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Original Communications.

THE OPHTHALMOSCOPE IN RELATION TO DISEASES OF THE NERVOUS SYSTEM.*

BY G. STERLING RYERSON, M.D., C.M.,

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A recent writer¹ has said, "It seems to me the best and most useful feature of ophthalmology that it has closer or more remote relations with every branch of medicine and surgery—indeed with almost every branch of science." With Mr. Tweedy² I would emphasize the correspondence between the development and functions of the brain and those of the optic nerve, since these last are genetically direct and early outgrowths of the brain. It is also notable, that the eye and its appendages receive the whole or parts of six, out of the twelve pairs of cranial nerves. These things point to the intimate relationship existing between the eye and the rest of the body. No other organ of the body contains so many different kinds of histological elements or textures of so high a quality as the eye. Hence the immediate participation of the eye in general and constitutional diseases. It is thus seen that there is a histological and physiological relationship between the epiblastic elements of the eye and the epiblastic tissues of the body, and between the meso-blastic elements of the eye and all the other meso-blastic elements.

The pathological relationship is no less intimate and exact; the cutaneous eruptions of strumous children, eczema, etc., are concomitants of the phlyctenulæ of the epithelial layers of the cornea.

*Read before Ontario Medical Association, June, 1890.

1. Dr. Jas. Anderson, *Ophthalmic Review*, April, 1889.
2. Bulletin de la Société Anatomique (*Annual Univ. of Science*).

Syphilis, on the other hand, is a disease of meso-blastic textures, and ocular syphilitic affections are found to be of meso-blastic origin. The defective teeth of hereditary syphilitics are not faults of epiblastic enamel, but of the meso-blastic dental papillæ. I would also remind you that the optic nerve sheath is directly continuous with and almost identical in structure with the dura mater; whereas the optic nerve and its expansion the retina are direct offshoots from the brain itself, and Schwabe in 1869, showed that the cavity of the sheath was a prolongation of the arachnoid cavity. It is not surprising, therefore, to find that diseases of the brain are generally attended by eye symptoms and with lesions which are recognizable either with the ophthalmoscope or by an examination of the pupil and the extrinsic ocular muscles. These symptoms sometimes precede the general symptoms and become of great diagnostic importance. I would draw attention to the fact, that among the first observers to point out the importance of examining the eye ophthalmoscopically in cases of brain disease or suspected organic disease of the nervous system, was Bouchut, in 1866, who somewhat later suggested and used intubation, since revived by O'Dwyer, of New York. (he was preceded by Coccins³). Like most pioneers in medicine, he fared badly; was refused admission to the Academy of Paris and was treated with contumely. I had the advantage of attending his lectures at the Paris Sick Children's Hospital, in 1875. He called the ophthalmoscope as applied to diseases of the nervous system—the *cerebroscope*. The writers who have done the best work in medical ophthalmoscopy in England are Hughlings Jackson, Clifford Allbutt, and Stephen Mackenzie. Ophthalmoscopic examination in nervous diseases has become so established a custom that no neurologist would consider his examination of a case complete without an examination of the eyes.

I will briefly pass in review a few of the diseases of the brain in which the ophthalmoscope may be of especial use in diagnosis. Miliary aneurism of the brain is by no means easy of diagnosis. Yet a series of cases have been reported in which these aneurisms were also found in the retina, and were confirmed by Lionville⁴ at the *post mortem*. But

3. Anwendung des Augenspiegels, 1852.
4. Graefe u. Sæmisch, *Handbook*.

it is more especially in cases of what Jackson calls "coarse" disease, disease with gross macroscopical change in the brain or its membranes, that the ophthalmoscope is most useful, such as tumor of the brain, abscess of the brain, effusion from meningitis and gumma of the brain. In such cases optic neuritis makes its appearance; of the form known as "descending neuritis." In these cases there are often no external signs. The vision may be good and remain so for some time. A case recorded by Manthner retained good vision until death. Even the pupil is unaffected at first; the ophthalmoscope alone reveals the true state of affairs. We find the optic nerve swollen, cedematous, its borders hazy or lost, the veins enlarged and tortuous, the arteries normal, or small and buried in effusion. It has been proved both practically and experimentally that increase of the intra-cranial pressure will so influence the fluid in the sub-dural and sub-arachnoid spaces as to force it into the vaginal lymph spaces of the optic nerve and cause swelling and inflammation of the connective tissue of the optic nerve, obliteration of the space, and atrophy of the nerve fibres. This is what is known as "Stauung's papilla," or "choked disc." The tables of Edwards and Lawford¹ show that choked disc occurs in 66% of tumor of the brain, and Beonhard statistics show that in 45% of cases of choked disc vision remains intact.

As regards the frequency with which changes are recognizable with the ophthalmoscope. Heinzl² has published a series of sixty-three cases of cerebro-spinal meningitis, intra-cranial tumors, tuberculous meningitis and sclerosis of the brain. Among these cases 47 had alterations in the optic disc, and 16 had not. Allbut observed among 38 cases of tubercular meningitis, 29 who had ophthalmoscopic lesions. Annoke³ and Reich collected 88 cases of intra-cranial growth with ophthalmoscopic examinations and autopsies and found ophthalmic changes in 75 per cent. In cases in which the ophthalmoscopic examination gives negative results limitations of the field of vision may be mapped out by the perimeter and give valuable diagnostic indications

When we remember the direct connection which exists between the eye and the brain through

Schwabe's space, it is rather a matter of wonderment that we do not find cent. per cent of eye lesions to brain lesions, especially in such cases as epidemic cerebro-spinal meningitis. It does not unfrequently happen that we meet not only with neuro-retinitis, but with purulent choroiditis in these cases.

In epilepsy the optic nerve is not usually affected. In the so-called thalamic epilepsy, the "flimmer scotom" of German writers, Forster's amaurosis partialis fugax, the ophthalmoscopic appearances are negative. It happened to me once to be present when a patient of mine was so attacked. I found the optic disc pale and the vessels contracted; there was an irregular pulsation of the veins.

In insanity, atrophy of the optic nerve or neurites opticæ are frequently observed. Allbutt, publishes the following interesting statistics of 43 cases of epilepsy with dementia, 15 had alterations in the optic nerve. Of 51 cases of mania 25 showed ophthalmoscopic changes. In 38 cases of dementia without epilepsy, 23 times were disease of the optic nerve and retina observed. In cases of melancholia the retina is very often anæmic. In paralysis of the insane, of 53 cases only five were found in which there were no optico-retinal changes. To recapitulate, diseased fundi to normal, bore the following proportions: — Dementia, 12.6, acute and subacute mania, 14.6, chronic mania, 3.3 melancholia, 1.4, general paralysis, 11.0.

Having thus shown the intricate relationship between disease of the brain and disease of the optic nerve, I invite your attention to the consideration of the connection between diseases of the spinal cord and of the optic nerve.

The title of this paper precludes the consideration of the alterations of the pupil and paralysis of the ocular muscles in spinal disease, but I would draw your attention to the great frequency of atrophy of the optic nerve in tabes dorsalis. Leber⁴ of 87 cases of atrophy observed by him, 23 were associated with tabes, this is about 26 per cent. of the cases. Charcot states that the optic nerve trouble often precedes the spinal disease by many years, and that the pain and muscular incoördinance follow. It usually begins with a contraction of the field of vision; of the subjective

1. Trans. of the Soc. of United Kingdom.

2. Jahrbuck für Kinderheit Kunde 1875.

3. Coleman, The Ophthalmoscope in Brain Disease.

4. On the use of the ophthalmoscope, page 364.

5. Arch. für Ophthal. XV. 3, p. 33.

symptoms, red and green blindness and photophobia are the most constant. Together with these is a gradual failure of sight. I will conclude with the following interesting table compiled by Cyon¹; of 203 cases of tabes dorsalis eye affections were present 105 times, thus:

Amblyopia, 33 times; paralysis of eye muscles, 30 times; mydriasis, 3 times; myosis, 9 times; amaurosis and muscular paralysis, 16 times; amaurosis with mydriasis, 8 times; amaurosis and myosis, 1 time; paresis of muscles and mydriasis, 4 times; amaurosis with mydriasis and paralysis of ocular muscles, 2 times.

Of functional diseases of the nervous system, headache is the commonest. It is rarely attended by disease of the optic nerve, but is frequently caused by the errors of refraction, such as long and short sight, and particularly by astigmatism. And also by muscular defects requiring the proper adjustments of prisms for its relief.

From the facts stated in this paper, I would draw the following conclusions:

1. That diseases of the brain and spinal cord are frequently associated with ocular disturbances.
2. That serious eye trouble may be present without subjective symptoms.
3. That eye troubles often precede and give warning of impending nerve disease.
4. That disease of the optic nerve and retina are of great diagnostic value in nervous diseases.
5. That it is the duty of the physician to examine the eye and its muscles in all cases of nervous diseases.

A REVIEW OF THE TREATMENT OF FIBROIDS OF THE UTERUS WITH SOME REMARKS ON DISPLACEMENTS OF THE UTERUS AND SURGICAL MEANS OF CORRECTING THEM*

BY G. S. RENNIE, M.D., L. R. C. P. LOND., HAMILTON.

(Continued from March number)

Removal of the Uterine Appendages is the only other method of surgical treatment. This usually stops menstruation and induces the menopause. The operation does good in two ways: 1st, by

checking the hæmorrhage, and, 2nd, by stopping the growth of the tumor.

The mortality for this operation is low, *i.e.*, under 3%, and Tait reports 148 cases without a death, so that this operation, were it always practicable, would have a large field in the treatment of fibroids.

But, unfortunately, in case of large tumors it is impossible to get at the ovaries, and consequently the operation cannot be performed.

We might summarize the operative treatment of fibroids as follows: 1. When polypoid or submucous they may be removed through the vagina. 2. When sub-peritoneal, if causing no inconvenience, though large, leave them alone. 3. When growing rapidly or threatening life from hæmorrhage, and where the patient is not near the menopause, we may operate. (a) We may remove the uterine appendages if they are accessible. It should be kept in mind that it is sometimes very difficult, or even impossible, to do so. (b) Abdominal section and extra-peritoneal treatment of the pedicle by clamp, serre-nœud or stitching give the best results.

The Position of the Uterus with some remarks upon Displacement.—The uterus is normally *anteflexed*, which is termed the physiological anteflexion, in contrast to the pathological anteflexion described by Schultz.

When the bladder and rectum are empty, the uterus lies with its anterior surface touching the posterior aspect of the bladder, no intestine usually intervening, the external os looking downward and backward. It must not be forgotten, however, that although it is customary to speak of this as the normal position, there are in fact a number of normal positions. For as the bladder distends, the uterus is pushed back, as a whole, so that it becomes retroverted, and as the bladder is emptied the uterus returns to its original position of slight anteflexion.

Many authorities speak of the normal position of the uterus as forming a certain angle with the cervix. But they cannot have any just grounds for arriving at any fixed angle, as the mobility of the uterus is one of its most characteristic features. Its position being altered with every movement of respiration, in singing, in walking, and in all violent movements, as well as by the dilatation and evacuation of the bladder. The normal angle, therefore, may be at one time acute and at another more obtuse.

1. On spinal disease, Berlin, 1867.

*Read before the Hamilton Medical and Surgical Journal Club.

Let us now consider for a moment that condition termed *pathological ante flexion*. It is simply an exaggeration of the normal position. Its usual seat is at the upper portion of the cervix or junction with the body. The connective tissue framework is thinnest at the os internum; hence the usual seat of flexion is at this point. Many authorities maintain that a fatty degeneration takes place at the angle of flexion. Virchow denies this, and says "that all the difference that can be found is that the tissue is anæmic at the angle of flexion, but congested elsewhere." Two kinds of ante flexions are usually described. 1. The congenital. 2. The acquired. In the congenital the whole uterus is small and imperfectly developed, the cervix is small, with the pin-hole os looking downwards and forwards.

Fritsch explains the congenital ante flexion as follows: The uterus of the new born child has thin walls and is flexible; the intra-abdominal pressure acts on the posterior surface of the fundus and produces ante flexion; this action is counteracted by the bladder on which the uterus is, as it were moulded. When the uterus remains small and thin walled, it does not offer such a large surface to the bladder so as to be raised by it and have its flexion undone. Accordingly a pathological degree of ante flexion is produced. He also refers some cases to congenital shortening of the utero-sacral ligaments.

In the acquired ante flexion it is undoubtedly due to inflammatory changes behind the uterus. The cause of this condition was brought to our notice by Schultze, who described it as a cellulitis in the utero-sacral ligaments; this producing in its turn cicatricial contraction, so that the cervix is drawn upwards and backwards and the fundus thrown more forward.

This cause of ante flexion appears to be the most probable one, if we bear in mind the relation of these ligaments to the uterus. The utero-sacral ligaments, two in number, are folds of peritoneum, enclosing connective tissue and unstriped muscular fibre, passing from the lowest lateral part of the uterus upwards, outwards, and backwards to the second sacral vertebra, thus forming the lateral boundaries of Douglas' pouch.

It is quite evident from this, that if we have a cellulitis or peritonitis involving these ligaments and a cicatricial contraction taking place, as

Schultze points out, the cervix will be drawn upwards and backwards, while the fundus will be thrown forwards. Graily Hewett refers all flexions to softness of the uterine tissue and thinness of its walls. Schroder holds that the retraction of the cervix is produced by adhesions resulting from peritonitis. Tumors and pregnancy, which increase the weight of the body of the uterus, favor ante flexion.

The two most important *symptoms* of pathological ante flexion are dysmenorrhœa and sterility.

1. *Dysmenorrhœa*—Two different explanations of the pain have been given; 1st, The one known as the obstructive theory, and, 2nd, the congestive theory.

1st. *The Obstructive or Mechanical Theory*—According to this view, the flexion of the uterus produces a narrowing of the uterine canal at the point of flexion. Hence the menstrual decidua and blood find an obstacle to their free exit. There is consequently retention and coagulation, which bring on uterine contractions to overcome the mechanical resistance, and that these uterine contractions are the cause of the pain. This is the view held by Barnes, Thomas, Schroeder and others. Emmet, Matthews, Duncan, Schultze and other authorities will not accept this theory. They maintain that there is no obstruction to the flow, that there is not an angle formed, but a mere alteration in the direction of the canal, produced by a curve. Schultze showed that during the existence of the most intense dysmenorrhœal pain, the sound could be repeatedly carried easily to the fundus without a drop of blood showing itself. He says that the pains generally begin before—sometimes long before—the menstrual flow, and persist with intensity while the flow is scanty, and as soon as the blood becomes more profuse in quantity the pains intermit and cease. The appearance of a copious discharge of blood relieves the distended vessels and diminishes the contractions and their pains. He holds that the pain is not due to any obstruction, but due to the inflammatory processes associated with ante flexion. Emmet regards the whole obstruction theory as a myth, and Duncan says that the flow of menses out of an acutely flexed uterus would not be nearly so much obstructed as the passage of water along a bend of the river Thames.

2nd. *The Congestive Theory* is advocated by

Fritsch. He says that the pain is not due to obstruction, but to the resistance which the muscular tissue of the uterus offers to the hyperæmia. He maintains that when we have a uterus bent in itself, there is an obstruction offered to the flow of blood, that the mucous membrane cannot swell up as it does normally, and consequently there is undue vascular tension and compression of the nerve-endings in the uterus which causes the pain. This argument at first sight appears well, but let us look for a moment at the normal circulation of the uterus.

The ovarian artery of each side passes between the layers of the broad ligament, running tortuously toward the upper angle of the uterus; as each artery nears the uterus it divides into two branches. One supplying the uppermost part of the uterus, while the other descends to join the uterine artery. Thus there is, as you will see (Fig. 2), a lateral channel on each side, from which branches are given off, that have a transverse direction over the uterus. These transverse branches anastomose with corresponding branches from the opposite side.

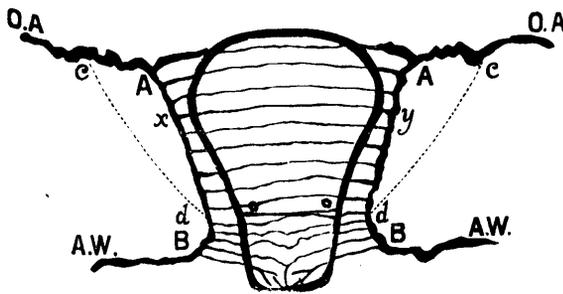


FIG. 2.

