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THE CANADA MEDICAL RECORD.

Vol. XVI.

MONTREAL, NOVEMBER, 1887.

No. 2.

CONTENTS.

ORIGINAL COMMUNICATIONS.			
Retrospect of Gynecology.....	25	Sick Headache.....	35
The Morbid Changes and Surgery of the Nail.....	28	The Treatment of Rheumatism.....	36
CORRESPONDENCE.....		A Ready Method for Removing Foreign Bodies from the Anterior Nares....	37
		Philadelphia Hospital	37
		Injectons of Warm Water in Dysentery	39
		Fibroid Tumors of the Uterus.....	40
		Chronic Constipation.....	43
		The Abuses of Milk Diet in Therapeutics.....	45
PROGRESS OF SCIENCE.		Boracic Acid in the Treatment of Leucorrhœa.....	46
Menstruation, its Nerve Origin not a Shedding of Mucous Membrane....	31	Cause and Cure of a Certain Form of Backache.....	47
The Treatment of Palpitation.....	34	Treatment of Psoas Abscess.....	48
		EDITORIAL.	
		New Hospital in Toronto.....	48
		Obituary.....	48
		PERSONALS.....	48

Original Communications.

RETROSPECT OF GYNECOLOGY.

By A. LAPHORN SMITH, B.A., M.D., M.R.C.S., ENG.
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The past year has been an eventful one in the history of the medical sciences, but in no department of them have the workers been more active than in Gynecology. The reason for this is not difficult to find; the field is large, almost unlimited; the workers are comparatively few; and the rewards won by success are larger than in almost any other branch. Such being the case, it has attracted to the ranks a considerable number of very able men, with the result that it has rapidly advanced from the position of an uncertain and indefinite science to that of one of the most exact. In the limits of this article we can only attempt to give a very brief outline of the most important improvements in treatment. One of the most remarkable changes which have lately taken place in gynecological practice is the almost complete abandonment of the pessary, and the substitution for it of operative procedure. This is due to the more rational comprehension of the causes which lead to displacements of the uterus. So that instead of trying to bolster up a too heavy organ with a hard mechanical and unnatural support, such as a pessary, the modern gynecologist takes immediate steps to reduce its size and weight, and then to tighten up the weak and relaxed ligaments. This result is obtained in various ways by different operators. Thus Martin of Berlin and Soleris

of Paris at a single sitting perform partial amputation of the cervix, then anterior and then posterior colporrhaphy. The three operations are generally completed in one hour, for being performed under constant irrigation with weak antiseptic solutions, no time is lost in sponging; while for the colporrhaphies the running catgut suture is used in one, two, or three layers, according to the size of denudation, and this saves the time which would be spent in tying the knots in the interrupted suture. Others, such as Alexander of Liverpool, make use of the round ligament, which they shorten to drag the uterus upwards and forwards. Kellog of Battle Creek combines Alexander's operation with Lefort's operation of medium colporrhaphy, which consists in making a bridge or raphé in the vagina by uniting the anterior and posterior walls for such a distance as the case may require. A strip of surface from three-fourths of an inch to an inch in width is denuded from each wall, from a point about an inch below the utero-vaginal junction, as low as may be necessary to turn in completely both the rectocele and the cystocele present. The edges are properly brought together with sutures. Dr. Kellog, in speaking on this subject before the International Congress, said: "A woman who is dependent upon a pessary is almost equally dependent upon a doctor to inspect the appliance at stated intervals, and substitute a new one as each successive ring or lever or other device loses its efficiency by the stretching of the vaginal walls, or other injurious modification of the parts, and has little or no hope of radical cure, even after years of treatment." And he added: "If this operation succeeds half as well as present

predictions seem to indicate that it will, many thousands of pessary pestered women will rise up and call great and blessed the fortunate discoverer of this most valuable surgical procedure."

Others again, while recognizing the uselessness of the pessary, are not quite so ready to advocate operative procedure. They hold that the weight of the organ can be reduced by favoring involution and activating the general and local circulation by appropriate treatment, while the uterine supports can be made to do their duty by exercising the abdominal and pelvic muscles, and by building up the general health. Their method is perhaps the most rational one. Formerly their treatment consisted in the introduction of glycerine of tannin tampons, alternately with the hot douche, in the vagina, and the application of Churchill's iodine to the endometrium and cervix. This treatment though tedious is fairly successful in cases of slight or medium severity. But in severe cases Apostoli's discovery of the wonderful trophic influence of the galvanic current in causing the absorption of fibro-plastic exudation, by which involution can be rapidly artificially produced, and his application of Tripier's method of toning up relaxed muscular tissue with the Faradic current of low tension has already begun to work a revolution in gynecological treatment. Veit, Wyder, and Martin consider the mucous membrane as the starting point of uterine disease, and they remove it in nearly every case with the semi sharp curette. Apostoli removes it with the galvano-chemical cautery, which at the same time renders the uterus more able to form a new and healthy lining membrane. It is remarkable to see how much interference the uterus can bear on condition of a rigorous antiseptis. One sees many times a day in Berlin the uterus dilated, the mucous membrane scraped away until one hears the steel scratching on the raw muscle beneath, and then injected with tincture of iodine, and irrigated with sublimate or carbolic solution, without the slightest risk. And yet without antiseptic precautions, the mere passing of the sound alone has often proved fatal. It is thus that Goodell practises rapid dilatation of the uterus to one and a half inches, with the vagina full of antiseptic solution, while some honest country doctor sends for his instrument and soon has a fatal case of peritonitis. The first lesson for everyone to learn who intends to practice gynecology is the thorough appreciation of the importance of keeping himself, his instru-

ments, and his patient *clean*, with or without antiseptics.

The treatment of cancer of the uterus has also made much progress, principally through the labors of Freund, Schreder, Martin, Olshausen, and Gusserow in Germany, in perfecting the method of total extirpation of the uterus per vaginam or vaginal hysterectomy, as it is called. The mortality which was 29 per cent. in 1881 has now been reduced to 15 per cent. in 1886.

The following is Martin's method: The bowels are thoroughly emptied, the vagina thoroughly disinfected by an antiseptic irrigation, the patient placed on her back and anæsthetized. The vault of the vagina is exposed by means of a Simons speculum and side pieces; the cervix is seized by bullet forceps on its posterior border, and drawn forward as much as possible toward the symphysis pubis. This stretches the posterior arch of the vagina and the insertion of the vagina can be nicely determined. He then makes an incision along the whole length of this insertion so as to get into Douglas' cul de sac as quickly as possible. This is frequently attained with the first cut. This accomplished he enlarges the cut so that the forefinger of the left hand can enter, and then with a small needle very much curved he sews the peritoneum and vagina together all along the cut, thereby arresting hæmorrhage. The cervix is then drawn forcibly backwards, and the anterior vaginal vault is cut through in the same way, the bladder is peeled back from the cervix with the thumb nail, and the peritoneum sewed to the vagina as behind. The fundus is then grasped with the bullet forceps and retroverted little by little until it is dragged into the vagina. The left broad ligament is then sewed with strong thread in a double row of stitches and the tissue is cut between them. The uterus is then further dragged down, being only held by the right broad ligament which is tied in several segments and divided. During the operation a weak warm solution of carbolic acid plays constantly on the field, doing away with sponges, except when the operation is over to dry out Douglas' pouch, into which he then introduces a thick aseptic drainage tube which is held in place by a cross piece; and the other end of which is turned into the vagina which is filled with iodoform gauze. Of course vaginal hysterectomy will be followed by recurrence, unless it is performed at the beginning of the disease before the neighboring tissues have become infiltrated. When this has

happened the disease may be delayed, and life made tolerable for a long time, by destroying the diseased tissues with the "Paquelin's cautery," and then carrying out the dry treatment with insufflations of iodoform, and plugging the vagina with tampons of sublimated absorbent cotton. We have at present a case under our care where the disease completely fills the pelvis, and yet the patient only requires treatment every five or six days. Fritch employs iodoform gauze, and he says that it relieves the pain, foul discharges and hæmorrhage so that the patients think they are well.

Dr. Chauvin, of New York, recommends Alveloz which has the power of diminishing to a marked degree the amount of the discharge, and rendering it decidedly less offensive.

Dr. Carpenter, of Cleveland, says that Lactic acid has the power of dissolving sloughing tissue, leaving a healthy, granulating surface. It is applied freely on absorbent cotton, and then washed off.

The Gynecologist often needs to know whether the uterus is gravid or not, and sometimes this is a difficult matter to decide. We recently had a case of fibroid sent to us for Apostoli's treatment, and having just previously read an article by Dr. McKee, of Cincinnati, on the characteristic color of the vagina in pregnancy, we were able to state our opinion to that effect at the first examination. It may be described as greyish purple, or dark purple. Dr. Z. W. Farlow (*Boston Med. & Surg. Journal*, July 21, 1887) calls it a blue color, and he gives the following analysis in 141 cases:

- 36 no color.
- 55 color suggestive.
- 70 color characteristic.

In our case an abortion a month after beginning the treatment bore out our conclusion. In this case we went on with the treatment with our eyes open, because she was so much reduced by suffering that her life was in danger, and her abdomen was so distended with fibroids that the uterus could not expand much further. Besides, she had come a journey of nearly a thousand miles to be treated with electricity, and was determined not to go back until their growth was stopped. The tumors are diminishing, and she has passed through the miscarriage at five months safely and without any hæmorrhage whatever, although she suffered severely from the dragging on the adhesions of one of the tumors to the abdominal wall, caused by the return of the uterus to its non-pregnant size.

She would probably have miscarried soon at any rate, and now the tumors will be rapidly reduced in size by the electric current.

Dr. Weeks reported a case of myoma in a pregnant lady, where after consultation an abortion was brought on, and which was followed by death. In that case there were no urgent symptoms for interference, and we thought it would be better to leave such cases alone until after delivery; for as Dr. Reed (*Cincinnati Lancet-Clinic*, Dec. 3, 1887) says many women not only go through their pregnancy and delivery without any trouble, but their fibroids participating in the general resorptive process of involution sometimes disappear.

Apostoli's treatment not only bids fair to completely do away with the knife in the treatment of fibroids, but also promises to throw considerable light on their nature and cause. We know that the uterus will become heavy and indurated whenever the processes of nutrition and circulation are slow, and a section of such an organ reveals an abnormal amount of fibrous tissue. And it is no longer a theory but a fact that this exudated fibrous tissue can be called back into the circulation under the stimulating influence of the galvanic current, so that the organ becomes soft and muscular. To us it seems that a fibroid tumor is but a deposit of lymph which has exuded from the vessels under the influence of a tardy vital power and circulation. Under certain conditions of improved health the trophic nerves call back this exudation into the circulation, while in others this can be done artificially by the aid of electricity. As an instance of this we may cite a case under our care, and which will be reported in due time, where a uterus which was hanging several inches outside of the vulva and into which the sound entered five and a quarter inches, has with less than thirty applications of the galvanic negative current been so much reduced in size, that the sound only enters three inches, and the weight is so much less that it can very rarely be seen at the vulva at all.

The teachings of Macan, Master of the Dublin Rotunda hospital, are beginning to make his British brethren realize that the uterus has no fixed position either antero posteriorly, or with regard to its height in the pelvis. We have long held this view, that the organ is never for ten consecutive seconds in the same position. It is carried backwards when the bladder is full, and forwards when the latter is emptied; and in the same way its posi-

tion is modified by the state of the rectum. We showed in a paper read before the International Congress that its height in the pelvis varied also from hour to hour according to the degree of strength or fatigue of the muscles in its so called ligaments or supports. For the uterus to lie helpless on the pelvis flow is not a normal position because every movement communicates a jar to it.

It matters little whether it is anti-verted or retro-verted, as long as it is floating or suspended. The result of the appreciation of this fact will be that, fresh air, good food, removal of corsets and healthy exercise, with iron and strychnine, will be prescribed more, and pessaries less and less.

Principally owing to the teachings of Lawson Tait, a new method of treating peritonitis has been introduced. Instead of keeping the bowels rigorously locked with opium he gives large concentrated doses of salines (we prefer sulphate of soda in $\frac{3}{4}$ ss doses), repeated several times and aided by large turpentine enemata. Dr. Baldy (American Journal. Obstetrics, Dec. '87) says the symptoms begin to subside almost immediately when the bowels commence to discharge watery stools. Osmosis takes place from the lighter to denser fluid, so that if the saline solution is many times denser than the peritoneal effusion, the latter will be drawn into the intestine and thus leave less pabulum for the microbic fermentation. Besides there will be less chance for the formation of adhesions, and even when formed they may be broken up.

Some doubt has been cast on the ability of electricity to kill an extra uterine foetus, and consequently laparotomy has been advised the moment intra uterine foetation is diagnosed. We can say that 125 milliamperes of the constant current does not kill it when applied directly to it in the uterus, for in the case mentioned above, the foetus was born alive after having had that strength applied several times. But of course it had been applied without shock.

We shall review some other advances in Gynecology in a future article.

