus. The condition resembled that frequently seen in the inner and outer canthi, especially of elderly people, known as pterygium, only much redder, and covering exactly the upper half of the eye, which was photophobic, lachrymated and was much irritated by wind and the movement of the upper lid, which was thickened, prominent and drooping, having a heavy and dropsical appearance.

There was no history of exciting cause, either material, thermal, chemical or organic, neither was there any peculiarity of diathesis apparent to me. On everting the upper lid it was found much congested and thickened by increased gland growth and granules, some of which were yellow, while the lower lid was simply congested.

To this Trachomatous condition of the lid, I attributed the morbid conditions of the cornea and sclera. The original disease being true

* Read before the Ottawa Medical Chirurgical Society.

trachoma or a granular condition due to a micrococcus, discovered by Sattler.

The treatment was chiefly local, an alterative being also given; generally, the eye was rendered anæsthetic by 10 per cent. Hcl. cocaine on a pledget of absorbent cotton, placed beneath upper lid three minutes before using Troy's forceps for stripping the granulations off the everted lid. This treatment, supplemented by cupri sulph. stick, followed by hot boracic acid lotions applied by himself, after his return home from my surgery, under which he steadily improved to recovery, which was reached on October 18th, that is, in little less than a month after coming under the treatment. The cornea had become quite clear, and vision = $\frac{6}{6}$, or normal.

He presented himself two weeks after, when there had been no relapse. I shall not here say anything of trachoma, of its treatment by massage and boracic acid, which is a recent method or jequirity, or what not, but simply state that this disease was due to the state of the lid, and that treatment of it alone proved the correctness of this belief. This condition in trachoma, I have since learned by reference to my text books, is, in Europe, a well recognized disease, of which there are three grades described: pannus tenuis, pannus crassus, pannus sarcomatosa, when it was very thick and flesh like, as was the case I have endeavored to describe. The inflammation is said to take place between the epithelium and the cornea, and the anti-elastic layer. It may be complicated by ulceration of the cornea, and perforation of its deeper layers and bulging or staphyloma of the cornea, or it may render it opaque

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A BLOW ON THE EYE IMMEDIATELY FOLLOWED BY
LOSS OF VISION, AND A FEW WEEKS LATER BY
OPTIC ATROPHY.

Mrs. W., a healthy woman, aged 60 years, kindly referred to me by Dr. Small, on account of sudden and complete loss of vision of her right eye, presented herself to me on March 7th. Two weeks previously she received a sharp blow upon the right eye with a rubber shoe held in the hand, when her sight, which had in this eye been previously good, was totally extinguished.

There was much chemosis beneath the orbital

conjunctiva, particularly its upper and inner parts. Pupil normal in size and shape; reflex to light not wholly lost. (Concensual contraction very marked), that is, contraction in the wounded eye after shading and uncovering opposite eye, excessive, showing that the optic nerve of the sound eye carried the impulse of light to the reflex centre of the injured eye—upholding the theory of the decussation of the optico-pupillary fibres. Vision *nil*—not even perception of light.

Ophthalmic Examination—Media perfectly clear, hyperæmia of fundus generally, optic neuritis, upper and lower margins of disc obliterated, vertical vessels blurred, no rupture of choroid, no detachment of retina nor hæmorrhage. Fundus of left eye normal, vision = $\frac{6}{24}$. To bathe frequently with warm acidi boracici lotion.

March 9th.—Two days later, no perceptible change in external condition of the eye, nor fundus; no perception of light.

R—Ung. hyd. nit. to temple.

Pot. Iod., gr. x.—ter die.

March 11th.—External extravasation absorbing; blurring of margins of disc lessened; fundus looks less red; optic disc paling; margins still ill-defined; stippling of lamina cribrosa; beginning optic atrophy.

April 8th.—Six weeks after injury; margins of optic disc clearly defined; atrophy clearly visible and increased; retinal arteries lessened in size.

April 24th.—Atrophy increased.

Prognosis was at first hopeful for the return of vision, as there was no gross lesion found in fundus. Hæmorrhage may have taken place in the choroid, which time would absorb (though likely to leave atrophies).

But after the lapse of several weeks, the superficial chemosis clearing, and also the optic neuritis, without any return of vision, and the supervention of optic atrophy, a prognosis consistent with these observations demanded a reversal of the former hopeful prognosis.

The probable cause of the sudden and complete loss of vision was injury to the optic nerve, involving its structural integrity, followed by atrophy at its periphery, or, possibly, hæmorrhage within its sheath, causing subsequent wasting.

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HERNIA OF THE LACHRYMAL GLAND.

I was called to the case I am about briefly to

relate, on the evening of Oct. 5th (1890), viz.: Hernia of the lachrymal gland, which must be exceedingly uncommon, as I have not been able to find it mentioned in text-books—though it is not on account of its rarity that it is brought to your notice; but for the serious mistake this rarity may entail in the treatment; by removing it as a redundant piece of fat, in order to more readily facilitate the closing of a wound of the orbit, thereby rendering the eye dry and lustreless, and perhaps engendering other changes.

Cora B., aged 4 years, while carrying a teacup, fell with her face upon it, breaking it, and inflicting an incised and somewhat punctured wound near the upper and outer angle of the right orbit, dividing the upper lid between its tarsal cartilage and the brow, in an upward and obliquely outward direction, to the extent of $\frac{3}{4}$ of an inch through which wound protruded what at first sight was thought to be a globular piece of intra-orbital fat, and I am not sure that the thought of getting rid of it from the wound by snipping it off, did not momentarily occur to me.

But fortunately the little gland was thought of, and the position and extent of the wound such as would be most favorable for its escape. On closer examination by a better light, as it was after dark, the gland was satisfactorily made out, and replaced as near as possible to its normal position, and the wound carefully stitched together, which, after a few days, completely healed without any ill results.

There is, perhaps, no part of the lachrymal apparatus which gives so little concern surgically, as the lachrymal gland, which stands in marked contrast to the excretory lachrymal apparatus, the ducts and sac, which are so frequently the seat of disorder. This, no doubt, is in a great measure due to its sheltered position in the fossa of the temporal bone, its under-surface, resting on the globe of the eye, upon which its secretion is poured out by means of several short ducts. The gland appeared to be the larger lachrymal gland, which occupies the temporal fossa, and not the smaller and frequently concomitant gland, which is covered by the fascia of the lid. The wound in position and extent corresponded to the incision sometimes made for the removal of the gland after removal of the globe, so as to render the orbit more free from moisture.

POST-SPINAL SCLÉROSIS.

George B., æt. 24 years, formerly a slaughterman, at present a laborer in a railway yard, came to me on February 6th, 1891, on account of failing sight for two years past. With right can only see shadow of hand, cannot count fingers. With left counts fingers at four feet. Color-sense completely wanting. Right pupil dilated, unaltered by light or accommodation. Left pupil does not contract to light, but does so feebly to accommodation.

Ophthalmoscopic examination — Right media clear; refraction normal; O. D. showed marked atrophy, especially at its outer side, causing excavation; lamina cribrosa plainly seen, giving it the usual stippled appearance; arteries diminished in size, veins somewhat tortuous; left O. D. greyish and showed atrophy less advanced.

These conditions being highly suggestive of spinal sclerosis, his reflexes were tested and found wanting. Enquired for lightning pains, which elicited the reply that he was much troubled with rheumatism in his legs, which often came and went suddenly. His gait is not ataxic, but he sways when standing with feet together and eyes closed. Sexual desire somewhat lessened. The special senses, other than sight, apparently unaffected. Some months ago had a hesitancy in making his water, that is, when the desire to void it was felt and he was ready to make it, he had to wait some time before it was voided.

This in my opinion, in all probability, is a case of post-spinal sclerosis or progressive locomotor ataxia, doubtless specific in its origin, as he admits having a sore on his genitals twelve years ago, followed by constitutional phenomena—which we know is the most frequent origin of it—Gowers giving it as the cause in about 50 per cent. of the cases.

I have presented the patient and reported the case to you to-night as one of much interest, showing, along with other things, the value of the ophthalmoscope in the diagnosis of a general disease in its earlier stage.

N.B.—Since reporting this case to the Society, patient consulted a neighboring ophthalmologist, who confirmed the conditions seen in the eye and also the diagnosis.

THE SYMPTOMS AND CAUSE OF EYE-STRAIN, AND ITS DIAGNOSIS BY THE GENERAL PRACTITIONER.*

BY W. CALDWELL, M.D., PETERBORO', ONT.

Mr. Chairman and Gentlemen,—I feel that I should almost apologize for introducing to you the subject of Eye Strain; and do not do so on account of any large experience, nor because I can present any original observations, but because it is a field not much occupied by the general practitioner, and, therefore, a favorable one for a few brief, crude, but I hope, practical remarks on a subject which has of late received a great deal of attention from the specialist in nervous diseases, as well as from the specialist in eye diseases.

The diagnosis of this condition, however, is of not less importance to the general practitioner, especially if he is not convenient to the oculist.

I feel sure, both from my own experience and my reading, that it is just as essential, in some of the cases that present themselves to us for treatment, to ascertain whether the patient is suffering from some defect of vision, which may be the cause of reflex symptoms that simply need a pair of spectacles for their relief, as it is in other cases to ascertain the cause of fever, a rigor, or a convulsion; and it can be done more easily and with greater certainty.

Eye-strain may be defined as any abnormal exertion of the ocular muscles, resulting from errors of refraction, or any want of their equilibrium from other causes; the latter we do not intend to discuss.

The most frequent causes are an eye-ball too long, causing myopia, or short sight; or one too short, constituting hypermetropia, or far sight; and variations in each of these conditions called astigmatism.

According to some authorities whose opinions and conclusions are entitled to every respect and consideration, eye-strain often causes such diseases as epilepsy, chorea, hysteria, migraine, bilious attacks (so-called) neurasthenia, dyspepsia, mal-assimilation, and consequently anæmia; one observer asserting that the iron in the spectacle frames do the red corpuscles more good than it would do in pills.

I think, however, I shall not be occupying un-

certain ground in stating that headache, migraine, neuralgia, and nervousness, are frequent and persistent symptoms of eye-strain. Reading, sewing, or continued effort at any close work, may produce a wearied, tired feeling not easily described; the eye-balls ache, or the eyes become watery or suffused; after reading for a time the letters run together, there is blurring, and the patient must rest. These or other symptoms may be present, and yet the patient not suspect anything wrong with the eyes. Boys with short sight like their books, while boys with far sight dislike them, and will take to outdoor amusement.

With regard to the importance of headache as a symptom, Dr. Geo. Gould, in a paper read less than a year ago, before the Philadelphia Hospital Medical Society, says that in the first thousand refraction cases that occurred in his private practice, a chief complaint in over 800 was headache, and the failures to cure or relieve were not over half a dozen.

Dr. Peter Callan, of the N. Y. E. & E. Infirmary, in a paper in a recent number of the *Jour. of the Amer. Med. Assocn.*, gives it as his opinion that 75 % of functional headaches are due to eye-strain, while other authorities consider that it causes more headache than all other causes combined.

Squint, styes, blepharitis and conjunctivitis, are often due to the same cause, a squint often requiring no operation if a proper pair of spectacles are worn.

As I have intimated, the diagnosis of defects in vision or errors of refraction, which cause eye-strain, is not difficult; needs neither special skill nor expensive instruments. All that is required is a card of Sn's Test Type for distance, and it is better to have two differently lettered.

Each line has a number that indicates the number of feet distant at which the line should be read by those whose vision is normal, *i.e.*, the first letter marked 200, should be read at 200 ft. distance; the line 40 should be read at 40 ft. distance; and so on; and those whose vision is normal can always read the line numbered 20 at 20 ft. distance, and this is the distance the card should be placed from the patient in a good light. If you cannot place it 20 ft., 15 feet will do, and then the line marked 15 should be read.

Each eye is now to be tested separately, and a

*Read before the Ontario Med. Association, June, 1891.

record is kept for future reference. The number of the last line read, plus any letters read in the next line, is marked down. Oculists write it in the form of a fraction, 20 or the distance in feet from the card is always the numerator, and the number of the line is always the denominator, *e.g.* if the line marked 20 is read at 20 feet, the record for that eye would be vision $\frac{20}{20}$ or normal; if the line marked 40 is read it would be $\frac{20}{40}$ and if three letters in next line $\frac{20}{40} + 3$. Now paralyze the accommodation with a *vi. gr.* solution of homatropine; the same quantity of cocaine may be added. This is preferable to the sulphate of atropia, as the effects pass off in 24 to 48 hours; the latter lasting ten or twelve days. The effects of the mydriatic should be explained or the patient will become alarmed. One or two drops of the solution instilled in each eye every ten minutes for an hour will answer very well, or once an hour for a day before the examination is considered preferable. Each eye is now to be separately tested as before, and, better, with a different card. If the patient read the 20 line before and now reads it again with each eye, vision is normal, and no cause for eye strain exists from any error of refraction. If the 20 line was not read before, but the same line is again read with the accommodation paralyzed, the case is myopic or short-sighted, and it is not probable that eye-strain exists if both eyes read the same line, though for convenience spectacles may be required.

But now with the accommodation paralyzed if the same line cannot be read as before, but only the larger ones, there is either hypermetropia or astigmatism, or both, and a diagnosis of an existing cause of eye-strain can be made with certainty. When the cause has been removed by a proper pair of spectacles, it will become apparent whether the headaches or other symptoms have been due to that or not, and the patient can be treated more rationally.

As to how much the defect should be, before deciding whether spectacles are required, I will quote from one of the papers already referred to.

With reference to this Dr. Gould says:—This entirely depends on two things, the nature and occupation of the patient.

1. "If the patient be one of civilization's hot-house plants, a neurotic, sensitive, nimble-witted girl, the smallest defect is sufficient to play havoc with such a bundle of quivering nerves. If in

such a case there is the slightest falling off of distant acuity under the mydriatic, if the same line of test type cannot be read just as easily, pack her off quick!

Between such a case, and the rugged out-of-door-living farmer there are a 1000 degrees to tax the best judgment of the best oculist as to what to do."

Lastly, patients under 40 years of age should never have spectacles prescribed for them by the druggist, jeweller, nor the optician, though it is frequently done, sometimes with the consent of the doctor.

To briefly summarize:—

(1) Errors of refraction often give rise to many symptoms that may effect the comfort and health of the patient, though not apparently referable to the eye.

(2) Hypermetropia, or far-sight, which is the most frequent cause of eye-strain, is often present, though vision is quite good.

(3) Patients, especially women, who suffer from recurring attacks of headache, neuralgia, dizziness or other symptoms that may be reflex, and children who have a dislike for their books, should have their eyes tested, no matter how acute the vision may be.

(4) Every general practitioner can easily ascertain with certainty, whether any error of refraction is present which may be the cause of reflex symptoms.

(5) Patients should be sent to the oculist, and not allowed to go to the druggist, jeweller, nor optician.