O. A. Ovarian artery; W. A. Uterine artery; A. B. Lateral arterial channel on each side; O. O. Indicates the position of the internal os; X. Y. One of the transverse branches given off from the lateral channel; C. D. Position of pressure on each broad ligament when uterus is incarcerated in Douglas' pouch.

From these transverse branches, secondary smaller branches are given off, which run at a right angle to the wall of the uterus and supply the mucous surface. (Fig. 3). The veins have a similar arrangement to the arteries. So it is seen that each transverse section of the uterus has its own vascular supply, and that a flexion cannot offer any obstruction to the circulation. Besides if flexion caused congestion, we should have excessive menstruation in cases of flexion. But cases continually come to one's notice where there is

marked flexion and still we have no menorrhagia. The argument brought forward by Berry Hart is more reasonable. He says that the tissues of the uterus are frequently in a state of chronic inflammation, and there is usually an increase of the connective tissue, making it of less yielding structure. The monthly flushing of the pelvis with blood would, under these circumstances, be accompanied by pain. Cellulitis and peritonitis are often present with ante flexion, and increase of pelvic congestion will, of course, produce increase of pain.

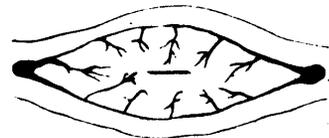


FIG. 3.

Transverse section of the uterus showing the arrangement of the uterine arteries, the arterial circles formed by their primary branches, and the branches of the latter supplying the mucous membrane.

There can be no doubt but that the connection between ante flexion and dysmenorrhœa has been greatly over-estimated. Vedeler found that out of 67 cases of dysmenorrhœa, 25 had well marked ante flexions, or 37.3%, but out of 138 cases without dysmenorrhœa 46 had well marked ante flexions or 33.3%. From this you will notice that ante flexion with dysmenorrhœa only has 4% over ante flexion without dysmenorrhœa.

Another symptom so frequently associated with ante flexion is *sterility*. This symptom is said to be due to the obstruction in the uterine canal produced by the flexion, but as there is practically no obstruction to the exit of menstrual fluid at the so-called angle of flexion, so there should be none to the entrance of spermatozoa. However this may be, the fact still remains that dilatation of the cervix places the patient under more favorable conditions for conception.

The Surgical Treatment for Retro-displacements of the Uterus—Dr. T. G. Thomas is a firm believer in the anterior fixation of the uterus to the abdominal wall, by his operation termed *hysterorrhaphy*. After he has broken down the adhesions about the uterus, he denudes the peritoneum covering the fundus, and fastens the organ by silk sutures brought directly through the abdominal wall.

Owing to the possible risk of death attending laparotomy for this ventral fixation of the uterus, another more conservative, less dangerous, and, for many cases, much more desirable operation has kept pace with hysterorrhaphy. I refer to *Alexander's* operation for the relief of retro-displacements of the uterus by shortening the round ligaments. His directions for the operation are as follows: "The pubic spine is felt for, and an incision made up and out from it, two inches in length, and in the line of the inguinal canal. The incision passes through the skin, and into the external abdominal ring, known by oblique fibres crossing it and protrusion of fat at its lower end. The tissue now bulging out from the ring (which is the end of the ligament, before reaching the mons veneris), is lifted by an aneurism needle, grasped with the finger and pulled out gently, any bands preventing this being cut with a knife. The other side is treated in the same way, both ligaments being pulled out as far as possible. The wound is then stitched, the sutures being, passed from side to side of the incision, *i. e.* through skin, pillar of abdominal ring, round ligament, pillar of ring and skin." After the operation the patient wears a pessary for some time. This operation is also performed for cases of prolapsus uteri.

I had the pleasure of hearing a paper entitled "A Modified Alexander's Operation," read at the International Medical Congress, in Berlin, by Dr. Edebohls. He makes his incision, and proceeds as Alexander does, until the external abdominal ring is reached. He then passes a grooved director along the inguinal canal, and with a knife or scissors he cuts up the full length of the canal; the round ligament is then picked up with a blunt hook, at the internal ring, and gradually drawn forwards, carrying the anterior layer of the broad ligament with it; the latter is then gently peeled off the round ligament, and allowed to drop back through the internal ring. The ligaments are then secured by passing the sutures through them in re-closing the canal. He claims that by this method the ligaments are more easily secured, less liable to be broken, and, with care, there is no reason why the peritonium should be opened. After either of these operations, owing to the disturbance of the inguinal canals, there is, no doubt, a slight tendency to hernia, as Alexander himself ad-

mits. There is also a matter of uncertainty about finding these ligaments, and especially if pelvic adhesions, etc., have taken place.

Dr. A. Palmer Dudley condemns both of these operations on the following grounds: He claims that nature never intended that the body of the uterus should ever be fastened to any portion of the abdominal wall. The diaphragmatic action of the pelvic floor is one of nature's safe-guards against intra-abdominal pressure in breathing, in exercise, and, to some extent, in disease. He maintains that if the uterus be fastened to the abdominal wall it will interfere to a great extent with the proper actions of the muscles of the pelvic floor. It will also imprison the bladder to a marked degree, necessitating its expansion in a lateral rather than in an upward direction, thereby bringing into action two opposing forces, one from above forcing the uterus downward, and another from below forcing it upwards; and that this action after a time separates the union between the uterus and abdominal wall. For these reasons Dr. Dudley has introduced a new operation: He denudes with scissors the peritoneum from the anterior wall of the uterus in an oval shape, taking care not to go too near the bladder. Then each round ligament is brought up and a portion of peritoneal covering upon the inner side of it denuded to correspond with that upon the uterus. The three denuded surfaces are now stitched together with a continuous catgut suture, and the uterus allowed to drop back into the pelvis. Dr. Dudley has operated with success in this way on a number of cases, and claims the following advantages for his operation over either hysterorrhaphy or Alexander's operation.

1. It corrects the displacement by utilizing the natural supports of the uterus without sacrificing any of them.

2. The proper diaphragmatic action of the pelvic floor is not interfered with.

3. The bladder is not imprisoned in the least, and its proper action is undisturbed.

4. There is no chance for intestinal adhesions to take place about the line of sutures, for the latter lie in apposition to the posterior surface of the bladder, and adhesions taking place at this point simply elongate the utero-vesical junction.

5. In cases of impregnation the uterus is free to rise in the abdominal cavity naturally.

6. The use of catgut as a suture material in this operation, does away with the dangers of the formation of sinuses, as occasionally happens in ventral fixation.

Selected Articles.

HOW A GENERAL PRACTITIONER MAY TREAT CHRONIC ATROPHIC RHINITIS.

From the time when the Chinese Emperor, Hoang-ty, four thousand five hundred years ago, first described specific ozena until the present day, the treatment of chronic atrophic rhinitis has been, more or less, the bug-bear of the general practitioner of medicine. True, the modernizing influence of thorough-going reason has shorn the disease of much of its mystifying elements, still to many, even in this enlightened day, it remains a book sealed with the superstition of the past, and bound tightly by the cords of enforced destiny.

Notwithstanding the great amount of literature which has resulted from the pains-taking study of this disease, the vast majority of doctors are indifferent, some perhaps ignorant, as to its proper treatment. Some do not believe that an iota of benefit can result from treatment of any kind; others declare that they have no desire to treat it; still others, by temporizing, hold their patients day in and day out, in the vain hope that some kindly providence may relieve doctor or patient. Amid all this array of indifference, disinclination and lack of knowledge or its application, is it strange that the poor sufferer should read, with a shudder, the advertisements which deal out his symptoms so exactly, and which alarm him by unnecessary enunciation of dangers which never occur? Is it to be wondered at that his mind becomes filled with visions of consumption—visions which, by reason of their indistinctness, magnify the evils thus portrayed? Is it remarkable that he should swallow with avidity such unwholesome morsels as this: "The microbe of catarrh, in your sleep, crawls down your throat, and coming in contact with your lungs, produces consumption?" Is it further a matter of wonder that the poor, bewildered mortal, whose fears have now changed his nose into a mountain of woe, ready to boil and to seethe with the fury of evil spirits, should seek his family physician, and, receiving the unsatisfactory advice, which in many cases he will get is it strange, say I, that he should place his tender organ of facial ornamentation into the hands of a quack! I think not. From a popular standpoint, at any rate, the charlatan who boasts loudly of his cures, and who points out the evils that may result, knows far more than the dilly-dallying doc-

tor. Here lies the trouble, doctors imagine the nose is beyond their ken, too far removed for their comprehension, in fact, many do not hesitate to say so. Why, bless you! those same doctors would never admit a lack of knowledge in the treatment of a cervicitis or an endometritis, and yet the organs concerned in these latter diseases are far more difficult to examine than the nose.

Thoughts such as these are calculated to make a specialist ponder, and to seek some plan of benefit. That some good may come from a tacit and clear statement of the treatment of this disease, I am assured; and that the general practitioner will, by the application of a few general rules, be able to benefit almost all of these cases, I am still more assured. I have seen this very thing exemplified in my own students in the Marion-Sims College of Medicine, to whom I have assigned cases for treatment in the clinic, with results highly satisfactory. What students are thus enabled to do, I feel certain that the great body of our upright, conscientious and earnest practitioners of medicine can do far better.

Many means have been devised and many remedies have been suggested for the treatment of this very refractory disease, but as its theoretical consideration forms no part of the subject of this paper, they are placed aside. Therefore the radical treatment of the disease, requiring, as it does, an extensive knowledge and technique, will not receive attention. That the disease is ever entirely cured, is still a controvertible question. Reports have been made of cures by cauterization with chromic acid, and the galvano-cautery, and by galvano-cautery, and by galvanism of the nasal mucous membrane.

The condition can be ameliorated! Not only this, but every practitioner who possesses an intelligent conception, may become the high priest of this benediction.

From the nature of the disease, the vitiated secretion and scab formation which go with it, one can easily understand that two features of treatment are indicated, viz.: cleanliness and stimulation, cleanliness so that there can be no irritation from the presence of scabs, and for the thorough application of medicines, and stimulation, to counteract the passive inflammation, and to cause the blood, more nearly to approximate the normal.

Now, cleanliness does not mean the promiscuous douching or spraying of the nose—by no means. The most persistent care must be taken to remove every scab and particle of abnormal discharge. Granted—but how can this be done by the general practitioner? Easily enough. His *armamentarium nasale* need not be very extensive. A lamp, a student's lamp being preferable, a head mirror, a nose speculum, a small cotton applicator (a knitting needle with one end roughened will answer), constituting an equipment not elegant,

but sufficient. The cost, exclusive of the lamp, is little enough, being less than \$4.00. Cotton, absorbent or borated, should be on hand, as well as plenty of the old-time Dobell's solution, or the following modification, which I like better :

R Sodii Bicarbonatis
 Sodii Biboratis aa ʒij.
 Listerine or Katharmon ʒss.
 Aquæ q. s. ad ʒviiij.
 M.—Sig. Nose-wash.

To the list I should perhaps add some sort of atomizer or post-nasal syringe, costing in either case not more than \$1.25. However, one could get along without either of these. The nose should first be sprayed out with the solution whose formula I have just given (better warmed) or by means of the post-nasal syringe the cavities can be washed out from behind. Understand, however, even this does not constitute the cleansing of the nose, for after this has been done, the work really begins. The light being reflected into the nose, held open by means of a speculum (Knight's modification of Duplay's preferred) the probe, to which a pledget of cotton is attached, is made to dislodge and to remove each scab or portion of discharge which is presented to the view. Anyone can do this, for anyone can see the scabs and can with ease remove what he sees. This accomplished, the nose is clean, and the first essential part of treatment has been applied.

For the stimulative plan of treatment, various drugs have been recommended, out of which I select menthol, thymol and eucalyptol as having been most efficacious in my hands. I have used menthol more frequently than any of these agents, and have been so well pleased with its action that I should be unwilling to exchange it for any other remedy. The following is the customary formula :

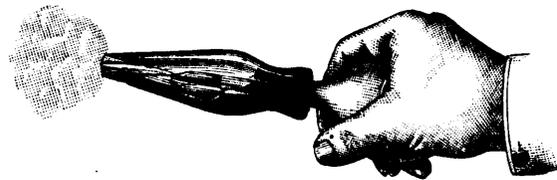
R Menthol gr x.
 Liquid Albolene ʒj
 M. Sig.—Spray for the nose.

The amount of menthol may be increased to gr. xx or even ʒj to the ounce. This, or thymol, gr. x to ʒj liquid albolene, or eucalyptol gtt. x to ʒj liquid albolene, should be well sprayed into the nose, first directing the patient to breathe through his open mouth, thereby shutting off the oropharynx and causing the spray to pass out of the other nostril. The first sensation is that of warmth, and no little itching is frequently occasioned ; but this is soon succeeded by a feeling of coolness and comfort in the nose, which is gratifying to the patient. While the menthol, thymol and eucalyptol have a stimulative effect, the liquid albolene is not void of benefit. It takes the place of vaseline of quondam fame, but possessing nothing of the almost nasty character of the latter. By means of the spray the oily albolene is thrown over a large portion of the mucous membrane, and

by bathing it with an oily film, aids not a little in its improvement. This cleansing out and treatment of the nose should be done every day, if possible, for some little time ; later, the intervals may be lengthened. It is useless to attempt any permanent or even transitory improvement, for that matter, by treating the nose twice a week, or less ; three times a week is seldom sufficient at the outset.

Nor is this all there is in the treatment. The patient should be directed to clean his nose three or four times daily, by snuffing up Dobell's solution, or the modification which I have given, and thereafter to use a spray of menthol, thymol or eucalyptol and albolene. A special sort of atomizer must be used from the fact that all atomizers do not act with oily solutions. Each patient must provide himself with one and use it three or four times daily. The Codman & Shurtleff, No. 356, or the Brooklyn Throat Hospital atomizer will answer. The latter is better for the doctor, in that having three nozzles it may be used for the nose, pharynx or larynx.

Of late I have been using a new atomizer lately designed and manufactured by the A. M. Leslie Surgical Instrument Company of St. Louis, the Acme Vaseline Atomizer ; in fact, I now prefer it to any other kind. It has the advantage of simplicity and cleanliness. Though intended as a vaseline atomizer, it can be used to the greatest satisfaction for the spraying of liquid albolene.



I would again urge that, whatever the form of the atomizer, it should be used systematically, thoroughly and regularly. It is surprising how much better the patient will become under this sort of treatment ; the excessive scabby discharge ceases, the odor disappears, the hawking diminishes and the patient's mind turns to other thoughts than an untimely death from the fancied change of catarrh into consumption. Not only this : the relief is so decided and rapid in its occurrence, that the patient becomes a friend and patron whose good word will reflect credit and money to the doctor who is so fortunate as to have applied this plan of treatment.

It is well to state one danger which may occur not only from this form of treatment, but in any case where douching is used : I refer, of course, to the otitis media, catarrhal or suppurative. Where there is the slightest tendency to this disease, one must be guarded and must avoid the douche, and sometimes the spray. In such cases the only

recourse is to remove the scabs as well as possible by means of a probe and pledget of cotton.

Very naturally there are other plans of treatment which are not to be despised. I desire to make no reflection whatever upon any other method. This I do say, however, the method which I have detailed is one which must commend itself to every one. It is simple in its application, scientific in its procedure and sufficiently easy in detail as to be within the range of every practitioner of medicine.

I turn now to the title of my paper: "How a general practitioner may treat chronic atrophic rhinitis." I feel that I have answered the question in so tangible a manner that its acceptance and adoption by the general practitioner is a matter of choice and not one of long-considering deliberation. The question narrows itself down to this: Will you treat these simple cases in this simple manner, to the credit of yourselves and to the benefit of yourselves, or will you, with less pride, less reason and less professional honor, allow those who have placed their well-being in your hands, to go on day by day, without any relief, subsequently to fall into the unscrupulous hands of some catarrh nincompoop? I believe you will adopt the former course.—H. A. Loeb, M. D., in *Saint Joseph Med. Herald*.

DR. APOSTOLI'S LATEST CONCLUSIONS ON THE CONSTANT GALVANIC CUR- RENT IN GYNÆCOLOGY.