THE MORBID CHANGES AND SURGERY OF THE NAIL.*

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MR. PRESIDENT AND GENTLEMEN: I read this paper more for my own instruction than for yours, hoping that it may provoke discussion, and that I

*Read before the Surgical Section of the Suffolk District Medical Society, April 6, 1887.

may thereby learn the views of members of riper experience and maturer judgment than my own. The nail seems a somewhat trivial and ordinary subject to occupy the minds of learned members of this Society, but it is only by contemplating the smaller objects that we are fully able to appreciate the larger; and in practice, as in life, the careful attention to little things often tends greatly to one's success. In order properly to understand the morbid changes of the nail, it is necessary to be familiar with its normal structure. Pardon me, therefore, if I refresh your memories by briefly referring to its anatomy. A nail is a peculiar arrangement of epidermal cells: the undermost of which are rounded or elongated; the superficial are flattened, and of a more hairy consistence. That modified portion of the corium by which the nail is secreted forms the matrix, and extends beneath its root and body. The back edge of the nail or root is received into a shallow, crescentic groove in the matrix. The front part is free, and projects beyond the extremity of the digit. The intermediate portion of the nail rests by its broad under-surface on the front part of the matrix, which here forms its bed. The part between the root and free extremity of the nail makes up its body. The matrix beneath the body is not uniformly smooth on the surface, but is raised in the form of longitudinal and nearly parallel ridges, on which are moulded the epidermal cells of which the nail is made up. The growth of the nail is effected by a constant production of cells from beneath and behind.

Excessive growth of nail substance occurs either by multiplication of the nails or increase in bulk. This anomaly includes the occurrence of nails in unusual places, such as on scapular region, on last phalanx of supernumerary fingers or toes, double nails on fingers or toes, etc.

Both go by the name of onychia or hypertrophy. These vary. In the first it appears spherically curved, glossy on surface; a grayish-white color, unshapely, thick, opaque, has a massive feel, and is very hard. When the whole nail is affected, its free border has a tendency to curve downwards. It may occur in various directions, according as it is disturbed in the vertical or transverse way (onychogryphosis). In its simplest form, it becomes clam-like. In other cases, it may curve spirally.

Symptoms. Loses its elasticity; becomes thickened. Loss of tactile sense. It is very much diminished, and reduced to a minimum. Patient unable to execute fine work, and, when enlargement considerable, incapacitated for work. When toe-nails affected, walking interfered with; and, at the same time, most unpleasant effects (inflammation and suppuration) are produced by nails enlarged laterally. If uncared for, they penetrate toward the lateral groove and grow in. In the second form they are slightly lustrous, dirty, yellowish-brown, or yellowish grayish-white. Externally, have well-marked longitudinal ribs; at

intervals, transverse, more or less elevated ridges, and here and there horny plates.

Etiology. Onychiauxis may be congenital or acquired. In the former case, it dates from the embryonal period, and the anomaly appears in the course of life in the great majority of cases acquired.

Defective or altogether neglected care of nail may cause it. Uncleanliness, accumulation of all sorts of substances on the nail-bed act as irritants. This sometimes occurs in old people and bed-ridden patients.

Traumatic Influences. Any considerable pressure for some time from in front or sideways on the extremities, as too short or narrow shoe, increases nutrition of nail-bed by augmented afflux of blood, and gives rise to hypertrophy.

Extension of morbid inflammatory processes of the corium and the connective tissue of the cutis to the matrix of the nail, as psoriasis, eczema, etc.

Defective formation of the nail, atrophy, etc., absence of the nails (anonychia), or their retarded growth, may also be congenital or acquired—causes much the same as in hypertrophy. Thermic and chemical irritations, traumatic influences, knock, blow, or pinch, inflammations associated with suppurative and ulcerative processes, febrile diseases, and all chronic wasting diseases, may be ranked as etiological factors. The cutaneous and nervous affections causing hyperplasia may also give rise to aplasia.

Characteristics of an imperfectly developed nail. Lustritious, delicate, a whitish-gray color, giving the impression of a thickened membrane, possessing but a slight hardness, readily broken and flexible. Dr. Ashurst observes, in a foot-note in his "Principles and Practice of Surgery," that Guenthre, a Danish surgeon, and Nillien, of Illinois, have noticed that the growth of nail is retarded during the early stages of fractures, to be resumed as repair goes on. They suggest this as a means of testing the progress of the cure, without disturbing the dressings in cases of delayed union or false joint. The growth of nail, however, may be checked by any cause which interferes with the nutrition of the part. Hence the test might not be universally applicable. Mitchell has noticed an arrest of growth in cases of cerebral paralysis. Gay the same, as a result of compression of the subclavian artery.

Nails may be deformed, degenerated, or discolored. They may be abnormally long or short, broad or narrow, flat or curved. A cut of a pen-knife will cause a bending of the nail. These deformities are not generally amenable to treatment. Too much stress is laid in works on clinical medicine as to the value of the color of the nail in various diseases. These are due to processes of nail-formation.

Animal and vegetable parasites affect the nail. The sarcoptes scabiei attacks the nail. In tropical regions, there are a number of flies which

lay their eggs under the nails. Sand-fleas will cause, first, violent pain, and subsequently, paronychia, associated with loss of nail.

Vegetable parasite, onychomycosis. In only two mycoses of the skin, favus and herpes tonsurans, has it been clearly demonstrated that transference of their fungi will cause changes in the nail, that is, onychomycosis. Tinea favosa is rarer than trichophyton or tonsurans. The clinical features are similar. Nails brittle, frayed out, intersected, are lifted up according to the quantity of epidermis under them, become gryphotic, thickened, flake off, faded, dirty yellow color, and often become greatly disfiguring. Both the achorion schonleinii and trichophyton tonsurans produce the above alterations. In a few cases, the nail presents a yellow-sulphur color, due to favus.

Horny growths sometimes spring from beneath the nail.

Ungual exostosis frequently appears. Both require excision.

The nail is closely related to the hair. I might mention, in passing, an instance known to me, which will serve to bear out this remark. A gentleman was camping out, some summers ago, in the Hudson Bay region. One night a dreadful lightning-storm took place. The following morning, not only every hair on his body fell out, but he was also bereft of every nail, and remains hairless and nailless to this day, notwithstanding the use of the whole armamentarium of the pharmacopœia. The matrix of the nail is sometimes the seat of inflammation, etc. In its simpler form, we have onychia simplex; in the more severe, onychia maligna. This last occurs almost entirely in children under ten years. It is not very frequent. In Holmes' "System of Surgery," Mr. Thomas Smith states that out of seven thousand surgical out-patients of children under ten, he found the disease in nine instances only, and these cases occurred between the ages of one and seven years. May commence from a pinch or crust of finger-end, or result from explosion of fire-crackers. The swollen, bulbous-looking finger-end; the fluid effused beneath the nail; the thickened, flattened, or curled-up, unnatural-looking nail; the foul and painful ulcer exposed beneath it, with its peculiar, characteristic foetor, and the hardened, shiny, and livid-red integument around it, are, no doubt, familiar to you all. The disease may go on until the joint is lost, or the phalanx necrosed.

I take a paronychia to be an acute inflammation of tissues underlying the nail. The ancients define a paronychia as an inflammatory tumor near the nail, involving its pulp or matrix. But in most modern works on surgery you will find described under the head paronychia, whitlow, felons, and even inflammation extending up to the hand or arm. The middle or side of the subungual tissues may be affected. Puncture, concussion, contusion, laceration, etc., may give rise to a paronychia. If the nail enlarges in width, it

will press on the lateral furrow, and this, coupled with compression from a shoe, will cause a paronychia lateralis. At first, there will be great irritability of the parts, later, inflammation, suppuration, great proliferation of granulations, destruction of the cutis, of the tendon, opening of the phalangeal joint, caries and necrosis of bones. Usually the internal angle of the great toe is affected, rarely the outside of the little toe, seldom any other toe. It may assume a mild form or become chronic, with now and then an exacerbatory character, may be covered with irregular, spongy, easily-bleeding granulations. It may last for years.

Ingrowing toe-nail almost invariably occurs on the outer side of the nail of the great toe. Psoriasis may affect the nail. It may be although not necessarily so an evidence of syphilis. Central part of nail diseased; scabrous thickened, rough, convex, splits, deep fissure between the skin and finger. Nail resembles the concave shell of an oyster. Affection chronic and difficult to cure.

Syphilis may attack the nail. Jonathan Hutchinson† was one of the first to draw attention, not only to the state of the nail in syphilitic psoriasis but in congenital syphilis. Nails, symmetrically affected, dry, brittle, fissured and broken at their edges, superficial layers alone diseased. There is, however, a more remarkable affection in the form of a chronic general onychitis. The nails decay and fall off; they first become opaque and much thickened, their substance is soft. The disease is due to inflammation of the matrix which is swollen and readily bleeds. Syphilitic onychia usually attacks the toe-nails, and is often associated with ulcerative fissures between the toes. The inflammation is not so severe as in the non-syphilitic form. Perionychia is a syphilitic inflammation surrounding the nail, exists in a dry and moist form. It also has a simple and ulcerative variety. Deep ulcerations forming in the latter. Mucus patches are sometimes seen under the free border of the nail.

The surgery of the nail resolves itself into operative and general treatment. If it be troublesome on account of its longitudinal growth, this must be removed with the scissors in simple cases; when the thickness is increased at the same time, use cutting pliers or saw. Paronychia lateralis in its early stage may be treated by removing that part of the nail which threatens to grow in, besides putting into the groove fine threads of charpie, and ordering wide shoes. When the inflammation is extensive it is well to use the method of complicated pressure, as devised by Kaposi of Vienna. This consists in first removing that portion of the nail projecting into the inflamed surface, then the swollen edge of skin is carefully pressed downward, and the widened space thus gained at the furrow is filled with accurately inserted threads of charpie

cotton. In doing this, care should be taken that the sharp edge of the nail does not come in contact with the irritated part of the skin. This done, strips of adhesive plaster (emplas diachylon) are wound round the unguis phalanx, commencing at the affected part from above downwards, each turn being moderately stretched, so as to remove the border of the skin as much as possible from the edge of the nail, to crowd it downwards. If this is done skilfully, it will cause no pain to the patient, and eases his condition at once. He can not only walk, but wear his shoes. After twelve or twenty-four hours, the dressing is taken off, foot bathed and bandaged anew. Kaposi claims that this will cure the patient in from two to four weeks. Some add medicated solution to the charpie, carbolic acid, etc. If greatly developed fungous granulations are present, they should be cut with the scissors, down to the base, and the bleeding points touched with nitrate of silver. In rare cases will be obliged to resort to Dupuytren's radical operation, that is, inserting pointed end of scissors beneath the nail, divide it into two parts firmly seizing the diseased side of the nail with pliers, and pulling it out. The nail usually reappears. A great object in in-growing toe-nail is to give the feet all necessary room. In the early stage, when there is no considerable mass of overhanging integument or fungous granulations, pressure of the nail on the soft parts may be relieved by packing into the groove on the affected side, oiled cotton wool with the flat end of a probe or pen-knife. This may be done without pain. The quantity of wool may be increased at each application, until the soft parts are raised and pushed aside. The free edge of the nail is exposed, beneath which wool should be inserted until the natural state is restored. Nails should be allowed to grow so as to form a right angle at the outer corner. If much inflammation, the toe may be kept in water dressing during treatment. Overlapping integument kept in natural relation to the nail by strips of adhesive plaster. Dr. Tribury Fox says, "In-growing toe-nail is easily cured by softening it, and then scraping off as much as possible, so as to thin it in the middle." A similar plan may be adopted to remove splinters imbedded in the nail. Nail scraped thin over the splinter and then cut through. It can in this way be painlessly removed. When the nail cuts deeply into the flesh, causing ulceration and fungous granulations, remove it at once, using either spray or cocaine. Dupuytren's method, as described above, is the one usually employed by surgeons. Nails may be cut by knife instead of dividing by scissors. Some surgeons prefer to remove the whole nail.

Dr. Monks has kindly called my attention to Dr. Cotting's, of Boston, method of treating in-growing toe-nail. Anything emanating from Boston is sure to bear the impress of sterling worth. It seems to me to be the most feasible of all methods. He removes the fleshy part of the toe at

†British Medical Journal, 1865, p. 45.

the side of the nail so that it will have nothing in which to imbed itself. It is no doubt well known to you all. In treating onychia, remove the nail by evulsion, then dress the ulcerative surface with Black wash, or the old standby, Abernethy's solution, ii 3 liq. potass; arsenitis ad aq. i. $\frac{3}{4}$ Arsenic has a beneficial effect on onychia. Dr. Moreloose, of Ghent, was the first to recommend the powdered nitrate of lead in onychia maligna. It has afterwards been used with great success by Prof. Vauzetti, of Padua, and Sir William MacCormac, of London. It causes considerable pain when applied, but its results are excellent. In severe cases a great portion of the disease with nail may be sliced off. In syphilitic onychia a Black wash is the remedy "par excellence." Amputation has occasionally been performed for the cure of onychia maligna. Tonics should always be given. Dr. Living recommends very highly the giving of arsenic in non-syphilitic psoriasis; a tonic will add to the effect. In the syphilitic, mercury is of course the remedy. Appearance of nail improved by filing down with sand-paper. Skin near the margin dressed with white precipitate ointment. We must trace and treat the etiological factors. If an eczema exist this must be treated on dermatological principles, diachylon ointment, etc. In stubborn cases, Prof. Geben recommended using vulcanized rubber stockings and gloves. When all these diseases associated with connective tissue and papillary hypertrophy at the terminal phalanges, pachyderma, ichthyosis, verucca, etc., little can be done except keeping the affected part clean, and removing injurious influences. When syphilis attacks the matrix, anti-syphilitics required; when animal and vegetable parasites are present, anti-parasitics indicated. Ulcerative perionyxis is one of the bugbears of surgical therapeutics. Iodoform and nitrate of silver might be tried. In defective nail-formation, endeavor to find out the causes and treat them. Build up the system with tonics. Pressure by means of the wax nail is useful here. In all cases we should see that the shoe is not at fault, that it fits well, not too loose nor too tight. If the patient is a baker, carpenter, etc., and liable to irritation of the fingers, it is well to surround the end of the phalanx with soft wax.