Note.—The mydriatic is not necessary in patients 50 or over, as a rule.

Selected Articles.

OBSERVATIONS ON THE NATURE OF CANCER.

The late Mr. Marshal proposed to devote the following pages to the elucidation and amplification of certain statements and views which could only be but briefly expounded in an extempore lecture of one hour's duration. In the present posthumous lecture he has, furthermore, dealt briefly with several questions relating to cancer which were altogether passed by in that lecture.

1. *Definitions and nomenclature.*—The confu-

sion begotten of the threefold use of the term "cancer," sometimes to define a *class*, sometimes a *genus*, and sometimes a species of tumors, or even in two or three of these senses, or at all events in a general and a special sense in the same page, is much to be regretted; but it is, perhaps, hopeless to attempt to rid ourselves of it for the present. A trace of such confusion lurks in the title of this lecture and of its two predecessors; for it is only by regarding the term "cancer" in one sense and the term "cancerous diseases" in another sense that the two terms become logically discreet, and subject to the copula "and." Otherwise, the combination is not merely tautological, but illogical; for a "cancer" must be a "cancerous disease," and a "cancerous disease" must be "cancer." It might be well if, although as physicians and surgeons we are wholly unable to exclude the word "cancer" from our vocabulary we could, under the guidance of the pathologist, more strictly limit its use. In practice, from kindly motives, the word "sarcoma" is frequently employed, when it is legitimate to do so, as a verbal mitigation of the more dreaded term. Doubtless, in ancient medicine and surgery, the earliest application of the term "cancer" was especially or chiefly to those forms of spreading and ulcerating growths which are typified by the hard, and hence so-called "scirrhus," tumors; but it was also applicable and was probably used, in regard to the softer and rarer forms of ulcerated new growths, later distinguished as encephaloid tumors; and, furthermore, it was employed in relation to the worst forms of progressively *eroding* cutaneous ulcers. But the term "cancer" undoubtedly came also to be used in relation to the larger forms of those tumors which are now designated "sarcomas," especially to those which are prone to ulcerate or slough, or have actually undergone those morbid changes. This is abundantly manifest by the descriptions and illustrations contained in theses and systematic works dating from the period of the revival of learning down to the present day. Notwithstanding the precise differentiation now established on anatomical grounds between these several tumors, their general characteristics, pathological significance and behaviour, serve sufficiently to unite them under the one term "invading or infecting tumors." But, it appears to me, a likeness or unlikeness in structure affords a more definite basis of a sound classification and just nomenclature than any resemblance or difference in their modes of *life*, propagation, or decay. The use of the term "true cancer," now sanctioned as a mode of distinction between the two chief and well-recognized divisions of these invading growths, is convenient, but unsatisfactory; for, again, a "cancer" is a "true cancer," and a "true cancer" is a "cancer." Moreover, no one dreams of seriously employing the

complimentary opposite "false cancer." For my own part, I cannot bring myself to designate any sarcoma which is derived from non-glandular tissue elements as a cancer. I prefer to adopt the subdivision of these "*invading tumors*" into two leading groups; (a) the *theliomas*, and (b) the *sarcomas*, according as they are derived from the "covering or lining" constituents, or from the "substantial framework" constituents, of the body.

A. *Theliomas*, whatever may be their site or basis of origin in the body, are "cancers." They originate in or from parts of the body which are descended from one or other of the three so-called embryonic layers of the blastoderm—viz., the *epi-*, the *meso-*, or the *hypo-*blastic layers, and are either (a) *epitheliomas*, (b) *mesotheliomas*, or (c) *hypotheliomas*. The epitheliomas (a) and the hypotheliomas (c) either effect mere plain membranes or surfaces, thus producing flat masses—the so-called plaques; or they effect the elevations or projections of a cutaneous or mucous surface, and so give rise to *warts*, or *papillomas*; or they effect the minute involutions of those surfaces, such as simple or compound open follicles, branched or contorted tubules, or small racemose glands, whether these belong to the skin or to the mucous membranes; or, lastly, they effect smaller or larger portions (never the whole) of the lobulated glands, such as the mammary gland, the salivary glands, the pancreas, the liver, the lungs, the testis, or the ovary, thus giving rise in these situations to more manifest and often very large tumors. In the case of the larger glands, and probably in smaller ones, the cancerous disposition may primarily affect the epithelium of the ducts or that of the acini of the gland, and thus either *duct cancers* or proper *gland cancers* arise. If the acini only are involved, an *adenoid cancer* is developed, which, indeed, constitutes a potentially, if not an actually invading *adenoma*. Lastly, the closed glands, such as the tonsillar and thyroid bodies and Peyer's patches, are liable to theliomatous disease. *Mesotheliomas* (b), which as *primary* formations are rare, are represented by such theliomatous growths as can be distinctly shown to originate in sites acknowledged to be within the area of those parts of the body which are derived directly from the mesoblastic embryonic layer—such, for example, as any well-established case of primary thelioma of the peri- and endo-cardium and the lining membrane of the bloodvessels, that of the lymphatic vessels and glands, and of the synovial membrane. These tumors must, of course, always be distinguished from deep-seated *secondary* growths, the products of invasion of an original *epi-* or *hypo-*thelioma. I believe there exists in every form of "thelioma," however minute, a substratum of modified basal tissue, not necessarily a distinct basal membrane which, as it seems to

me, may probably be descended from the substance of the corresponding embryonic layer, whether epi-, hypo-, or meso-blastic; but the subject demands further investigation. I have long ago felt assured, from microscopic observations, that in every form of epithelioma and hypo-thelioma this modified basal tissue exists. It is obviously present in an elevated cancerous patch of skin or mucous membrane. It distorts a papilloma; it forms a loose and delicate stroma in soft gland, like the liver; and in an encephaloid growth it constitutes the firm and stubborn stroma of a scirrhous tumor; and it may even form a chondroid or osteoid framework in an originally theliomatous growth. The variety of invading new growths, known as *colloid cancers*, whether derived from epiblastic, hypoblastic, or mesoblastic tissues, are colloid theliomas, having very special characters, both as regards their peculiar cell elements and their interwoven stroma. In this respect they depart from the theliomas generally, in which, as a positive rule, the diseased and distorted individual cell elements maintain a general likeness to those of the healthy tissue in, upon, and from which they immediately spring.

B. The other group of invading tumors, the *sarcomas*, which originate in and from tissues which are especially derived from the mesoblastic embryonic layer, follow quite naturally the several varieties of those tissues. Such, for example, are the soft myxomas or mucoid tissue tumors, the round-celled, spindle-celled, and fibroplastic growths or fibromas, the myomas or muscle tumors, the soft and hard chondromas, the lipomas, myelomas, and the open and compact osteomas. As is well known, two or more of these varieties of sarcomatous tissue frequently exist intermixed in the same growth—an incident referable doubtless to their community of origin and type. Those interesting lower forms of tumor which consist of elements smaller and more single than of the proper tissues—such as tuberculous, gummatous, and inflammatory deposits—are necessarily excluded from special consideration here. Besides this, however, there are found occasionally mixed, thelio-sarcomas—that is, tumors in which some portions have a theliomatous and other portions a sarcomatous structure, or in which these two forms of morbid tissue are in places closely and intimately blended. Seeing that the body itself is so composite an organism, and is descended from all three of the embryonic layers, the occurrence of these (*A plus B*) compound growths need not excite surprise. The primary separation of the germinating membrane of the ovum, whether into two, as ectoderm and endoderm, or into three, as epiblast, mesoblast, and hypoblast, is doubtless of the highest consequence and most essential character. A twofold division is, indeed, a mechanical necessity for any mucous membrane,

and is naturally suitable for the foundation of a hollow organism; whilst a third, or mesial stratum, seems almost equally an unavoidable material consequence. But these necessary dispositions are not less wonderful on account of their simplicity; whilst such early, if not actually primal, arrangements would seem to have an obvious fundamental character and force, and to imply a kind of future controlling or hierarchial office and duty. From this point forward each lamina tends to *breed true and keep true*, and the distinction between them as to their constituents and functions respectively is henceforth maintained, and not easily, perhaps never actually, to be broken through. Within each layer the most complicated and yet definite, metamorphic, metabolic, and synthetic tendencies and processes are manifested and realized, but in each these are distinctly and regularly restricted. Definite evolution within them individually is the law for each; whilst the notion that a cross interference occurs, whether affected in a direct manner by simple metamorphosis of the tissue elements or by a process of previous reversion to a common and primitive uniformity of type and office, is difficult of acceptance, somewhat improbable, and, at all events, not proved; nor has it actually been shown that it is from hidden *archaic protoblastic* elements that the requisite varieties of forms are produced in late adult life. Certain elementary epithelial or hypothelial protoblasts may, indeed, be supposed to shape themselves, if needful, into spherical, oval, squamous, polyhedral, columnar, or even ciliated forms; and, indeed, transitional forms of epi-, and hypo-thelium are well known, and even occasional transmutations of forms have been observed. A parallel instance of transmutation is to be seen in the flattening down and disappearance of cilia where the tracheal mucous membrane in the newborn kitten becomes subject to friction opposite the over-lapping cartilages of the windpipe after respiration has been established. In the case of certain theliomas of primary origin, developed on the confines of the epiblastic and the hypoblastic regions of the body, the elementary constituents, though diseased and disfigured, still obey the particular type of the healthy tissue from which they have sprung, and, although conterminous, it must not here be concluded that the one kind of thelial element has been changed by contact, influence, or interactionary metamorphic power exercised upon it by the other. The hypothesis of the action of special antecedently existing *germinal* or *seminal* influence or force, giving rise to these transmutations, is needless to account for them, and in regard to any transmutation of a mesoblastic elementary particle into a resemblance or copy of an epiblastic or hypoblastic element, the cure involves a still more difficult assumption. The further supposition that this effect is possible, either

by a preliminary reversionary process, or by an undoing of the metamorphic process, is pure speculation. Direct observation is at fault. Mere deformation of neighboring types of form, together with close contiguity or intermixture with lower ones, may account for appearances which might be attributed to subtle metamorphic change. The actual proof of positive transformation or interchangeableness is difficult to imagine, and is at present wanting. An approximation in form and character, as seen under the microscope, may obviously be delusive, and the evocation of a germinal or seminal influence of one tissue element over another, or even of traumatism upon one variety of neoplasm is merely speculative, and absolutely without foundation. Further facts and clearer demonstrations may some day be forthcoming. Meanwhile the limitation of the material involved, the definite nature of function, and the rigid exactitude of the evolutionary processes implied in the recently announced theory of Weissmann are altogether opposed to the theory that, when once the three layers of the protoblast are discriminated, any cross action or jumble of development from an epithelial cell to a connective tissue element is probable, or even possible, nor yet between a cancer cell and a round or spindle-shaped sarcoma element. Each kind of morbid growth continues true to itself, but intermixtures of them may and do occur in the highly composite animal frame.

From general considerations, as the foregoing, we may now turn to the examination of what are frequently termed more practical points. Nevertheless, no one part of this important subject is without its close connection with the rest, and those upon which I now wish to add a few short comments exhibit this inter-relationship in the highest degree.

As regards *age*, a sufficient regard, it seems to me, has not been paid to a possible source of general fallacy—namely, that facts are often derived from death records or mortality, without due reference to the *duration* of the disease. A further special fallacy is naturally the great difficulty of ascertaining the real date of the origin of the neoplasm; the fallacy still remains, even if the date of *apparent* commencement be, as is sometimes the case, taken as the starting point. Allowing for this, or even, I believe, without such strict allowance, my own experience would be, not from the fortieth to the sixtieth year, but from thirty-five to fifty as the most frequent period of the onset of the malady.

As regards the influence of *sex*, with which that of special *organisation* is concerned, everyone will admit that women suffer more from true cancer than men; but that if sexual specialities be set aside men suffer more than women, as in the case of cancers of the lips, mouth, and alimentary

canal generally. The most reliable numbers drawn from clinical experience are merely the result of so many associated and intervening provocative influences, and can only have approximate relation to the truth. As to special organs, their derivation from one or other of the three embryonic layers has the highest significance, for true cancer largely predominates in the epiblastic and the hypoblastic organs, as compared with the fully formed mesoblastic structures.

As to *hereditary influence*, it is of undoubted and large significance. *That*, at least, is the personal experience I would here put on record. The idea is old, and, indeed, is itself inherited; and it is faithfully enshrined in the well-known phrase, capable of a physical as well as a moral and social interpretation, "the ills which flesh is heir to." It is noteworthy to observe how its admitted effects are exaggerated and insisted on, or minimised and almost ignored, in view of the different opinions held as to the causation of cancer itself. The constitutionalist inclines to exaggerate, the parasitist to minimise, the influence of inheritance. The absence of evidence of heredity may be due to want of knowledge or the concealment of knowledge on the part of the patient, or to the premature death from accident or other disease of individuals, who yet had a latent proclivity to cancer. On the other hand, the instances on record of multiple inheritance in the members of the same family may be overvalued by some and undervalued by others; though they are certainly of real and grave significance. Hereditary influence most probably enters into the problem of the prevalence of cancer within certain localities or districts in which constant intermarriages probably occur generation after generation, and this may conduce to a special proclivity to the disease in certain self-limited races, as I have myself often observed amongst Jews; and on a larger scale in certain absolutely limited tribes or nations. The difficulties of following mentally an inheritable *materies morbi*, in the shape of a substantive morbid molecule, is not greater than that of assuming the perpetuation of such a substantial modification of a tissue, which must be associated with a proclivity to a certain disease. The student of the almost infinitely little of molecular constituency and of the almost infinite distance and number of unseen stars, and above all the mathematical mind, will find no inherent difficulties in either of these conceptions. But until the cause of cancer itself is known, the nature and conditions of itself cannot be definitely indicated. At present my own impression, founded on experience, is that its influence is larger than that frequently or usually assigned to it. As to the *personal equation* due to original differences in the digestive, assimilative, and secretory functions or the actual metabolism of the body, it is quite incommensu-

able. So, too, the acquired peculiarities due to the antecedence or co-existence of a phthisical tendency, or any stage of enthetic disease, cannot yet be accurately estimated or even clearly distinguished. In the antagonism between a proneness to phthisis and a liability to cancer I am personally constrained to believe. Here the numerical exceptions seem to me to prove the rule. Again, an apparently increased personal liability may be really a diminished power of resistance, and *vice versa*; and an apparently positive immunity may be quite accidental, and not due to any constitutional conditions. The alleged increase of cancer amongst our own population at all periods of life, especially at the period of greater liability, and more amongst males than females, involves serious considerations. The disease is now said to prevail more in England than in Ireland; but, on the other hand, it has been pointed out that in the United States it is more prevalent amongst those of Irish and of German descent than amongst the rest of the population. Still, further researches on all those points are required.