The following summary of Dr. Apostoli's conclusions in regard to the subject of which he is at present the greatest authority, will be of interest to our readers:—

1. The constant galvanic current, he says, is indicated in gynæcology principally in endometritis and in fibroid tumors. It is very effective in abnormal conditions of uterine circulation (amenorrhœa and menorrhagia) as well as in painful menstruation; is a powerful aid in arresting the development of simple neoplasms and in facilitating the absorption of peri-uterine exudations. It exercises a salutary action towards resolution in many peri-uterine phlegmasiæ, and in certain forms of catarrhal ovaro-salpingitis; but it is powerless in suppurative inflammations of the appendages, nay, even it is injurious in strong doses, particularly if the intra-uterine pole be negative. The variable intolerance of the current which increases with the degree of the inflammatory action of the appendages serves as a valuable means of diagnosis in determining the existence and the nature of undetected or only suspected peri-uterine fluid collections, hæmic or suppurative, and in deciding the necessity for surgical interference or not.

2. The effects of the constant galvanic current

2

are polar and interpolar. The interpolar action is trophic and dynamic, which increases as the square of the intensity of the current used, and is super-added to the polar action. The polar action is utilized for a different purpose according to the pole employed, as first shown by Apostoli himself. A calorific action is developed by the passage of the current which augments the interstitial circulation; and lastly, the antiseptic action of the positive pole has been recently demonstrated by Apostoli and Laguërière.

3. Strong galvanic applications exceeding 50 milliampères, employed in a variable manner according to the tolerance of the individual patient and the special clinical indications form the basis of Apostoli's method, and find their justification in the circulatory depletion, "*drainage circulatoire*," a direct consequence of the calorific action due to the resistance offered to the passage of the current, and proportionate to the square of the intensity; in the antiseptic or germicidal action, which increases with the intensity of the current used; in the rapidity and efficacy of the effects produced, which are proportionate to the square of the electric energy, according to a formula analogous to that of the measure of energy in other natural forces: $Q = \frac{1}{2} m V^2$; in the easier generalization of the method as applied to obstinate cases, as hard fibroids of the subperitoneal variety or fungous endometritis, and to conditions in young subjects; and in lessening the frequency of relapses, which, all other things being equal, are less to be feared the stronger has been the current employed.

4. If the vaginal application of the galvanic current (which is the method introduced by M. Chéron for fibroids only, and applied since by A. Martin, Brachet, Ménière, Onimus, Carpenter, Munde, and others) produces certain results, these are very inferior to those obtained by intra-uterine applications, which must remain the method of selection, because it utilizes at once the maximum of the current expended and of its energy, and at the same time the antiseptic action of the positive pole, which is entirely local, and which disappears in the interpolar circuit and at the level of the negative pole. It also utilizes the derivative and caustic action of the intra-uterine application, thus treating at the same time either a simple endometritis or, as is often the case, one complicating a fibroid or a peri-uterine inflammation, and ensuring thereby a more rapid, more complete, and more permanent cure. It also enables us better than by vaginal applications to palliate pain, and to render the use of strong doses more tolerable.

5. The vaginal galvano-punctures to the depth of from two to five millimetres, by means of a filiform trocar made of gold, insulated in all its extent except at the point, form the complement of intra-uterine electro-therapeutics introduced by Apostoli as a more accurate means of localizing galvanic

action, and of increasing the efficiency in certain cases of the application of small or medium doses.

6. The innocuous character of his intra-uterine electro-therapeutics is demonstrated by comparing it with those of the chemical and operative intra-uterine methods of treatment, and particularly by comparative statistics. Dr. Apostoli made from July, 1882, to July 1890, 11,499 galvanic applications, as follows:—8177 positive intra-uterine galvano-caustic, 2486 negative intra-uterine galvano-caustic, 222 positive vaginal galvano-punctures, 614 negative vaginal galvano-punctures. He has treated 912 patients, comprising 531 fibroids, 133 cases of simple endometritis, and 248 of endometritis complicated with peri-uterine inflammation.

Of these 313 fibroids, 70 cases of simple endometritis, 163 of endometritis complicated with peri-uterine inflammation occurred in the clinique, and 218 fibroids, 63 cases of simple endometritis and 85 complicated, with peri-uterine inflammation, occurred in private practice. He has had three deaths attributable to operative defects. Two galvano-puncture, of which one was for a subperitoneal fibroid, the other for an ovaro-salpingitis, and one galvano-caustic application for a cyst of the ovary, mistaken for a fibroid.

He has observed 30 cases of pregnancy which occurred after intra-uterine galvanic applications.
—*The Lancet*

EARLY DIAGNOSIS OF SOME SERIOUS DISEASES OF THE NERVOUS SYSTEM; ITS IMPORTANCE AND FEASIBILITY.

VERTEBRAL DISEASE (CARIES, ETC.).

It may seem strange that I should call your attention to conditions which apparently belong to quite a different specialty from neurology; but, gentlemen, the first and the last symptoms of these diseases (spondylitis, caries of the spine, vertebral cancer) are nervous symptoms. The case appears at first as one of rebellious neuralgia or muscular rheumatism, and lastly as one of paraplegia. The early symptoms do not very distinctly point to the vertebræ as the site of disease; and thus usually the cases remain a long time—during the best time for successful treatment—in the hands of the general practitioner; then, later, they are passed on to the neurologist or orthopedist.

Many precious months are thus lost. Yet, if the few symptoms present during the first stage of these diseases are rightly appreciated and correctly interpreted, I believe a diagnosis should always be possible long before angular curvature (representing the breaking-down of one or several vertebræ) or tumor appears. The early symptoms of spondylitis or tumor are the same in *kind*, no matter what part of the spine is affected, but their

distribution varies according to the location of the lesion up or down in the vertebral column. This distribution is so peculiar as to enable us to tell with almost absolute certainty which vertebræ are affected.

The capital symptoms of the first stage of Pott's disease or of vertebral cancer are only two in number, namely: (a) a fixed pain seemingly of a neuralgic character, far away from the spine. (b) Rigidity of certain muscles attached to the spinal column; a reflex protective or conservative spasm. The distant pain is increased by attempts to overcome the muscular spasm, and by jars.

It will be necessary to consider these symptoms as distributed when the disease (caries, tubercle or cancer of the vertebræ) attacks different regions of the spinal column.

(a) The "neuralgic" pains, and spasm.

(1) Disease of the uppermost cervical vertebræ, spondylitis colli, is not rare. The patient complains in the first place, and chiefly of pain in one occipital region, aggravated by motion or jar. On analysis, we find the pain to follow the range of distribution of the greater and lesser occipital nerves; one or both. Occasionally there is also pain in the temple of the same side. Almost invariably this neuralgic pain for which the patient asks relief, is unilateral.

Inspection reveals at quite an early period, a slight or decided "wry-neck," a deviation of the head from its proper vertical position. It is a peculiar oblique attitude, dissimilar from that produced by (functional) spasm of one sterno-mastoid. Any attempt to correct this deviation, and indeed any passive movement of the head and neck cause greatly increased pain in the occipital region (not in the spine). Sudden pressure on the top of the head by the physician's hand causes excruciating pain of similar distribution. The spine itself is not tender or deformed. The patient tells you that the jar of a carriage or horse-car, or of a false step, causes intense agony. Some patients very early acquire an instinctive habit of supporting or steadying their heads with their hands, to avoid effects of shock. Further examination shows that the deeper cervical muscles, extensors, flexors, and rotators are in a state of constant spasm, more especially on the side of the pain.

Let us see if anatomy helps us in diagnosis. The occipitalis major nerve is mainly a branch of the second cervical nerve; the minor, of the first cervical nerve. They, however, have branches of intercommunication. Most filaments of these nerves are sensory, supplying the scalp of the occiput and parietal regions. Motor fibres from these two cervical nerves supply the small, deep muscles which govern the movements of the skull upon the vertebral column.

Consequently, both the "neuralgia" and the spasm point infallibly to disease in or about the

two upper vertebræ. The exact nature of the lesion may be in doubt, but we have by strictly scientific methods located the disease; it is so placed as to irritate the first and second cervical nerves.

(2) Disease of the lower cervical vertebræ is very rare. In such a case the pain would be in the lower part of the neck, or in one arm or hand according to the exact location of the lesion. The spasm would be in the lower cervical muscles and in those of the arm.

(3) The most common location of these lesions is in the dorsal region, between the fifth and the twelfth dorsal vertebræ. Many and many a child is treated for months for "colic" because he complains of a pain in one side of the abdomen. The too frequent neglect of thorough objective examination here leads to the erroneous diagnosis of intercostal or abdominal neuralgia, or of colic; even of "hepatalgia," according to the exact seat of pain. The muscular symptoms are present here also, but not in as striking a shape as in spondylitis colli. They must be sought for by careful examination. This reveals one of several conditions or several combined. The respiratory thoracic or abdominal movements on one side (rarely on both) are hindered, and the muscles appear to palpation hard or rigid. The various movements of the spinal column are not normally free. Turning the head about as if to look for something is done by a turning of the whole body, flexion and extension (latero-flexion more especially) of the spine are checked by pain, or directly hindered by rigidity of the erector spinæ muscles. A segment of dorsal spinal column is rigid during all attempts at movement. The tenderness of the dorsal nerves cannot be demonstrated by direct testing with finger pressure, but it is strikingly revealed by what I call the heel-jar test. This consists in placing the patient standing in the military position of "attention," on a hard floor. Then tell him to rise on his toes, and then suddenly to drop his whole weight on his heels. If there is vertebral disease, decided or excruciating pain is caused by this jar, not in the spine but in the location of the "neuralgia" for which the patient consults you. This heel-jar test is useful in any location of the vertebral disease. The origin of the nerve which is the seat of pain, the range of the muscular rigidity will enable us to localize the lesion to the exact vertebra or vertebræ.

(4) The lumbar vertebræ are sometimes diseased. In such a case the pain would be in the groin and anterior and inner parts of the thigh; the spasm in the same parts; especially in the psoæ and iliac muscles.

(5) Caries of the sacrum gives rise to pains in the perineum, posterior part of the thigh, and in the leg and foot. Cramps or spasms would occur in the same parts (seldom present).

The general diagnostic law may be formulated as follows: The seat of neuralgia and of spasm, though occasionally not in corresponding parts, clearly refer to irritation (compression) of one or more spinal nerves on one side. A knowledge of the distribution of spinal nerves enables us to state with great accuracy which vertebræ are diseased.

(b) With reference to paralytic symptoms.

Occasionally they appear before actual destruction of bone brings about angular curvature; the spinal cord being compressed by inflammatory or caseous masses originating in pachymeningitis; or by a tumor. When the disease affects the two upper cervical vertebræ, the paralysis may be hemiplegic, face not affected. This is because the caseous masses have formed on one side of the canal and exerted pressure on one side of the spinal cord, where the large crossed pyramidal fasciculi run downward; hence hemiplegia. Below the level of the second vertebræ the masses which compress the cord are formed anteriorly as a rule, and cause pressure almost equally on both sides of the median line; hence paraplegia; of the type "cervical paraplegia," where the whole body below the neck is paralyzed, or "common paraplegia," when the lower limbs and a varying extent of the trunk are paralyzed. It is important to determine the uppermost limit line of the paralysis, as this usually indicates the limit of intra-vertebral lesion.

When caries exists in the mid-dorsal region, vesical paralysis (retention) is, in my experience, a very early symptom; sometimes existing without other paralysis. With disease of the upper cervical vertebræ we also observe paralysis of the small, deep muscles connecting the head with the spine ("loose head").

When the lumbar vertebræ below the second, or the sacrum is the seat of caries (or cancer), a very peculiar paralysis results. As there is no spinal cord below the level of the first lumbar vertebræ, pressure below this point will affect only nerve-bundles: the constituents of the *cauda equina*.

Physiologically, therefore, the resultant paralysis is a peripheral or neural paralysis (precisely the same as when an outside nerve-trunk is injured), characterized by a flaccid atrophic paralysis, with degenerative reactions; co-extensive anesthesia; absence of all reflexes; relaxation of the sphincter ani and vesical paralysis. The paralysis is nearly all below the knees, as some of the thigh-muscles are supplied by the crural plexus.

We can thus—I hope to have made it clear and easily understood—readily make a diagnosis of a vertebral bony lesion or of an intra-spinal tumor at a very early period; months before angular curvature (kyphosis) or external tumor shows itself. In my opinion there is no justification for waiting till kyphosis appears before reaching a diagnosis. The exact seat of the lesion we can, also, by the

help of anatomy, always determine with accuracy. The further diagnosis, namely, that of the nature of the vertebral lesion, is a most interesting but complicated problem, which I cannot enter upon to-night. The neural irritation or spinal-cord compression, may be due to pachymeningitis, to vertebral caries (spondylitis), to peri-vertebral or intra-vertebral tumors, or to cancer of the bodies of the vertebræ themselves.

Let it suffice if I have made it clear, that occipital neuralgia, with rigid, painful wry-neck; intercostal or abdominal local pains (neuralgia so-called), one-sided pains along some nerve of the lower extremities; with associated spasm, mean, or at least suggest, vertebral disease of some sort, and call for a careful objective examination, instead of an off-hand prescription, for the symptom complained of.

CHRONIC ENLARGEMENT OF THE TONSILS OF CHILDREN.

Gentlemen: The first case I have to show you this morning is one of a character which is quite frequently met with, namely, an enlargement of the tonsils with some follicular inflammation, but chiefly consisting in an increase in the connective tissue, an interstitial tonsillitis of a chronic type. This condition is accompanied by a protrusion of the tonsils across the pharynx, in this case touching the uvula on one side, and almost touching it upon the other. Often the uvula is touched upon both sides. On examining this throat, you will notice that the mucous membrane over the tonsils is hyperemic, reddened and inflamed, but not covered with the white spots which are frequently seen. This tells us that this is not a case of pure follicular tonsillitis; for in it we have large quantities of a cheesy material poured out, which so closely resembles the false membrane of diphtheria, that a false diagnosis is often made. The exudate can be removed, however, on a small probe and leaves behind it no bleeding or raw surface. This is not the case in diphtheria, where the membrane is adherent, and on removal leaves a bleeding surface. In acute tonsillitis, true quinsy, or suppurative tonsillitis, death seldom occurs. It is curious that strangulation does not more frequently occur from rupture of the abscess during sleep, or that pneumonia does not result from the swallowing or breathing in of this material, the so-called *Schluck-pneumonie* of the Germans.

Most commonly these cases come to the physician because the child has a constant paroxysmal cough, which almost ceases during the daytime, but is persistent at night, especially in the early hours of sleep. A careful examination of the chest in these cases of tonsillitis shows no sign of

pulmonary trouble. The cough is a pharyngeal or uvular cough due to irritation. The cause of the cough is not identical with that of an ordinary cough, but is due to the two enlarged tonsils which protrude and tickle the uvula. During the daytime the muscles are held tense, and the tonsils are thus prevented from touching the uvula; but if an involuntary relaxation occurs, as in sleep, the uvula is tickled, cough results, and the child awakens. At times it is even necessary for the child to sit up in bed to relieve the cough.

It is difficult to treat such cases; much more so than cases of acute follicular tonsillitis, which may be treated with diuretics and cardiac sedatives, and with the local application of cold or heat. In the treatment of the present variety, several interesting points must be considered. Is chronic interstitial fibrous enlargement of the tonsils severe enough to interfere so seriously with respiration as to make the removal of the tonsils necessary? A great many physicians, especially in France, recommend their removal. On the other hand, I have seen several experienced surgeons operate upon the tonsils and encounter excessive hæmorrhage. As you well know, any severe operation upon the mouth is very apt to be accompanied by profuse hæmorrhage.

The next heroic treatment after tonsillotomy is igni-puncture or the use of the actual cautery. It consists in the insertion into the enlarged mass of a small electric cautery, or the ordinary red-hot iron. The inflammation which ensues around the burns results in fibrous or cicatricial contraction, with a consequent decrease in size of the organ. This results in a ragged-looking tonsil, with crypts in which food may accumulate and undergo decomposition, with the production of fetid breath. A mouth wash or gargle of carbolic acid (1 to 100), sweetens the breath and prevents decomposition from going on. Notwithstanding its drawbacks, however, igni-puncture is the operation to be resorted to, instead of tonsillotomy. It is safer and just as efficacious. However, in all these cases, the patient at first desires you to temporize with medicinal measures; and probably the best medicine for an adult is iodide of potassium, five grains three times a day, at the same time painting the tonsils with equal parts of iodine and glycerine, or one part of iodine to three parts of glycerine, and also painting the skin externally with tincture of iodine, or rubbing in iodine ointment. If you employ iodine ointment over enlarged glands in children, it must be mixed with lard; as it is too strong to be applied in its officinal strength. Simple or benzoated lard may be used with an equal amount of the iodine ointment. If the child is of the age of this one (8 years), probably you will not be able to give it iodide of potassium in effective doses, as the drug would be apt to disorder the stomach. You

should use in its place the syrup of the iodide of iron internally. Most of these children are anemic, and iron is needed. Iodide of iron also exerts a peculiar influence over inflammation of the upper air passages. The syrup should be given in doses of five drops or more three times a day.