Correspondence.

To the EDITOR OF THE CANADA MEDICAL RECORD.

SIR,—In your last number, just received, I observe a quotation from "*Le Journal de Geneve*," that a woman has given birth to seven children within an interval of four years, and that they are all alive."

Very good—! brave woman—! I am sorry to take from her any portion of her claim as the *largest* benefactress, but she is eclipsed in that direction,

in the city of Montreal, where a woman has given birth to twelve children in five years. There were two arrivals every ten months. And let me tell ladies with fewer children and greater wealth her happiness was in direct ratio to the number.

Yours,

VERITAS.

Montreal, Oct. 6th, 1887.

Progress of Science.

MENSTRUATION, ITS NERVE-ORIGIN— NOT A SHEDDING OF MUCOUS MEMBRANE.

By JAMES OLIVER, M. B., F. R. S. Edin.,
Member of the Royal College of Physicians, Assistant
Physician to the hospital for women, and Honorary Physi-
cian to the Farringdon General Dispensary, London,
England.

In every healthful human female, during the so-called childbearing epoch, which extends, on the average, over a period of thirty-two years, the uterus becomes the seat of a periodically recurring functional disturbance, evidenced by the emission of a more or less marked hemorrhagic discharge. As the initial establishment and each subsequent recurrence of this monthly phenomenon is frequently accompanied by symptoms of a general as well as local character, we shall designate under the appellation *menstruation* the whole essential train of events, and not its mere outward manifestation.

The molecular world, organic as well as inorganic, exists in a perpetual state of trepidation, and equilibration of a vital character is the outcome of an inherent power of adaptation. Normally the structural and functional integrity of the organism is maintained by a mutual dependence of the organs upon each other, and according to the manner in which these, each and all, respond to those multifarious changes, which from time to time arise in the environments of the individual. The variations in the waves of molecular motion occurring in every organ, and associated with physiological activity, are radiated to, and affect, however feebly, every ultimate tissue of the body. So completely is this intercommunication, through the medium of the nervous system, carried on, and so apt are the different structures of the organism to perform functions other than those for which they have apparently become specialized, that vicarious compensation may be readily established. In the case of double organs it is a noteworthy fact, with which everyone is familiar, that the removal of one may affect but little, if at all, the well-being of the body; generally the remaining organ at the same time becomes of augmented functional activity, undergoing slight or even well-marked enlargement. This compensatory change will be

manifested, not only by organs recognized as active, but also by such as have hitherto been viewed as obsolete. In many of the lower organisms, where structural differentiation is ill defined, vicarious function is readily fulfilled. The animal may, for example, be turned outside in with impunity, the vital integrity of the organism being still maintained unimpaired—the endoderm, already but feebly specialized, although set apart for assimilation, performing with ease the function of the ectoderm, that of elimination; while the ectoderm, in turn, assumes forthwith the power of assimilation, and discharges effectually a function hitherto foreign to it and performed previously by the inner layer. In the animal economy we see constantly enunciated the fact, too frequently ignored, that functional activity and structural integrity proceed together, hand in hand, and are regulated by a mutual action and reaction upon each other.

If the functional activity of any organ be augmented, but not unduly, the structural integrity will be maintained and be rendered more perfect. Again, the more complete the structural arrangement has become, the more likely we are to find the function actively performed. All visceral activities are now, through habitation, fulfilled in a somewhat automatic manner; and although these transitional states may at one time have excited a conscious sensation, they are at the present stage of evolution wholly ignored by the higher cells of the cerebral lobes which participate in feeling. What is true of one organ of the body is likewise true of all the others. It is, therefore, more than probable that the physiological changes recurring from time to time in the uterus are anticipated by, and in reality the sequence of, a molecular disturbance arising spontaneously in some centre located in the higher part of the cerebro-spinal tract, possibly somewhere in the medulla oblongata. The mere fact that the functions of the uterus may be revealed uninterruptedly after the spinal cord has been completely severed in the dorsal region is no criterion, and cannot justify us in concluding that there exists no representative higher centre. Structural evolution itself forbids the acceptance of such an hypothesis. Like all other nerve-centres fulfilling a similar dispensation, this uterine centre is undoubtedly beyond all volitional control, but is, nevertheless, capable of being disordered by emotional impressions. With this fact everyone is familiar. A sudden shock experienced during menstruation, and apart from any bodily injury, will produce, as I have frequently noted in some females immediate cessation of the flow, and even interrupt for a more or less indefinite length of time thereafter its amount and periodic regularity. The resulting disturbance will depend essentially upon the state of the nervous system and its proneness to molecular instability.

With the approach and appearance of the monthly flow, the whole frame, as one would

naturally expect, participates more or less in the change, and the amount of disturbance experienced, as well as manifested, is commensurate with the power the organism possesses of adaptation, and hence of equilibration. The simple determination of blood, because of increased functional activity, to the genital and, in many cases, to the other pelvic organs, of itself produces a definite alteration in the waves of molecular motion proceeding therefrom, and which, radiated in all directions, must necessarily affect the vascular state of other very important structures. In many chronic disorders, of whatever system, affecting the female, every observer must have remarked that, according to the menstrual type of the individual, there is often, either in anticipation or with the appearance of the flow, a proneness to aggravation, or in some very exceptional cases, it may be, to alleviation of symptoms, and with the cessation or disappearance a corresponding gradual reversion to the original already stationary or slowly progressive state. In some few cases the loss of blood may account for much of the disturbance manifested, yet it cannot be the sole factor. In many women, where, from some inexplicable cause, there is for a more or less indefinite period a total suppression of the characteristic discharge, we may detect frequently such a regularly recurring alteration in the symptoms or manner of the patient as to place beyond denial a direct relationship. In no class of functional disorder do we find so regularly and markedly an interference with the outward manifestation of uterine activity as in *epilepsy*, a disease the pathology of which is still undetermined. It is more than probable, however, that as we may consider the *epileptic female* as *epileptic* throughout, even to the finger-tips, the interruption of the periodically recurring functional change in the uterus is the result of some occult condition of the corpuscular elements governing the activity of this organ, and wholly independent of any defective structural state of the viscus itself. The structural integrity of the uterus may, however, eventually suffer, for inaction and overaction alike tend to exert a prejudicial influence.

Gestation, as a rule, although not invariably, determines for a period of nine months a cessation of the monthly recurring flow. Not infrequently, however, we see women who throughout one or more pregnancies continue perfectly regular, the amount or character of the flow being unaltered by the physiological process going on in the uterus. Usually the fertilized ovum affects in some unknown manner the uterine organ, thereafter destined to be its source of nutrition, and the gradual molecular variations so produced are radiated to the uterine centre, alter the corpuscular state, and determine the sequence of events. During the period of lactation, and consequent activity of the mammary glands, we find not only the manifestation of the monthly recurring functional change of the uterus held in abeyance, but also the activity

of the generative glands, as impregnation rarely occurs while the mother continues to suckle the offspring. Should, however, lactation be prolonged indefinitely, the secretion of milk may become more or less habitual, as in the case of the cow, and the generative glands regain their activity. The life of every organism is twofold: first, the maintenance of the individual, and then the perpetuation of the species. The latter, however, is always subservient to the former, and so long as there exists a demand for nourishment from the mother on the part of the child in utero, so long will the reproductive power, as a rule, continue latent. Occasionally, however, I have noted that while the child is being suckled by the mother, the uterus itself, and the generative glands, may throughout continue active; and impregnation resulting, signs of early constitutional enfeeblement are apt to accrue. In inflammation of the mucous lining of the Fallopian tubes with puriform exudation, menorrhagia is frequently an associated symptom, and apparently results from some interference with the nerve-supply to the uterus. In all mammals there are two ovaries, and the oviducts are known as the Fallopian tubes. Each oviduct dilates, on its way to the external surface, into an uterine cavity, which in turn opens into the vagina. In the monkey and man only do we find the two uteri coalesce inferiorly, producing a single cavity, into the fundus of which the Fallopian tubes enter. It is more than likely that the nerves governing the functions of the uterus are transmitted along the Fallopian tubes, and although menstrual disorder may frequently result, with distinct pathological changes existing in these tubes, we must not too hastily conclude that these structures, *per se*, govern the uterine changes.

The true nature of the catamenial discharge is still conjectural; yet its elimination from the body renders it highly probable that, having already served some special end, its detention in the blood may exert some deleterious influence on the animal economy.

It is generally admitted that ovulation and menstruation are coincident; that they may or may not be, I am not prepared to dispute; that, however, they are invariably associated there seems to me much reason for doubt. That the discharge of an ovum may, and frequently does, occur quite independently of menstruation, I have no misgivings. No one would entertain the idea of gauging the reproductive power of the female either from the regularity or amount of the catamenial discharge. I have occasionally noted that women who menstruate with marked irregularity are specially prolific.

It is alleged as an established theorem, that from the period of puberty to the climacteric age there is, besides a gradual death of the mucous membrane lining the whole uterine cavity—which must ever occur to be compatible with life—a more or less regularly recurring and complete death of

this coat. In the whole animal kingdom we search in vain for a physiological change truly analogous with this. The serpent, it is true, may shed its skin more or less intact; but ere it casts off the old coat a new one is already regenerated to protect its body from all extraneous injurious influences. In vital structures change is wont to be gradual—creation and destruction proceed together. There is apparently no departure from this inexorable law. Death of the mucous lining of the uterus takes place imperceptibly; the change is one ever going on, as in all organs of the body.

In several cases I have examined uteri removed from women who have died, not only during menstruation, but just before an expected period. In two cases the death was sudden, the patient at the time being in apparent good health. In three cases the uterine organ was invaded by growths of fibroid character, which were chiefly submucoid. To the naked eye the mucous lining, in all, appeared in every respect like that of a normal uterus examined at any time indiscriminately. In no case did I detect any breach in the continuity of the lining membrane of the uterus, except in those in which this organ had become the seat of fibroid growths. In such the mucous lining had in places become markedly thinned, or even vanished altogether, because of a constant vital pressure exerted on this coat by the underlying new-growth. Here gradual absorption had resulted, very much in the same manner as bone and soft tissues disappear before the constant pressure of an increasing aneurism. I have never at any time detected any evidence of structural change, microscopically, in the inner linings of the uterus, in cases in which this organ has been removed from the bodies of females, who have died either during or just before an expected menstruation. The glands which stud the inner coat of the uterus in its entirety, consisting of columnar cells, lined by a basement as well as a limiting membrane, have, however, shown marked enlargement, in many cases so pronounced, that the outline, not only of the separate cells but even of the gland itself, has been lost. The columnar cells appear swollen, and contain frequently large corpuscular-looking bodies, which I believe to be the simple manifestation of increased functional activity. Prior to cutting, by freezing in gum, the tissues had been hardened for two days in spirits, and finally in a weak solution of chromic acid. The sections I stained in a variety of ways, my best stain, however, and that affording clearest definition, being *iron and pyrogallic acid*.

Those who support the denudation theory assert that each recurring monthly flow is anticipated by a fatty degeneration of the mucous lining of the uterus; that blood is extravasated into its substance, and eventually the whole, becoming disintegrated, is washed away imperceptibly with the escaped blood. A new mucous membrane is thereafter by degrees regenerated from the inner layer of the muscular coat, which

in its turn, too, like its predecessor, must undergo a similar degenerative change, and ultimately be removed from the body. Some of the lower animals, it is true, retain the power of reproducing limbs, and possibly other parts of the body removed by accident. If, however, the separation of the part be too frequently practised, we eventually exhaust the power—wholly irrecoverable—the structural integrity of the regenerated limb or tissue becoming less and less marked with each removal. Clinically, if the mucous membrane were shed with each catamenial flow, it must be capable of completing its cycle of degeneration, shedding, and regeneration, in an incredible number of days. Many are the menstrual anomalies which preclude the acceptance of such a phenomenon.

Taking all the facts into consideration, it is more than probable that the recurring monthly discharge in the human female is a secretion, or rather excretion, from the inner lining of the uterus and Fallopian tubes, without degenerative change other than that commonly associated with augmented functional activity, and comparable with that occurring in any other organ of the body under similar circumstances. —*N. Y. Med. Record.*

THE TREATMENT OF PALPITATION.

BY BENJAMIN WARD RICHARDSON, M. D., F. R. S., LONDON, ENGLAND.

The treatment of palpitation is moral, hygienic and medical, and the value of these stands in the order in which I have placed them.