The influences due to *social status*, and of the many conditions which accompany wealth or poverty, appear to me, in relation to the actual proportions of the rich and the needy, to be adverse to the well-to-do classes. Excess of diet, especially of animal food, used to be said to conduce to cancer; and carnivorous mammalia and birds, especially in a state of domestication, are known to suffer more than the herbivora. The latter, however, are killed earlier, not only for the necessities of the human race, but also for those of animals of prey. Tame and wild vegetable-feeders, as a rule, fall early victims to their predatory fellow creatures. Long-lived domesticated animals, even if herbivorous, suffer from some forms of cancerous disease; and I well remember dissecting and examining a wild hare, sent to my old master, Robert Liston, which had a well-marked, soft adenoid tumor of the mammary glands on the left side of the body, which weighed more than two pounds. The genuine effects of habit and irritation were especially seen in regard to the former use of the clay pipe, and are now shown in reference to the action of tobacco vapors on the tongue and palate. Many instances of both these facts are engraved upon my memory. But I would now add that I have never met with a due inquiry into the effects of chewing tobacco. Is there any peculiarity in the mode of preparing tobacco for mastication and for smoking? Is there any mischievous empyreumatic evolution in the distilling action of the pipe or the cigar? Why did not or does not the use or the abuse of snuff give rise to the development of cancer in the nose—of which I may say that I do not know of a single instance?

Finally, I have to note that the influence of *occu-*

pation, and of its concomitant exposure to the effects of external agencies in relation to the provocation or prevention of cancer, has not been sufficiently investigated, more especially in regard to the continued inhalation or swallowing of vapors, or of minute particles of mineral substances contained in the air which workmen breathe, or the water they drink, or in the dust which lights upon their skin. Especially would I direct attention to the advisability of making an inquiry into the apparently bad or good effects of particular vapors or dust, which might contain zinc, lead, copper, silver, mercury, antimony, or arsenic. This investigation should also extend to the influence of organic vapors or of dust, consisting of living or of dead organic matter.

Lastly, to revert to the real object of all such inquiry—viz., the discovery of the causative agent in the production of cancer from what appears to be healthy tissue—I would urge upon our modern investigators the great desirability of comparing not merely the histological details of cancerous and normal structures, but to attempt a chemical analysis of the same. By a combination of all such methods of research we may ultimately remove the reproach of ignorance on this most common and most fatal disease.—By the late John Marshall, F.R.S., F.R.C.S., in *Lancet*.

MIGRAINE; CLINICAL REMARKS ON HEADACHE.

Severe, more or less persistent, headache in a young man, or one at the prime of life, is often associated with syphilitic infection arising from a gumma or syphilitic meningitis. Another cause of common occurrence is chronic meningitis, due to insolation, or to a local congestion remaining after sunstroke. Such patients are liable, on exposure to the sun, even at ordinary temperatures, to have attacks of severe disabling headache. The next most frequent cause is migraine, or hemicrania, of which the present case is an illustration.

Although in the characteristic form of migraine the pain is confined to one side of the head, yet very frequently it is dull and diffused, and the patient is unable to localize it, or it may extend all over the head, although worse on one side. As you well know, headaches are also often caused by eye-strain and by nasal catarrh.

Migraine is common in young people of nervous temperament, being especially liable to come on when they are overworked. The attacks often commence with some disturbance of vision, hemipopia, or more properly hemianopsia. The patient, looking at his face in a looking-glass, or at anything immediately in front, will be able to see only one vertical half of the object. One-half of the retina being rendered insensible in each eye, so

that we have the inner half of the right eye and the outer half of the left eye insensitive, or *vice versa*. When this is the case, only one-half of an object is seen if looked at directly in front. Other patients have spots before the eye, or they complain of weakness in vision. If they try to read the letters become blurred, or slight effort in reading brings on headache. This hemicrania comes on often, following indiscretion in diet; certain articles cannot be eaten without having an attack. I have known of cases where it was due to excessive taking of tea, or indulgence in a small amount of cheese. In others it is produced by greasy articles of food. In such attacks the patient generally wakes up in the morning feeling poorly, and unable to eat much breakfast, and either before, or shortly after breakfast, a dull pain commences in the head, which gets worse and worse during the day, and with it is associated a great deal of depression of the body, and physical powers and digestion seems to be entirely suspended, or to go on very imperfectly. Some time in the afternoon or evening the stomach rejects the food taken during the day, and, perhaps, the day before as well, showing that digestion has been interfered with from want of nervous supply. On account of the prostration the patient is generally obliged to lie down and discontinue all brain work, as well as physical labor.

These nerve storms are of two kinds. In one the face is congested; in the other case the patient's face is unnaturally pallid. In one case it will suggest to us that the blood supply of the brain is sufficient but irregularly distributed, and in the other case it looks as if the blood supply to the head was inadequate. In the first case the anæmia would be only local; in certain centres, or in one hemisphere, or in the course of one artery, while in the other case it would be general in all the great nerve centres.

After such a nerve storm the patient will rest for an hour or two, and, after emptying the stomach, generally recovers in a short time, except for a slight weakness which disappears by the next day.

These attacks, as I have already told you, are brought on partly by indiscretion in eating, and partly by mental work. Not always does the same article of food bring on an attack in different patients. The impaired nerve power so weakens the digestion that even ordinary articles of food are not digested.

In the treatment of this affection we must advise the patient to abstain from food which does not agree with him. As the blood supply to the brain is defective in these cases, some stimulant, such as hot whiskey, or alcohol, will often help to prevent an attack which is coming on. In other cases, coffee combined with the whiskey will help, or caffeine given alone. If any undigested food

remains in the stomach it will be well to give an emetic and wash out the stomach with hot water. Where the patient is well nourished, and able to take opium, the following may be given:

R—Tr. opii deodoratæ . . . gtt. x or xij.

(Tr. cannabis indica may be substituted when opium is considered objectionable.)

Potassii bromidi . . . gr. xx,

with two drachms of camphor water. In addition, give some cinnamon or peppermint water to disguise the taste of the combination.

We do not, as a rule, combine anything sweet with bromide of potassium, on account of its salt taste. Antipyrin in gr. x-xv doses also will relieve headache, but is often followed by great depression, or even collapse.

Such a dose, taken and repeated every two hours, will generally ameliorate an attack, and enable the patient to keep on his feet and do a certain amount of work.

As to the treatment between the attacks, it is possible this deranged blood supply may be due to some poisonous product circulating in the blood, the result, perhaps, of infectious dyspepsia and butyric or lactic acid fermentation, to the products of which when carried to the nerve centres this attack may be due. The headache may, on the other hand, be due to defective elimination by the kidneys, or even of some excrementitious matters. In favor of this view is the fact that the kidneys generally act very freely when the attack is passing over, a large amount of limped urine being generally thrown off. Here is a suggestion for our therapeutics, the remedies which increase the eliminative action of the liver and kidneys may prevent recurrence of these attacks. In some cases there may be a congenitally inadequate liver, which, owing to its small size, or some other cause, does not sufficiently purify the blood. It would be well to keep the patient on a vegetable diet in these cases, in addition to paying proper attention to the secretions.

When the kidneys are at fault and acting scantily, diuretics, citrate of caffeine, gr. j or ij, given three times a day, will do well, or it may be combined with gr. xx of acetate of potash given at night. Sweet spirits of nitre, or hot lemonade, with a teaspoonful of gin or whiskey, at bedtime, are also good adjuvants.

When the liver is constantly deficient in its secreting power, succinate of soda in two-grain doses, several times a day, has been used with success, but probably the use of the podophyllin, leptandrin, cascara, and similar cholagogues will prove all that is necessary, if given regularly, with due regulation of the diet.

Such patients should pay especial attention to the functions of the skin, by frequent warm bath-

ing or sponging, and wearing woolen or silk under-clothing.—Frank Woodbury, M.D., in *Times and Reg.*

PERINÆORRHAPHY.

I wish to bring before the notice of my gynecological brethren an operation I have designed for the restoration of a lacerated perineum, easy of performance, and which will, when properly executed, form a good perineal floor, and I might almost say practically a perineal body. The patient, having been prepared by the usual preliminary steps required for the old operation when under the influence of an anæsthetic, is placed in the lithotomy position, the left index finger being introduced almost its entire length into the rectum, a long straight double-edged bistoury is made to pierce the tissues in front of the anus at right angles to the vulva, and, guided by the finger in the rectum, is made to penetrate the septum for two and a half inches upwards, the incision being enlarged laterally to two inches as the knife is withdrawn.

The patient is then turned on her side, and on the points of incision being pressed together, a lozenge-shaped opening will be seen, and when all sutures required have been introduced and are properly adjusted and approximated, the two cut surfaces are brought into direct apposition. The sutures are introduced by a strong cycle-shaped needle with eye near point, mounted on a handle, strong silver wire being the suture preferred.

The needle is introduced at edge of incision, and, guided by a finger in the rectum, is to travel under the cut surface to its full depth above, describing the arc of a circle; and on point of needle appearing *directly opposite* it is threaded with suture and drawn through. On the ends of this being drawn together with the fingers, a good idea can be formed of how many original stitches may be required. When all considered necessary have been inserted and approximated, being first passed through perforation in leaden plate (see illustration), a finger of each hand passed into rectum and vagina will at once recognize the gain in thickness of septum, the external tissue being pushed fully an inch forward from anus, and forming a thick and solid perineal body.

The incision being a deep one, on union taking place between the raw surfaces, a considerable amount of support must be afforded in cases where a pessary is required, or where there is much tendency to prolapse of uterus or vaginal walls. My experience of the operation has satisfied me with the results, and there being *no loss of tissue whatever*, should the operation fail, it cannot add any difficulty to a subsequent one.

Even should the perineum be lacerated to verge

of anus, what I describe can be done. I find that leaving the sutures for ten days is generally sufficient, but if I am in doubt as to the union being strong, I cut the wire, but leave it in situ for a day or two longer, thus affording some support and relieving the strain on the edges of suture holes, and I also support the parts by long strips of adhesive plaster carried from hip to hip over new perineum.

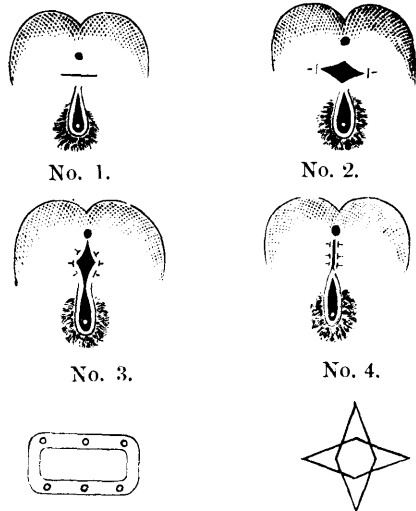
The wire should be stout and not too tightly twisted. My friend, Dr. More Madden, has kindly given my operation a trial, and was much pleased with the result, especially in one of his cases where the old plan of operation had been tried previously but failed owing to the patient's poor state of health and want of healing power. The advantages of my plan of operation are briefly these:

1st. The simplest of performance as yet proposed, no danger of hæmorrhage, the surfaces when dry being brought together.

2nd. No danger of sepsis, as the incision is not open for the admission of any discharge from either vagina or rectum during healing process.

3rd. No loss of tissue, and consequently no harm done should the operation fail.—Alexander Duke, F.R.C.P.I.

STEPS OF OPERATION.



SPLINT FOR SUTURES.

DIAGRAM OF REVERSED LOZENGE.

VOMITING OF GASTRALGIA.—

R.—Cocain, 10
 Antipyrin, 1.00
 Aq. destil., 90.00

Sig.—A teaspoonful every one half hour to an hour.

CONCENTRATED FOOD IN THE TREATMENT OF PULMONARY CONSUMPTION.

Calling attention to the importance of nourishing diet in the treatment of pulmonary consumption, is so trite that it barely deserves repetition; yet, old as it is, it is no less true to-day than it ever was. Indeed, it may be laid down as a fundamental proposition, that the cases of consumption which cannot be reached through the instrumentality of food have certainly slim prospects of recovery. It is also no less true on the other hand that if your patient can be made to partake of, digest, and assimilate a sufficient amount of food, it matters little in what condition his lungs may be, he will, with ordinary good management, make a good recovery in the great majority of instances. Failure to get well under these circumstances is the exception. To make your patient eat, then, is the great problem to solve in the cure of this disease, yet every one realizes the enormous difficulties which are constantly placing themselves in our way. Very little can be done to attain this end by only addressing medicines to the stomach. You are required to rise higher than this, and to take a general survey of the whole condition of your patient. In other words, it is absolutely indispensable that you should regulate his exercise, his rest, his sleep, and his eating; in fact, you must have a systematic supervision of all he does during the whole twenty-four hours.

I arrived at the conclusion long ago that a consumptive patient who is fatigued cannot eat. So, his appetite will greatly depend on how much or how little exercise you prescribe for him. If much exercise tires, then less must be taken, and if little exercise tires, then absolute rest must be insisted on. Many of these poor people exercise themselves to death. Digestion, like exercise, requires a certain degree of bodily strength. The strength which is expended in performing exercise deducts so much from the sum total of the bodily forces, and in most cases leaves too small a residuum to carry on the processes of digestion, absorption and assimilation, and is the principal cause of the persistent anorexia. I am well aware of the prevalent impression that exercise is one of the essential promoters of a good appetite, but all you need to do is to ask your patient to give you an opportunity to demonstrate the falsity of this belief by a prolonged dose of rest, and I dare say that a single chance will be sufficient to dispel the allusion. Rest will not only restore his appetite and save his strength, but it will reduce his fever, diminish the cough, and make him feel more comfortable in every respect.

If your patient eats, what kind of food should he have? It is that kind which concentrates a large amount of nutritive material in a small bulk,

and which requires a small amount of digestive energy on the part of the stomach and the digestive tract. Such foods exist without question, in the freshly prepared juice of beef, oysters and clams, and they are prepared as follows: Beef, preferably the round-steak, is cut in pieces of the size of a walnut, and is placed in a pan and held over the fire for a few minutes in order to heat the outside slightly. The whole is then dumped into a large Bartlett beef press, and this separates the juice from the fibre. About one and one-half pounds of beef will yield a teacupful of beef juice. This juice, divested of all fat, is well seasoned, and taken cold in half teacupful doses, three or four times a day. In the case of oyster and clam juice, the same process is followed in extraction, and it is likewise taken cold and seasoned. These juices contain the very essence of nourishment, require very little or no digestion, are easily absorbed and assimilated, and may be administered to the most fastidious stomachs. They are very much superior to any kind of beef tea, or extract, that can be made. Additionally, I prescribe five or six glasses of milk a day.

Much may be done in feeding these patients by going about it in a systematic manner. Begin at seven o'clock in the morning with a glass of milk, and repeat the same every three hours. If a whole glass is too much, be satisfied if only half a glass is taken at first. At eight o'clock administer half a teacupful of beef juice. At first this is given three times only, but as soon as possible, four times a day. If desirable, oyster or clam juice may be substituted once during the day for the beef juice. Besides, you must persuade your patient to eat an egg, or oatmeal gruel, with cream and sugar, and bread and butter, and a cup of coffee for breakfast; beefsteak, roast beef, mutton or lamb, with vegetables, for dinner, and a lighter meal for supper. Beer, wine, champagne, whisky, or brandy may also be taken in moderate quantities throughout the day.