On looking at this child's tongue you will notice that it is black. This is due to the iron, which also blackens the *faeces*. The discoloration is due to the presence of sulphide of iron. It is well to warn the mother that this will occur, to prevent needless alarm.

To be more definite, what shall we do for this case? We shall give her five drops of the syrup of the iodide of iron three times a day, and apply externally over the enlarged tonsils ichthyol ointment, night and morning, two drachms to the ounce of lard. If no irritation of the skin is produced, we shall apply it at noon as well. It is impossible to make applications to the tonsils internally every day, and it is dangerous to give iodine solution to parents of young children, with which to paint the child's throat. If I should give anything, it would be a solution of one drachm of tannic acid to two ounces of glycerine, to be applied with a camel's-hair brush.

I forgot to mention one other course of treatment which may be resorted to after *igni-puncture*, and that is the use of the solid stick of silver nitrate. This is especially useful when there is a complication of chronic interstitial tonsillitis with follicular tonsillitis. By using the stick in these cases you mildly cauterize the tonsils, and achieve good results.

The slight deafness which is frequently complained of by patients with enlarged tonsils is due to an extension of the inflammation from the tonsils to the Eustachian tubes, which either become patulous or plugged with mucus.—H. A. Hare, M. D., in *Med. and Surg. Rep.*

MR. JONATHAN HUTCHINSON ON THE RELATIONSHIP OF LUPUS TO TUBERCULOSIS.

A few days ago Mr. Jonathan Hutchinson delivered an important lecture on "The Nature of Lupus, with Especial Reference to its Relation to Tuberculosis," at the examination hall of the College of Physicians and Surgeons. It is, I believe, the first time that such a use has been made of the building, and the occasion was the commencement of the second London post-graduate course, in which, from its beginning, Mr. Hutchinson has taken great interest. The audience, which numbered about one hundred persons, included Sir Joseph Lister and Sir Andrew Clarke.

At the commencement of the lecture Mr. Hutchinson demonstrated the prominent features of the disease, as exemplified in a young woman whom he brought before his hearers, and pointed out how the disease tended to attack the areas especially concerned in flushing or blushing, and those much exposed, for example, the cheeks and tip of the nose. Premising that he approached his subject solely from a clinical point of view, he said that the first thing to consider was whether the typical form of *lupus vulgaris* is always of bacillary origin. There are two possibilities to be borne in mind; first, the lupus-process may be always due to the implantation of the parasite bacillus in the tissues, or, second, the process may originate as a variety of inflammation, induced by any one of many local causes of irritation and nutritional change. He at once expressed his own leaning to the view that it is highly improbable that true lupus is always the result of contagion, and that it usually begins in inflammatory action made peculiar by the special proclivities of the individual. In his opinion, lupus is not always a well-defined and easily-recognizable disease, and no symptom or set of symptoms will enable one to recognize with certainty all cases of lupus, and to determine what should and what should not be included under that name. His definition of the lupus-process was given in the following words: "Whenever a chronic inflammation of skin or of mucous membrane, not due to syphilis, shows a persistent tendency to spread at its edges, to produce satellites near it, and to leave a condition of scar behind it, such a process is for me one of lupus. In a few cases the production of satellites may be omitted and the patch may remain absolutely single, but its infective edges and the resultant scar are essential. No form of lupus is without them, although it must be admitted, perhaps, that in a few the demonstration of the scar may be difficult. There is another condition which when present is to trained minds definitely diagnostic of lupus. I refer to the presence beneath a thinned layer of epidermis of a deposit or growth of semi-translucent granulation-material, often in considerable thickness. This 'apple-jelly-like' deposit, as it has been named, is, when present, perfectly characteristic of common lupus." Amongst minor features of the lupus-process he mentioned that if the surface does not ulcerate it is usually covered with white papery flakes of epidermis which, however, do not fall off; if the patch is ulcerated a dried crust forms, which, when removed, leaves a bleeding surface."

Lupus vulgaris is most common on the tip of the nose, the next most frequent seat being the cheek. It is not uncommon on the limbs but very rare on the trunk. The patches are never symmetrical. Though occasionally seen in children, it does not often develop until after the period of

puberty. The lymphatic glands, lungs, bones, joints, and intestines, are never affected. Nothing is less common than to see a lupus-patient develop phthisis. The most typical forms are often co-incident with good general health, and with the absence of any family history of tuberculosis. He believes that lupus is as closely related to cancer as to tuberculosis, and that an unbiased statistical investigation would show that the latter association is not so frequent as is commonly assumed.

Reminding his hearers that syphilitic symptoms could imitate lupus, he said that since syphilis in its tertiary stage is only a chronic infective inflammation, deriving its peculiarities from the antecedents of the patient, and having nothing whatever to do with tuberculosis or bacilli, it is reasonable to suppose that lupus, which so exactly resembles it, might also be a process of chronic inflammation made peculiar by the vital proclivities of the patient. If lupus were of bacillary origin he thought it remarkable that in gland struma the skin does not assume a lupus-state and that the glands never become involved in lupus. Of primary tubercular ulceration of the skin he has had no personal experience but tubercular ulceration of mucous membranes presents characters quite distinct from those of lupus in that situation.

In conclusion he said, "I may own that the sum of the evidence seems to me much in favor of the belief that lupus is a specialized form of chronic inflammation rather than the result of infection. In suggesting this I am well aware that it is merely a negative conclusion, which is liable to be overthrown at any time by the accumulation of positive evidence. It may be that in the future the presence of bacilli in lupus-products may be demonstrated in earlier stages, and much more constantly than has yet been the case. The results of Koch's injection-treatment may possible force us to believe that there is something about lupus which connects it far more closely with tuberculosis than I have admitted."—*Correspondence Med. News.*

MANAGEMENT OF LINGERING LABOR.

A discussion on the modern methods of managing lingering labor, before the British Medical Association, was opened by Dr. W. S. Playfair. After referring to the dread of meddling midwifery, on the part of leading obstetricians, of thirty-five years ago, and the readiness with which these men resorted to bleeding and debilitating medication, the speaker proceeded to review the methods of the present day. The mere wear and tear of a labor lasting more than twenty-four hours seemed to him to be a very serious thing,

and he did not think it right that we should sit with hands folded waiting until serious symptoms should arise before taking action. He first considered the frequently-met-with difficulty arising from non-dilatation caused by inertia, or by irregular and cramp-like pains, premature rupture of the membranes, and over-distension of the uterus from excessive liquor amnii. For the relief of rigid os uteri prolonging the first stage of labor, Dr. Playfair advocated most strongly the internal administration of chloral hydrate. Under the use of this agent the pains become longer, steadier and more efficient. The patient falls into a somnolent condition, dozing quietly between the pains, which are not lessened or annulled as when chloroform is used. The wild state of excitement is calmed and soothed. Fifteen grains should be given at the first dose, repeated in twenty minutes. Possibly a third dose may be required, but never more.

As an oxytocic Dr. Playfair recommended quinine. In a labor with feeble, ineffective pains, one or two doses of quinine of fifteen grains each will have a beneficial effect in altering the character of the pains. This drug does not possess any of the dangerous properties of ergot.

Speaking of mechanical means for producing dilatation of the os, the speaker referred to a suggestion first made by Trenholme, of Montreal, that the finger be swept around the inner surface of the os, separating it from the membranes. Why it is so Dr. Playfair did not know, but he was satisfied that this simple procedure did excite marked dilatation of the os.

When the head is pushed down low in the pelvis, the os being soft and relaxed, and the membrane ruptured, it was his belief that gentle manual dilatation, pushing, as it were, the os over the head, is frequently extremely useful. Pushing up the swollen anterior lip when impacted between the head and the pubes is not only legitimate, but essential to save injury to the os.

In prolonged second stage, Dr. Playfair referred to ergot and condemns its use at this time in the strongest terms. The only oxytocic he would recommend at this period of labor was manual pressure applied over the uterus to increase the pains when they are feeble, or to take place when they are absent. The best way of using it is for the practitioner to stand by the side of the patient, and to spread his left hand over the fundus. When the pain comes on, strong downward pressure is made in the direction of the axis of the brim. If the finger of the right hand be placed simultaneously on the head, *per vaginam*, it will be felt to be pushed down in a very marked way. One may often push a head through the brim where it has been delayed for hours and on to the perineum in two or three pains. One may often avoid the use of forceps.

As to the latter means, the speaker expressed the fear that there was a tendency to use the instruments too frequently. In the period from 1815 to 1821, 21,867 cases of labor were treated at the Rotunda Hospital, Dublin, without the forceps being used once. The present practice in this institution is such that forceps are now used on an average of 1 in 16.5 cases. The use of the forceps when the head is high up is a serious operation always and should not be undertaken lightly.

Unnecessary delay, when the head is in the pelvic cavity, is not only useless, but dangerous. By timely interference we lessen the risk to both mother and child. It is quite impossible, however, to lay down any precise rule as to when the forceps should be used in lingering labor. Every case must be treated on its merits, after a careful examination of the effect of the pains.—*Brit. Med. Jour.*

THE TREATMENT OF HÆMORRHOIDS.

Dilatation of the sphincter may not, in a surgical sense, be worthy the name "operation." If such is the case, I advise the "family doctor" to appropriate it, for, with the multiplied and multiplying specialities devoted to diseases affecting all organs and tissue between the fields of the alienist and chiropodist, inclusive, there is very limited territory in which he may practice.

My confidence in the superiority of the treatment by dilatation was secured by the same nature of accident which convinced the French surgeons—that is, by observing the complete and permanent disappearance of a number of large internal pile tumors in the case of a gentleman who, in connection with his other trouble, developed an anal fissure, dilation for the cure of which also cured hæmorrhoids.

Dr. Brenton of this society reports similar experience, his patient being a lady who had suffered greatly from strangulation of the tumors and great loss of blood; her fear of any operation suggested the cure of the piles was to great to be overcome, but the fortunate intervention of an anal fissure induced her to consent to the procedure of dilation, with the result of curing both fissure and hæmorrhoids and her speedy restoration to health.

I have used no other method in affecting the radical cure of piles for the past eight years, and during that time have succeeded in curing many cases of the most aggravated character. I will now state the number of cases nor the percentage of cures, realizing that advocates of new methods too often excited distrust by alleging too much. I know of no condition that would forbid application of this treatment. I have applied it at almost every stage of pregnancy, in four hours succeeding labor, in patients suffering from cirrho-

sis of the liver far advanced, in cases complicated with enlarged and indurated prostate gland, those with urethral stricture—in fact, I know no reason, where it is demanded for relief, why it should not be resorted to. In 1888 Verneuil reported the result of his application of the treatment during the 14 years then just passed. He alleged 98% of cures. He made no distinction in the cases, "both external and internal, old and recent, large and small, those associated with relaxed sphincters and those with the opposite condition." My experience with the treatment has been no less satisfactory than that reported by Verneuil.

The dilatation is affected as follows: Hook the thumb of your left hand and the middle finger of your right hand so as to include both sphincters on opposite sides of the anus and gradually but forcibly separate your hands until all resistance ceases, the object being to paralyze the muscles completely. It is commonly advised to oppose the thumbs, but in a great many cases the resistance will be found so strong that it will be impossible to separate the thumbs a sufficient distance. I have in some cases found the sphincters from long contraction developed to such a degree as to give the impression of pulling on an iron ring. I have never known any bad results follow the procedure. No after-treatment is necessary, except in cases where there is complaint of smarting, which may be relieved promptly by the application of a pledget of cotton saturated with a 4% solution of cocaine. It is always advisable to perform dilatation under the influence of an anæsthetic, the A. C. E. mixture being the one I always use.—*Dr. Higgins in N. Y. Med. Jour.*

WIRE-GAUZE FOR SPLINTS.

Permit me to call your attention to the zinc, wire-gauze splint. This has been for many years a great favorite with me. One who has a little ingenuity can do almost everything with this as a splint.

I consider it the splint par excellence for the country practitioner, and in fact can see no splint which would be better for any surgeon in ordinary cases.

It is made from wire $\frac{1}{10}$ of an inch in diameter, and woven into squares of the size of $\frac{3}{8}$ of an inch across, and is well zinced together.

In going into the country, it is often a matter of conjecture, and sometimes of serious study and misgiving, as to what is necessary to take for a splint. It is not at all convenient, as I have sometimes found, to take a box of felt splints, or splints of various kinds and shapes and sizes, if one is so fortunate as to be so supplied, which is not usually the case. Splints made from pasteboards or wood for the occasion are often unsat-

isfactory, and almost any appliance is likely to be found hot and uncomfortable. Few permit of proper antiseptic dressings without discomfort to the patient or danger to the part, nor do they admit of the easy applications of anodynes or evaporating lotions. The wire-gauze splint fits all sizes of limbs and all portions of the body. Buy a yard or more of the gauze. Get also a small pair of tinner's shears, and you are ready to fit the body with any splint desired. In making, cut the gauze into strips of four or five different sizes. These will be the stock splints. Nip off the protruding where cut through to make smooth edges to the splint. A set of these splints in the rough may be rolled into a bundle and be ready for use as occasion may require.

Bend, and if over a joint cut through nearly across the splint and put in the angle, wiring the overlapping fragments with small-sized copper wire. Notch out to fit such joints as may be necessary. The flexure in the joint is superior to other solid removable splints; in that the angle can be made at any degree desired. When fitted, place the bandaged limb in the splint in the usual manner. If it is desired, a layer of absorbent cotton may be placed in the splint before bandaging. In case there be an open wound, which is desired to be dressed without removing the splint, nip out a section of the gauze of such a size as may be desired. If deemed not of sufficient strength, the splint may be reinforced by another strip of the gauze.

This splint is light. It is easy to keep on hand and never wears out. It is cool. It is non-absorbent and easily cleaned. It permits the application of liniments and evaporating lotions at the sight of injury as desired. It is easily applied. It is and remains aseptic, and its cost is trifling. Why it has not come into more general use is a mystery to me.—H. W. Coe, M.D., in *Northwestern Lancet*.

THE NEUROPATHIC ELEMENT IN SPASMODIC ASTHMA.—Although the general explanation of the asthmatic paroxysm is that it is due to bronchial spasm, which may often be excited by peripheral nervous irritation—a view that has received much attention of late in respect to the causal relationship of nasal polypi and asthma,—nevertheless there have not been many attempts to demonstrate the existence in the asthmatic of an underlying state of nervous instability. This lacuna is in a measure filled by a paper by Professor E. Brissaud (*Rev. de Méd.*, Dec., 1890), in which he collates a considerable amount of evidence to show that the (true) asthmatic may be regarded as a neurotic; and hence the removal of the supposed exciting cause (e.g., nasal polypi) can hardly be expected to be curative. Indeed in many cases, he avers, the asthma has recurred

some time or other after the patient has undergone prolonged treatment at the hands of the rhinologist. The probability of some inherent nervous defect in a disease like asthma, the periodical recurrence of which reminds one of the epileptic nerve-storms, seems so self-evident that it is singular so little attention has been paid to it, even by such a strenuous advocate of the nervous theory of the paroxysm as Hyde Salter, for instance; but the fact is that attention has been fastened too much on its alleged diathetic relationships, and also to the existence of local organic disease, of digestive, respiratory, or generative organs as possible sources of reflex irritation. On the other hand, the association of asthma with insanity and alternation of attacks of the mental affection with those of the respiratory apparatus, has been noted by several alienists, and Professor Brissaud quotes in this connexion the writings of Savage, Kelp, and Conolly-Moore. Cases are given of asthma associated with hypochondriasis, melancholia, and hysteria, or combined with some mental disturbance or other nerve disorder, as neuralgia or epilepsy. The general conclusion is that asthma is only one manifestation of the general neuropathic tendency, and that an inheritance of nervous disorder is a main predisposing factor in the affection. Like migraine, which once was considered in France to belong to the "arthritic" group, but which is incontestably regarded now as "neurotic," asthma, too, has relationships far more close with the neuroses than with any diathetic state. Of course, it is not implied that in the same subject other nervous manifestations must necessarily occur, even in their slightest form, for this is not essential to any single neuropathic affection. It is only that the asthmatic belongs to the group of neuropaths, and that his special affection may be the sole expression of his alliance therewith. Hence it is explicable how comparatively slight peripheral irritation of sensory nerves—e. g., of the nasal mucous membrane, or odors, or even simple mental apprehension or dread of attacks supervening under certain circumstances—may suffice to induce the asthmatic paroxysm in the individual of nervous constitution. Nor, as stated, can the cure of spasmodic asthma be reasonably expected to invariably occur after the removal of the supposed exciting cause.—*Lancet*.