1. *Moral Treatment.*—In the moral treatment the grand point is to impress the sufferer that there is no instant danger from the seizure; for palpitation is fed by fear, and so little as an expression of fear by the looker-on increases the intensity of the over-action. In like manner all hurry and worry aggravate the symptom, and so, during the attack, the utmost care should be taken to avoid noise, haste and fussiness. A gentle persuasion toward quietness, a firm assurance that the seizure will very soon pass away, and the best help of an encouraging kind is supplied.

2. *Hygienic Treatment.*—The hygienic measures for the treatment of palpitation have reference to the directions which should be given for warding off the attacks, and for removing the unhealthy conditions of body which dispose toward them. In these directions it is essential to include, first and foremost, the removal of all possible causes of excitement, worry and exhaustion, mental or physical. To this must be enjoined regular habits of life. Early hours for bed are requisite, and a continuance in bed in the recumbent position for eight hours out of the twenty-four at least is very important. During the day moderate out-door exercise, with avoidance of rapidity and of over-action from climbing steep ascents, should be specially enforced.

To the moderate open-air exercise above sug-

gested should be added daily and free ablution in water just sufficiently warm not to create a shock or leave a sense of chilliness of the skin. Brisk friction and the use of a flesh brush may follow the bath with advantage. I would, however, while on the subject of baths, offer a word of warning as to the Turkish or Roman bath in this class of cases. Good as that bath is in cases of disease properly selected for it, it is not good for persons subject to acute and extreme palpitation. The stimulus of the heat has caused in two patients I have known a severe and troublesome seizure.

Meals should be taken at regular times; at no time should a heavy meal be indulged in, and the simpler the diet the better. Some articles of diet in ordinary use should be limited. Too much animal food is bad. Light and easily digested foods, in moderate quantities, and fresh fruits are always good. In one of my cases a trial of a purely vegetarian system of diet had unquestionably a very good result, but as different scales of diet are suitable for different persons, I cannot here lay down any hard-and-fast rule. The plan I am accustomed to follow in prescribing diet is to find out from the patient's own report what articles of diet suit best, and then to use my own judgment, at the time, for advising the selection.

As regards drinks, there are three which, in my experience, are always unfavorable in cases of palpitation. These are tea, coffee, and alcohol in every shape. I know of no cases of the kind in which tea has not proved injurious. Coffee is not so bad as tea, altogether, but there are very few instances in which coffee can be readily tolerated. Alcohol is often much craved after, but it is a most deceitful ally. A little excess of it is prone of itself to excite the over-action without any other spur, and soon after it has been removed from the body it causes a depression which favors a recurrence of palpitation, under any excitement, in the most marked degree. The quantity of fluid taken should be limited in amount; and as to quality, the nearer it comes to water pure and simple the better.

Something requires to be said about mental as well as physical food. Readings, amusements, and pastimes, which keenly affect the emotional faculties, are to be avoided as much as any more plainly physical forms of excitement. Whatever mental food keeps the mind awake, whatever makes the sufferer hold his breath with wonder or anxiety, is bad as bad can be. Exciting novels, plays, exercises, games of chance, should most surely be put aside. But good, pleasant, steady mental work is not harmless merely; it is useful; it prevents the mind from brooding over the bodily incapacity, and it becomes an element of cure.

Under this head of hygienic practice there is one habit, bearing chiefly on the male sex, to which I must allude, and against which it is absolutely necessary to protest. I refer to the habit of smoking tobacco, and to the use of tobacco as a luxury in every way. Tobacco is the worst of

enemies to soundness of heart and steadiness of heart work. To those who are subject to acute palpitation, tobacco is so mischievous that it is hopeless to attempt to treat them until the habit is abandoned. On this point there must be no mistake.

3. *Medical Treatment.*—During an attack of acute palpitation, medical treatment of a direct kind can only be palliative. It is a common practice to place the patient in the perfectly recumbent position, but as this position leads, frequently, to breathlessness and much discomfort, I never enforce it unduly. The sufferers usually find out the best position for themselves, and standing up, and even gentle walking backward and forward commonly appear to bring relief, as if the general muscular action equalized the local over-action.

For the actual palpitation, digitalis is the only remedy I have found of any positive service, and it combines well with remedies which have a tendency to promote quickly the cutaneous and renal excretions. I usually prescribe the tincture of digitalis in five or ten minim doses, with half a fluid drachm of nitric ether, and two fluid drachms of the liquor ammoniæ acetatis. In instances where there has been prolonged sleeplessness, with palpitation, I have combined morphia, in full doses, with digitalis, with good effect, adding the narcotic dose to the formula just named.

In general treatment I am accustomed to follow, whether the heart be organically sound or unsound, the same methods as those prescribed in my previous essay on intermittency. The organic bromides of iron, quinine, and morphia, and the mixture of iron carbonate, ammonia, and morphia (*Asclepiad*, Vol. 1, p. 204) are excellent remedies. The only difference in treatment, in fact, relates to the use of alcohol, which, valuable in some cases of intermittency, is less compatible in cases of palpitation.

4. *Treatment of Epigastric Palpitation.*—The rules already ordered for the management of cardiac apply equally to the epigastric palpitation. There is, however, in cases of epigastric palpitation more frequent necessity to meet dyspeptic symptoms, including flatulency and consumption, by alternative and mild aperient correctives.—*Asclepiad*.

SICK HEADACHE.

By PHILIP ZENNER, A.M., M.D., Cincinnati.

There are few diseases which are the source of so much suffering as that which is the subject of this paper. Beginning usually at an early period of life, most frequently about the time of puberty, it returns as an unwelcome visitor for the greater part of the remaining life. Often it recurs with such frequency and severity as to make existence a terrible burden.

Like most diseases which, in themselves, never lead to a fatal issue, its pathology is very obscure.

Hughlings Jackson considers it to be of the nature of epilepsy, and to be caused, as he believes to be true of the latter disease, by a discharging lesion in the brain, in this case, in the sensory area. It must be acknowledged there is much in the manifestations of the disease, the manner of recurrence, and the influences which control it, which lends weight to this view. Of late years the most prevalent view of the nature of this disease is that it is caused by changes in the sympathetic nervous system, and that the paroxysms are brought on by a spastic or paralytic condition of the cerebral blood-vessels. When there is a spastic condition the paroxysm is termed spastic, or sympathetic-tonic; and as further indications of irritation of the cervical sympathetic, it is found that on the affected side the face and ear are paler and colder than on the other side, the eye is prominent, the pupil dilated, and the salivary secretion is very viscid and much increased in quantity. The paroxysm, with parietic condition of the vessels, is termed angio-paralytic, or neuro-paralytic. The paresis on the part of the cervical sympathetic is further indicated by heat and redness of the face and ear, suffusion of the eye, and contraction of the pupil on the affected side.

I have had occasion to examine a large number of cases during the height of the paroxysm, and only rarely, though the headache was distinctly unilateral, have I found decided manifestations of irritation or paresis of the cervical sympathetic. Therefore, I cannot but doubt the correctness of this explanation in many cases, though it is still possible that the pain may be due to varying conditions of the circulation within the skull, while there are no external manifestations of changes in the sympathetic nervous system.

Practically the important consideration is that of treatment. What can we do to ameliorate or to cure the disease? We must consider separately treatment for the relief of a paroxysm and that for the improvement or cure of the systemic condition which causes the paroxysms.

In case of a severe paroxysm all sources of irritation should be removed. The patient should be at rest in a darkened, quiet room; if anæmic, should lie down; if hyperæmic, maintain a sitting position. Firm compression of the head or the application of cold sometimes affords considerable relief. In the spastic forms of migraine, with contracted cerebral vessels, the inhalation of nitrite of amyl, or the internal administration of nitroglycerine, or other remedies which produce dilatation of the blood-vessels, will cause more or less complete relief. In the paralytic forms ergot often acts very admirably. Various other remedies are used whose indications can not be so distinctly given. Quinine, in from five to fifteen grain doses, will often arrest an attack. Many old sufferers with migraine, who have tried almost everything, find greater benefit from this than any other drug. Coffee, or its active ingredients, caffeine and guarana, often relieve lighter paroxysms.

Chloride of ammonium, chloral and croton chloral are of more or less service in most cases. Anstie believed that the administration of twenty grains of chloral, the patient at the same time keeping his feet in hot mustard water, and inhaling the steam from the mustard, was the ideal treatment for migraine. Bromide of potash affords relief in some cases, but it is usually necessary to give very large doses. A new remedy, antipyrine, has proved a valuable auxiliary in our treatment of migraine and other forms of headache. One or two doses of ten or fifteen grains, given at the beginning of an attack of sick headache, will often act like a charm in cutting it short. A still newer remedy, antifebrine, is said to act equally well.

In some very severe attacks, hypodermics of morphia may be called for to procure relief, and even these may afford but very little benefit.

In our efforts to prevent the attacks of sick headaches, or lessen their frequency and severity, we should attempt to remove all the causes which have any influence in their production. In some instances stomach disorders, diseases of the womb or the like, either directly or indirectly, occasion their development. Wherever diseases of this character exist, they should, if possible, be removed.

Special remedies are sometimes used with the idea of preventing future attacks. Cannabis indica is a favorite with some physicians. Its use for a long time is said to have a very decided effect in some cases. I have, myself, very rarely resorted to any specific medication in these cases. When I did so it was to administer the bromides, and only at such times when the headaches appeared to occur with unusual frequency or severity. Periods of this kind, of longer or shorter duration, are not rare occurrences to those suffering with migraine. I have almost invariably found that ten to fifteen grains of bromide of potash, given three times a day at such times, would be productive of much benefit.

Probably the most important consideration in cases of sick headache is that it occurs chiefly in those with a neurotic taint, where there is a history of headache or other nervous diseases in the family, and where the individual is of a nervous temperament and predisposed to nervous disease. Therefore, the important point in treatment is the toning up of the nervous system. Many such patients are anemic, debilitated women, and demand iron or other tonic medication, and a tonic regimen in every way. Hydrotherapy, sea baths, a trip to the mountains, will often prove of great benefit. Headaches are often brought on, or greatly aggravated by the worry or excitement of daily life, sources of ill which cannot be removed; but all such trouble must be avoided as far as possible.

When the disease has been of many years' standing, all our efforts will often avail but little, though the disease is likely to disappear after the climac-

teric period. It is in the young, when the disease is recent, that we may hope to accomplish most good. In such cases we must attempt to cure the disease before the habit, if I may so speak, has been established. To do this we must not only try to cut short each attack, but by proper habits of life, careful education, tonic medication, etc., so far as possible, eradicate the neurotic basis of the disease.—*Cincinnati Medical News.*

THE TREATMENT OF RHEUMATISM.

By E. S. F. ARNOLD, M. D.

When the late Dr. Robert Nelson, for many years the Mott of Canada, went to California, I succeeded him in his office in New York. During his absence constant inquiries were made of me for his remedy for rheumatism. On his return I asked him what this wonderful remedy was. He smiled, then simply answered, "Colchicum." Seeing that I was incredulous, he then told me that he had once at the Hotel Dieu, in Montreal, experimented with colchicum, trying all the official preparations, sometimes with benefit, but in the main finding all unreliable and often totally worthless. He ultimately tried a strong alcoholic tincture prepared from fresh seed. He found that the shell of the seed contained a volatile oil, that when water was added to the tincture it became opalescent, like tincture of myrrh, and by its use he obtained extraordinary effects. He prepared it by adding to one ounce of the seed half a pint of highest proof alcohol. After standing a fortnight and shaking once or twice daily it was fit for use. Add five drachms of this tincture to half a pint of water, or rather, enough to make a half pint, and of this the full dose is half an ounce. "Now," said he, "if you have a case of acute or subacute rheumatism, give this every four hours, night and day, avoiding acids and giving a light diet until the toxic effects of the colchicum are induced, viz., nausea or even vomiting, with active purging, which occurs generally by the time the sixteen doses are taken, and the rheumatism will disappear like a flash. Up to this period there will be apparently no relief." He cautioned, if I would secure the beneficial effects, always to prepare it myself.

In cases of acute and subacute rheumatism I have never found its equal, also in rheumatic gout. In simple local or chronic rheumatism, I do not expect anything from it. When I was first appointed Physician to the Sisters of Charity at Mt. St. Vincent, on the Hudson, I was shortly afterward called upon to attend the chaplain, a Canadian, between fifty-five and sixty years of age. I found him in a high fever and racked with pain from head to foot. "Ah," he said, "my dear doctor, I am in for a long siege of it. I have had a similar attack of rheumatism once before, and did not leave my bed for three months". I told him I thought we could do better than that. In a few days he was entirely free from pain, and in a

little over a week I found him strolling in the garden in a drizzle, without experiencing any ill effects.

Another case was that of the English foreman in a silk-dyeing establishment. This was built against a dam. Water poured from the wall, at the same time the atmosphere was so full of hot vapor from the vats that a person unaccustomed to it could scarcely see through it. It was a bad place for a rheumatic person. I found the man had rheumatic fever, as he called it, affecting every limb. He told me he once had a similar attack in England and was laid up for six weeks, suffering horribly. He was at his work in less than a fortnight, and was never again, during the many years I stayed in Yonkers, attacked. I have mentioned this remedy to many, more recently to my friend, Dr. Gouley. He says he has found it most valuable, and that he will never be without it.