Much can be done to stimulate the appetite; for this purpose I often give the following:

R Acid. phosphoric. dil.,
Acid. nitromuratic. dil.,
Acid. sulphuric. aromatic.,
Tinc. ferri chloridi, āā fl ʒ ss. M.

Sig.—Thirty drops in half a glass of cold sweetened water during meals.

A coated tongue, which so frequently exists in these cases, is no contraindication to the giving of iron. Additionally, two or three grains of quinine are prescribed in the forenoon and in the afternoon. The bowels must also be kept regular. If constipated, a glass of Hunyadi water, or a Lady Webster's pill in the evening, will generally suffice, or Parke Davis & Co.'s cascara cordial, also serve well for this purpose. Occasionally, a blue mass pill will not be out of place. If there is a ten-

dency to diarrhoea, the above-mentioned acid preparation will often check it. In most instances of this kind, the diarrhoea follows a meal, and is due more to a hypersensitiveness of the alimentary tract than to any other cause. To the acid mixture you may, therefore, add subnitrate of bismuth and pepsin with advantage.

MEDICAL EDUCATION AND THE STUDENT'S WANTS.

Another first of October has passed and a large number of young men have commenced their medical studies. So important a step as entry into a medical school is apt to make the student, his friends, and even the public forget that his studies are a means, not an end. He must ultimately earn his bread by physic, provided that he satisfies examiners. It may pertinently be asked: Does the education at medical schools fit a man for earning his bread? and do examiners necessarily pass the fit, whilst rejecting the unfit?

That our medical schools do honestly endeavour to give the student a good, solid, scientific ground work of knowledge there can be little doubt. Unfortunately the teachers must above all, pass as many of their men as possible. Hence medical education is too closely associated with passing examinations. In short, the end is partly sacrificed to the means.

Another shortcoming in the modern system lies in the fact that the student will most probably become a general practitioner, whilst his teachers are purely scientific professors or members of the hospital staff. Their knowledge of general practice is at the best indirect. The hospital teachers in many cases is a product of the school where he teaches. Professionally speaking, he may have never stirred from his hospital. He has had a hard struggle, but not of the kind which most of his pupils must undergo. He has been a demonstrator or a registrar, has read papers at societies, and has had to send testimonials to governors—documents which usually inform them that he is "peculiarly fitted" for the appointment which he has afterwards gained, and that he is a "gentleman." Then he has discharged the duties of physician or surgeon and teacher, first in the out-patient department and lastly in the wards. We all know what patience and self-denial are demanded of men who work their way up to leading positions in great medical centres. But they are not in a position to teach the student precisely what is required of the general practitioner. The young qualified man will have to start at once with his patients—provided that they come to him. His teacher has often not so much as thought about patients till he has

nearly attained his 30th year. His substantial gains are more often derived from pupils.

The young practitioner must learn human nature, and must not prescribe by rule-of-thumb nasty ready-made mixtures. He may at any moment be called to undertake a serious responsibility far from consultants, assistants, good nurses, and sanitary "homes" for patients. Thus he has to learn much that he has not been taught in his school, and this at his own or his patient's cost.

Lastly, the merited success of many men possessing only the so-called "lower" qualifications suggest that hard examinations sometimes crush common sense, and even discourage perseverance, whilst favoring youths of scientific or literary ability. In short it is clear that something is wanting in medical education. A move in the right direction has been made by the General Medical Council, which has recommended:

"That the fifth year should be devoted to clinical work at one or more public hospitals or dispensaries, British or foreign, recognized by any of the medical authorities mentioned in Schedule A of the Medical Act (1858), provided that of this year six months may be passed as a pupil to a registered practitioner possessing such opportunities of imparting practical knowledge as shall be satisfactory to the medical authorities."

If the spirit of this recommendation is loyally carried out; if students are encouraged by their teachers to take advantage of the opportunity suggested to become really acquainted with the every day detail of general practice, a great gap in our present curriculum will have been filled up.—*Br. Med. Jour.*

LOCAL TREATMENT OF DYSENTERY.

There seems to be in modern medical thought a very strong tendency to consider disease as constitutional rather than local. I do not doubt but that there are one or more forms of dysentery dependent upon the presence of poisons in the blood, but I feel very confident that the dysentery, as we see it ordinarily in this climate, is essentially a local inflammation, independent of any blood poisoning. If this be true, the disease should be especially amenable to local treatment. It is true that the ordinary treatment, which seems not to be local, really owes much of its efficiency to a local influence. Thus, the purgative acts by a purely local depletion; the mercurial, or the ipecac, by a local stimulation of the glands involved; whilst the bismuth spreads itself upon the mucous membranes and by its local action lessens inflammation. It has seemed to me, however, worth while to draw the attention of practitioners to the

value of the direct application of remedial agents to the effected parts.

Many years ago I published a series of cases of chronic dysentery, demonstrating the extraordinary efficiency of forced enemata containing one-half a drachm to a drachm of nitrate of silver dissolved in two or three quarts of water, and further experience has corroborated all that I have said. Indeed, from time to time articles have appeared papers in the medical journals proposing the treatment as both novel and efficacious.

In acute dysentery, involving the colon high up, I have found large enemata, containing two to three drachms of subnitrate of bismuth, much more efficient than the exhibition of bismuth by the mouth. When the symptoms are severe, this local treatment may often be preceded with advantage by washing out the colon with large quantities of cold water. I have never used injections of nitrate of silver in acute dysentery, although the effect of the local application of the nitrate in other inflammations of mucous membranes would justify trial of the remedy. I have seen, in one or two cases, large enemata of very hot water injected without affording relief, and believe that hot water enemata are, in their ordinary results, not at all comparable with large injections of ice-cold water.

When the lower part of the colon is effected, the local use of ice sometimes has an almost marvellous effect. I have, indeed, seen the whole aspect of a very severe and alarming case, in which the symptoms indicated that the colon was effected high up, changed in a single hour by the continuous use of *ice suppositories*. While it is not necessary to have the pieces of ice entirely regular in shape, care should be exercised that no sharp edges are left. The suppositories should be rapidly used, one being put into the rectum every three to five minutes, so as to get, for at least half an hour to an hour, the effect of the continuous application of cold.

When the tenesmus is very severe, iodoform suppositories are often much more efficient than opium in bringing relief.

A remedy which has been from time to time recommended very highly in dysentery, but has not, I think, been much used, is ergot; and when the passages contain large quantities of blood, or are nearly pure blood, the extract of ergot would seem to be indicated. I have never myself used ergot by the mouth in these cases, but have employed suppositories containing twelve grains of extract of ergot and four grains of iodoform, used every two hours until four or five suppositories had been taken with, seemingly, great advantage.

I do not mean to advocate the local treatment of dysentery as a substitute for the use of mercurials, purgatives and ipecacuanha, etc., but as a very important adjuvant to the older forms of treatment. Nevertheless, in my experience, the effect

of local remedies has been more prompt and decided than that of drugs given by the mouth; but in cases of any severity the attack upon the disease may be made from each end of the mucous tract.—Prof. H. O. Wood, M.D., in *Univ. Med. Mag.*

THE ORIGIN OF CHOREA.

Chorea bears in many respects a great resemblance, in its outset, course, and general characters, to the group of infective diseases. In man it most frequently follows or accompanies acute articular rheumatism; it generally occurs in children aged from four to twelve years, which is the age at which there seems to be a special predisposition to infective diseases; it generally runs a definite course, and even without treatment tends to disappear after a certain period of time.

These facts led Dr. Pianese to make an examination of the disease from a bacteriological point of view, and he now publishes (*Riforma Medica*, July 14, 1891) a preliminary communication on the subject. After seven months' work, he has come to the following conclusions:

1. From the cervical portion of the cord of a patient dead of chorea he has succeeded in isolating a bacillus, which grows on the usual culture media between 20° and 38° C., develops gas when cultivated in gelatine, grows on bread paste, shows slow movements when grown in a hanging drop, forms spores, and can be stained well with carbolic-fuchsin.

2. Inoculation of this bacillus into guinea-pigs, dogs and rabbits, whether subcutaneous, intraperitoneal, or intravenous, always gave negative results.

3. Inoculation under the dura mater, either of the cord or of the sciatic nerve in six dogs and thirteen rabbits gave a positive result. Inoculations into the nasal mucous membrane of four guinea-pigs were also successful.

4. Inoculation into the anterior chamber of the eye in rabbits succeeded in two out of three cases.

5. In the successful cases the symptoms produced were as follows: A tremor, sometimes general and at other times confined to special groups of muscles, particularly those of the back and shoulder; the animals became extremely irritable, even to trifling disturbance, and cried out when touched along the vertebral column. These phenomena generally appeared twenty-four hours after inoculation, and became more marked in the following days; there next appeared contracture in one or other of the limbs, and the gait became more and more uncertain and difficult; the animals got very thin, and generally died on the fourth day. Guinea-pigs inoculated in the nasal mucous membrane generally died in twenty-four to thirty-six hours; the dogs and rabbits inoculated

in the sciatic, however, recovered completely after presenting during twenty to thirty days a general tremor, with contractures and progressive wasting.

6. In the animals which died after inoculation, bacilli were found only in the brain, cord, and nerves, and cultures could be obtained from these parts.

7. The ganglion cells, especially those of the anterior cornua of the cord, showed changes in their protoplasm quite similar to those met with in cases of chorea.

8. In association with the red blood corpuscles of the vessels of the spinal cord in a choreic patient he found bodies clearly bacillary in nature, some exactly similar to those of the cultures, others apparently being involution forms.

Dr. Pianese is continuing his researches, and hopes soon to be able to bring forward further confirmatory evidence as to the real bacillary nature of the chorea.—*Supp. Brit. Med. Jour.*

SPECIAL HYPNOTICS.

Dr. Phillip Zenner, of Cincinnati, Ohio, writes in the *College and Clinical Record*:

Morphia is most indicated when the sleeplessness is the result of pain, fear or anxiety, or other bodily or mental discomfort. It is one of the surest of the hypnotics, and its sleep comes nearest to the natural one in its refreshing effects. It is specially indicated in anæmic subjects, and is, on the other hand, to be used cautiously in congestive conditions, or where there is cardiac weakness. It is to be avoided in children.

Chloral is perhaps the most powerful of the sleep-producing remedies. On account of its weakening influences on the heart it should not be used for very long periods, and should be used cautiously in cases of weak heart. In small doses it is a very favorite hypnotic, and deservedly so. Usually it is given in combination with the bromides, which increases its usefulness. A mixture of morphia and chloral has an unusually sedative effect.

Paraldehyde is a less powerful hypnotic than the preceding, but does not subject the patient to the danger of habit, nor does it threaten the heart. Its taste, occasional disturbance of the stomach and irritating effects on the bronchial tubes, in cases of bronchitis, are its chief objections. Its usual dose is one drachm, but it may safely be given in four times that quantity.

Amylene hydrate is said to be about equal to paraldehyde as a sleeping medicine, and to have none of the objectionable qualities of the latter, just mentioned. It is given in all forms of insomnia, the dose varying from ten to one hundred grains.

Urethan is a mild and agreeable, but less certain, hypnotic, and is not used very extensively.

Sulphonal has, perhaps, become the most popular of the recent hypnotics. The average dose necessary to promote sleep is from twenty to thirty grains. It is slower in producing its effects than other hypnotics, usually a few hours intervening before drowsiness is felt. This is because the medicine is very slowly absorbed from the stomach. This can be remedied to some extent by having the medicine finely pulverized and administered in a large quantity of hot fluid, bouillon, milk or the like. It will generally fail to promote sleep when the latter is prevented by pain. On the other hand, it is of special value when there is great motor restlessness, in chorea, maniacal conditions and the like. In large doses, when long continued, it is likely to cause a sense of vertigo.

A still newer remedy, and likely to receive equal favor with sulphonal, is *chloralamid*. This is a combination of chloral and formamid, but is said not to have the ill effect of the former, especially not to affect the heart or disturb digestion. Like sulphonal, it usually acts slowly, one to one hour and a half usually passing before sleep is produced. But it seems to have a somewhat more favorable influence than sulphonal in promoting sleep when pain is a disturbing element. The dose varies from fifteen to sixty grains. It is soluble in one and one-half parts of alcohol, or twenty parts of cold water. It should not be given in hot solutions, as it is decomposed by heat.

I will only mention one other hypnotic, *hydrobromate of hyoscine*. This is of special value in motor restlessness and the like. It is most frequently used in cases of insanity, especially maniacal conditions. Ordinarily the dose mentioned is from $\frac{1}{10}$ to $\frac{1}{20}$ of a grain, but it is given in maniacal cases in much larger doses, even as much as one-tenth of a grain hypodermically.

Perhaps I should not close this paper without mentioning some simple suggestions often sufficient in lighter cases of insomnia, and important in all, such as sleeping in a cool room, seeing that the feet and extremities are not cold, having warm, but light covers, not eating heavy meals shortly before retiring (though a light repast is often an aid to sleep), darkening of room and removal of other possible external disturbances. If in addition to all this, the patient retires with the determination and the belief that he will sleep (and the assurance of the physician is often of great aid in this particular), there is considerable prospect of his being successful.—*Pacific Med. Jour.*

IODIDE OF POTASSIUM, in large doses is said to be curative of urticaria.—*Central. f. Klin. Med.*

TREATMENT OF PHTHISIS.

In a clinical lecture, Dr. William Pepper deals with certain points in the treatment of pulmonary phthisis. Inhalations are better than the use of drugs in paroxysms of cough. As an inhaler, he prefers a simple jar with ample cork. Through the cork insert two tubes, have the material to be used placed in the jar, and allow the patient to draw air through the shorter tube. This apparatus can be made in a portable form by using short bent tubes, corked at each end, in which is placed sufficient of the preparation for one dose. A number of these tubes can be carried in the pocket; when the patient feels that a spell of coughing is coming on, he can open a tube and inhale its contents. A fair prescription for this purpose is the following:

R—Creasoti, 5j.
Tr. iodi, ʒij.
Chlorformi, ʒij.
Sp. vini rect, q. s. ad. ʒj.—M.

Sig.—Inhale ten drops.

Carbolic acid can be substituted for the creosote in somewhat smaller doses. Thymol, a highly volatile antiseptic, agreeable in odor, can be tried; tincture of conium may replace the chloroform. Occasionally, for a variety of reasons, a cough mixture may be necessary. Given in syrup form the expectorants are apt to be somewhat nauseating. Dr. Pepper prefers some such pill as the following, which relieves cardiac excitement in case of fever, is rather expectorant, and allays irritation:

R—Ext. opii, gr. iii-v.
Pulv. digitalis, gr. xv-xxx.
Pulv. scillæ, gr. xv-xxx.
Quinina sulph., gr. xxx.—M.