PANACEA HUNTING.—The medical profession claims and receives the respect of mankind on the plea of basing their action on the observed phenomena of nature. It was that a body of educated scientists, men not to be led astray by every wind of doctrine, would be provided for looking after the health of the community, that Linacre asked for and obtained the charter of the physicians. In Italy he had seen the blessing to the people of an

educated body of physicians. He had seen how the popular fallacies and the numerous and disgusting nostrums were gradually but effectually gotten rid of in the great republics of Venice and Florence, and how the citizens of these republics had learned to discard the charlatan and respect the physician. Vicary actuated by the same love of nature that Linacre felt, on the same grounds sought and obtained the charter for the surgeons. The after history of medicine in England is a glorious testimony to the enlightened wisdom of Linacre and Vicary. Good results, epoch-making discoveries, soon followed on the careful observation of natural phenomena. The merest tyro knows of Willis, Harvey, Sydenham, Smellie, Denman, William Hunter, John Hunter, James Cheselden, O'Halloran, Chamberlain, Charles Bell, John Bell, Black, Priestly, Cavendish and Waller, and in more recent times may we not add Jacob, Graves, and Stokes? All these great lights of medicine obtained immortality by unremitting observation of nature. Sydenham spent years in the study of the diagnostic characteristics and normal course of the fevers; William Hunter spent years on the study of the womb; John Hunter's life was spent in study; Jacob's accurate and beautiful dissections of the eye tell to all succeeding students of his marvellous patience and perseverance; all who have read Stokes' books know of his extreme caution. From those who thus achieved greatness, we learn that the respect and admiration of posterity can neither be won nor retained except by an intelligent and continuous study of nature. As we read the lives of these great men we may notice their mental stability; they indeed "proved all things," and their lives present an example to those who, "unstable as water, shall not succeed." Indeed, latterly, we have changed all the old lines of conduct. To-day men rush forward proclaiming a panacea for all the ills of life and, in conformity with modern ideas, the only question is, "whence cometh this man?" If the answer is "from Germany," he at once acquires the confidence of the multitude, and to doubt of his accuracy or to hint the desirability of testing the power of his panacea, or the asking some information concerning its nature, incurs the risk of ostracism. Certain of our profession repudiate the teaching of our forefathers—discard caution, close their eyes and ears, and as unreasoning creatures follow a self-elected, leader whithersoever he may go.—*Med Press & Circular.*

ON HOT-WATER FLUSHING OF THE UTERUS DIRECTLY AFTER DELIVERY.—In every case of labor I now attend I make it a rule to wash out the uterus directly the placenta has been expelled, either by expression or by the natural efforts, with hot water. The advantages claimed are:—

(1) Stimulant to the patient; (2) produces contraction of uterus, removing shreds of membrane, clots, etc.; (3) the prevention of "after pains"; and last, but not least, setting the practitioner's mind at rest by ensuring a permanent contraction of the uterus and a clean and untainted cavity.

The facility with which the uterus can be washed out *directly after labor* is a strong argument in favor of the proceeding. An endeavor to do so forty-eight hours later will be found much more difficult and not nearly so effective.

In several cases which I had observed while assistant master to the Rotunda Hospital, the sudden rise in temperature (sometimes accompanied with rigors) was entirely due to a portion of membrane, or *débris* of some kind being retained *in utero*, discovered only when that organ had been flushed with hot water.

Nothing can be more mischievous than the plan I have seen adopted by many midwives, viz., that of "making a rope of the membranes." Though not condemned as yet by any of the text-books or manuals for midwives with which I am acquainted, the fact of rotating the placenta when extruded (or nearly so) brings on a uterine contraction, and the membranes which have not left the uterus are gripped by the os or cervix. The twisting is continued till the membranes break, leaving a considerable portion behind, setting up after-pains, which, if not sufficient to expel for good and all the offending portion, allow it to become a source of extreme danger to the patient by subsequent decomposition, as shown by the high temperature, rigors, etc.

I am now so convinced of the value of washing out the uterus with plain hot water (*previously brought to boiling point*), that I hope I shall be excused for saying, that, in my opinion, *such should be made a routine treatment in all cases of labor and miscarriage, whether in hospital or private practice.* The little additional trouble involved will amply repay the practitioner who adopts this treatment, by whom alone it should be done in all cases.—Alexander Duke, F. R. C. P. I., in *Hosp. Gaz.*

THE TREATMENT OF SYPHILIS.—Professor Köbner, of Berlin, at the conclusion of a discussion on "The Treatment of Syphilis," gave the following *résumé* of his experience and opinions.

1. Regarding excision of the primary affection, in only a small minority of cases was he able to prevent further symptoms of syphilis by this means. As a method of operation he recommends excision combined with electro-cauterization. It is indicated as a prophylactic only at an early stage of the chancre, and in extensive breaking down of the induration, or, if the latter is obstinate to ordinary treatment, for the purpose of

removing the focus of the disease. The extirpation of inflamed inguinal glands is still more rarely successful and absolutely futile if deeper glands are involved.

2. He does not believe in the preventive treatment of syphilis by mercury, and thinks that the use of the remedy should be limited to hastening the healing of a serious primary sore, and to diminishing the danger of contagion, as in the case of a man with a family.

3. He considers the continuous mercurial treatment of Fournier by no means infallible, and for many cases superfluous, as demonstrated by several cases.

This method should be limited to certain indications, as to impending marriage or grave localization of the disease.

He further calls attention to the destructive influence of mercury on the digestion and on the nervous system.

In harmony with the majority of the specialists who attended the International Medical Congress, he refutes Fournier's statement that syphilis becomes "*presque fatalement tertiaire*" without a saturation of the system for years with mercury.

Mercury alone cannot cure syphilis in a person who was not previously healthy, unless the health is greatly improved by hygienic treatment. Upon the hygienic management he lays great stress.

In several individuals, who could not take mercury by the mouth, the rectal administration proved efficient and safe.—*Berliner klinische Wochenschrift—Medical News.*

PEROXIDE OF HYDROGEN.—Peroxide of hydrogen is a drug which has been gradually and steadily gaining in favor, and which has yielded to each who has faithfully tried it, results so constant and so satisfactory that he has learned to depend upon it. As ordinarily found in the shops, peroxide of hydrogen is a 3.2 per cent. solution, yielding fifteen times its bulk of oxygen. This solution is far more potent than is water charged with fifteen times its volume of oxygen, since in the peroxide preparations the gas is given off in its nascent state and is peculiarly powerful in its chemical affinities.

There is abundant evidence as to the value of the peroxide, from both the clinical and the experimental standpoint. The number of those who have reported excellent results from its use is very large, and to this must be added the testimony of the bacteriologists, who find in this drug a potent and almost immediate germicide. It is devoid of septic properties, its worst effect being, when used in a too concentrated form, to cause some local pain and irritation. It is applicable in all cases where pus is present, and where the discharge is foul and profuse its effect is admirable. In suppurating otitis media, in purulent conjunctivitis, the

aurists and ophthalmologists have long prized it as one of their most valuable medicaments. In the sloughing inflammations following scarlet fever and diphtheria the laryngologists place great confidence in its powers. Surgeons, however, in whose work it might prove generally valuable, have been somewhat slow to recognize its virtues. But its use in a great variety of sloughing and suppurating cases, has given results better than those obtained from any other germicide, bichloride of mercury not excepted. Where the discharging area is represented by a surface of granulations, the drug can be applied by means of an atomizer. This enables a small quantity to reach every portion of the infected surface. In the case of a suppurating fistula or cavity the peroxide may be injected by means of a syringe. Immediately following its application to a purulent surface, an active effervescence goes on, and every particle of pus which it reaches is destroyed. Not only this, but the microbes, the active agents of pus formation, are also devitalized, so that a large surface can sometimes be rendered aseptic by one or two thorough applications. Even if this result is not reached, the discharge is greatly lessened, and it is by no means uncommon to see a case, in which the pus had amounted to drachms, so favorably affected that the dressings contain but a few drops of purulent matter.

The strength in which the fifteen-volume solution is used will vary with individual cases. It can be employed without harm in full strength. Where this is painful, one, two, or four parts of water may be added.—*University Magazine.*

DOES SWEET OIL REMOVE GALL STONES.—Most striking results are at times obtained from the administration of sweet oil in cases of hepatic colic. A pint or so of sweet oil (or, in some cases, of other bland oils) is administered to a patient who has been for some time suffering from this form of colic, and some hours later an evacuation of the bowels takes place with the expulsion of numerous green masses believed to be gall-stones. At any rate the patient feels greatly relieved, and may remain free from colic for years. In the Medical Society of North Carolina an interesting discussion arose on a paper presented by Dr. Burbank (*North Carolina Medical Journal*, June and August, 1890), touching the value of sweet oil in this affection. Dr. Burbank stated positively that the green masses referred to are not gall-stones at all; that they are composed of soap (formed from the oil and the alkalies of the bile), of oil which is in excess, and of bile pigments and very small quantities of chlosterin—the latter constituent forming less than one per cent. of the green masses, whereas it forms seventy or eighty per cent. of gall-stones; that examination, in patients with thin-walled abdomens, proved beyond a doubt

that the gall-stones felt before the administration of the oil were still present after the oil had produced its benign effects. He subjoined a brief account of three cases in which large doses of sweet oil were given. None of them presented any history of hepatic colic, yet the use of the oil was in each case followed by the expulsion of masses dark green and whitish in color. In each of these cases the administration of the oil had been preceded by a dose of calomel. In a fourth case no calomel was given, and no masses were seen in the evacuations. This seems to show that the masses are formed when the oil is met in the intestines by a large quantity of fresh bile.—*New York Med. Rec.*

VARIETIES OF HEPATIC CIRRHOSIS.—Saundry (*Brit. Med. Jour.*), in an interesting article on this subject, recognizes ten varieties: Alcoholic, cardiac or cyanotic, biliary, diffuse syphilitic, gummatous syphilitic, tuberculous, malarial, scarlatinal, rachitic and diabetic.

The alcoholic variety is caused by the abuse of alcohol. It is most frequent in adult males. The symptoms usually complained of are hæmatemesis, or abdominal dropsy; those who present the symptom of ascites are usually without hæmatemesis, and those who have hæmatemesis are usually without ascites. Dyspeptic symptoms are common. The skin is of earthy tint and rarely jaundiced. The spleen is usually enlarged, and the liver diminished in size. Cases of hæmatemesis are without dropsy, because the dilated veins surrounding the œsophagus allow the blood from the portal vein to reach the vena cava without passing through the liver. The liver is small, granular and of an olive color, having bands of connective tissue in the portal canals surrounding groups of acini, and invading them from the periphery. Early and repeated tapping in cases of ascites may indefinitely prolong life if alcohol is abstained from.

The cardiac variety is due to the chronic congestion of the right side of the heart. The liver is enlarged and tender. The cirrhosis begins in the radicles of the hepatic veins. There are often slight jaundice and ascites. The biliary variety he considers due to chronic obstruction of the common duct. Jaundice is the initial symptom; ascites is generally absent. The liver is generally enlarged, and he considers it the best-known form of what is called hypertrophic cirrhosis. The trabeculae of fibrous tissue surround the single acini. The treatment is palliative, unless the obstruction can be removed by surgical means.

Diffuse syphilitic cirrhosis is caused by hereditary syphilis. The liver and spleen are both enlarged, and the lesion is diffuse. It is best treated with calomel. The gummatous syphilitic form is due to fibrous tracts left by old gummata. The liver is puckered.

The tuberculous variety is little recognized. The liver is enlarged, the trabeculae surround the lobules, and there is enlargement of the biliary canaliculi, but ascites is absent. In malarial types of this disorder the liver is enlarged. The cirrhosis begins in the portal canals and invades the lobules. There is no ascites. The scarlatinal form is known only to pathologists, and it may explain some large livers found, *post mortem*, in children. There is increase of the fibrous material in the portal canals. The rachitic variety is the cause of much of the gastro-intestinal catarrh in children. The liver is enlarged, and the fibrous material surrounds single acini. The treatment includes calomel and cod-liver oil. Diabetic cirrhosis is little known. There is no ascites. The skin is bronzed, but jaundice is absent. The fibrous tissue is formed about the hepatic radicles.

WHAT IS PAIN?—It was John Hilton, I think, who gave expression of greatest import to a truism in regard to pain, that is well worthy of our remembrance. Indeed, he has so forcibly written upon this subject in his valuable work of "Rest and Pain," that he has been quoted up on this subject more often than any other writer. He declares that "every pain has its *distinct* and pregnant signification if we will but search for it"; that "pain, the monitor, and rest the cure, are *starting* points for contemplation."

In this connection it may not be out of place to consider, but for a moment, something of the nature of pain; its laws of production and conduction; of radiation and reflection, as having direct bearing upon our case.

Buzzard has defined the term pain, "a representation in consciousness of a change produced in a nerve centre by a certain mode of excitation."

Accepting this definition, as we do most as merely a "*working* definition," we observe that it presupposes a knowledge of at least two histological structures, viz. a kind that is susceptible of being excited and conveying impulses, as the nerves and their terminations; and, secondly, structures capable of receiving impulses conveyed by these nerves, viz., *centers*, both of cord and brain. It is to be understood that the cause or place of the irritation of any pain may be located any place between the centers and nerve terminations; but by the "law of peripheral reference of sensations," as it is called, the pain is invariably referred to the peripheral end of the nerve of one or more of its branches. This law is most emphatically and wonderfully observed after amputations, and our surgeons tell of many interesting incidents in this connection.—Beebe, *Lancet Clinic*.

ACUTE TRAUMATIC TETANUS; CURE.—The mortality attending this form of sepsis reaches such a high rate that the following case presents

marked interest. The patient was a boy, aged fourteen. The history obtained was that twelve days prior to admission he had trodden upon a wooden plank from which projected a rusty nail, that had run into the sole of his foot. The wound produced was but a slight one, and he returned to his work the following day. A week later he began to complain of severe pain in his leg, which he attributed to the limping he was forced to undergo while the wound was healing in his foot. Another three days elapsed, when he began to have stiffness about his jaws, and spoke, as his mother describes, through his teeth. When admitted on the twelfth day after the receipt of his accident, he showed all the well-marked signs of acute tetanus. Every ten or fifteen minutes, and sometimes oftener, he was convulsed. His whole body became rigid, and his back arched into a typical opisthotonic position; his face also showed the symptomatic risus sardonicus. As each fit came on he cried out and begged to have his abdomen pressed upon. Chloral hydrate, thirty grains, was given every two hours until the patient was seen to be markedly affected by it. In the course of twenty-four hours he received three quarters of an ounce, and was then profoundly under its influence. After a spasm he would fall back into an almost profound slumber. The dose of chloral was reduced in quantity and frequency, the spasms lessened; amount of chloral was decreased, and with any increase in their frequency the drug was increased. Within the first three days of his hospital residence he had no fewer than two hundred and fifteen spasms, having on the second day the largest number, eighty-two. Within this same period he took $1\frac{3}{4}$ ounces of chloral. In all $5\frac{1}{2}$ ounces of chloral were given.—*Glasgow Med. Jour.*

SOME SOURCES OF ERROR IN SOUNDING FOR STONE.