In the local and chronic cases it is less efficient. In these I have found the St. Catherine mineral water of very great value. A gentleman, about sixty, came to ask me about Sir Astley Cooper's remedy for rheumatism, which was iodide of potassium. I suggested a trial of the St. Catherine water first. He said that as winter approached he was so constantly troubled with rheumatism on exposure, that it confined him during the cold months entirely to the house. He commenced a course of the mineral water, with entire relief, and during the last fifteen years of his life went out in all seasons and in all weathers, without ever suffering any inconvenience. He was never without the remedy in his house, and he told me subsequently that whenever he felt a little bilious he would take a teaspoonful (concentrated) half an hour before dinner. In half an hour after this meal he would have one or two good movements and he felt perfectly well again. He very seldom had occasion to resort to it. Another case was that of a middle-aged French gentleman, who had been a great sportsman, often passing whole days in the marshes. He was ultimately attacked with a rheumatic neuralgia, which seemed to affect the tendo Achillis. He suffered at times for many days with it, keeping him from his business, and endured acute pain. It seemed determined to resist all remedies, both local and general, until I tried the mineral water. He found it horribly nasty, but experienced so much benefit from it that he persevered, and a cure was effected. Of course I do not recommend these things as absolute specifics, but I have, nevertheless, had great reason in numerous other cases to think more highly of them than any other I know of.—*Coll. and Clin. Rec.*

A READY METHOD FOR REMOVING FOREIGN BODIES FROM THE ANTERIOR NARES.

Physicians are often called to remove peas, buttons, and various substances from the nostrils

of children who have themselves introduced them there. A ready method for removing such substances is described by Mr. T. Osborne-Walker in the *Lancet* for Sept. 17, 1887, where he states that recently a little boy was brought under his care with a button tightly impacted in the angle between the vomer and os nasi at the bridge in the right nostril. Ineffectual attempts at extraction had evidently been made, as shown by blood oozing from the nostril, and some, coagulated, adherent to the button, partially concealing its outlines from view, and also by the button being fixedly jammed in. In such cases, to prevent struggles and interruption, the child's arms, hands, and legs should be first confined, by folding tightly round these and the body a long, clean apron, and then placing the child on an attendant's lap, facing a window, while the operator stands behind the patient, and, bending over and depressing with two fingers of the left hand the apex of the nose, to admit as much light as possible upon the object to be removed, with the right hand very carefully, to avoid its descent into the pharynx or larynx, the spoon end (with the concavity directed forward) of an ordinary pocket-case director should be introduced, with which at once with a simple lever movement or jerk the foreign body may be readily ejected.

By attention to the following points the removal is instantaneously effected. The close confinement of the hands, arms, and legs by a shawl, blanket, or apron; a good light; a reliable person to securely hold the child; the position of the operator behind the patient; depressing well the apex of the nose to obtain a good view of the object; and, lastly, getting the concave face of the spoon of a director fairly behind the body before making the forward lever movement.—*Therapeutic Gazette.*

PHILADELPHIA HOSPITAL.

CLINICAL REMARKS BY WM. OSLER, M. D.,
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of Pennsylvania; one of the Attending Physi-
cians to the Hospital, etc.

TYPHOID FEVER, CASES ILLUSTRATING RELAPSE AND NERVOUS SYMPTOMS; CIRRHOSIS OF LIVER, LATENCY, FATAL HÆMORRHAGE FROM RUPTURE OF A DILATED OESOPHAGEAL VEIN.

Two cases of typhoid fever are shown to the class:

Case I. illustrates an important point in connection with the history of this disease, namely, relapse. She was admitted six weeks ago, and as the temperature chart indicates, had a well-characterized attack of typhoid fever. We cannot distinctly ascertain how long she had been ill previous to admission. When she was brought to the hospital, the chief symptoms were pulmonary. She had a most intense bronchitis, involving especially the smaller tubes. Rales were heard throughout the lungs, and she was cyanosed. We

were at first rather in doubt whether we had to do with a simple pulmonary trouble, or with a complication of typhoid fever. The spots, however, soon appeared, and the disease ran a characteristic course. About three weeks ago, her temperature became normal, and remained so for one week. It was then noticed that she was not so well, and the temperature rose to 102° , and there has been since an evening rise to 103° or 105° , with marked morning remissions.

You must carefully distinguish between a post-typhoid elevation of temperature and a positive relapse, and it is to this point I would especially call your attention. Post-typhoid elevations of temperature occur quite frequently, and may take place within ten days or two weeks after the evening temperature has reached normal. Probably, the most common cause is some indiscretion in diet. A return to solid food is sometimes followed by a slight rise. Sometimes mental excitement or worry will cause it. At times, after allowing the patient to see his friends or to transact business, you will find that the temperature will go up and remain above normal for a few days. In one or two instances, I have seen constipation induce a rise of temperature. In these cases the elevation of temperature is usually the only symptom. There may also be increased frequency of the pulse. The fever, however, is usually transitory, and there are not the well-marked symptoms which characterize the relapse, which, when typical, is a repetition of primary disease. The temperature rises gradually, and may attain a maximum as great as in the original attack. There is usually abdominal tenderness, often diarrhoea, and frequently a re-appearance of the rose-spots. This patient has certainly a relapse which is running a very mild course. The eruption has been well defined, and some spots are still present upon the abdomen. There has been no special abdominal tenderness, and she has had no diarrhoea. She had no recurrence of the bronchitis, but the character of fever and the distinct eruption are sufficient to establish the fact that we are dealing here with a positive relapse, occurred and not simply with a post-typhoid elevation of temperature. There was another interesting feature in this case, namely, that when the relapse occurred she had attacks of epistaxis. The course of the relapse is usually, as I have stated, a repetition of the original attack, but you may meet with many variations. As a rule it is milder, the temperature rarely reaching the same height, and the course of the disease is rarely so prolonged. The majority of cases do well, and a fatal termination is not so common as in the primary attack. In this patient the original attack was mild, and the probability is that she will do well.

Case II.—Of the seven or eight cases of typhoid fever in the wards, this, perhaps, has been the most severe. The patient was admitted to the hospital eight days ago. There is nothing special in his family history, and his personal history is

excellent. He was compelled to give up work sixteen days ago. The illness began with stiffness in the neck and soreness over the eyes. He did not have much pain in the back or the legs. There was pain in the stomach, and the bowels were constipated, and for the relief of this pills were taken, and the bowels moved freely. He also suffered with epistaxis, and thirteen days ago was compelled to go to bed.

When admitted to the hospital, the face was flushed, the eyes were bright, and he was quite rational. The temperature was 103.4° , the pulse a little over 100° , and dicrotic, and the respirations were not increased in frequency. Examination of the abdominal and thoracic viscera gave negative results. There was neither diarrhoea nor rash. Since admission the fever has been persistently high. He is now at the end of the second week of the disease. The eruption has been quite characteristic, not copious; the abdominal symptoms have been slight, as in most of the cases this autumn. The abdomen is slightly distended, and the spleen is somewhat enlarged. The most serious symptoms which this patient has presented have been those relating to the nervous system. If you watch him for a few minutes you will see that he is very tremulous. This began early in the case. It is best noted about the face, and when the patient responds to a question you will see that the muscles are quivering. When he protrudes the tongue, it trembles. The muscles of the hands and arms are in a state of jactitation, —sebsultus tendinum. This, as a rule, indicates profound involvement of the nervous system. He has had also pretty active delirium. He has attempted to get out of bed, and has had wandering, sleepless condition at night. He has not been in that torpid, heavy, stupid state which is seen in many instances of typhoid fever. The mental condition in the severer cases of the disease is usually one of stupor or semi-coma, or it is one of active delirium. Of the two the semi-comatose condition, as a rule, carries a more favorable prognosis. The active delirium is more serious.

A special condition calling for treatment in this case has been the persistently high temperature. He has been given antifebrin, and it has acted well, reducing the temperature two or three degrees in as many hours. Yesterday the temperature at 8.20 a. m. was 104.4° . He was then given eight grains of antifebrin, and the temperature was reduced to 100° by 11.50 a. m. Three days ago, the same dose of antifebrin reduced the temperature from 104° to 100° within three hours. The drug seems to have acted satisfactorily as regards the reduction of temperature, but it has the unfavorable effect which most of these new antipyretics have, and which quinine has not, namely, that they produce profuse sweating, which is most distressing to the patient. The patient after the use of one of these drugs may be drenched with sweats as copious as those of phthisis. I have stopped the antifebrin and have resorted

to sponging. This I think will suffice to keep the temperature down. Another symptom which has called for special treatment in this case is cardiac weakness. The pulse has been frequent and feeble, and for this we have given alcohol in repeated and large doses, twelve to fifteen or more ounces in the day, and it has had an influence in quieting the nervous disturbance and also improving somewhat the vigor of the heart's action.

CIRRHOSIS OF THE LIVER.

I have recently shown you two instances of hemorrhage from the stomach in middle-aged men, possibly due to cirrhosis of the liver. Since then I have had several other cases under observation. Two of these cases are quite interesting, and illustrate a point on which I wish to speak, namely, the latency of the affection. One-third, possibly one-half, of all cases of cirrhosis of the liver, coming under observation in any large hospital, are met with for the first time on the post-mortem table. There may have been no special symptoms, or the patient has complained of other conditions, and at the autopsy extreme cirrhosis may be found. Of this there have lately been two interesting illustrations. A man was admitted into the drunkard's ward with acute alcoholism and pneumonia, and died at the end of twelve hours. He was slightly jaundiced, not more so, however, than is frequently seen in pneumonia. He had no œdema of the feet and no dropsy of the peritoneum. At the post-mortem we found in addition to the lesions of pneumonia, extreme cirrhosis of the liver. The organ was very irregular, and in the condition of advanced interstitial hepatitis. The man had apparently presented no symptoms of this affection.

The second case was that of a man aged 44, sent from the surgical wards on account of sudden hæmorrhage from the stomach. He vomited three or four pints of blood, and died within a few hours after admission to the medical ward. When I saw him he was comatose, and the only thing detected on physical examination was extreme reduction in the area of liver dulness. He had apparently had no symptoms except the dyspepsia which all chronic alcoholics have. At the autopsy we found the following interesting condition:

The body was fairly well nourished; there was a small ulcer on the leg, for which he had been under treatment in the surgical ward. There was no œdema of feet; no fluid in peritoneum. Left lobe of liver two inches below ensiform cartilage. Heart and lungs normal. Stomach did not contain blood (a point of interest, as he was stated to have vomited the blood); the mucosa was pale; no erosions. Veins at the cardiac end much dilated. Cœsophageal plexus of veins very prominent, and several large branches were directly continuous with those in the stomach. For three-fourths of the tube the submucous veins were dilated. On the posterior wall was a long varicose vein as thick as a small quill, and at one point this

presented a greyish white spot, elevated and covered with a thrombus. A small probe passed into the vein came out through this spot, which represented a laceration in the vein, and no doubt from this had come the bleeding.

The liver weighed three pounds; was nodular, tough, and on section showed an advanced grade of cirrhosis; portal canals were much constricted, and the interlobular connective tissue much increased. The diaphragmatic plexus, the veins of the suspensory ligament, those of the lateral peritoneum, and particularly those over the kidneys were enlarged. The hemorrhoidal vessels were not very much dilated. The vena azygos was large.

In both of these cases the cirrhosis was extreme. The contraction of the ultimate branches of the portal vessels in the liver substance was most marked, and yet there were no symptoms of portal obstruction. The point I desire you to remember is this: that if in any case of cirrhosis the collateral circulation is established, then so long as it is *effectively* maintained, so long will the characteristic symptoms of cirrhosis be absent. There may be no dropsy, no jaundice, and no extreme dyspepsia. In both of these cases the collateral vessels were very distinct. It is chiefly through the diaphragmatic and cœsophageal veins, and the communication with the mesenteric and lumbar veins, and by hemorrhoidal veins that the collateral circulation is maintained. In both cases, the anastomoses of these vessels were extensive enough to prevent engorgement in the portal circulation, which is the effective factor in producing dropsy. Dilatation of the cœsophageal veins in cirrhosis is a well recognized condition. Communication between the cœsophageal and diaphragmatic veins, and the union of these with the azygos veins aids materially in carrying off from the stomach, from the spleen, and even from the liver itself, a large quantity of blood which under other circumstances would pass through the portal circulation. Rupture of an cœsophageal varix is a rare but well recognized mode of death in hepatic cirrhosis.—*Phil. Med. News.*

INJECTIONS OF WARM WATER IN DYSENTERY.

Dr. R. Tripier, in the *Lyon Médicale*, writes concerning the action of injections of hot water in dysentery. He sometimes gives, in addition, infusion of ipecac internally. When a patient is able to retain the hot water (heated to 105° or 115°) a sufficient length of time, the pain is immediately relieved, the blood quickly disappears from the stools, and even these soon become fewer. The amount of water injected should be as large as can be borne; from 10 to 12 ounces for children and about a quart for adults.—*Journal de Médecine et Chirurgie Pratiques.*

FIBROID TUMORS OF THE UTERUS.