Div. in pil. xxx.

Sig.—One, two to four times a day.

If the squill nauseate, it may be left out. In place of the opium, if it be found to be too constipating, codeine may be given. Constitutional measures which will at the same time favor the appetite, be antiseptic, and help to render the lung a less favorable nidus for the bacillus, can all be added in one prescription, such as the following, which is not unpleasant to take:

R—Creasoti, gtt. xxxij.
Tincturæ gentianæ co., . . . ʒj.
Tincturæ nucis vomicæ co., . ʒij.
Sp. vini gallici, ʒij.
Glycerini, ʒj.
Vini xerici, Oj.

Sig.—A dessert to two tablespoonfuls.

—*St. Louis Med and Surg. Jour.*

THE TREATMENT OF ANEURISM OF THE AORTA BY POTASSIUM IODIDE.—Balfour details one case of aneurism of the aorta and makes reference to several others in which most satisfactory curative results were obtained by the administration of potassium iodide. To cure or even to improve an aneurism by the administration of the iodide the patient must not be starved, but must be well fed. The cure is effected by an hypertrophy of the walls of the sac, not by coagulating the blood within the sac, and is interfered with by lowering the nutrition. The iodide may possibly have some effect in producing hypertrophy of the fibrous tissues; indubitably, its most important effect is to cause a permanent lowering of the intra-arterial blood-pressure. To obtain so important a result it is not necessary to give the iodide in large doses. The proper course to pursue is to put the patient in the recumbent posture for several days, so that the normal pulse in recumbency shall be five or more beats lower than in the erect posture. Five grains of potassium iodide (sodium iodide has not the same effect) in some bitter infusion are given every eight hours, the pulse-rate being carefully observed daily at a stated time; after two or three days the dose of iodide is increased to ten grains every eight hours. In this way the dose may be gradually increased until the pulse-rate is observed to rise; then the administration is withheld for a day and the previous dose resumed. As soon as the pulse-rate increases, the benefit ceases and the constitution begins to suffer. But seldom is it necessary or advisable to increase the dose beyond ten grains every eight hours; commonly enough five grains suffice. The maximum of benefit is obtained from a dose just below that which lowers the blood-pressure so far as to cause the pulse-rate to rise. The remedy is administered every eight hours for two or three months. At the end of that time it need be administered but every twelve hours. The length of time the remedy should be continued depends upon the size of the aneurism when the treatment was begun. At least from three to six months are required to make the patient comfortable.—*Med. News.*

PATHOLOGICAL ANATOMY OF ECLAMPSIA.—In fifteen cases of puerperal eclampsia, Schmorr (*Centralblatt für Gynäkologie*, No. 29, 1891) found necroses in the liver in almost every case. He divides them by their microscopic and macroscopic characteristics into hæmorrhagic and anæmic, the first being much the more frequent. In five cases in which the heart and pancreas were also examined, necrotic patches were found mostly anæmic in the pancreas, mostly hæmorrhagic in the heart. In the kidneys there was invariably more or less of a degenerative process to be seen in the epithelium, and frequently hæmorrhages along the boundary line of the cortex. In almost

all the cases hemorrhages could be discovered in the brain, some macroscopic, but most microscopic. Pathological conditions were also found in the bloodvessels. There were numerous ruptures of smaller vessels which the writer ascribed partly to the compression of internal organs by the muscular spasms, partly by the contraction of the vessels themselves which accompanied the convulsions. There was noted, moreover, a separation of the endothelium in goods-sized shreds, which led to embolic obstruction of the vessels. This was also favored by the rupture of small vessels and the entrance into the circulation of parenchymatous cells. There were found not only emboli of liver-cells, as observed previously by Jürgens and Klebs, but also indubitable renal cells, and cells of placental origin in the circulatory system. The presence of these cells not only stopped up small vessels but also gave rise to thrombus formations and consequently to grave disturbance of the circulation. The whole pathological picture, says the writer, points to some poison in the maternal blood. Curiously enough, he would ascribe this poison to the decomposition of the parenchymatous cells within the blood, instead of giving the obviously correct view, that the poison emanates from the foetal body and is not excreted because the maternal kidneys have become, from some cause, insufficient to do their work of excretion.—*Univ. Med. Mag.*

A RARE HAIR TUMOR OF THE HUMAN STOMACH.
—Böllinger (*Münchener Med. Woch.*, June 2, 1891) details a case of rarity and interest as follows: A young woman, aged 17 years, was seen two and a half years before death; she was well preserved and had only the symptoms of a chronic catarrh of the stomach. It had been noticed that she bent forward in a peculiar way, especially at school. In the course of the disease she developed pain in the stomach and vomiting. In the course of the last year of life the patient took only milk, beer and water into her stomach, and that in small amounts. Six months before death the patient was confined to the house. Three weeks before death dropsy of both extremities and ascites developed. One year before death a very hard tumor was found in the gastric region, which was supposed to be a malignant growth. The *post-mortem* showed the stomach and duodenum to be packed tightly with hair. The contained hair weighed *thirty-two* ounces. The pieces of hair averaged six inches in length. The hair was so closely packed that it was scarcely possible to force fluid from the cardiac end of the stomach to the duodenum. As a young child, the patient frequently pulled hair from her head and drew it through her mouth. The mother had never known the patient to swallow hair, and thought she had in later years given up drawing

hair through the mouth. The author then quotes a case from Schörrnborn, in which he did a successful gastrotomy and removed a mass of hair weighing eleven ounces. Besides these two cases the writer mentions seven others. The tumors were found mostly in patients who swallowed hair. The time consumed in the formation of the tumor varied from ten to twenty-two years. The nature of the tumor was never diagnosed during life before removal. Only one of Schörrnborn's lived. The author calls attention to the fact that "hair balls" are not unfrequently found in the intestinal canal of domestic animals.—*Univ. Med. Mag.*

PUERPERAL ECLAMPSIA.—Having made a special study of the question of eclampsia, and having published a pamphlet on the subject in 1888, I wish briefly to lay before you my views on the pathogenesis and treatment of this affection. Normally the elimination of organic waste products is effected (1) by the kidneys, (2) by the liver, (3) by the intestines, (4) by the lungs, and (5) by the skin. The kidneys and the liver are, however, the organs of elimination *par excellence*. When for any reason this elimination does not take place, the organism is poisoned by the accumulation of these waste products which occurs. This intoxication manifests itself most frequently towards the termination of pregnancy, giving rise to convulsions known as puerperal eclampsia. Eclampsia, then, is obviously the result of a "strike" on the part of the organs of elimination, a cessation of function which may be restricted to one of them—the kidneys or the liver, for example—hence the frequency of jaundice and albuminuria in association with this malady; or it may involve the entire apparatus of elimination. From this pathogenic theory we may at once deduce the therapeutic indication. The great thing is to restore the elimination of organic waste products, and there are three principal ways of attaining the object we have in view: purgation by means of jalap or other drastic purgative; diuresis by means of digitalis, milk, water, and the mineral diuretics; diaphoretics, such as the hypodermic injection of the hydrochlorate of pilocarpin or the hot air bath. While we are waiting for these remedies—which take some time to act—to produce their effects, the convulsions may be allayed by anæsthetics (chloroform or chloral). In plethoric subjects one may have recourse to venesection, for the double purpose of securing the elimination of a certain quantity of toxic effete material and of favouring the re-establishment of the circulation normally slowed down by pregnancy. Lastly, delivery must be expedited by every possible means, because pregnancy itself, by the modifications which it causes and maintains, is the virtual cure of the eclampsia. To sum up: the pathogenic theory views eclampsia

as the result of a "strike" on the part of the organs of elimination, giving rise to intoxication of the organism. The therapeutics of eclampsia comprises the threefold indication to favour elimination by means of purgatives, diuretics, and diaphoretics, and the threefold indication of sedation by means of anæsthetics, venesection, and by emptying the uterus.—Dr. Auvard, Paris in *Brit. Med. Jour.*

BIRDS AS SURGEONS.—Some interesting observations relating to the surgical treatment of wounds by birds were recently brought by M. Fatio before the Physical Society of Geneva. He quotes the case of the snipe, which he has often observed engaged in repairing damages. With its beak and feathers it makes a very creditable dressing, applying plasters to bleeding wounds, and even securing a broken limb by means of a stout ligature. On one occasion he killed a snipe which had on the chest a large dressing composed of down taken from other parts of the body and securely fixed to the wound by the coagulated blood. Twice he had brought home snipe with interwoven feathers strapped on to the site of fracture of one or other limb. The most interesting example was that of a snipe both of whose legs he had unfortunately broken by a misdirected shot. He recovered the animal only on the day following, and he then found that the poor bird had contrived to apply dressings and a sort of splint to both limbs. In carrying out this operation some feathers had become entangled around the beak, and not being able to use its claws to get rid of them, it was almost dead from hunger when discovered. In a case recorded by M. Magnin, a snipe which was observed to fly away with a broken leg, was subsequently found to have forced the fragments into a parallel position, the upper fragments reaching to the knee, and secured them there by means of a strong band of feathers and moss intermingled. The observers were particularly struck by the application of a ligature of a kind of flat-leaved grass wound round the limb, of a spiral form and fixed by means of a sort of glue.—*Med. Rec.*

A NEW AND VOLATILE ANTISEPTIC FOR THE TREATMENT OF PHTHISIS.—This is another effort directed to destroy the tubercular microbe which Dr. Passerini has proved to be a success! The same experimenter has long endeavored to modify the trichlorphenol, but the odor and irritation to the mucous membrane is always a serious objection to its use. Dr. Tacchim, of Pavia, has now obtained a preparation of chlorphenol which has as much antiseptic power as trichlorphenol, and is free of all the objections against the latter. Chlorphenol is a very volatile fluid, whose vapor is heavier than air. When applied to wounds,

and discharging glands the improvement is marked. Ozæna, laryngitis, bronchitis, and more particularly tubercular affections, are beneficially affected. Passerini has treated five of the latter cases with the vapor, which being heavier than air, presumably reaches the bronchioles, if not the alveoli, of the lung itself, and he finds that the bacilli rapidly disappear after commencing the inhalations. All the five cases have quite recovered, varying from two to six months from beginning of the treatment, and are apparently well at the present time. The claims put forth are: 1. The inhalation of chlorphenol is easily borne in advanced phthisis, and is convenient in application. 2. No injurious effects arise from its continuous use. 3. Changes in the quality and quantity of expectoration till pus and bacilli disappear; cough is diminished; fever is reduced; appetite and sleep soon return; the weight of the body increases rapidly, and the local improvement is speedily performed. Hence the three conditions, applicability, innocuity, and efficacy are the dominant recommendations of the drug.—*Medical Press.*

LIFE INSURANCE AND SYPHILITIC "RISKS."—Mr. Jonathan Hutchinson has published a paper in the *London Practitioner* on the "Modern Treatment of Syphilis," in the course of which he considers some of the more important relations of syphilis and life insurance. He states that he has recently been requested by a life insurance company to formulate a code of rules for the guidance of its examiners when considering the acceptance or rejection of applicants for insurance who have had syphilis. His advice on this subject was for the most part favorable to the applicants; with this exception, however, that he would decline those persons who, at the time of their presentation, shall be undergoing the active development of secondary symptoms. These applicants, he advises, should be told to wait until these symptoms had disappeared. He based this counsel on the fact that it is always desirable to know how well or how ill the syphilitic patient sustains the specific treatment proper to the second stage of the disease, and also how willing and attentive he may be to follow out the directions of his physician. Mr. Hutchinson holds that an insurance company might make a profitable business out of syphilitic risks accepted in the early stage of the disease and taken at the ordinary rates, for he has found that the threatened life is often a long one. In his experience such syphilitic persons appear quite as likely to attain to length of days as others who have not been syphilitic. In the cases of those who present themselves free from symptoms, but who have the history of a former attack, the advice is that they be not refused, provided that they have not definitely become the subjects of the

tertiary lesions of the disease, or have not, owing to idiosyncrasy or inadequate treatment, had a prolonged siege of secondary symptoms. But even among these there are not a few who would be regarded by Mr. Hutchinson as eligible risks at ordinary rates.—*Jour. Am. Med. Assoc.*

ON THE SURGICAL TREATMENT OF IMPERFORATE HYMEN.—My ideas, then, as to the proper method of procedure, are as follows :

1. Warn the husband or friends of the danger of the operation.
2. Give the patient an anæsthetic.
3. Incise and tear the hymen freely.
4. Wash water in at once to take the place of and to wash out the blood and *débris*, and wash until the water comes out clear. Several quarts will be required.
5. Pack the cavity full of iodoform gauze. Use no compression on the abdomen.
6. Stitch the internal and external mucous surfaces of the hymen together.
7. Apply an antiseptic pad to the genitals.
8. Remove the gauze in forty-eight hours, wash out cavity, re-apply gauze.
9. Keep the patient in the recumbent posture for two weeks, and in bed or on a sofa for a week or ten days longer.
10. If symptoms pointing to ruptured or leaky tube, with accompanying peritonitis, set in, open the abdomen, remove the cause of the peritonitis if possible, wash out the peritoneal cavity, and drain. To be successful this must be done early.—*J. F. W. Ross, in Jour. Am. Med. Assoc.*

A NEW METHOD OF INDUCING PREMATURE LABOR.—Dr. Schrader, of Hamburg, has published a method of inducing premature labor based on his observation that cold is a greater excitant of the nervous, and consequently also of the muscular, system than warmth. Continuous irrigation at the temperature of 45° Fahrenheit is impracticable on account of the pain it causes, but a cold douche alternating with a warm one can be borne. Dr. Schrader connects a vaginal glass tube by means of a T-shaped piece and the necessary india-rubber tubes to two irrigators, one of which contains the cold and the other the warm water. By allowing now one instrument and now the other to work, cold or warm water may be sent through the vaginal tube into the vagina. Two people are required—the one to fill the irrigators, the other to work the douche. For each sitting about twenty-four litres of cold and half the quantity of warm water at 112° Fahrenheit are required, and the douche has a fall of about one metre and a half. The irrigation begins with the warm current, and before the cold water is turned on pressure is made on the perineum with the vaginal tube, so as to allow all the warm water to run

away from the vagina. The same plan is observed before the change from cold to warm, by which means the alteration in the temperature as felt by the patient is always sudden. Each time about two litres of cold and half the quantity of warm water are used. The douche is generally repeated about every hour and a half until labor is active enough to make its continuance probable. Of eighteen women treated by this method exclusively, and four others who were partly so treated, one died of eclampsia twelve hours after delivery, but all the others made a good recovery. The eighteen women who were treated by the douche exclusively had twenty children, of whom fifteen, that is, seventy-five per cent., were alive. These cases required on the average ten douches and a half ; in half the number three douches and a half were sufficient.—*Central für Gynak.—Med. Rec.*

BORAX IN THE TREATMENT OF EPILEPSY.—Borax was proposed for the first time by C. Folsom in the treatment of epilepsy in 1881. Gowers reported four cases treated with this remedy, out of which in three a cure was obtained. Dr. Dijoud (*El Siglo Medico*, 1913, 1890) has tried it in twenty-five chronic epileptic patients in which the bromides had been used either without success or with no satisfactory results. The duration of the treatment was from four to seven months ; the dose varied from one to six grammes daily. He entirely cured one, and notably relieved all the others, except six. From this it is apparent that borax is able to diminish—in a great number of cases which do not yield to the bromides—the frequency of the epileptic attacks. The dose may, without inconvenience, be carried up to six grammes per day, yet one should be careful to commence with one to two grammes daily, and progressively increase the dose. The following is a convenient form for a one to four grammes dose :

R—Sodii biborat, pulverizat, . . . 1-4.00
 Syrup corticis aurant, . . . 30.00
 Aquæ destillat, 100.00—M.