—In a recent lecture Mr. Buckston Browne said his first proposition was, that in cases where the prostate was enlarged, stones are often missed when the bladder is examined, because the sound has not reached the bladder, but is arrested in the prostatic urethra. He illustrated this by several examples, and expressed an opinion that in many cases where the bladder was found contracted and the sound could not be turned, the real truth was that the sound had never entered the bladder. Next he proved that many stones were missed because the post-prostatic pouch is not explored. It was shown that in certain cases it was very difficult to explore this pouch by means of instruments passed in by the urethra, and that in certain other cases it was impossible to do so, and that in these rare cases the only way to thoroughly search was by means of suprapubic incision into the bladder. Several interesting and important cases from the author's personal experience were cited in illustration. The sound described was of solid burnished

steel, with a round, smooth handle, a shaft ten inches long and equal to No. 7 of the English scale, ending in a smooth, broad, flat beak, exactly like the end of a broad, flat-bladed lithotrite. The author asserted that the beak of this instrument allowed it to ride easily over the bar at the neck of the bladder, and that it was not caught in one or other prostatic sinus at the end of the ordinary sound was so prone to be, and that when in the bladder it slipped more easily than an ordinary sound under a projecting prostatic middle lobe, and so enabled the surgeon to thoroughly search that favorite habitat of a stone—the post-prostatic pouch.—*Medical Press and Circular.*

KNITTED BANDAGES FOR ULCERATED LEGS.—

Staff-Surgeon Pannwitz reports in a German military medical journal the success he has had in the treatment of obstinate chronic ulceration of the leg by using tubular bandages of knitted material. Decided improvement followed the first dressing, and by persevering with these bandages a complete cure was obtained. Ordinary antiseptics may be used at the same time, and of these he prefers iodoform. These bandages were also used in varicose veins and œdema of the leg in the place of the ordinary elastic bandages or stockings, and produced the best results, while even in valvular affections and Bright's disease considerable improvement followed their application. He thinks them sufficiently elastic for the lower extremities, and they do not cause an injurious constriction of the vessels as rubber bandages often do. Uniform pressure prevents a thickening of the margins of the ulcer and existing indurations gradually disappear. The greater porousness of the bandages is often also an advantage, as the function of the skin is not interfered with. The skin never becomes macerated, as is often the case when rubber bandages are applied, as through the great permeability of the knitted material part of any liquid discharged may be evaporated. The bandages are also easily cleaned and disinfected, and do not lose their elasticity for some time.—*The Lancet.*

A NEW METHOD OF EXAMINING SPUTUM FOR TUBERCLE BACILLI.—Dr. Biedert, of Hagenau, in Alsace, has devised a new and considerably surer method for the discovery of tubercle bacilli in sputum. He collects a tablespoonful or more of the sputum, mixes it well with a glass rod, takes some of it and stirs it together with two tablespoonfuls of water and four to eight drops of solution of caustic soda according to the density of the sputum, and then boils it, stirring it the while in a shallow cup, gradually adding four to six tablespoonfuls of water till he gets a pretty thin fluid mass. This he allows to stand for two hours in a high glass tapering as finely as possible downwards, and all the formed particles sink with the tubercle

bacilli to the bottom. Then he pours off the fluid, retaining the sediment, parts of which he takes out with a platinum needle and rubs them fine on a cover-glass. When the preparation is dry he passes it through a flame, stains it with a carbolised solution of fuchsine, and then bleaches it with 25 per cent. sulphuric acid. If there are any tubercle bacilli they remain red, and are thus distinguishable under the microscope. Even a single bacillus is discoverable in this way, whereas the older methods yielded a positive result only if there were many.—*The Lancet.*

HOT WATER IN ACNE OF THE FACE.—Hot water applied twice or three times a day for about five minutes is one of the most reliable local remedies which we possess for the treatment of acne of the face. To derive the full benefit from the effects of this simple remedy, it is necessary that the physician, and through him the patient, should be thoroughly familiar with the proper method of using it. The water should be very hot, so hot, in fact, that it can hardly be borne by the patient. Care should of course be taken not to scald the face, but if the water is only warm instead of really hot, more harm than good will be produced. The face should not be washed, rubbed or bathed with hot water, as is so frequently done, but a small portion of the diseased area of the face should be soaked with it for a very short time only. The heat of the water which is brought in contact with the skin is deeply dissipated for a moment and causes an intense but transitory local hyperæmia. This is exactly what we want to produce. If the hot water is allowed to act on the skin for too long a time, say more than a minute, or if the application is renewed at two short intervals, an acute inflammatory condition is added to the disease already existing. It is sufficient to go over the effected parts twice in one sitting, and the entire operation need not take more than three to five minutes. A handkerchief or a piece of soft linen is commonly used to convey the hot water to the face. I use for this purpose a very small glass holder, which I have constructed. Since this little instrument, which I have named "Thermophor," has proved itself very useful and convenient, I shall take the liberty of shortly describing it here. The instrument consists of handle and head. The latter is nothing else than an ordinary test tube. About half of this test tube is filled with cold water. A thick pad of absorbent cotton is thickly stuffed into the opening of the tube. The holder is then reversed, and the water inside the tube allowed to soak the cotton. The latter is thus kept in place by dint of the weight and adhesion of the water. During these few preparatory steps water has been brought to the boiling point in a small vessel on a stove, or over a gas or alcohol lamp. The holder with cotton is dip-

ped into hot water, left in it for a few minutes and then carefully carried to the affected portion of the face. The advantages of the "thermorhor" are manifold. It saves the patient's hands from coming in contact with the hot water; it renders possible the use of water of high temperature, and makes it easy to confine the action of the heat to a limited portion of the diseased area. Besides, it is clean, handy and cheap. Not only plain, but also medicated hot water may be used in the manner described above. Hot solutions of boric acid, bicarbonate of soda, salicylic acid, resorcin etc., are all very serviceable. I have had excellent results from the so-called "lotio alba," to which resorcin is added, according to the following formula:

R.—Zinc. sulf.
Potass. sulfuret., āā ʒj.
Aq. rosar., ʒiv.

Dissolve each of the ingredients in water, mix and add resorcin, ʒj.

S.—Lotion. Shake well.

This lotion is to be used hot at night and cold in the morning.—Frederick J. Levisour, *N. Y. Med. Rec.*

TREATMENT OF HÆMORRHOIDS BY DILATATION OF THE SPHINCTER ANI.—Dilatation of the sphincter may not in a surgical sense, be worthy of the name "operation." If such is the case, I advise the "family doctor" to appropriate it, for, with the multiplied and multiplying specialities devoted to diseases affecting all organs and tissues between the fields of the alienist and chiropodist, inclusive, there is a very limited territory in which he may practice. My confidence in the superiority of treatment by dilatation was secured by the same nature of accident which convinced the French surgeons—that is, by observing the complete and permanent disappearance of a number of large internal pile tumors in the case of a gentleman who, in connection with his other trouble, developed an anal fissure, dilatation for the cure of which also cured his hæmorrhoids.

The dilatation of the sphincter is as follows: Hook the thumb of your left hand and the middle finger of your right so as to include both sphincters on opposite sides of the anus and gradually but forcibly separate your hand until all resistance ceases, the object being to paralyze the muscles completely. It is commonly advised to oppose the thumbs, but in a great many cases the resistance will be found so strong that it will be impossible to separate the thumbs a sufficient distance. I have in some cases found the sphincters from long contraction developed to such a degree as to give the impression of pulling on an iron ring. I have never known any bad results follow from the procedure. No after-treatment is necessary, except in cases where there is complaint of smart-

ing, which may be relieved promptly by the application of a pledget of cotton saturated with four per cent. solution of cocaine. It is advisable to perform dilatation under the influence of an anæsthetic, the A. C. E. mixture being the one I always use.—*New York Med. Jour.*

ON THE ACTIONS OF THE SIMPLE BITTERS.—The use of bitters as remedial agents are based upon the four following actions:—

1. They increase secretion.
2. They increase peristalsis.
3. They diminish fermentation; and, they do

this not only by their antiseptic action, but, very likely, partly on account of the increased digestion, so that there is not left so much material to ferment, and also by hastening on the material into the duodenum that it does not have time to remain in the stomach and ferment.

4. They increase absorption.

From the above actions you can readily deduce the conclusion that wherever there is diminished secretion, wherever there is diminished peristalsis, wherever there is undue fermentation, wherever there is sluggish absorption, that these drugs may be indicated and may be of service.

Hence, in atonic dyspepsia, where the mucous membrane is pale and inactive, bitters are of great service by increasing secretion and peristalsis. The same is true of the sluggish digestion that occurs in convalescence from acute disease; especially is this true of the emaciated typhoid patient. It is also of use in chronic gastric catarrh. It is not only of use to increase the action of the stomach, but in diarrhoea, due to relaxation of the mucous membrane, by increasing the tonicity of the various structures of the membrane, the diarrhoea is often improved. It is also of service where there is habitual accumulation of flatus, because it increases peristalsis, and removes the accumulated material and arrests fermentation, so that it will not be formed.—*N. Am. Practitioner.*

TREATMENT OF FISSURED NIPPLE AND ENGORGED MAMMARY GLAND.—In the treatment of fissured nipple, when the cracks are at all extensive, the ordinary remedies recommended from time to time have been found more or less unsatisfactory. Painting with tincture of benzoin, for instance, while an excellent procedure for small superficial cracks of the nipple, is perfectly worthless in more advanced cases.

The writer has found in hospital and private practice that excellent results can be secured in bad cases by the application of an ointment made up of equal parts of castor oil and subnitrate of bismuth. This mixture makes a very smooth, soft ointment, which relieves the pain, and is an excellent protective to the part. Before application, the nipple and surrounding skin should be care-

fully cleansed and disinfected, and then the ointment should be smeared on plentifully. If it is necessary for the child to nurse from the affected nipple, it can be allowed to do so without the necessity of removing the ointment from the nipple, as must be done if tannic acid or the salts of lead are used. This is a serious disadvantage of many forms of treatment recommended for fissured nipple, for the irritation of removing the substance employed as a local sedative neutralizes its action.

For the engorgement and pain in the mammary gland itself, which so often accompanies fissured nipple, the writer has had excellent results from the use of an application of lead water and laudanum, which is applied by means of a cloth covering the whole breast, renewed at frequent intervals, and kept in place by a suitable mammary binder, either that recommended by Richardson or the Murphy bandage. This not only retains the dressing, but supports the breast and exercises even pressure upon it. With this treatment the development of mammary abscess is a rare event. If the child can be nursed from the other breast alone it is safer, I think, to draw the milk from the affected gland by means of a breast-pump until the cure is almost complete. If it is necessary that the child should nurse from the cracked nipple, a glass nipple shield with a rubber tip must be employed.—B. C. Hirst, M.D., in *Univ. Med. Mag.*

AFTER PAINS.—Dewees is authority for the following rules for the prevention of after-pains:

1. Do not rupture the membranes before the neck is completely dilated.
2. After the head is born make no traction, but allow the uterus to expel the shoulders and trunk.
3. Do not extract the placenta until the womb is thoroughly contracted.

4. After the placenta is delivered, excite the womb so as to oblige the muscular fibres to contract as much as possible.

Leishman says: "Nothing does so much to prevent their being severe as pressure outside upon the womb during the expulsion of the child and placenta, thereby producing firm contractions." When traction is made upon the cord before the placenta has been expelled from the uterus, the placental vessels are often torn and bleed, and thus a clot is formed. Efforts to deliver the placenta should be directed to producing contractions. These will expel it without leaving a clot; then by continuing to grasp the womb through the abdominal walls, should it soften, the fact should be recognized, and efforts made to prevent relaxation. This can be done with one hand and the placenta removed from the vagina with the other.—*Med. Summary.*

POSTURE IN TREATMENT OF NOCTURNAL INCON-

TINENCE IN CHILDREN.—Dr. van Tienhoven suggests that in this condition though the bladder act normally through the day, it misbehaves at night. He believes that the vesical sphincter is not strong enough to keep back the urine which collects in the bladder in the early hours of the night and permits it to find its way into the, prostatic portion of the urethra. The detrusor vesicæ is thus reflexly stimulated and the bladder emptied. In order to prevent the urine from running into the urethra in this way the children were made to sleep with the pelvis elevated. In this position the bladder is capable of holding a certain amount of urine before the liquid reaches the level of the urethral opening. The foot of the bed must be elevated so that the bed forms an angle of forty-five degrees, with the horizontal. The children should be sent to bed with empty bladders, and should not take any liquid just before retiring. They sleep well in this position and do not complain. Fourteen cases were treated by this simple method only, and all were cured in a short time.—*Schweizer Aerzte*.

CYSTITIS.—One of the commonest ailments among women which the general practitioner is called upon to treat, and which seems to be peculiarly prevalent in this class of patients, is a troublesome cystitis, due possibly to derangements of the pelvic circulation. Not rarely a very considerable amount of difficulty is experienced in overcoming the affection, which not only disturbs the rest of the sufferer, but often also very seriously affects her mental state, causing her to be irritable, nervous, and a source of discomfort to all around her. For the treatment of such cases, resort has been had to innumerable remedies, and success has been claimed in this connection for the most dissimilar drugs and methods. Most frequently the cause of the distress is a vesical catarrh, the cure of which affords more or less complete relief of the condition. At other times the treatment which is found to be called for is constitutional rather than local; and cases are also met with that necessitate a union of both procedures. To this probably it is attributable that the recommendations of different practitioners cover so wide a range of ground; while it explains, too, the reputed success of those who claim to have met with good results from the employment of medicines newly introduced into the Pharmacopœia. The drug most lately reported as being curative of the form of cystitis in question is salol; and three obstinate cases which were completely cured by its administration are described by Dr. Abbot in the *Boston Med. and Surg. Jour.* Each of the patients had been suffering for a considerable time, and had been treated with palliative means with more or less success, but without any permanent relief being obtained. The dose of salol given was 10 grains three times a day, and in

each, marked improvement of the symptoms was very speedily observed. One most satisfactory feature in the history is the rapidity with which the cure was effected, a week or ten days sufficing to bring it about in all three instances. When we remember that even months of treatment by other means may terminate in disappointment, it may well be considered that a method which promises so favorably deserves the widest possible trial, and no doubt the usefulness of the drug in question will soon be tested on a larger scale than has hitherto been the case.—*Medical Press*.

DIET FOR DIABETICS.—Arranged by Bransford Lewis, M.D., Lecturer on Genito-Urinary Diseases, Missouri Medical College, St. Louis.

ALLOWED.

All kinds of meats (except liver). Poultry, all kinds of game.
 All kinds of fish, fresh or salt, sardines.
 Oysters.
 Eggs in any style (without addition of flour, starch or sugar.)
 Fats and fatty meats
 Butter, cheese.
 Soup (without flour or the prohibited vegetables).
 Celery, cabbage, cauliflower, string beans, asparagus, lettuce, spinach, mushrooms, radishes, cucumbers (green or pickled), young onions, water cresses, slaw, olives, tomatoes.
 Graham bread, rye bread. Occasionally stale light (white) bread.
 Acid fruits, such as oranges, lemons, apples, plums, cranberries, currants, cherries, strawberries, gooseberries (sweetened, not with sugar, but with saccharine and sod. bicarb.)
 Gelatine (without sugar.)
 Almonds, walnuts, Brazil nuts, hazel nuts, filberts, pecans, butternuts, coconuts.
 Salt, vinegar, pepper.
 Drinks: Coffee, tea (without sugar), skim-milk, cream, soda-water, (without syrup), mineral waters of all kinds, but especially vichy.
 Claret, Rhine wine.

PROHIBITED.

Liver.
 Sugar, in any form.
 Starch, in any form.
 Sauces containing flour, sugar or starch.
 Cakes of all kinds.
 All cereals, such as cracked wheat, oatmeal, mush, cerealine, etc.
 Potatoes (either Irish or sweet), corn, carrots, turnips, homing, parsnips, beans, peas, beets, rice.
 White bread, corn bread, white biscuits.
 Pears, peaches, grapes.
 Sweet jellies.
 Chestnuts.
 Malt Liquors, beer ale.—*St. Louis Med. Herald*.

IPECACUANHA IN LABOR.—While the accelerating action of ergot in cases of lingering labor is universally known and acknowledged, there is another drug which, so far as I am aware, is not noticed in works on midwifery, and which yet is capable in such cases of rendering signal service;

I allude to ipecacuanha. Not only in cases of rigid cervix, where possibly it might be considered to act in a similar manner to antimony, but in cases of simple inertia, in either first or second stage, it is a potent instigator of uterine contraction.