By W. W. WOODHAM WEBB, M. D., M. R. C. P. London

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The comparatively speedy results obtained by the use of the pole of the battery in the case of hemorrhagic fibroids is very striking. When we see a woman who, in months or years of suffering, has passed through the stages of depression, debility and exhaustion, till at last she lies down in her bed helpless and in despair, rise up after a few applications, with her pains soothed, her bleeding stayed, her countenance brightening, her appetite returning, and the dawn of a new life opening upon her, one is apt to think that medical science has justified itself. Yet it has not by this feat reached the end of its powers, it can respond even to further demands. The woman has still her burden upon her. The surgeon may have recourse to his knife and take it away. But at what risk? Such a risk that only despair will never him to face it, or make the patient submit to it. Those only who have long felt the crushing responsibility of cutting operations, and have had sufficient experience to gain the conviction that a known percentage of recoveries is hardly enough to counter-balance the pains and perils of forlorn-hope surgery, can fully luxuriate in the sensation of relief given by the prospect of being able to control the growth of these tumors and render them harmless by a scathless process. This is for the future to be the work of the negative pole of the battery. And that is not all. Before advancing far with the patient-taxing proceedings against the *corpus delicti*, we have the satisfaction to find the earlier steps lead to such a modification of a certain class of symptoms, and such a change of health conditions as to make the question of time of but secondary importance. With loss of pain and ease of mind, a woman may wait calmly for the restoration of the symmetry of her body.

The second group of fibromas is that in which the leading troubles are those of difficult or suspended menstruation. In some cases the displacement of the uterus is so considerable that no entrance into the cavity can be obtained for cauterization, and the alternative of puncture has to be adopted. The character of the tumor varies. It is sometimes a mere mural thickening, complicated with inflammatory deposits around. In other women there are subperitoneal accumulations and protuberances, or large pedunculated outgrowths. Accompanying them are all the usual functional disorders and nervous irregularities, which take away the enjoyment of life and even make it a burden. But as the most notable distress arises from the periodical pain, the scanty or unnatural discharge, and the local uneasiness which is always present, we begin with attempting to ease that.

Faradization of the uterus may be of use as a palliative remedy, but generally recourse is had at once to negative galvano-cauterization, of more

or less force, and at intervals more or less long, as the patient bears the treatment, and according to the change that takes place. The periods soon become more regular, the intermediate time is less disturbed, the general health improves, and the local distress is not so urgent. Such an amelioration is a great point gained, but we must not stop there. As more has to be done in regard to the riddance of the tumor, the useful but slow-working intra-uterine cauterizations are superseded by the negative galvano-punctures. As Althaus has said, "No animal tissue whatever can resist the disintegrating effect of the negative pole; and the force and rapidity with which the disintegration is brought about are directly proportional to the electro-motive force which is employed, and to the softness and vascularity of the structures acted upon." This action of the negative pole is a double one. The negative electrolytic decomposition of animal substance or liquid give rise to an evolution of bubbles of hydrogen, which mechanically affect the tissues near the pole by insinuating themselves between the structural elements and driving their fibres asunder. This is a point established by microscopical observation. The second effect is a chemical one—that of the alkalis. These, soda, potash, lime, with the hydrogen, are liberated by the decomposition of the animal matter, and go to the negative pole. The metal remains untouched by them, so that they are all free to act upon the adjacent parts in that manner of potential caustics. An eschar is formed, suppuration takes place, and sometimes a considerable discharge continues.

Such are the notable effects produced at the seat of puncture by the negative pole, and it is this only which in these cases is used therapeutically. Cauterizing action, which would be as powerful at the point of exit of the current at the cutaneous pole, if it issued as dense as it went in, is not wanted. It is, therefore, guarded against by disseminating the current through the intervention of the wet clay. But the main factor in determining a diminution in the size of the tumor is the repeated action of the intense current of electricity which is made to traverse the inter-polar tissues. Whatever explanation may be given, the fact is that nutrition is interfered with, the vessels shrink, the form alters, the substance contracts, and the tumor remains smaller to an extent which renders its presence of but little importance. It still exists, but without any disposition to throw out new offshoots or to resume its former power of expansion.

The operator must be guided in his choice of the part in which to make the puncture by the form and situation of the tumor, or by the condition in which he finds the prominent part of the uterus. If it can be done conveniently, the punctures are best arranged on and about the neck of the uterus; if the neck be obliterated, in a series round the orifice; or where the displacement of the organ only leaves the option of a projecting part

of the tumor, then they may penetrate the tumor itself through the expanded vaginal wall. I have mentioned the precautions necessary, and have only to add that the length of puncture used at the present time is much less than it was at first. Rarely is it now found of advantage to leave exposed out of the sheath more than two centimetres of the trocar. This shallow puncturing lessens in a great measure the chance of wounding vessels or passing through the peritoneum. Even when it so happens that, on withdrawing the instrument, there is a flow of blood, it can be at once restrained by introducing a speculum and putting the parts on the stretch, or picking up the bleeding point with a pair of pressure-forceps. Generally the oozing, if there be any, is very trifling and stops spontaneously, and a moderate depletion of this kind is only beneficial.

The cases, of which I give very condensed notes, show what may be expected from the treatment by negative galvano-punctures.

CASE I.—Madame P., aged forty six: Natural pregnancy at nineteen. When thirty-first signs of abdominal tumor. As the abdomen distended the health declined. Surgeons consulted declared the tumor to be a uterine fibroid, but declined to operate. Gradually grew worse, with all the phenomena of compression; functions disturbed; difficult menstruation, and pronounced cachexia; disabled. Came to *Clinique* June, 1883. Fibrous tumor of uterus attached, not in any way movable, touching at its upper end the sternum, filling the belly and the pelvic basin. Abdominal measurement in line of umbilicus 110 centimetres. Neck of uterus raised up behind pubes and inaccessible to the sound. Puncture inevitable. After three negative galvano-punctures, three centimetres, seventy milliamperes for eight minutes each, the neck of the uterus descended, so that between July, 1883, and July, 1884, twenty-nine galvano-cauterizations, negative, intra-uterine, were possible, and a large and rapid diminution of the tumor took place. Measurement at one time showed a decrease of sixteen centimetres round the abdomen, but the deposition of subcutaneous fat soon brought it up to the point first noted. The tumor became pedunculated and movable, menstruation regular, and the woman was able, while undergoing treatment, to resume her work with ease.

From July, 1884, to December, 1885, thirty-eight negative galvano-caustic applications, intra-uterine, completed the treatment. The tumor went on lessening, all symptoms of pressure disappeared, and the general health was as good as when she was young.

In November, 1886, the tumor was quite free, with its upper border a hand's breadth below the point of the sternum. Menstruation ceased in September, 1885, and she gained weight.

June, 1887, lives as a woman in health, and if we may estimate the reduction of the tumor as one-third, the set off against the remaining bulk of the fibroid is the entire suppression of every symptomatic trouble.

CASE II.—Madame D., aged fifty-nine, mother of one child, came to *clinique* December, 1884. Had been ailing all her life. Menopause at fifty-three, when her health became worse, with bad abdominal symptoms caused by a tumor which rapidly formed at that time. Found to be a sub-peritoneal uterine fibroid, passing more than two inches above the umbilicus, fixed, bulging out the abdomen and blocking up the pelvis. The sound revealed excessive thinning of the anterior wall of the uterus, so that all intra-uterine interference was given up for fear of perforation.

Between January and November, 1885, fifteen negative galvano-punctures, one centimetre, were made with a current of from 80 to 100 milliamperes, five minutes. The neck of the uterus being turned up to the left, the punctures were directed into the projecting part of the tumor through the central part of the posterior vaginal wall. No chloroform. Some hysterical and gastric symptoms, which gave way to bipolar galvanization of the pneumogastriacs. During the first half year there was a regression of the tumor with corresponding amelioration of the health. She weighed five pounds more, and had a considerable accumulation of abdominal fat. The size afterwards went on lessening till, in December, when all treatment was suspended, the upper part of the tumor had become so movable that it seemed to be attached to the uterus only by a peduncle, and could be pushed, without causing pain, from one side of the abdomen to the other. When at rest the upper margin was more than two inches below the umbilicus, though the whole of the isolated mass could be raised above it. The pelvic section of the tumor was also so much smaller as to leave the uterus disengaged, and to permit the vagina to resume its natural form. Uterine measurement, which was at the first sitting nine centimetres and a half, had shortened to six centimetres, and the thickness of the uterine wall was more uniform.

She remained in good health through 1886. Some narrowing of the cervical canal prevented any introduction of the sound, but caused no inconvenience. A continued contraction of the tumor was manifest. At the present time (June, 1887,) she is quite well, still fatter, and has no abdominal deformity, except that owing to the adipose tissue.

CASE III.—Madame R., aged fifty-three, good constitution, no serious disease, mother of five children. Menstruation always natural, till in 1882 she was seized with sudden and violent hemorrhagia. This lasted three years, during which a painful abdominal tumor gradually reached a large size, with derangement of all the organic functions, and loss of strength and flesh. Treatment with ergot did no good. Diagnosis, September, 1885: Interstitial and subperitoneal fibroma of uterus, rising above the umbilicus, distending the abdomen, and on a level with the upper rim of the pubes, inaccessible to the finger. No introduction of sound being possible, negative galvano-punctures were commenced.

From the beginning of September to the end of December, 1885, sixteen punctures, one to five centimetres, with current of from 150 to 200 milliamperes, five minutes, through the vagina. On October 10th, after the fourth puncture, there was total cessation of hemorrhage. Amendment of health began, and the tumor had so much reduced that in December, the neck of the uterus had descended, and the sound could be introduced, showing a measurement of nine centimetres and a half. There was an unavoidable cessation of treatment. It began again in April, 1886, and between that date and the end of July two more punctures were made, and the effect completed by sixteen intra-uterine galvano-cauterizations. After this time nothing more was done. Natural menstruation appeared for the last time on August 10th, lasting four days without pain. At the end of 1886 she was healthy, growing fatter, carrying the remains of her tumor without cause for complaint, and regularly doing her work of *concierge*. In June, 1887, she called to report herself quite well. Her own words were: "Je me porte aujourd'hui aussi bien, en tous points, qu'il y a cinq ans, et sauf la présence du reste de ma tumeur, qui ne m'incommode plus en aucune manière, je me déclare en parfaite santé."

Dr. Apostoli has so recently explained his views as to the application of this mode of treatment to the many forms of chronic metritis, by which women are often as much disabled as by distinct tumors, that I need not repeat his observations. I may only remark that the subject is, perhaps, of even more importance, seeing that the condition is more common, and may generally be regarded as the starting point of definite abnormal formations.

But there is another matter associated with this question of electrical treatment that has long weighed upon my mind; and now, with this opportunity before me, I can not pass it by without a word that may specially interest ovariologists. I have been as much concerned with ovariectomy as most men, and always, when standing beside the operating table, have had the humiliating feeling which one must be conscious of when grubbing up weeds in a neglected garden. We all know what is the wretched state of a woman with a fully developed ovarian tumor, no matter of what kind. Fortunately, scientific skill has freed the delivering operation of many of its terrors. But the most brilliant performances of our operators only serve to throw a shadow of reproach over the pathological side of the ovarian question. Hanging criminals wholesale never was the means of ridding us of crime. Every good delivery only made place for fresh committals, and mounted up the statistics of social scandal. To strike at the vicious germ of the evil by moral training and education was more efficacious in staying the pest than the utmost perfecting of the art of hanging. Why should we not see a similar sanitary reformation among ovariologists? Instead of exhausting

their ingenuity in discussing the qualities of ligatures, the merits of various knots, and the advantages of the long peritoneal drop over the external strangulation of the pedicle, just as the sheriff's deputy puzzles himself about the length of his cord and the best way of noosing the necks of his human excrescences, when will they turn more ovariological, and take to the work of seeking out how to repress the proliferous tendencies of the nascent crop of ovarian cysts? It is a task that must be done, and will be done by some one who is duly impressed with a sense of professional responsibility. Is there a gleam of hope in what has been observed in the midst of these electrical uterine operations? Some few times it has happened that an incipient ovarian tumor has been recognized.

The cauterizations or punctures have been made, and the cyst has disappeared. Taking this as a fact, does it not open out a line of experimental investigation worth following up? It requires the disposition, the opportunity, and the devotion of time. Men harassed by the demands of actual practice can not undertake it, but surely there must be some who, in their waiting time, are on the lookout for the way of making themselves men of repute. They might profitably give themselves up to the speculation of projecting in an almost untouched corner of preventive medicine. *Hic patet ingenii campus*.

The following is a summary of the notes of one of the cases to which I have alluded:

Madame G., aged twenty-eight, good health, married at nineteen, never pregnant, constant leucorrhœa; regular menstruation, short and scanty, becoming more abundant after marriage. On examination, uterus found nearly natural, vagina sensitive, nothing wrong on left side, but on right side, in the situation of the ovary, a tumor was easily distinguished, hemispherical, having the feel of a somewhat solid cyst, not very tender under pressure, and easily recognized by its form, situation, consistence, and want of sensibility as an incipient ovarian tumor.

After consultation a vaginal negative galvano-puncture was made to the depth of one centimetre, and a current of 100 milliamperes passed for five minutes. No chloroform was used, and the patient bore what was done without complaint. The sensation to the operator was that of tapping a cyst with fluid. No fluid, however, escaped by the vagina. The patient was a little nervous in the evening, and had some rectal tenesmus, but slept well, and went home at the end of twenty-four hours' rest.