Sufficient for one day.

Sig.—To be taken in two doses ; one in the morning, and the other in the evening.

When the dose exceeds four grammes per day, one gramme of glycerin should be added for every gramme of borax over four grammes.

In the prolonged use of the remedy Dr. Dijoud recommends the following formula :

R—Sodii biborat, pulverizat, . . . 10.00
 Glycerine pur., 6.00
 Syrup corticis aurant, 94.00—M.

Sig.—To be taken by the spoonful.

—*Journal of Nervous and Mental Diseases.*

EUROPHEN.—This new antiseptic medicament designed to replace iodoform is obtained by the

action of iodine upon isobutylorthocresol. Its pharmacology and bacteriology have been studied by Siebel, and its therapeutic action by Eichhoff.

Europphen is an amorphous, yellow powder, exhaling a slight odor resembling that of saffron. It is insoluble in water and in glycerine, and is more soluble than iodoform in alcohol, ether, chloroform and the oils. Europphen adheres better than iodoform to the skin and to open wounds, and an equal quantity of it by weight, will cover a surface five times greater.

This iodide of isobutylorthocresol is not toxic. Dogs were found to take two or three grammes of it with impunity and the human organism will bear one gramme of it without unpleasant phenomena save a slight feeling of weight in the stomach.

The urine of patients who had absorbed europphen did not contain iodine.

Eichhoff employed it successfully in dressing both hard or soft chancres. He used it as a powder, and also in the form of one per cent. or two per cent. ointment. He furthermore employed it successfully in hypodermic injections of syphilitic patients suffering from the secondary and tertiary symptoms of syphilis. These injections consist of one gramme of europphen to 100 grammes of olive oil, and of this, one-half to one cubic centimetre was injected daily in one dose.

Eichhoff also employed europphen in varicose ulcer and ulcerative lupus as well as in eczema, psoriasis and favus, in all of which it proved to be efficacious.

Ointments containing one per cent. to two per cent. of europphen are as strong as need be used. Five per cent. ointments caused a certain amount of irritation

CASE OF SUDDEN AND UNEXPECTED DELIVERY IN THE ERECT POSTURE.—There being only a limited number of cases of sudden and unexpected delivery in the erect posture on record, the following case is perhaps worthy of mention :

S. D., aged twenty-one, who had previously after a lingering labor, given birth to one child, was recently visiting a friend, when she felt a sensation of giddiness. She therefore left and started on her way home. Having walked about fifty yards, a sudden pain in the abdomen was experienced ; the pain was so acute that she retired to a neighboring outhouse. She had no sooner arrived there than she gave birth to a full-term male child. The child fell headformost on to the stone floor. The fall was broken by the cord, the cord was ruptured, and no hæmorrhage occurred ; the child sustained no injury, not even a bruise being apparent and is still alive (two months after the occurrence). The mother walked back to her friend's house and has made a good recovery.

There had been a miscalculation of two months

in this case of the probable date of parturition, and the mother had no idea of the cause of the pain until the child fell from her.—E. Hugh Snell, M. D., in *Brit. Med. Jour.*

BRIGHT'S DISEASE.—*The Rev. de Clinic. et Thera.* publishes the following methods for the treatment of Bright's disease :

1. *Classic Method.*—The climateric prescription consisted in the avoidance of dampness and sudden changes of temperature. As to diet, rich or irritant articles of food were avoided, as were also eggs. A pure or mixed milk regime was followed, and such articles as wine, whisky, liquors and beer were entirely prohibited.

2. *Senator's Method.*—All white meats and pork are allowed, and the use of vegetables and starchy articles of food, fruits, fats and milk advised. Senator also recommends the employment of wine mixed with water.

3. *Semmola's Method.*—The author observes the preceding treatment and besides advises the employment of the following solution to be given in the course of twenty-four hours :

R—Iodide potassium, 15 grains.
Phosphate sodium, 30 grains.
Chloride sodium, 70 to 90 grains.
Water, 20 ounces.

4. *Bamberger's Method.*—Besides a milk diet, tonics and ferruginous remedies are employed. The author highly recommends the following preparation : Pills of perchloride of iron. Of these pills three to six are given per day. Each one contains :

R—Perchloride iron, $\frac{1}{3}$ grain.
Pulv. menyante (Buck-bean) $\frac{3}{4}$ grain.
Ext. gentian, q. s.

—*Med. and Surg. Reporter.*

THE CAUSE OF ANÆMIC HEART-MURMURS.—Anæmic heart-murmurs have been the subject of various ingenious explanations. The one given by the best text-books for a long time was a morbid condition of the blood, an explanation good as far as it went, but one that did not go very far. Recent investigations make it probable that these murmurs are due to a weakness of the papillary muscles of the heart, by which the curtains of the mitral and tricuspid valves are relaxed and so give rise to an adventitious sound. Experiments show that when in the death of an animal the heart gradually fails, the contraction of the papillary muscles lags more and more behind that of the ventricular wall, and ceases entirely some time before the rest of the heart stops beating. On account of their situation the papillary muscles are the part of the heart wall likely first to feel the effects of a decreased blood supply in anæmia ; corroborative evidence of this theory is found in

the fact that in acute anæmia and other conditions of sudden and great weakness, a heart-murmur is often to be detected, which disappears, upon compression of the iliac vessels or abdominal aorta, or upon the administration of alcohol or digitalis to strengthen the heart beat.—*North-Western Lancet.*

THE USE OF PURE BENZOL IN WHOOPING-COUGH.—After some years' experience of the use of benzol in whooping-cough, I can safely say that it effects better results than all the other remedies recognized as useful in this affection. In the adult and child it is of equal benefit. In an infant just now just now under treatment the attacks have been reduced from twenty to thirty in the night to two or three, and whereas when the treatment was begun evidences of bronchitis were present, now the chest is clear and the child able to be taken out of doors daily. All this improvement was brought about in less than ten days. I have administered benzol in whooping-cough, where convulsions and other complications were fast reducing all chances of recovery, with perfect success in a few days. In adults, where pertussis assumes often serious aspects, benzol has proved equally efficacious. Two minims in mucilage are sufficient for a child six months old, and five minims in mucilage on sugar or in a capsule for adults. I am indebted to an article in the *Practitioner* of some years back for information regarding this treatment, and can heartily recommend a trial of it. Whenever the benzol odor is observed in the breath of the patient, then all anxiety as to the result may be allayed.—W. Robertson, M.D., Glasgow, in *Lancet.*

IPECACUANHA IN LABOR.—While the accelerating action of ergot in cases of lingering labor is universally known and acknowledged, there is another drug which, so far as I am aware, is not noticed in works on midwifery, and which yet is capable in such cases of rendering signal service. I allude to ipecacuanha. Not only in cases of rigid cervix, where possibly it might be considered to act in a similar manner to antimony, but in cases of simple inertia, in either first or second stage, it is a potent instigator of uterine contraction. In the course of general practice extending over many years, I invariably carried a bottle of vinum ipecacuanhæ in my midwifery bag, and rarely, if ever, gave a dose of ergot in the first stage of labor. Time after time, on coming to a confinement case where the pains have been feeble and inefficient, or had totally ceased, two or three 10 or 15-minim doses of the wine at intervals of ten minutes, have been followed in a surprisingly short time by energetic uterine action, with a rapid termination to the labor. It never produces the quasi-tetanic contraction so often met with as the result of ergot, the pains

continuing to recur regularly, just as they do in natural labor, but with greater force and at shorter intervals. Conviction of the value of the drug for this purpose induces me to give my experience of it, believing that its merits will be recognized by any who choose to give it a trial.—*Drapes in Brit. Med. Jour.*

GONORRHOËAL RHEUMATISM.—In a discussion on the treatment of gonorrhœal rheumatism at a meeting of the Paris Société de Dermatologie et Syphiligraphie on May 14th, M. Jullien said that, having regard to the infectious origin of the disease, he had for the last five years systematically treated it with subcutaneous injections of bichloride of mercury with extremely satisfactory results. M. E. Besneir pointed out that joint inflammations of gonorrhœal origin often spontaneously underwent rapid modifications, which may be very difficult to judge of the effect of particular remedies. In his experience, local treatment was the most important therapeutic factor in such cases, and he placed most reliance on the method recommended by M. Lucas-Championnière, which consisted in touching the parts in a number of places with the point of the cautery, and then wrapping the joint in Vigo's mercurial plaster, with cotton-wool dressing afterwards. M. du Castel said he had tried mercurial friction in one case without result, while in another case, in which, however, the inflammation was less severe, it had done a great deal of good.—*British Medical Journal.*

DIETETIC TREATMENT OF EPILEPSY.—Whether the theory of the explosion of nitrogen in the brain substance as the cause of the epileptic seizure be true or not, certain it is, according to John Ferguson, that the malady is aggravated in patients subjected to nitrogenous diet. This fact seems to have been confirmed by clinical experience and actual experimentation. Ferguson, therefore, acting on the strength of such a fact, has subjected his epileptics to a strict vegetable diet, and has even dispensed with the use of drugs. This method has given, in his hands, excellent results, especially in well-marked cases of status epilepticus. In these cases a non-nitrogenous vegetable diet alone has rendered better service than the bromides, with restriction in diet.—*Therap. Gazette.*

PAINLESS CIRCUMCISION.—Dr. W. G. Overall, in the *Med. Record*, gives the following as his method of circumcision. Apply a rubber band around the penis half an inch back of the corona, in order to limit the effects of the cocaine. Place a pillow on the patient's chest to prevent his seeing the operation; then, with a small blunt-pointed syringe, inject a few drops of freshly prepared thirty per cent solution of cocaine into the pre-

putial orifice. Hold the end of the prepuce with the left hand, to prevent escape of the fluid, and with the right hand force the latter to come in contact with the entire mucous membrane. Hold the prepuce in this manner for five or six minutes, when the membrane will be anæsthetized. Now inject the necessary amount of the solution into the tissues of the foreskin, taking care that the needle is passed through the mucous layer instead of through the skin, pain being felt if the latter procedure be adopted. The operation can be carried out in this way without the slightest sensation of pain being felt. Absorbable sutures should be used.—*Med. Brief.*

NEURITIS DUE TO POISONING BY ARSENIC.—Dr. E. G. Cutler, in the *Boston Med. and Surg. Jour.* reports a case of neuritis due to poisoning by arsenic. The patient was in the habit of placing in his mouth a number of green paper labels—which were proven by analysis to contain arsenic—in connection with his employment. The earliest symptoms were numbness and pricking of the fingers, with weakness of the right hand. The weakness in a few days extended to the other limbs, and was accompanied by general soreness and cramps in the calf muscles. The grasp was feeble and the gait shuffling; knee-jerks absent, superficial reflexes weakened; no dyspepsia or urinary trouble; bowels rather constipated; no headache or disturbance of vision. The patient recovered under the administration of iodide of potassium, sponging with salt water, and subsequent daily rubbing with ice.—*Pract.*

CHRONIC RHEUMATISM.—The clothing of the patient must be attended to. It is essential that flannel should be worn next the skin. The Jäger underclothing is very good. The diet should be nourishing, and, if stimulants are required, a little whiskey is, perhaps the best. The internal treatment adopted is very various. I have found the following prescription most useful:

R—Pot. bicarb., gr. xv.
 Pot. iod., gr. ij.
 Tr. hyoscyam., ℥ x.
 Spt. chlorof., ℥ v.
 Inf. gentian., f ʒss.—M.

Sig.—Ft. haustus, ter in die.

In strong adults, a few drops of vin. colchici is beneficial. I have seen good results from three-grain doses of salicylate of soda three times daily. Gaiacum is very useful in some cases.

NAPHTHALINE AS A VERMIFUGE.—According to Dr. Mirovich, of Bielsk, naphthaline is an admirable remedy not only for ascarides, but for tape-worm. He considers it much more certain and far less poisonous than most of the other vermi-

fuges. For grown-up people he prescribes a fifteen-grain powder, to be followed immediately by two ounces of castor oil. For two days before this dose the patient is directed to live on salt, acid and highly seasoned food, then the naphthaline is given fasting early the following morning. In the case of children, naphthaline may be mixed with castor oil, flavored with a drop or two of bergamot. In all the cases in which this plan was carried out, including some in which more ordinary means had failed, the whole tænia was expelled with its head after the first dose.—*Lancet.*

IODOFORM IN THE TREATMENT OF BURNS.—Rotenberg (*Ther. Monatshefte*), advocates the following method of treating burns. He is surgeon to large ironworks, and sees many cases of all degrees of severity. The blisters, are pricked, and a silk thread soaked in corrosive sublimate solution run through them, and allowed to remain. The whole surface, no matter what the degree of burning, is coated thoroughly with a thick layer of vaseline containing 10 per cent. iodoform, and then covered with guttapercha. The ointment is renewed daily. The pain is always very speedily lessened, and healing takes place in an eminently satisfactory manner, and quickly.—*Suppl. Brit. Med. Jour.*

ADMINISTRATION OF ANÆSTHETICS TO CHILDREN.—Dr. Ness, in a discussion published at a recent date in the *Glasgow Medical Journal*, reports 1,000 cases in which anæsthetics were employed at the Hospital for Sick Children. In all these cases careful notes were, and there were at least a thousand more of which no record was kept. Chloroform was almost invariably used, ether being employed only in exceptional cases. No death has ever occurred during the administration of an anæsthetic. The mode and details of administration were not given.—*N. Y. Med. Jour.*

IN PRAISE OF WOMEN.

O woman, in our hours of ease
 Uncertain, coy and hard to please,
 When pain and anguish wring the brow,
 Then none so cheaply pleased as thou!
 We've only to submit to take
 Hot rhubarb tea and anti-ache,
 And gizzard oil and ipecac,
 And porous plasters on the back,
 A flaxseed poultice, catnip tea,
 And Quackem's pet discovery,
 Hot water bags, and sweets besides,
 And camphor nasally applied,
 And castor oil and vaseline,
 And coals with feathers burnt between,
 And soothing syrup, paregoric,
 Cold water cloths and drinks caloric,
 And all the housewife's category—
 'Tis then we see her in her glory,
 Needing, to make her bliss complete,
 But mustard plasters on our feet.