In the course of general practice extending over many years I invariably carried a bottle of vinum ipecacuanhæ in my midwifery bag, and rarely, if ever, gave a dose of ergot in the first stage of labor. Time after time on coming to a confinement case where the pains have been feeble and inefficient, or had totally ceased, two or three 10 or 15 minim doses of the wine at intervals of ten minutes have been followed in a surprisingly short time by energetic uterine action, with a rapid termination to the labor. It never produces the quasi-tetanic contraction so often met with as the result of ergot, the pains continuing to recur regularly, just as they do in natural labor, but with greater force and at shorter intervals. Conviction of the value of the drug for this purpose induces me to give my experience of it, believing that its merits will be recognized by any who choose to give it a trial.—*Brit. Med. Jour.*

FRACTURES OF THE FEMUR IN CHILDREN.—

Much use is made here of perpendicular extension in treating fractures of the femur in children. The ordinary plaster strips are bandaged to the limb, but instead of the cord which attaches the weight passing horizontally over a pulley at the foot of the bed, it passes perpendicularly over one directly above the patient's peivis, thence horizontally to a second, and then to the weight. This latter is just sufficient to raise the buttock of the affected side clear of the bed. The whole limb and half the pelvis is thus swung at right angles to the trunk. Thus defecation can be easily managed and perfect cleanliness secured. No coaptation splints are employed, and no device for preventing rotation. It is found that a muscular equilibrium is quickly established, which prevents inversion or eversion. Results are excellent.—*Correspondence in Med. Rec.*

SULFONAL FOR NIGHT-SWEATS—(*Therap. Monatschrift; Memorabilien*). Boettrich gave a woman, eighty years of age, four grains of sulfonal as an hypnotic. After using one powder she asked him if its virtue consisted in the abatement of night-sweats. She suffered so profusely from this trouble that she had been compelled to change her linen twice every night. After the fourth dose of sulfonal great improvement was noticed. Further observation proves to the writer that 0.50 (seven and one half grains) was generally successful in the prevention of night-sweats. Boettrich thinks its effects equal to those of atropine, and it possesses the advantages of freedom from disagree-

able after-effects. It retains its power, as he finds that the night after taking a dose the sweating is decidedly less.

WHERE TO PUNCTURE IN PARACENTESIS.—Prof. Keen selects the following points for the passage of the needle in the operation of paracentesis. In paracentesis thoracis the place of election is between the eighth and ninth ribs in the line of the axilla. In paracentesis abdominis the needle should enter in the middle line, the patient being in a sitting posture, and the bladder having been previously emptied. paracentesis pericardii the patient should be in the recumbent posture, and the needle should enter at the fifth interspace in front, due regard being had for the heart and large vessels.—*Col. and Clin. Rec.*

TREATMENT OF LARYNGEAL SPASM.—The treatment of spasm of the glottis is often difficult and uncertain in its results, but Sir Morell Mackenzie writes that by setting up a rival reflex the laryngeal spasm may be instantly overcome. The patient need only take a pinch of snuff or black pepper into the nostrils, or if neither can be obtained, the nares should be tickled by a feather. The immediate result is a paroxysm of sneezing, after which the breathing is relieved.—*Hospital Gazette.*

I. N. LOVE, M. D., Professor of Diseases of Children, Marion-Simms College of Medicine, and editor of the *Medical Mirror*, says: The subject of uterine disease reminds me that during the past six months I have had my attention drawn to a remedy which goes under the name of DIOVIBURNIA. I was not familiar with the component parts, but having read the emphatic endorsement by Drs. J. B. Johnson and L. Ch. Boisliniere, of St. Louis, two of the most eminent professors and practitioners of the city, as well as that of Dr. H. Tuholske, I was induced to give the compend, a fair and thorough trial, and I am convinced that in DIOVIBURNIA we have a valuable addition to our armentarium in the battle against the enemies of the noblest work of God—Woman.

JOHN MUIR, M. D. Member College Physicians and Surgeons, Ontario, Canada, Ex-Vice-President Ontario Medical Council, says: "I take pleasure in saying that I have found Papine (Battle) prompt, efficacious, and—better still—unobjectionable as to after effects. A patient, more than usually intolerant of other preparations of opium, has borne it well, and derived manifest benefit from its use."

THE world do move! England is beginning to ask why she cannot have lavatories on her railway carriages.

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IMPROVEMENT IN THE CHARACTER OF THE MEDICAL PROFESSION.

In Canada it is especially desirable to raise and keep raised the character and tone of the medical profession. There are innumerable ways and practices by which the tone of the profession can be lowered, but to proceed in the opposite direction is more difficult. No one can review the tendencies of modern times and their effects upon the practice of medicine without entering a strong protest against certain modern practices: that of contract work in lodges is perhaps the most pernicious, certainly it is the most general. In this class of practice the regulations which govern ordinary practitioners are overruled, the fees are cut down to the merest pittance and the physician himself made to feel under obligation to the "noble viziers" and tin-capped aristocracy who, by their great influence in the "lodge," have succeeded in securing his election as its physician; whereas, in truth, the doctor is the source of benevolence, by whose labors alone such organizations are able to exist. Is it not a lamentable fact that educated and able physicians of refined feeling allow their names to be put in nomination for the office of lodge doctor, in opposition to some other local physician? If asked the reason, the reply is that practice is poor and they are forced to do it.

Another growing and equally pernicious tendency is to engage as the physician to the shop

girls of some cheap bazaar, for a certain sum per annum, whilst the selfish employer of such labor deducts so much per week from the hands' pay towards the allowance of the physician and thus a profit is made out of the doctor's work. In Toronto we know such things to exist, and worse: that certain physicians living in large houses accept fifty cents as their consultation fee and give therefor, together with professional advice, a receipt in full for its payment. Is it to be wondered at, if the young physician, experiencing so many difficulties in obtaining an introduction to practice, should be led by such example to unprofessional acts: to advertise "Consultations free," or, just now, to introduce into the public press the startling notice that "through the personal influence of Lord Stanley, Sir Charles Tupper, Sir John A. Macdonald, The Dominion Government, Lord Salisbury and the Lord High Chancellor of England, he has secured a supply of Koch's lymph for use in his 'own' private practice." Enough of the evil. What is the remedy?

To raise the character of the whole profession of the country cannot be the work of any one, but rather the result of the concerted action of all its best members. When we enquire into the influences by which men have been prompted to enter the medical profession, the circumstances are not so surprising.

Notwithstanding the advancements made in medical teaching, the fees for the medical course have remained almost the same, or with but very little increase for the last ten years. If the cost of attending medical lectures could be increased to double what it is at present, the effect in reducing the number of students and lessening the evils of overcrowding in the profession would be apparent. If the colleges in Canada would combine to bring the lecture fees as nearly equal to those of the colleges of Europe as are the lectures themselves, the change would be beneficial on all sides.

FOR DIABETES.

Sulphonal is the latest drug in the market for diabetes. If the pathology of the affection be considered, it will be difficult to understand how any of these new compounds can do other than exert a temporary influence upon that undue excretion of sugar. Antipyrin certainly did, in one case

under our observation, notably diminish and, for a few days, absolutely remove all trace of sugar from the urine of a diabetic, who had been suffering for years from the disease, and whose urine contained, at the time of the experiment with antipyrin, 39 grains of sugar to the ounce. But its good effects, like those of all other known remedies, were fleeting, and in a few weeks the old story was told only too plainly and disappointingly by Fehling. It may be stated, that the same patient, a gentleman of education and intelligence, wearied of the futile attempts at cure, by the medical profession, went over to—shall we say the majority—and tried Warner's Safe Cure Pills and Safe Cure, with more benefit to his general health than from any of the previously tried remedies, and *that* having at last failed, *mirabile dictu!* to cure the disease, he his now doing well on Mother Seigel's Syrup.

This is what Dr. Casarelli, of Pisa, says as to the favorable action of sulfonal in diabetes. The drug diminishes the quantity of sugar in the urine, also reducing the polyuria and the thirst. These results were obtained by doses of from 5 to 30 grains per diem, but not to so marked a degree as with doses of 45 grains continued for several days. The 30-grain doses could be administered for some time without any ill effects; but although the 40-grain doses at first caused no disturbance, it was found that, when they were continued for any lengthened period, they caused giddiness and excessive sleepiness, which disappeared when the drug was discontinued.

To simply enumerate the remedies which have gone the rounds of the medical press during the past five years for the cure of this disease would, we think, astonish the profession, and yet we can vouch for the fact that in the case mentioned, the patient did improve more under the quack remedies, than under the use of several of the best endorsed remedies of the profession. Until the pathology of the disease is more definitely known, the empirical use of new remedies can hardly be expected to produce anything but disappointment as to successful treatment.

Dr. L. Webster Fox has been appointed ophthalmic expert to the Board of Pension Examiners of the Philadelphia district.

CONSERVATIVE TREATMENT OF ADHERENT BUT FUNCTIONALLY ACTIVE OVARIES AND FALLOPIAN TUBES.

In a very interesting paper in the *Lancet* of Feb. 21st., A. C. Butler-Smythe gives the results of five cases in which the conservative plan of freeing adherent tubes and ovaries was adopted. In all the cases the results were most satisfactory. The operation will commend itself to every medical man who has not a craze for "removing" these organs. There can be no doubt that there are thousands and tens of thousands of "emaciated creatures, racked with pain and often confined to bed," who would welcome the conservative or minor operation, when no amount of argument on the part of their medical advisers would induce them to submit to the total loss of the ovaries and tubes. Mr. Smythe says it is not his intention to discuss the treatment of cases in which the organs are diseased, nor does he wish anyone to imagine that he advocates attempting to save those organs where they are completely matted together or embedded in inflammatory tissue. "But," he says, "there are many cases where, on opening the abdomen, the operator finds that the ovaries and tubes are only partially adherent, and where no visible or tangible signs of disease can be discovered in these organs. Moreover, it is not always easy to decide, even when the abdomen is opened, whether an ovary is healthy or not. It appears to me that not infrequently it is the presence of adhesions of the ovaries and tubes, and this alone, that is the cause of the pain and other symptoms which have been complained of, and which have led to an intra-abdominal examination of the parts. Simple adhesions of these organs are not dangerous to life, nor do they necessarily destroy the functions of the ovaries and tubes. Why, then, should these organs be extirpated? The removal of the ovaries and tubes for such adhesions has always seemed to me an unnecessarily severe, almost an unwarrantable, proceeding; and I feel confident that the profession will welcome as an important improvement any method by which the conditions under consideration may be cured without resorting to such extreme measures. I hold that in such cases the separation of the adhesions and freeing of the ovaries and tubes can be accomplished, and is frequently sufficient to restore the patients to

health, and, what is more to the point, the operation leaves them with functionally active organs. This treatment seems to me a most rational one, and I have operated in this way on three occasions, the results being most encouraging. I therefore venture to lay them before the profession, in the hope that the operation may be given a more extended trial. I am quite aware that the results of three cases are insufficient to prove the worth of this treatment; but I am convinced that in other hands than mine the operation will be productive of much good. However, if it but tends to limit the number of 'spaying' operations, I shall be more than satisfied."

The only apparent difficulty encountered in any of the cases was hæmorrhage, and this was not alarming, and was apparently readily controlled

MEDICAL AND SURGICAL BRIEFS FROM NEW YORK HOSPITALS.

INFANT FEEDING.

There is a physiological limit to the amount of food which a child may take. When this principle is violated many morbid processes may result. In the treatment of disease, authors not infrequently speak of removing the cause. Now would it not be wise, in any case, to regulate the quantity of food, for its prophylactic if not for its immediate effects? How to so regulate the diet of children has been the question. A table for this purpose will be given at the end of this note which the intelligent reader will doubtlessly find definite and practical. The need for such a guide is apparent. It will be of special value in diseases of

HOW TO FEED AN INFANT.—DEvised BY A. SEIBERT, M.D.

WEIGHT IN POUNDS.	SIZE OF BOTTLE.	AMOUNT			TIME OF FEEDING.			
		OF MILK.	OF GRUEL.	OF SUGAR.	HOW OFTEN.	IN 24 HOURS.	6 AM to 6 PM	6 PM to 6 AM
6, 7 and 8	3 ounces.	1 ounce, or 2 tablespoonfuls.	2 ounces, or 4 tablespoonfuls.	$\frac{1}{2}$ teaspoonful.	1 bottle full every 2 hours.	8 bottles.	6 bottles.	2 bottles.
9 and 10	4 ounces.	$\frac{1}{2}$ ounce, or 3 tablespoonfuls.	$2\frac{1}{2}$ ounces, or 5 tablespoonfuls.	$\frac{1}{2}$ teaspoonful.	1 bottle full every 2 hours.	8 bottles.	6 bottles.	2 bottles.
11, 12, 13 and 14	5 ounces.	$2\frac{1}{2}$ ounces, or 5 tablespoonfuls.	$2\frac{1}{2}$ ounces, or 5 tablespoonfuls.	$\frac{3}{4}$ teaspoonful.	1 bottle full every $2\frac{1}{2}$ hours.	7 bottles.	5 bottles.	2 bottles.
15 and 16	6 ounces.	$3\frac{1}{2}$ ounces, or 7 tablespoonfuls.	$2\frac{1}{2}$ ounces, or 5 tablespoonfuls.	$\frac{3}{4}$ teaspoonful.	1 bottle full every $2\frac{1}{2}$ hours.	7 bottles.	5 bottles.	2 bottles.
17 and 18	7 ounces.	5 ounces, or 10 tablespoonfuls.	2 ounces, or 4 tablespoonfuls.	1 teaspoonful.	1 bottle full every 3 hours.	6 bottles.	5 bottles.	1 bottle.
19 and 20	8 ounces.	All milk and 1 teaspoonful of sugar.			1 bottle full every 3 hours.	6 bottles.	5 bottles.	1 bottle.

Never use a larger bottle than the one indicated by the child's weight. The weight, not the age, of the infant determines its food properly.

by "packing sponges down over the abraded surface." The possibilities of this simple operation are great, and we have little doubt that it will soon be generally practised.

DR. G. STERLING RYERSON has returned to practice after a two months' sojourn in Jamaica.

the intestinal tract, for so-called "bottle-fed" children, for those whose power of assimilation is impaired by over-feeding, and for many other disorders hitherto ascribed to teething. Much discussion has arisen concerning the basis of such a table. Prof. Seibert, the originator of this table, makes the weight of the child (naked) the proper

guide to the amount of food. The author does not claim that the exact quantity can be prescribed; nor is it necessary, since nature has provided the child with the power of enduring limited deprivations and excesses. We may be sure then that a table founded on experience obtained from a very large number of cases, will give and does give genuine satisfaction. It will certainly be appreciated in the absence of any other.

Dr. Seibert insists that the bottle used shall not exceed the one indicated by the child's weight as given in the above table, as he holds that the *weight*, and not the *age*, should determine its food proper.

DIPHTHERIA IN CHILDREN.

From Prof. Winters and others, I got the following ideas relative to the treatment of the above affection:

R.—Tr. ferri chlor., ̄ jss.
Glycerini, ̄ iijss.

Sig.—̄ j. every hour.

For a child from three to five years:

R.—Tr. ferri chlor., ̄ j.
Kali. chlor., ̄ jss.
Glycerini, ̄ ij.

Sig.—̄ j. every hour.

Bring a sulphur candle for ten or fifteen minutes every hour. Though disagreeable to the nurse, the sulphur process will increase the secretions and make breathing and swallowing easier.

Oil of eucalyptus ̄ jss., and water O ij., are heated in a croup kettle. The steam is inhaled for ten minutes every hour. A hot poultice of flax seed, covered by a dry flannel, is applied every half hour to the throat under and behind the jaw. Over the poultices oiled silk is placed to retain the warmth and moisture.

Heart failure is greatly to be feared, even after apparent recovery. To avoid this, the recumbent position is advisable until absolute recovery takes place. This same care should be taken in mild as well as in severe cases, the patient remaining in bed till the pulse becomes normal.

Calomel in ̄ gr. doses is given to promote regular evacuations of the bowels. The use of iron is necessary, and to obtain the best results it must be given in large doses every hour, both day and night, awakening the child, if necessary.

Stimulants should not be given early in the disease, as they would be less effective when most needed. They should be used without limit when the pulse is slow and irregular and the secretions begin to fail.

For a child of two years:

R.—Sp. frumenti, ̄ jss. to ̄ iij.
Sig.—Every hour.

The stimulant should be given with food. Concentrated nourishment, in the form of artificially digested food, may be introduced into the rectum. Prof. Siebert claims immediate and almost specific results from the injection of chlorine water (1 in 150) into the tonsils or sides of pharynx by means of hypodermic syringe. He uses ice packs, instead of the poultices, and mercurial ointment externally. In using the chlorine water, from two to five drops are injected. Its action is local. Acetic acid is now receiving some attention for this disease. In an experiment lately demonstrated in the Polyclinic in regard to the therapeutic value of chlorine and acetic acid, conclusive results were obtained. Blood serum and gelatine (after Koch's method) were used as a cultivating medium for the microbes. This was placed in three test tubes. A piece of diphtheritic membrane obtained from the pharynx was divided into three parts. One was dipped into the gelatine preparation just as it was; the second piece was first placed for two seconds in chlorine water; while the third was for the same length of time in a 5% solution of acetic acid, both being then placed in the gelatine. Microbes developed only in the first tube, showing the power of the chlorine water and acetic acid as antiseptics. Peroxide of hydrogen is recommended by Drs. Major of Montreal, Elder, of Seaton, Ill., and Hope, of New York. It may be used in full strength. It is perhaps best used in the form of a spray. It possesses the following advantages (1) it is not poisonous and may be taken into the stomach; (2) it gives no offence to taste or smell; (3) It is antiseptic and deodorant; (4) It dissolves the false membrane; (5) it is not incompatible with other remedies.