On examination five days afterwards no tumor could be found, and there was no tenderness. It is now nearly two years since the operation was performed. The woman has remained in her usual health, is somewhat stouter, and keeps constantly at her work. At the present time (June, 1887), there was no trace of a cyst on the right side, but the ovary can be detected on lower-

ring the uterus. On the left side a small tumor about the size of a chestnut, with all the characters of an ovarian cyst, has made its appearance. A little projection on the right vaginal wall marks the spot where the puncture was made.

Finally, and as the result of eight months, incessant observation, and of my own experience in the treatment of cases in conjunction with Dr. Apostoli, I can unhesitatingly assure those who are interested in the question, operators or operatees, that the conclusions at which I arrived at an early period of my investigations as to the value of the therapeutic influence of electricity in cases of uterine fibroids, used after the manner I have described, with a view to introduce it to the notice of English surgeons, are more than confirmed by my longer acquaintance with the subject. It is also worth mentioning that they have met with the assent of all, including such authorities as Sir Spencer Wells, Keith, and Dr. Playfair, who have been induced by what I have written to visit the *clinique*, and examine the evidence for themselves. Some, indeed, have at once resolved to adopt the practice, and others, who are not disposed to undertake a task which requires so much quiet perseverance and familiarity with technical details, have confided their patients to our care. These cases I shall hereafter publish, when time has proved that the benefits received are as permanent as those recorded of his own patients by Dr. Apostoli.

CHRONIC CONSTIPATION.*

By GEORGE J. COOK, M. D.,

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The part directly involved in chronic constipation is the large intestine. The contents pass through the small intestine in three hours, and through the large bowel in twelve hours. (Landois.) The contents are liquid in form as they are poured through the ileo-cæcal opening—in the colon, they are exposed to the open mouths of Luberkuhn's follicles, which take up the digested portion that has escaped the absorbents above. The longer the contents are exposed to the absorbents along the colon, the more of the watery portion will be extracted, and the more solid will be the mass of excrement. The secretion from the large intestine is mostly mucus, in quantity sufficient to lubricate its walls. There is not sufficient watery secretion from this part to modify the consistence of the fæces. The consistence of the excremental mass which passes from the rectum depends on the length of time required for the contents to pass from the cæcum to the anus, and the activity of the absorbents. The consistence of fæces should

be mushy, or at most only sufficiently hard to be moulded in form.

If the contents pass through the large intestine in twelve hours, and the resulting excremental mass is very hard, the contents have remained too long in this part, whereas, if they should be thirty-six or forty eight hours in passing, and the fæces is of normal consistence, they have remained in the large intestine the proper length of time. The proper time for the contents to remain in the large intestine is modified to an extent by the action of the small intestine. If the peristalsis is very active in the small bowel, and will carry the contents through rapidly, the quantity passing through the ileo-cæcal opening will be correspondingly large, giving the colon more work to do and it will require more time to do it.

If the peristalsis is sluggish in the small intestine, allowing the contents to be exposed to the active absorbents of this part a long time, the quantity passing into the colon will be smaller, and the less time it should remain there. In a like manner, the activity of absorption in both the large and small bowel will modify the time necessary for the contents to remain in the former. Thus the proper peristalsis of the large bowel is modified by the activity of the peristalsis in the small, and absorption in both small and large intestine.

Chronic constipation may be defined as that condition in which the contents remain too long in the large intestine. There are two forms of chronic constipation, viz.: Obstruction and atonic. In the former there is an obstruction to the free passage at some point along the large intestine, while in the latter the passage is free, but for want of proper tone in the muscular structure of the bowel, the contents are not carried along in the proper time. In enumerating the causes of the first form, we will begin on the external sphincter muscle. This little muscle, of wonderful power and endurance, performs an important function at the lower end of the alimentary canal. When natural, it will counteract and relax at the pleasure of the individual, but if irritated, it may pass beyond control, and refuse to relax at the proper time to allow the fecal mass to pass, and form an obstruction which the expulsive force is not able to entirely overcome, and the result is an incomplete defecation.

This irritation of the sphincter may be caused by inflammation or ulceration involving the margin of the anus, or the mucous membrane of the lower part of the rectum. The repeated voluntary contraction of this muscle to prevent defecation at the proper time, an act indulged in by so many persons, and the pressure above of the retained mass bring will about an irritable and hypertrophied condition of the muscle. Contraction at the upper end of the rectum is a cause of constipation, frequently present, but seldom recognized, and usually the result of chronic inflammation in that part of the gut. The contraction prevents the free passage of the contents from the sigmoid flexure into the rectum.

* Read to the Mississippi Valley Medical Association, at Crab Orchard, Kentucky, July 14, 1887.

Organic stricture may occur at any point in the rectum as a result of ulceration, or of syphilitic or malignant deposit. A very frequent cause of obstruction in females in displacement of the uterus, in which this organ presses down or back against the rectum, sufficient to interfere with the passage of fæces. Large hæmorrhoidal tumors may so obstruct the anal opening as to greatly interfere with the passage of fæces. Among the rarer causes of obstruction are strictures along the colon, from contraction in the calibre of the gut, or from fibrous band across the outside, compressing it.

Atonic constipation may result from a number of causes. The most frequent one, however, is the violation of nature's laws in regard to the evacuation of the large intestine. When the sensory nerves of the rectum indicate that the fecal mass is passing from the sigmoid flexure, and is ready for expulsion, and the time or circumstances are not convenient, the voluntary sphincter is closed, and farther progress prevented. An occasional occurrence like this may do no harm, but when it is frequently repeated, large quantities are made to accumulate in the colon and rectum, the muscles are stretched, the sensitive nerves blunted, and atony is established. Some persons seem to have a weak muscular development in the intestine, just as some may have a weak organization of the voluntary muscles. Such persons may have constipation almost from birth. Centric causes, interfering with the generation of nerve force, may bring about atony of the intestinal canal.

Both forms of constipation may exist at the same time, and bear the relation to each other of cause and effect. When there is an obstruction, the blocking back of the fæces in the colon and rectum may so stretch the muscles as to weaken them; and if from atony a hard mass is allowed to remain for a length of time at one point, it may cause inflammation and ulceration, which will result in organic stricture, or if this mass is lodged in the rectum it may cause spasm of the sphincters.

Insufficient intestinal secretion is usually given by authors as a cause of chronic constipation. I do not understand how this can be a cause, nor how they determined that such a condition exists.

As before stated, the contents pass into the colon in a liquid form, and the watery secretion from the large intestine is not sufficient to practically effect the consistence of the fæces. The passage of dry, hard stools is not evidence of lack of secretion anywhere. When there is a lack of secretion from the liver, there may be inactivity of the colon because of the absence of this natural stimulant. At times, when the person is indulging largely in meats and concentrated foods, from which there is little excrement, there may be torpor of the bowels, because the bulk of fæces is less than usual, and not sufficient to excite the colon, but when the person returns

to their usual mixed diet, the bowels will act with regularity. Chronic constipation is more prevalent among females than males. This is especially true under the age of twenty. One of the greatest neglects in the home education of young girls is in regard to the function of the large bowel, and its relation to perfect health. To fully appreciate this, it is important to understand the relation of the colon and rectum to the ovaries and uterus.

The left ovarian vein passes behind the sigmoid flexure, close to the descending colon, and empties into the left renal. The right one is shorter, passes close to the cæcum, and empties into the vena cava. These only occasionally have valves. The uterine veins empty into the internal iliac. If the large bowel is constantly filled, the effect on the circulation through these veins is easily understood. The distended sigmoid flexure and descending colon will interfere with the return of blood from the left ovary, and a full cæcum will press against the internal iliac and uterine veins, and interfere with the return of blood from this organ.

The result of such a condition as this in the generative organs of the female, especially between the ages of twelve and twenty, needs no description. I believe if more attention was paid to the proper performance of the function of the lower bowel in early female life, the gynecologists would have less to do. In the construction of a house, much attention will be given to sanitary plumbing, etc., to insure against the dangers of gas returning from the sewer to affect the health of the occupants, while, at the same time, many of these persons may be carrying veritable privies around within their own bodies. We can observe daily the vicious influence of the poisons from the fermenting and decomposing mass in the colon, manifested by the impaired digestion, faulty assimilation, foul tongue, muddy complexion, and depressed nervous energies.

If we expect to cure chronic constipation, we have first to know the cause, and to know this a thorough examination is necessary, and only when this is done can we proceed intelligently. If an obstruction is found, proper measures must be used for its removal. After this, the colon must be cleared of any accumulations which may be lodged in the sacculæ. The proper method to cleanse the colon is by injections of hot water, which must be thrown as high as the ileo-cæca valve. Purgations should never be depended upon for this purpose, for it is often impossible to dislodge hard masses with them, and in the attempt we may do harm to the gut; but with water we are certain of thorough cleansing, and no harm can result. When the obstruction is removed, and the colon cleared, it is then in a condition to resume its normal function. But if the bowel has been greatly distended, it may need some assistance to regain its proper tone and strength, and appropriate tonics for this purpose will have to be

given. If an examination reveals no obstruction, then there must be a want of tone or power in the large bowel to carry the contents along in the proper time. In the commencement of these cases also, we must first see that the colon is cleared of any fecal accumulations, and let me repeat, do not depend on purgatives for this purpose. Purgatives, as taken, are the bane of the human family. After cleansing we must use means to strengthen the muscles of the large intestine, and enable it to properly perform its function, and while this is being done, care must be taken to correct any habits of the individual which may predispose to constipation.

The principles of treatment which we would apply to a weakened voluntary group of muscles are proper for a like condition of the muscular coat of the large intestine. To promote circulation and excite muscular contraction, and also assist directly in propelling the contents of the bowel, we can use massage; at the same time we can add another stimulant, by applying electricity. We have medicines which act directly on the motor centre of the muscular coat of the intestine, this motor centre being the plexus mesentericus of Auerbach, located between the two layers of muscular fibres in the wall of the bowel. (Lindois.) Aloes is a type of these medicines. Nicotine also acts directly on this centre, and promotes peristalsis, hence the pleasure in an after dinner cigar. Other medicines act indirectly through the cerebro-spinal nerves. Strychnia, for instance. The impressions are carried to the plexus mesentericus through the cerebro-spinal nerves, which stimulate this centre, and contraction of the muscular coat is the result.

In this same indirect way, we can promote peristalsis through volition. Our aim in stimulating the muscular coat of the bowel should be to bring about natural contraction, and not spasmodic action.

The natural contraction of the bowel is indicated by the term peristalsis—contracting in successive circles. In this the contraction is gentle, and passes in successive means along the bowel, propelling the contents without irritation to any part. To promote this action we must be careful not to give medicines in too large doses. If the dose is too large, it will cause spasm, which will retard the passage of the contents, and by this hyperstimulation increase the paresis. So, in giving colon tonics, we must begin with small doses and slowly increase until we get the desired result. While we are thus toning up the bowel, we must keep it clear of any fecal accumulations. For this purpose salines are our best remedies, but care must also be taken with these not to give too large doses, or you will do harm. A goblet of water, with thirty to sixty grains of sulphate of soda in it, taken on rising in the morning, will be carried rapidly along the alimentary canal, and not overstimulate either the muscular or glandular system of the intestine, but will evacuate the large

intestine. The quantity of soda in the water renders it more alkaline than the blood, and prevents absorption, and at the same time is not so alkaline as to cause any appreciable flow from the blood into the bowel; and this quantity of water taken on an empty stomach is of sufficient bulk to promote peristalsis, and it is carried rapidly to the large intestine, where it liquifies the feces, and causes a free evacuation. Salines may be taken in this way for a length of time without harm. They do not tone up the bowel, nor do they in small doses weaken it, except as we weaken any muscle by relieving it of work. When the contents are made fluid, only slight peristalsis is necessary to evacuate them. When the large intestine is inflamed or ulcerated at any part, we should give salines alone when necessary to evacuate it with medicines. The atony in chronic constipation may not affect the entire large bowel, but may be confined to the rectum and sigmoid flexure, or to the latter and descending colon, and great good may be done by stimulating injections. Sometimes we seem to get better results by giving the medicines by rectum instead of through the stomach. In selecting medicines to relieve chronic constipation, we should be careful not to punish the liver and small intestine for the sins of the rectum and colon. Unless we are certain that there is not sufficient secretion from the liver, we should not add a cholagogue to the pill; and if we think the contents pass from the stomach to the colon in three hours, we should not stimulate the small intestine.

If atony is due to centric disease of the nervous system, the remedies must be directed there, but at the same time care must be observed to keep the colon and rectum clear. I will not attempt to give formulas, nor speak of the medicines proper to give in different cases of chronic constipation. This can be determined only by studying each case by itself, and knowing the physiological action of medicines.

THE ABUSES OF MILK DIET IN THERAPEUTICS.*

BY ROBERTS BARTHOLOW, M.D., LL.D.,
Professor of Materia Medica, Therapeutics and Hygiene in
the Jefferson Medical College.

The therapeutic employment of milk, not only has been popularized, and the lay public made familiar with its various adaptations, but in the wake of the general appreciation has followed the usual exaggerations, and hence it is prescribed with little regard to the conditions properly requiring it. Under these circumstances it seems desirable to indicate the limitations of this therapeutical food, and to show wherein it may be hurtful rather than beneficial.