—C. F. L. in *Harper's Bazar.*

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A FEW CAUSES OF ALBUMINURIA.

We have come to look upon the presence of albumen in the urine of non-*puerperal* persons, as of much less importance than did medical men one or two decades ago. Current medical literature abounds with discussions on the significance of the symptom. Especially has the question been mooted as to whether a slight, transient, or even recurring albuminuria, should prevent insurance companies issuing policies to persons so affected. This question is not definitely settled, but the general opinion of pathologists seems to be that, while such an expression as *physiological albuminuria* is a contradiction of terms, yet we may have an albuminuria without any apparent lesion of the kidneys, or other organic disease, and that such condition is not at all a menace to life, and is quite amenable to treatment. Six causes have been, so far as we know, assigned for this condition of things. First, in persons who are suffering from oxaluria, in which case, it has been suggested, that the albumen is derived from the mucous surfaces of the urinary passages being torn and scratched by the sharp edges of the crystals. These persons are profoundly depressed, are more or less dyspeptic, and are greatly benefited by the administration of one of the mineral acids, notably nitric, or nitro-hydrochloric.

The second class comprises the lithæmic type, which usually occurs in children who are over-fed, especially with solid food and with an insufficiency of water or other fluids. It is also noticed in

adults who have a tendency to gout or rheumatism, on too heavy feeding. The treatment in this class is obvious.

The next group is what is described by some writers as *paroxysmal albuminuria*, but for which a better name would be *hæmoglobinuric*. In this condition, instead of a true *hæmoglobinuria*, with its red colored urine, caused by the presence of the red coloring matter of the blood being dissolved from the red blood corpuscles, and its subsequent transmission to the urine, we have albumen passed. It is caused often by sudden exposure to cold, as by the patient taking a very cold bath.

A fourth class is what Dr. Goodhart calls *neurotic albuminuria*; out of a list of thirty-nine cases, seventeen were placed in this class. The theory of causation is the exhaustion of the higher brain centres from work and worry; the lower centres lacking "the inhibitory influence of the higher centres fall into a turbulent condition," the result of which is an intermittent discharge of albumen—a condition "analagous, perhaps, to the flushing of neurotic women." This seems delightfully vague, but is perhaps as clear an explanation as can be given in a few words, of a condition that undoubtedly exists in over-wrought, nervous subjects, and others suffering from *neurasthenia*.

Another group which the same author classes as *extra-renal albuminuria*, is that in which the albumen is derived from the genito-urinary passages, as from *leucorrhœa* in women, and from *gleet* or other venereal discharge in men, or indeed from seminal fluid or prostatic secretion. This class can hardly belong, in the proper sense of the term, to the *albuminurias*, and yet must be taken into account in any careful examination of the urine.

Another, and more important group, consists of those cases in which the discharge of albumen is due to the action of drugs on the renal secretion. Thus *digitalis*, causing a temporary contraction of the renal vessels, has been shown to produce a transient albuminuria, acting in a similar manner to *ligature of the vein*. Poisoning by *strychnia* acts in a manner similar to *digitalis*; *cantharides*, by producing congestion of the kidney and alterations in the glomeruli and convoluted, and, eventually, in the straight tubules. The tension of the blood is markedly increased, and the liquid constituents of the blood pass through the vascular

walls and carry with them granules, red and white corpuscles.

Mercury, when ingested for a long time, seems also to produce in persons with apparently perfectly healthy kidneys an albuminuria, though it might be interesting to know whether it is really the drug that is at fault, or the disease for which the mercurial course is prescribed. Lead and opium are the two other important drugs which are credited with this evil influence upon the renal secretion. The latter drug, when persistently used in large quantities, has been noted as producing a chronic discharge of albumen which eventually ended in uræmia.

As to the question of this latter class being truly functional, there is no doubt that cantharides produces transient structural changes in the kidneys, while all the heavy metals in the process of their elimination by the kidneys, if they have been thrown into the circulation in large quantities, also produce—by irritation—changes in the glomeruli and tubules.

Among the more common diseases which produce transient albuminuria, may be mentioned croup, diphtheria, typhoid, erysipelas, intermittent fever, pemphigus, acute pneumonia and scarlatina.

From a consideration of the above facts, it will be seen that in placing an albuminuria in its proper place as regards etiology, and in coming to a conclusion as to its probable effect upon the patient's future, the physician must take a wide survey of all the attending circumstances, and keep the patient for some time under close observation lest a serious error be made as to prognosis and treatment. There can be no doubt that hundreds of quite healthy persons are annually rejected by insurance companies, because of transient and functional albuminuria, thereby entailing much worry and loss, not only upon the unsuccessful applicants, but also upon their families and friends.

FRIEDRICH'S ATAXIA: ITS RELATION TO THE CONDUCTING PATHS IN THE SPINAL CORD.

At the Congress of American Physicians and Surgeons, Dr. David Inglis, of Detroit, read a paper upon the above subject before the American Neurological Association.

He reports, in brief, a case of Friedrich's ataxia in a boy of six years of age, in which the symptoms conformed accurately to Friedrich's own summary of the characters of the disease, viz., "Impairment in the combination and harmony of movements, developing gradually, and spreading from the lower to the upper half of the body, and always involving finally the organs of speech. Sensibility and the functions of the special senses and of the brain being intact, paralysis of the sphincters and trophic disturbances are absent. Less common phenomena are curvature of the spine, sensations of vertigo and nystagmus. From a clinical point of view we must regard the disease as a progressive paralysis of the faculty of combination of movements."

A review of the thirteen recorded autopsies shows a practical agreement that the pathological condition underlying the disease consists in a progressive sclerosis which always effects the column of Goll, the column of Burdach also, but not so completely, the direct cerebellar tracts with Clarke's column in most cases, and the crossed pyramidal tract in some cases, but the sclerosis is here not so intense. We have to deal with a disease of the tracts which degenerate upward, which are usually looked upon as centripetal, and as conveying sensory impulses.

Authors contend that the symptoms of Friedrich's ataxia afford a demonstration that these tracts do not convey sensory impulses upward, for sensation is not impaired, but that they are the main tracts for the conveyance of co-ordinated motor impulses downwards; that their anatomical relations with the medulla, cerebellum and mid-brain, as well as the facts of Friedrich's disease, agree in showing them to act to co-ordinate motor impulses of the mid-brain, cerebellum and higher and lower levels of the cord.

The facts of embryology strengthen this theory; at the end of the fetal life, at a time when the pyramidal tracts are undeveloped, the posterior columns and direct cerebellar tracts are complete. Their function evidently begins at once after birth. When we remember that the new-born infant is characterized, not by voluntary control of its muscles, not by accuracy of sense perception, but by an extensive co-ordination of involuntary motor functions, the conclusion is easy, that these, the

only tracts fully developed at birth, subserve these purposes.

The direction of Wallerian degeneration is not necessarily the same as the direction of normal physiological impulses in any given nerve tract.

THE NEW HYPNOTIC: SULPHONAL.

Sulphonal was first discovered, says the *New England Medical Monthly*, by Professor E. Baumann, of the University at Freiburg. Its physiological actions and clinical uses were first examined by Professor Kast, who is also a member of the medical faculty at Freiburg University.

Sulphonal has been found to be a reliable hypnotic which has none of the peculiar effects of the narcotics on the nervous and circulatory systems. It has no injurious secondary effects, and may be taken in the proper doses with impunity in order to produce natural quiet sleep.

It has another great advantage which is of considerable practical importance, viz.: its absolute freedom from taste and odor.

This new hypnotic has been tried quite extensively during the last twelve months, and very favorable results are reported by various observers.

Professor Kast, of Freiburg, published the results of his experiments in the *Berliner Klinische Wochenschrift*, No. 16. He gave the drug to 20 healthy persons, after having convinced himself of its relative harmlessness by experimenting on dogs. These had demonstrated a decided physiological action on the gray cortex of the cerebrum, inducing sound, natural sleep, without any disagreeable after effects. The dose usually employed was 2.0 to 3.0 Gm. (30 to 50 grains.) Healthy persons would feel tired and sleepy after its administration, but only a minority of the whole number experimented upon (20) would actually fall asleep and remain asleep for a number of hours. Then sulphonal was given to more than thirty hospital and private patients, about 120 single observation being recorded. Nervous sleeplessness, due to neuroses or psychoses, insomnia accompanying acute febrile diseases and sleeplessness of old age where principally selected for the purpose.

Almost without exception sound and quiet sleep was produced from within thirty minutes to two hours after the administration of the drug. No untoward symptoms were observed on awakening, the sleep being as refreshing as if it had been due to natural causes. Pulse, perspiration and digestion were not interfered with. The average dose was 30 grains, 15 grains being sufficient for women, while men occasionally required 45 grains.

Another remarkable feature is mentioned by Kast: that no tolerancy is established towards the drug. Its action is the same after many doses have been taken by the same individual as after the first dose.

Similar observations were made by Dr. G. Rabbes (*Berliner Klinische Wochenschrift*, No. 17): he administered sulphonal 220 times to 27 patients suffering from various forms of insanity, —e. g., melancholia, mania, general paralysis, etc.

No untoward symptoms are produced, not even when larger and repeated doses are administered, —i. e., 60 grains, changing off in short intervals with 30 or 45 grain doses. One patient took one ounce in six consecutive days. Rabbes never saw digestion, respiration or the heart's action unfavorably influenced by sulphonal, and therefore warmly recommends its use.

If given several hours before bedtime sulphonal will produce sound, uninterrupted sleep.

EXCISION OF THE APEX OF A TUBERCULOUS LUNG.—*La Gazetta Médica de Granada—Med. Rec.* reports a case of the successful excision of the apex of a tuberculous lung by Dr. Tuffieri, who, prior to the operation, had satisfied himself of its safety by a series of experimental operations on the lower animals. Cutting through skin and some fibers of the pectoralis major, Dr. Tuffieri laid bare the intercostal muscles of the second intercostal space, and cutting through these he exposed the parietal layer of the pleura, which he detached from the thoracic parietes. Opening the pleura, he found the lung apex studded with tubercle and slightly shrunken. Round the apex he passed a ligature, which he attached to the second rib, and then excised five centimetres of the tuberculous mass. The patient was, on his recovery, exhibited before the Surgical Society.

SOME FALLACIES IN GYNÆCOLOGY.—The following rather sweeping statements from the *Times and Reg.*, taken with a grain of salt, will be read with interest by some of the younger members of the profession, and perhaps by some of the older ones, too:—The pessary fallacy is a most pernicious one. The pessary craze still has a firm hold, not only upon women, but clings tenaciously to a majority of the profession. There are some cases where a well adjusted pessary serves a good purpose as an adjunct to the cure or promotion of the comfort of the patient, but the indiscriminate, unscientific, and, perhaps, criminal use of pessaries by amateur gynæcologists and physicians experienced in general practice, but unskilled in gynæcology, is only mentioned to be condemned in the strongest terms. Another fallacy is "the ulceration of the os." This disease exists, in the majority of cases, only in the mind of the physician. Laceration of the cervix does not necessarily require an operation for its cure. Experience has taught Ferguson that the great majority of cases of laceration of the cervix can be cured without subjecting the victims to dangerous operation. During the past year he has operated on but one laceration of the cervix; during the same time a dozen have been cured by other treatment. The "change of life" is not necessarily a period of peculiar peril and intense suffering as is often supposed. If a woman has good health and no organic disease of the reproductive organs, she will suffer nothing more at this period than slight nervous symptoms, such as flushes, slight headaches, etc., the results of vaso-motor disturbances. If she has pain or hæmorrhage, or profuse leucorrhœa, singly or combined, it is almost certain she is afflicted with organic disease, as cancer, fibroid tumor, endometritis, salpingitis, or ovaritis. During the past year four women who were supposed to be suffering from "change of life" have passed through the hands of Ferguson, and three of them are now dead from cancer. A fallacy of firm hold in the minds of many is that pruritis vulvæ is frequently a neurosis—that is to say, that it is of centric origin without any lesions of structure, or accompanying affections to account for it. Where uncleanly habits of the patients are not the cause, the trouble can be traced to some disease existing in the vagina, the uterus, or the bladder. These are only a few of the numerous fallacies.

Though not practicing gynæcology as a specialty, we have known pessaries to give relief, even when introduced by our unskilful hands, and are persuaded that ulceration of the os is not entirely a dream. All the same, we are with the writer in thinking that pessaries and ulceration of the os have been run to death.

ARISTOL, one of the most recent additions to the dermic remedies, occurs in the form of a brownish, amorphous powder, and is an iodide of thymol. Both of these drugs have been used extensively, and now the reports indicate that by their combination a medicament has been produced which bids fair to supersede both iodoform and iodol, although the claims with reference to its antibacterial properties which were first advanced have not been demonstrated. In the treatment of diseased structures, ulcers, wounds, and as a topical dressing, it is used in the form of a powder or ointment, but should not be combined with starch, caustic alkalies or carbonates, or in fact any substance which has an affinity for iodine. When it is desired that the remedy should penetrate the tissues to which it is applied, it would be well to combine aristol with lanolin, as by this means the moisture of the tissues would be absorbed, thus permitting the medicament to come into direct contact with the diseased structures. Aristol is now enjoying a deserved popularity with surgeons and gynæcologists, and is highly prized by those specially engaged in the treatment of cutaneous and venereal diseases.

In the *Alabama Med. and Surg. Age*, Dr. Cunningham reports the case of a mulatto woman delivered of a monstrosity. A cut is given, that shows the resemblance to a dog to be so strong as to render the explanation given inadequate. This is, that while the woman was "breeding," she was frightened by an opossum. We should be more inclined to think there had been a "coon" around.

ABOVE THE COMMON HERD.—Robert Louis Stevenson says:—"There are men and classes of men that stand above the common herd; the soldier, the sailor, and the shepherd not infrequently; the artist rarely; rarer still the clergyman; the physician almost as a rule."

THE TREATMENT OF ACUTE EFFUSION INTO THE KNEE-JOINT BY TAPPING.—Owen (*Practitioner, Am. Jour. Med. Sciences*) has treated a number of cases of traumatic effusion into the knee-joint by means of paracentesis, and has met with such satisfactory results that he indorses this procedure in all such cases.

An ordinary hydrocele canula should be employed, the operator fulfilling all the requirements of antiseptic surgery. The treatment does not differ whether the fluid is blood or sero-synovia. If the joint has begun to swell directly after the injury the distending fluid must necessarily be blood. If, however, one or more days have intervened between the hurt and the swelling, the fluid has been poured out by the inflamed synovial membrane.