In treating diphtheria it is usually granted that it is bad practice to remove the membrane by force, so leaving a raw surface open for infection already present.

DIAGNOSIS AND TREATMENT OF METRORRHAGIA.

—In a paper read before the British Gynecological Society, Edis (*Br. Gyn. Jour.*) lays special stress, says the *Univ. Med. Mag.*, upon the exclusion of constitutional conditions in the diagnosis of uterine hæmorrhage. Such conditions may arise from heart, liver and kidney disturbance, especially in the menorrhagic chlorosis of young girls and in climacteric floodings. Among the various local causes of metrorrhagia he considers one of the most frequent to be, retained products from incomplete abortion, and refers to a dual cause often producing bleeding which is obstinate and excessive, owing to its added character. This he exemplifies by a villous degeneration of endometrium added to a previously existing intra-mural fibroid.

The treatment of metrorrhagia, or menorrhagia, is divided into the constitutional and local. The constitutional condition requires the administration of cardiac sedatives, cholagogues, diaphoretics and purgatives; and in menorrhagic chlorosis, potassium bromide during the periods, and iron and strychnia between them. Where local cause exists, he advises immediate exploration and removal of cause, avoiding tampons. Where there is retained placental tissue the curette must at once be used if there is severe hæmorrhage or offensive discharge. Of the few reliable remedies to check uterine hæmorrhage, ergot, *hydrastis canadensis* and *hamamelis* are the most efficient, with quinine and strychnia in systemic depression, and *digitalis* and iron in heart cases, and in myoma. The use of ergot is always to be avoided when there is any foreign body in the uterine cavity.

In the discussion which followed the reading of this paper, Fancourt Barnes spoke of retained placental tissue as a frequent cause of uterine hæmorrhage, and advised removal, using the finger as the safest curette, followed by thorough application of a solution of iodine. Hugh Fenton suggested electricity, the continuous current, in obstinate cases. Heywood Smith advised the application of the solid nitrate of silver, after curreting for retained membranes, and spoke of a case in which, in the treatment of a fibroid, the continuous current had started a hæmorrhage. Inglis Parsons favored hot douches where no cause for hæmorrhage could be found. The positive elec-

trode he considered superior to ordinary caustics. Bantock laid stress upon the use of saline aperients, and iron and ergot in young subjects. In cases where there was retained placenta and pyæmia developing, he advised the administration of muriate of iron every two or three hours. He spoke of large doses of ergot frequently increasing hæmorrhage when ten minim doses diminished it.

ELEVATION OF THE PELVIS IN ABDOMINAL SECTION.—Dr. Leopold has performed (*Central fur Chir.*) all his abdominal sections recently with the patients' hips elevated. The patient is placed horizontally on the operating-table, with her hips and legs over a flap. When she has been brought under the influence of the anæsthetic the flap is raised, and is kept at the desired angle by the same contrivance as in an ordinary bed-rest. The intestines then fall anatomically toward the diaphragm, the pelvis becoming free of them. No troublesome prolapse of the gut through the abdominal wound during imperfect narcosis can occur. A large flat sponge is placed over the intestines to guard them, and thus eventration of some coils of gut, in order to explore puzzling conditions in the pelvis, becomes needless. The pelvic organs can be seen with ease; the promontory of the sacrum comes into view. The sewing up of a large peritoneal wound after removal of a uterine fibroid can be managed with comparative ease. The by-standers can see all the area of operation. As the operator can get so deep a view of the pelvis, there is no fear of clots or pools of pus and sanies being left behind. The ureters and other structures passing over the brim of the pelvis can be seen; this is often impossible when the patient lies flat on her back. The flap is lowered when the superficial sutures are applied to the abdominal wound. The elevation of the pelvis did not prove prejudicial to patients. Dr. Leopold finds so many advantages in this position that he always operates in severe cases after the new fashion, which was originally recommended by Trendelenburg. The patient's right thigh is a support for the operator when necessary. Sixty-four cases have been operated upon this way.

THE BANDAGE AFTER LABOR.—While the majority of the profession have discarded the abdominal pad in ordinary cases of labor, and indeed have come to look upon the "Binder" with less

respect than formerly, yet it holds its place, and very properly, as one of the essentials to the after-labor toilet. The following from the editorial columns of *The Med. Jour.*, will be of interest. "Before the Obstetrical Society of London, Dr. Herman considered the use of the binder or bandage during the lying-in period, and concluded that its sole utility consisted in the comfort it gives the patient. He did not think it had any effect in keeping the waist measurement small and so preserving the figure of the patient. To counteract the injurious effects of the sudden lowering of the intra-abdominal pressure it should be applied at the moment that evacuation of the uterus takes place. Dr. Gervis said that patients wanted it not so much because it might influence the size of the waist, but for the support it gave to the lower abdomen and its effects in checking any tendency to undue fullness there afterwards. It promotes uterine action and checks hæmorrhage. Non-use of the binder leads occasionally to 'pendulous belly,' and its consequences. When properly adjusted it promotes involution."

TREATMENT OF VENEREAL DISEASES.—For syphilis, there are three methods in use. 1. The radical cure, or Hutchinson's plan: Small doses of mercury are given for a very prolonged period, with a view to prevent the appearance of tertiary or even secondary symptoms. 2. The ordinary London plan: Treat the symptoms of syphilis as they arise, by the internal administration of mercury. 3. The expectant, or Edinburgh plan: Use only local applications to cure the earlier syphilitic manifestations, and avoid giving mercury internally.

Just here it will be interesting to note, for the benefit of those who follow the last plan, the following from *Monats. für Chir.*, as to the duration and method of treatment of syphilis. The plan of treatment employed by Leloir, of Lille, is as follows: The initial lesion is treated with applications of a mercurial preparation. Constitutional treatment, which is withheld until secondary symptoms appear, consists of daily inunctions of from thirty to sixty grains of mercurial ointment, and the first course is continued for a period of from six to ten months. An interval of freedom from treatment, from three weeks to two months is then allowed, and the inunctions are again in-

stituted and kept up until the end of the second year. To prevent the accumulation of the drug, a diaphoretic or a laxative is occasionally given; and in the exceptional cases in which headache or bone pains are severe, iodide of potassium in combination with the bromide is prescribed. After the end of the second year, the course depends upon the severity of the case. If symptoms have been absent for a long period, the inunctions are made every three months for ten days, and then the iodide of potassium is exhibited for several weeks, in doses of from thirty to forty-five grains daily. After the third or fourth year, if there has been absence of symptoms for one year, the inunctions are made twice a year for ten days, and followed by a course of the iodide as before. This plan is continued if the patient is seen after the fourth year.

Leloir avoids the internal administration of mercury, on the ground that it may give rise to unfavorable symptoms, and employs it only when there is some reason why the inunctions cannot be practised. Hypodermic injection of mercurial preparations he seldom resorts to, and then only in hospital patients.

THE TREATMENT OF A RED NOSE.—One-fifth of the cases, according to Unna, are due to acne rosacea, with vascular dilatation; it has often a direct connection with seborrhea of the scalp; this seborrhea should be treated by the ordinary methods.

When acne rosacea is present, Unna administers fifty centigrammes of ichthyol internally, and prescribes at the same time aqueous lotions of the same substance. The following is also used:—

R.—Zinc ointment, 20 grms.
Powdered rice, 5 "
Sulphur, 2 "

Unna also advises punctures of the dilated venous trunk with Hebra's instrument, repeated two or three times a week. The use of ichthyol soap is also indicated. Warm water alone should be used.

THE TEN COMMANDMENTS OF ABDOMINAL SURGERY.—Dr. Griffiths (*Med. Herald*) gives the following. 1. The arrest of hæmorrhage. 2. The avoidance of mechanical irritation. 3. The guarding against infection. 4. The proper apposition

of the edges of the wound. 5. The provision of necessary drainage. 6. To apply gentle pressure to prevent exudation. 7. To give perfect physiological rest. 8. To secure the best possible position of the parts to promote comfort and healing. 9. To provide for hygienic surroundings. 10. To attend to the patient's general health.

TREATMENT OF LARYNGEAL SPASM.—The treatment of spasm of the glottis is often difficult and uncertain in its results, but Sir Morel Mackenzie writes (*Hospital Gazette*) that by setting up a rival reflex the laryngeal spasm may be instantly overcome. The patient need only take a pinch of snuff or black pepper into the nostrils, or if neither can be obtained, the nares should be tickled by a feather. The immediate result is a paroxysm of sneezing, after which the breathing is relieved.—*Med. News.*

KELOID.—In the treatment of small keloid growths, Dr. Browning (*London Med. Rec.*), has obtained satisfactory results from the application of perchloride of mercury in collodion (1 in 30). The tumor is thickly coated with this application, which is allowed to remain on until it peels off, which usually takes 5 or 6 days. Another coating is then applied, and so on, until by successive coatings, the growth is reduced to a level with the surrounding surface.

ETHER INJECTION FOR NEURALGIA.—Dr. Kunes, of Antwerp, has conceived the plan of using subcutaneous injections of ether in the treatment of neuralgia. He prefers to use Hoffman's anodyne, containing equal parts of ether and alcohol. He injects as near the seat of pain as possible, a quantity equal to what an ordinary Paravaz syringe will hold. Often a single injection has sufficed, but in a certain number of instances, two or three have been found necessary.

THE CURE OF HYDROCELE.—Prof. John A. Wyeth always cures hydrocele by injections of pure carbolic acid. All the liquid must be first drawn off with an aspirator. About thirty minims of carbolic acid is a sufficient quantity to sear the sac. This is not as painful as might be supposed. The first effect is to cause swelling, which soon subsides. In fifty operations two cases only have failed to be cured by the first injection.

A REMEDY FOR PHTHEIRIASIS.—There is certainly no lack of remedies for phtheiriasis (*Med. Press*) but the simpler plans are often those last thought of. One of the best washes for the removal of the ubiquitous parasite from the hairy parts of the body is a decoction of quassia to which a little borax and glycerine have been added.

FOR IRRITABLE BLADDER.—Prof. Bartholow, whom the whole profession sympathize with on account of his failing health, induced by long-continued over-work, says that gelsemium will often do more good in irritable bladder than any other remedy. It is especially adapted to those women of hysterical type, troubled by irritability at the neck of the bladder calling for constant urination.

LAWSON TAIT, *Cleveland Med. Gaz.*, lays down this rule: If pain precedes menstrual flow, it is tubal; if the pain follows the appearance of the flow and chiefly referred to the back and spasmodic in character, it will be found to be due to some mechanical obstruction in the uterus. Sterility following this symptom should be treated by dilatation. When the menstrual epoch is unaccompanied by pain, dilatation will not avail.

LASSAR'S PASTE.—The following is the celebrated Lassar's paste. It may be applied directly by the finger or on strips of cloth. Its usefulness is best seen in many varieties of eczema and interbrizzo:

R.—Acidi salicyl., ʒ js.
 Zinci ox., ʒ ij.
 Amyli, ʒ ij.
 Vaselini ʒ ij.—M

ARSENIC IN CYSTIC GOITRE.—Dr. Snow (*Brit. Med. Jour.*) speaks highly of arsenic in cystic affections of the thyroid gland. In one case in which he employed the drug, the thyroid enlargement entirely disappeared. In two other cases the improvement was very marked in a short time, but the patients ceased attending very soon after the treatment was beginning to show its influence.

DR. EWART lately showed (*Lancet*) at a meeting of the medical society of London, a woman, aged 48, who was the subject of complete situs inversus viscerum. The abdominal organs had been mapped out. She was right handed and complained of nothing but palpitation and dyspepsia.

NIGHT SWEATS.—In *Rév. Gén. de Clin. et de Thérapeutique*, we find the following formula, which may be useful to some of our readers, who, on account of the subsequent increase of cough, or some other reason may not be able to use atropine :

(a) R.—Sulph. or tannate of quin., gr. xv.
Powdered ergot, . . . gr. xxx.—M.

Divide into four powders and take two or three in the course of the day. This is also valuable in cases having a tendency to hæmoptysis.

(b) R.—Powdered agarcine, . . . ʒj.

Make into four powders and take one at night.

(c) R.—Powdered agarcine, . . . ʒj.

Powdered belladonna root, gr. vij.—M.

Divide into four powders, take one at night.

(d) R.—Powdered agarcine . . . ʒj.

Tannin, . . . ʒj.—M.

Make into four powders and take one or two during the day.

A YOUNG practitioner, after some four or five years' practice, took to himself a wife, and being desirous of combining business with pleasure, he decided to spend the honey-moon in Chicago, and while there take in the Polyclinic on abdominal and pelvic surgery, and on his return quite innocently remarked that he had had more experience with the *abdomen* and *pelvis* during those two weeks than he had had for five years previously !

MALE NURSES.—Among the names of the first graduates of the new training school for male nurses, New York, we notice those of R. Hood, London, Ont., and J. E. Maund, of Toronto. We wish them every success in their new profession.

Books and Pamphlets.

DISEASES OF THE EYE. By Edward Nettleship, F.R.C.S., Ophthalmic Surgeon to St. Thomas's Hospital, etc. Fourth American, from the fifth English edition, with a chapter on Examination for Color Perception, by William Thompson, M.D., Professor of Ophthalmology, in the Jefferson Medical College. Philadelphia : Lea Brothers & Co. Toronto : Carveth & Co. 1890.

This American edition is up to the latest developments of the specialty of the eye. There have been not a few important changes in, and additions to, the original text as found necessary by

the editor. While the work is really intended for the specialist, it may be read with great profit by the general practitioner who attempts to deal with the simple diseases of the eye, and also by students who are engaged in the study of such diseases during their hospital course.

ESSENTIALS OF PRACTICE OF MEDICINE, ARRANGED IN THE FORM OF QUESTIONS AND ANSWERS ; PREPARED ESPECIALLY FOR STUDENTS OF MEDICINE. By Henry Morris, M.D., Late Demonstrator Jefferson Medical College, Philadelphia, etc., etc.; with a very complete Appendix, on the Examination of Urine, by Lawrence Wolff, M.D., Demonstrator of Chemistry, Jefferson Medical College. Philadelphia : W. B. Saunders. Toronto : Carveth & Co. 1890.

This is a double number, and contains the most important points as to definition, causes, symptoms, pathology and morbid anatomy of the principle diseases. We can commend it as one of the best of a good series. In the same series we have received

A COMPEND OF GYNÆCOLOGY. By Henry Morris, M. D., Late Demonstrator of Obstetrics and Diseases of Women and Children, in the Jefferson Medical College, Philadelphia, etc. with forty-five illustrations. Philadelphia : P. Blakiston, Son & Co. Toronto : Carveth & Co. 1891.

A very useful compend based upon the works of Skene, Emmet, Goodell, Thomas, etc. Dr. Morris' name is sufficient guarantee of its being one of the best works of its kind on the subject that can be produced.

KOCH'S REMEDY IN RELATION SPECIALLY TO THROAT CONSUMPTION. By Lennox Browne, F. R.C.S. Ed., Senior Surgeon to the Central London Throat, Nose and Ear Hospital. Author of "The Throat and Nose, and Their Diseases," etc. Illustrated by thirty-one cases and by fifty original engravings and diagrams. Philadelphia : Lea Brothers & Co. Toronto : Carveth & Co. 1891.

A Good Opening for a Physician.

THE ADMINISTRATORS of the late James McLaughlin, deceased, offer for sale his late residence, together with three-and-one-half acres of land in the village of Fingal, in the County of Elgin, situated in the centre of one of the very finest agricultural districts in Ontario.

The late doctor had a very large and lucrative practice. This is a rare opportunity for a good doctor. The property will be sold on easy terms. Apply to John McLaughlin, Fingal ; or, David McLaws, St. Thomas.

JOHN McLAUGHLIN, } Administrators.
DAVID McLAWS, }

St. Thomas, Mar. 21st, 1891.