In certain disorders of the digestive functions, milk causes a sense of discomfort, decided uneasiness, oppression—sometimes even pain, and it

*Journal of Reconstructives, July, 1887.

prolongs the morbid condition. The cases of this kind may be grouped into two classes; those in whom the casein is the offending material; those who cannot properly digest the cream or butter. We find examples of the first class among children, but they are by no means uncommon in adults. They are detected the more readily in early life, because the curds are rejected by vomiting, or appear undigested in the stools. Adults unable to digest casein, or who digest it slowly or painfully, have epigastric distress, heaviness and oppression for several hours after meals, stupor and disinclination for exertion coming on after an hour or two, and continuing until the offending material has passed well down the intestines.

An excellent substitute for the milk when the casein disagrees is barley water with cream. The barley water should be carefully strained and have the density of good skimmed milk, and one-sixth or one-fourth cream added, so that the mixture has the consistency of rich milk.

The class of subjects to whom milk is unadapted are the cases of duodenal, hepatic and pancreatic diseases, because of the deficiency in the secretions necessary to the process of emulsifying fats, and preparing them for entrance into the lymph vessels. Fats decomposing form very irritating fat acids, and the change in the reaction of the intestinal juices is the cause of various secondary troubles in the biliary function and elsewhere. To fit milk for use under such circumstances, it must be skimmed, and about the time the stomach digestion is completed, aids to the intestinal digestion should be administered. Such aids are a soda alkali and, it may be, some pancreatic solution to effect complete digestion of the fatty constituents.

The mere bulk of the milk is an objection to its use in certain diseases. In dilatation of the stomach, the space occupied by the necessary quantity perpetuates the disease. The reflex effects of distention of the stomach in cases of weak heart and in angina pectoris, may not only cause distressing symptoms, but may even prove fatal. It cannot be too strongly stated that milk is a highly objectional aliment in heart disease, whenever the motor apparatus of the organ is diseased, and whenever its movements are readily influenced by morbid states of the stomach through the reflex channels.

In no malady, as I conceive, is milk more abused than in acute rheumatism. It is very often then the chief—sometimes the only—aliment employed during the whole course of this disease. Besides the objection inherent in its mere bulk, certain theoretical considerations of its nature should have considerable weight in deciding the question of use. The very obvious objection that milk furnishes lactic acid as a product of its fermentation should not be ignored. All the world knows the intimate relation between lactic acid and the rheumatic poison. By the introduction of lactic acid, a form of endocarditis, not distin-

guishable from the rheumatic, is set up, and of those diabetics treated by lactic acid, a considerable proportion suffered from attacks of rheumatic fever (acute rheumatism). It is difficult, of course, to determine this point with certainty, but I have reason to believe that patients with rheumatic fever do not get well so quickly, and are much more apt to have relapses, when they consume much milk during the course of this disease. Surely, sufficient reasons exist for undertaking a thorough investigation of the question. My own practice, in the cases in which I am consulted, is to advise against the use of milk as an element in acute rheumatism.

In typhoid fever, milk is one food now given irrespective of the character of the cases. Of late this almost universal practice has come to be challenged. It has been depended on, without investigating the state of the digestive functions, and quite unmindful of the effect it may have on heat production. It is often given in too great quantity at a time, or so frequently that the stomach has not disposed of one quota before another is thrust upon it. Unless the gastric juice has preserved to a considerable extent its power of converting the albuminoids into peptones—which we have no right to expect—the casein resists its action; hence it follows that material of digestion should be administered soon after the milk is taken, and to prescribe without reference to the ability of the stomach to dispose of it is to insure increased fever and delirium, and more frequent stools. Besides supplying the means for proper digestion of the milk, attention should be given to its administration at such intervals that every portion given may be disposed of before another is permitted to enter the stomach. It is a trite observation, which is not therefore less true, that it is more important to the nutrition if some food be well digested rather than a large amount be merely swallowed.

Notwithstanding, since Donkin's first reports, milk has entered largely into the dietary of diabetics, its utility has recently come to be seriously questioned. If conversion of milk sugar into grape sugar does not take place, there can be no doubt of the value of milk in this disease, since it possesses so great a number of alimentary constituents. If, as is now asserted, this conversion does take place, the free administration of milk in diabetes must be regarded as an abuse.—*Coll. Clin. Record.*

BORACIC ACID IN THE TREATMENT OF LEUCORRHEA.

For months past, I have made frequent use of boracic acid in the treatment of leucorrhœa in a manner hitherto unmentioned, at least so far as has come under my notice, and with surprising success; in every case where I applied it, prompt and permanent improvement resulted.

Having had some excellent results from the boracic acid packing in chronic suppurative otitis,

I determined to resort to its use in a similar way in a case of leucorrhœa, which had for several months resisted a most persevering use of the regular orthodox remedies—*i. e.*, nitrate of silver, tincture of iodine, fluid hydrastis and bismuth, hot water irrigations, etc. The experiment was eminently successful, and the patient returned home within a fortnight well and happy, and has so remained ever since—many months—during which time I have had occasion to resort to the remedy frequently, and with uniformly good results.

My manner of using it is as follows: Having first irrigated the vagina at as high a temperature as can well be borne by the patient, a cylindrical speculum is introduced, and the vaginal walls very carefully dried, first with a soft sponge and then with absorbent cotton. This done, boracic acid in crystals is poured into the mouth of the speculum, and pushed up against the uterus and vault of the vagina with a clean cork caught in a uterine sponge carrier, sufficient acid being used to surround and bury the intravaginal portion of cervix, filling the upper part of vagina. A tampon of absorbent cotton is then firmly pressed against the packing, and held *in situ* until the folds of the vaginal walls close over it as the speculum is withdrawn.

This should be allowed to remain three or four days, or even longer, as after this time there still remain some undissolved particles of the acid; nor will the tampon seem at all offensive. The ostium vaginae, if examined in twenty-four hours, instead of being besmeared with the leucorrhœal secretion or discharge, presents a clean appearance, and bathed in a watery fluid which begins to appear several hours after the packing has been placed; and, in my cases, this was the only discharge noticed afterward.

However, a second, or even a third, repetition may be necessary; but in none of my cases, numbering nearly a score, have I found more than a second packing called for, and in many one sufficed; and in no instances has it occasioned pain, not even inconvenience. I do not claim for this agent and method infallibility, nor should constitutional dyscrasias be ignored, and this local treatment be depended on unaided to effect a cure; but here, as in the treatment of leucorrhœa by other remedies, a proper association of all means having a curative influence upon the disease, constitutes the rational therapeutics. My individual experience with this remedy in the treatment of leucorrhœa, through limited to too few cases to establish its universal efficacy, if such a wide range of power can be claimed for any medicine at any time, none the less proves it as one of the agents which, when properly employed, promises much in the treatment of the annoying and, sometimes, intractable conditions constituting the pathology of leucorrhœa, particularly when the change is in the vaginal glands or mucous membrane, or from intracervical inflammation. Nor will harm likely result from its use, though it fail in maintaining

the place my experience would give it.—*Schwartz*, in *St. Louis Cour. of Med.*

CAUSE AND CURE OF A CERTAIN FORM OF BACKACHE.

BY SIR JAMES SAWYER, M. D., F. R. C. P.,
Physician to the Queen's Hospital, Birmingham.

Early in the year 1881, in a note which was published in a weekly professional journal, I asked the attention of my brethren to a form of backache which had not, so far as I know, been described before. I desire now to refer to this subject again, and to record that my further experience in practice has confirmed my previous remarks upon the point in question.

Subjective symptoms are always important diagnostic signs, and they are often clear therapeutic indications. Among such sensations, backache is frequently a leading symptom, and also one which is pressingly dwelt upon by patients. Of backache there are divers forms. Dr. George Johnson, in an able clinical lecture, and Mr. William Squire, in a practical memorandum, have drawn the attention of the profession to many of these. But they have not mentioned a variety of backache in which the cause of the pain is traceable to the condition of the large bowel. I find that some patients complain of a pain, aching, dull and heavy in character, and extending "right across the back." When asked to point out its position they indicate this by carrying a hand behind the trunk and drawing the extended thumb straight across the back, in a transverse line, about halfway between the inferior angles of the scapulae and the renal region. This pain I venture to attribute to a loaded colon; I conclude I have correctly found its proximate cause in fœcal accumulation in the large intestine. I have found it to disappear after the exhibition of an efficient cathartic. This form of backache is a concomitant of habitual constipation, and is especially significant of the alvine sluggishness of sedentary persons. In such a condition as I have stated elsewhere, I find aloes, given in combination with iron, to yield the best results. We owe the valuable suggestion of combining iron with aloes when aloes is given for laxative purposes, to the late Sir Robert Christinson. He showed that the cathartic property of aloes is much increased by its combination with sulphate of iron. Dr. Neligan, Dr. Kent Spender and Dr. David Bell have confirmed this experience. I prefer socotrine aloes, and I give of it one, two or three grains in a pill, combined with a quarter of a grain of sulphate of iron, and one grain of extract of hyoscyamus. This pill should be taken every night. We must aim at producing a full alvine evacuation after breakfast. When a saline cathartic is indicated, I usually employ the old-fashioned Rochelle salt. This "goes" well with tea, coffee or cocoa. One or two tablespoonfuls may be taken at breakfast, dissolved in a large cupful of one of these beverages.—*Lancet*.

TREATMENT OF PSOAS ABSCESS.

This much disputed question was brought up recently at the meeting of American Orthopedic Association and elicited views differing most widely from one another. Dr. H. Hodgen of St. Louis, inclined to the belief that the proper method of dealing with them was by early aspiration.

The treatment, although not new, had not he thought, received the attention it merited. The three methods of treating such abscesses were:

The expectant, the operative with drainage, and aspiration as soon as the diagnosis of vertebral disease could be made and the presence of pus detected. The objections to allowing the abscess to take care of itself were that there was destruction of tissue, that there was interference with function, and that there was inconvenience if not pain to the patient. The uncertainty as to where the abscess would burrow was also an objection to the expectant plan; it might burrow under Poupart's ligament, or point in the gluteal region and do no harm, yet it might enter the bladder or the intestine. In one of his cases he believed it had opened into the hip joint of the same side with the abscess. In each of his five cases the result after from two to five aspirations had been good. No evidence was left of their ever having been psoas abscess. He would not aspirate more than four, five or seven times; after that he would put on the plaster of Paris jacket and let the abscess alone.—*Weekly Medical Review*.

THE CANADA MEDICAL RECORD.

A Monthly Journal of Medicine and Surgery.

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SUBSCRIPTION TWO DOLLARS PER ANNUM.

All communications and Exchanges must be addressed to the Editors, Drawer 356, Post Office, Montreal.

MONTREAL, NOVEMBER, 1887.

NEW HOSPITAL IN TORONTO.

The Toronto daily papers state that a new Hospital will shortly be erected in that city. The Hon. John Macdonald has inaugurated the scheme by heading the subscription list with a donation of \$40,000. It is expected that the sum of \$150,000 will be required, and the University of Toronto will give the required ground.

OBITUARY.

DR. FRANCIS J. NELSON.

News has just reached us of the death of Dr.

Francis J. Nelson, late of Montreal, in Canon City, Colorado, August 28th, from pulmonary hæmorrhage.

The late Dr. Nelson was born in this city, Nov. 25th, 1861; He came of a family well known in Medicine, he being its tenth physician. He was third son of the late Dr. Horace Nelson of this city, and a grand-son of the late Dr. Wolfred Nelson, a former Mayor of Montreal.

With his brothers, Drs. Wolfred and George W. Nelson, he matriculated in the Medical Faculty of Bishop's College, in this City. Study and our severe winters told on his delicate constitution; under medical advice he left Canada, and proceeded to Atlanta, Georgia, where he graduated, in the Southern Medical College in the spring of 1884. Later he settled in the Ojai Valley, in Southern California, and had established a fair practice, when the hereditary enemy of his house, consumption, marked him out. He reported some improvement in Colorado, but a sudden hæmorrhage closed his career, while yet in the bud.

Dr. G. O. Beaudry, Professor of Physiology at the Montreal School of Medicine and Surgery (Victoria College), died on the 26th of November, of Typhoid fever, after an illness of three weeks. Dr. Beaudry will be much missed by his confrères, especially by those of his school, for he was an active worker in their interest.

PERSONAL.

Dr. Codd, Surgeon of the Mounted Infantry School at Winnipeg, has been appointed President of the Military Medical Board for the investigating of claims, arising from wounds received and sickness contracted while on service during the late Northwest Rebellion.

Dr. Rollo Campbell (M. D., Bishop's, 1887) sailed for Europe by the Allan Mail SS. Parisian on the 10th Nov. He is at present working at the London Hospital.

Dr. Duncan (M. D., McGill, 1885) has been appointed Surgeon of C. Battery Canadian Artillery recently organized, and which is stationed at Victoria, British Columbia.

Dr. Sutherland, of Winnipeg, has been appointed Resident Physician to the Manitoba Penitentiary, at Stony Mountain.

Dr. Kerr, of Winnipeg, proposes leaving this city, to settle in Washington, U. S.