The puncture is made on one side of the patella. Just as the fluid has ceased to flow through the canula the latter should be blocked by the finger and withdrawn. This prevents the introduction of air into the joint. The skin puncture is covered by a scrap of lint dipped in collodion or by a little pad of dry wool. The knee, together with the upper part of leg and the lower half of the thigh, is then enclosed in short splints or a plaster-of-Paris bandage, being fixed in the extended position with the foot slightly raised. The site of puncture may be rendered anæsthetic by the application of ice and salt.

The first reported case entered the hospital some hours after the infliction of a severe bruise of his right knee. The joint was greatly distended. It was put to rest and an ice-bag was applied. On the following day the patient was suffering from great pain and could not bend or straighten the knee. The trocar and canula were thrust into the joint; blood and synovia spurted out for some distance on withdrawing the trocar. Two and a half ounces of liquid were drained out. The small puncture was dressed with a pad of absorbent wool, and a plaster-of-Paris cast was applied reaching from a short distance above the malleoli to the middle third of the thigh.

Immediately on withdrawal of the fluid the patient experienced relief and vigorously flexed and straightened his leg. He was discharged on the fifth day still wearing the plaster splint.

A number of other cases are reported in which the results were equally satisfactory.

CHRONIC ARSENICAL POISONING FROM COAL.—

The force of these observations is less in this country, where much less coal is burnt in open grates and fire-places than in Britain, and yet the fact that arsenic may be diffused in the air we breathe is worthy of note even in Canada. When coal is burned it is roasted out and it is the only product of the coal which is at first volatile and afterward non-volatile. A part of the smoke that goes into the air is arsenious acid mixed with carbon, and a large part of it lodges in the chimneys. Now, take a city like London, or any of the great English cities where coal is burnt very freely, there the quantity of arsenious acid that is given into the air must be very considerable, and it would be interesting to make comparative tests of the urine of persons in a city like Boston and in a city like London. The English coal is very bad coal in this respect. Every ton of coal burns off about twenty to forty pounds of sulphur. That sulphur is transformed into sixty pounds of sulphuric acid, which has left its stain upon every marble building in London. I speak of the sulphur because the sulphur is largely accompanied by arsenic.

PHENACETINE IN SCIATICA.—Sciatica is not only one of those affections which are extremely annoying and painful to the patient, but on account of its persistency often greatly tries the patience of the physician. At the Clinic of Prof. Landon Carter Gray most benefit has perhaps been obtained from phenacetine, given, say, in tablets of four to eight grains every three or four hours. There are a good many cases, however, which do not respond to it very markedly. Doubtless, too, there are many cases of sciatic neuritis, rheumatism, gout, etc., in which a diagnosis of sciatica is erroneously made; but perhaps more frequently sciatica is mistaken for one of these affections.

ARISTOL IN ATROPHIC RHINITIS.—Dr. W. C. Braislin (*Brooklyn Med. Jour.*), recommends the use of aristol in atrophic rhinitis. He applies it by means of an insufflator, after the scabs and discharges have been cleansed, or washed away. It is germicidal and mildly stimulating in its action, and forms a sort of dry antiseptic dressing under which granulation seems to proceed with extraordinary rapidity.

NO DOUBT OF THE DIAGNOSIS—The following humorous description (*Western Med. Rep.*) will be read with appreciation by all who have gone through it:—Nature with a lavish hand has endowed the human body with no less than s'teen million of spots to which an ache or pain can be attached. When each one of these spots, both inside and out, is filled with a hard platinum-tipped pain; when your head aches so that you are conscious of all the ruffles and scallops on your brain, just as you see them in the pictures in your physiology; when your heart thumps and your stomach wobbles and you have the feeling that something is wallowing through your inside works; when your sternum feels stove-in and there is an uneasiness under your shoulder-blades as though your wings were beginning to sprout; when you are one moment alive to the finger tips with thinking of the things you must get up and do, and the next completely exhausted by even the thought of doing them; when your back-bone has the sensation of being twisted by a monkey-wrench; when you are so dizzy that you can't see, and your ears ring and eyes water and your nose is in such a state that it is presumption to lay aside your handkerchief for one short minute; when you cough and sneeze and groan in turn—in fine, when you feel like the very deuce—you can set it down that you have the grip.

THE TREATMENT OF CHRONIC ECZEMA BY CREOLIN.—In a paper read by R. Glasgow Pattison, of Dublin, before the Royal Academy of Medicine in Ireland, he gives directions for the use of creolin in chronic eczema. He states that the best strength is that of one drachm of creolin to eight ounces of water. In this proportion it forms a soothing emulsion which has a marked effect in allaying the itching and irritability. The mode of applying it must be modified to meet individual cases.

The parts affected must first be freed from crust or other accumulation, and then be bathed in the fresh emulsion for from ten to fifteen minutes. If there is much secretion, lint soaked in the liquid may be applied over all parts and retained in place by dressings; but if the eczema is of the squamous type, treatment in the intervals is best carried out by means of ointments. Under this treatment we have recently had cases recover with astonishing rapidity.

FOR SCIATICA.—Dr. Starr, in his work on Nervous diseases, gives the following as having proved useful in his practice, in the treatment of sciatica. Anything that holds out a hope of relief in this *bête noir* of the profession, may be welcomed:

R—Tinct. colchici, ℥ $\frac{3}{4}$.
 Tinct. cimicifugæ, ℥ $\frac{3}{4}$.
 Tinct. aconiti, ℥ $\frac{3}{4}$.
 Tinct. belladonnæ, ℥ $\frac{3}{4}$.—M

Sig.—One dose.

Again, Dr. S. J. Corbett, of San Francisco, writing to the *Med. World*, says: If Dr. E. H. Carlton wishes a remedy for sciatica that will relieve all cases and cure 80 per cent., I will call his attention to a remedy which I have used for twelve years, and one on which I depend in all cases.

If the patient is a lady of weak, nervous temperament, write this prescription:

R—Ol. tiglii, gtt. j.
 Pulv. lycopodii, q. s. ft., capsule No. 2.

Sig.—Take one capsule at 8 a.m.; the other at 2 p.m.

If the case is one of true sciatica, *i.e.*, congestion of sheath of nerve, the relief will be complete in twenty-four hours. If it is a case of rheumatic sciatica, it will be relieved but not cured.

If the case is that of a strong robust man, write,

R—Ol. tiglii, gtt. iij.
 Pulv. lycopodii, q. s. ft., capsule No. 2.

Sig.—Take one capsule at 8 a.m.; the other at 4 p.m., if the first has not operated fully.

I have practised medicine twenty-three years and have treated many cases of sciatica with all kinds of remedies, *i.e.*, hypodermics, blisters, hot and cold applications, electricity (both galvanic and Faradic currents), sun baths with all the different colored glasses, *etc.*; but I have found that the little drop of croton will get away with all the other remedies combined. By inducing immense watery discharge from the bowels, it relieves the congestion and thus cures the patient.

FARADIZATION IN INCONTINENCE OF URINE.—Dr. Jamin reports (*Med. Rec.*) a case of incontinence in a girl aged fifteen, where internal medication had failed of any result, in which a complete cure was obtained by faradization of the urethra—the negative pole in the urethra, and the positive on the thigh.

PERMANENT CATHETERIZATION OF THE URETERS.

—This procedure seems practicable, as the following, from *Univ. Med. Science*, goes to show :

MM. Albarran and Lluria, at the last meeting of the *Société de Biologie*, reported that having tried their method on the cadaver, they had operated upon a dog and placed a catheter in each ureter, which the animal retained without any inconvenience. Professor Guyon recently performed a supra-pubic cystotomy on a young girl who had chronic cystitis; he introduced catheters made after the author's model, in both ureters, which performed their functions very satisfactorily for four days. The urine from one kidney was purulent and that from the other was perfectly clear; it came out drop by drop externally, and was received in two sterilized vessels. The bladder could then be curetted and dressed like an ordinary wound. The patient did not suffer in the least.

PHENACETINE IN RHEUMATISM.—The Berlin letter in the *Med. and Surg. Rep.*, for April 12th, contains among other good things a statement of Dr. Collischon's success in the treatment of acute articular rheumatism with phenacetine. Twelve grains should be given four times a day, or thirty grains twice a day. After the pain has disappeared it is advisable to continue the drug in small doses. It is similar to salicylic acid, inasmuch as it acts best in cases of marked febrile type while it is useless in muscular cases; and in the necessity for the use of large doses. On the other hand it does not possess the disagreeable after effects of salicylic acid.

TREATMENT OF CONDYLOMATA.—Dr. G. Finco (*Gazette Medica Lombarda*, June 21, 1890) recommends the following in the treatment of condylomata :

R—Collodion, 2.00 grams.
 Mercur. corrosiv., 0.02 "

The collodion should be poured into a small cup, the corrosive sublimate added, and the whole well shaken, as the sublimate does not dissolve in collodion. The largest condylomata may be touched with a small brush dipped into the mixture, following this with the local application of cold water. On the following days the others may be treated until all are removed.

MOUTH WASH.—Dujardin-Beaumetz is said to recommend the following to keep the teeth in good condition :

R—Acidi carbolic, gr. xv.
 Acidi boric, ʒ vj.
 Thymol, gr. viij.
 Ol. menth. pip., gtts. xx.
 Tinct. anisi, ʒ ijss.
 Aquæ, O ij.—M.

This should be mixed with an equal part of water, and used two or three times a day.—*Bost. Med. and Surg. Jour.*

FOR WARTS.—Instead of the painful process of removing warts by nitric acid, which is perhaps the most usual method, the following formula is given (*Med. and Surg. Rep.*) :

R—Acid salicylic, gr. xv.
 Alcohol, ℥ xvj.
 Ether, ʒ j.
 Collodion, ʒ ij.—M.

Sig.—Apply daily to warts.

IVY POISONING.—Kite (*Med. News*) says that bathing the parts with "black wash" effects immediate relief and a prompt cure.

FISSURED NIPPLES.—

R—Balsam of Peru,
 Tr. arnica, āā ʒ ss.
 Oil of sweet almonds, ʒ j.
 Lime water, ʒ ss.—M.

Sig.—Apply a small quantity several times daily.

SUBINVOLUTION OF THE UTERUS.—Prof. Barton Cook Hirst, of the University of Pennsylvania, recently gave the following as the best combination to use :

R—Strychnine sulphatis, gr. ʒ¹/₅.
 Quinine sulphatis, gr. ij.
 Ext. ergotæ, gr. j.

M. ft. pil. No. 1. Sig.—At one dose; to be repeated thrice daily.

OUR esteemed contemporary, the *American Lancet*, does not know what "hen sense" is. It is a "high grade" of sense—that kind of sense which will not permit the bird to scratch on the sidewalk for grain, where there is not even chaff to delude. The expression is common here, and was intended to convey our appreciation of the sound practical work of the *New England Medical Monthly*. The phrase is not classical, but is, we think, very expressive.

THE Dominion Dyewood and Chemical Co., Toronto. Sole agents in Canada for the Farbenfabriken, vormals Friedr Bayer & Co., manufacturers of Phenacetine, and Sulphonal-Bayer, announce that they are now offering these valuable products to the trade in the form of lozenges. The Phenacetine-Bayer lozenges contain 4 and 8 grains, and Sulphonal-Bayer 8 and 16 grains, put up in neat boxes of 50 and 100 each. This will be a very convenient form for the prescribing of these valuable remedies.

THE *Christian Advocate* is responsible for the following story:—A lady living in Ohio is the mother of six boys. One day a friend calling on her said: "What a pity one of your boys had not been a girl." One of the boys, about eight years of age, overheard this remark, and promptly interposed: "I'd like to know who'd 'a bin 'er; I wouldn't bin 'er; Ed wouldn't a' bin 'er; Joe wouldn't 'a bin 'er, and I'd like to know who'd 'a bin 'er."

PERSONAL.—Dr. Millman has removed from 544 Spadina Avenue to 490 Huron Street, fifth house north of Bloor Street.

DR. OLIVER WENDELL HOLMES is 83 years old.

Books and Pamphlets.

SAUNDERS' QUESTION COMPENDS. No. 1. Essentials of Physiology, arranged in the form of questions and answers, prepared especially for students of medicine, by H. A. Hare, B.S., M.D., Professor of Therapeutics and Materia Medica in the Jefferson Medical College of Philadelphia, etc., etc. Third edition, revised and enlarged by the addition of a series of handsome plates. Philadelphia: W. B. Saunders. Toronto: Carveth & Co. 1891; pp. 186. \$1.

This little work is so well known to students that we need say no more than that the present edition has been rendered much more useful by the insertion of plates from Oonold's "*Icones Nervorum Capitis*," which will certainly be of great value to the student in mastering both the physiology and anatomy of the cranial nerves. Their points of origin both superficial and deep; their modes of exit; their distribution and functions are all given. The book will be found useful for examination purposes.

A PRACTICAL TREATISE ON DISEASES OF THE SKIN. By Henry G. Piffard, A.M., M.D., Clinical Prof. of Dermatology, University of the City of New York; Surgeon in Charge of New York Dispensary for Diseases of the Skin; Consulting Surgeon to the Charity Hospital, etc., etc. Assisted by Robert M. Fuller; with fifty full page original plates, and thirty-three illustrations in the text. New York: D. Appleton & Co. Toronto: Carveth & Co. 1891.

The work before us is one of the best yet published for the general practitioner. The author's name is sufficient to give it authority on any subject with which he deals; and his method of treating the various subjects, appears to us, impossible to be improved upon. His definitions and classifications will be of the greatest possible value to practitioners who do not, in the ordinary routine of practice, treat cutaneous affections every day.

There are no theoretical or controversial discussions, which would serve only to perplex any one but a specialist, and what is necessary to be said is put in the most practical manner, and in the fewest possible words. The author considers that our present knowledge of the pathological histology of the skin is in a too inchoate state to permit its being introduced in the present work. The last article in the work deals with these recently discovered and much discussed bodies—psorosperms. Wickham and Dorier, and many other foreign observers, hold that these are living animal parasites, which infest the human skin, producing varied lesions, all coming under the title psorospermose. These bodies are found abundantly in Dorier's disease—psorospermose *folliculaire végétante*, in Paget's disease and molluscum contagiosum. From a series of experiments conducted with polarized light, Dr. Piffard has concluded that these so-called molluscous bodies are not, at least in molluscum contagiosum, animal parasites, but are simply rete cells undergoing a species of corneous degeneration. If the author be correct in this, he has elucidated a matter of the greatest importance in regard to the pathology of these diseases. Paget's disease, Mammilitis Maligna, he believes to be a superficial epitheloma *ab initio* in which the proliferation of rete cells, with here and there a pearl of stratified horny cells, occurs laterally instead of downwards.

The plan of the work and its execution are both indeed excellent. We have seen no work which we can, with so much confidence, recommend to our readers, who are in need of help in the diagnosis and treatment of this very important class of diseases. The plates and figures are really illustrative of the text, are beautifully executed, while the letter-press and binding are all that can be desired.