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## The Northern Lancet And Pharmacist.

*Glean from the journals of the World all that is new in Medicine, Surgery and Pharmacy, placing monthly before its readers in a condensed form Medical, Surgical, Obstetrical and Pharmaceutical advances in both hemispheres.*

WINNIPEG, OCTOBER, 1890.

### WINNIPEG GENERAL HOSPITAL NOTES.

BY W. S. ENGLAND, M.D.  
Medical Superintendent.

Two cases of the Furneaux-Jordon's operation for sarcoma of the femur.

CASE 1.—J. V., aged 28, farmer, was admitted to the Winnipeg General Hospital, June 17th, 1890, under Dr. Ferguson, complaining of pain in his right knee and swelling extending up the thigh.

About six years ago, the patient noticed a tender spot upon the inner side of his right knee joint. This gave him considerable trouble at the time and has continued to trouble him at intervals ever since.

During the early part of December, 1889, he experienced a cramp-like pain in his knee which would shoot up the thigh and down into the calf of the leg. This did not completely disable him till March 6th, 1890.

Early in April he noticed considerable swelling of the thigh immediately above the knee joint. The swelling was confined to the outer and anterior part of the femur. It was hard and unyielding but not particularly tender.

Later on the joint itself became swollen and puffy. Since then he has suffered from severe attacks of pain in the lower part of his right thigh but no starting when at rest. The patient is able to bear his weight on the leg without pain, but experiences difficulty in walking from stiffness of the joint. The glands of the groin became enlarged after the application of dry

blisters to the thigh, but these soon subsided.

Since last April he has lost 28 pounds in weight, and at present is emaciated and pale. Cachexia is beginning to show itself decidedly. The skin is dry and warm; eyes dull and heavy; pulse 120, regular and moderately full; respirations, 20; temperature, 100.5° F.; tongue coated, digestive powers good, urine normal.

On examining the right leg the knee joint is found pouched, the patella movable and floating. Fluctuation over the joint is well marked. The thigh is enlarged nearly as high as the trochanter major, the swelling being most marked on the outer and anterior surfaces and about six inches above the joint. The swelling appears to be deep seated, probably connected with the bone. The skin and subcutaneous tissues covering the tumor appear normal and are freely movable over it. The knee is slightly flexed. The patient complains of pain in the thigh, which is dull and aching being worse after exertion. There is tenderness on pressure over the internal and external condyles of the femur; no point of fluctuation over the thigh; no enlarged veins over the tumor. The measurements of the right thigh as compared with those of the left show an increase in circumference of 1½ inches over the patella, also 3 inches directly above the patella 3½ inches at the middle of the thigh and ½ inches at the gluteal fold.

June 18th: The knee joint was aspirated and a considerable quantity of a greenish yellow fluid was withdrawn. This being examined under the microscope showed numerous large and small round uncleated cells. A few drops of bloody serum was also withdrawn from the thigh which contained similar cells. Chloroform was given and an exploratory incision was made down to the bone. The bone was found rough and eaten into by the new growth. Scrapings removed, under the microscope, showed large nucleated round cells contained in a thin fibrous stroma.

June 19: After explaining to the patient the seriousness of his case if left alone and the great danger of a high operation on the thigh, the patient decided to accept

the latter. Chloroform was given and Dr. Ferguson proceeded to do a modified Furneaux Jordan's operation, by sawing the femur off at the circular incision before attempting to dissect out the upper extremity of the bone. Hemorrhage was controlled as well as possible by Jordan Lloyd's method, besides both hands grasping the thigh tightly. As large blood vessels were cut they were caught and tied as rapidly as possible. There was pretty copious hemorrhage. The operation was completed within  $\frac{3}{4}$  of an hour and the patient removed to his bed. Hot bottles were applied to the body and extremities and stimulants given freely. He came out of the anaesthetic for a short time when he rapidly sank into a comatose state and died from shock about six hours after the operation. On examining the femur the periosteum was found about  $\frac{1}{2}$  inch thick and the growth extending from it into the surrounding muscles, the bone itself was honey combed superficially.

CASE 2—A. McC——, aged 30, married, was admitted to the Winnipeg General Hospital, July 14th, 1890, under Dr. Ferguson complaining of a tumor on the left hip. The patient's previous health had been very good and there is no family discrasia. The history of the case is somewhat obscure as the patient met with an accident about 8 years ago, having been thrown from a buggy, and receiving a comminuted fracture of the leg. During the same year she noticed her thigh stiff on bending forwards. This stiffness gradually increased and for the last three or four years she has suffered more or less pain about the thigh. About a year ago she first noticed a distinct tumor at the upper and outer part of the thigh. This growth has gradually increased in size since. The patient has suffered considerable pain, of a dull heavy character in the thigh since then and has become very much emaciated. At present she is pale and the skin gives a suspicion of cachexia nutrition poor, pulse 80 regular and full; temperature 98° to 100° F.; bowels regular, urine normal. There is a large tumor involving the upper third of the left thigh which is most pronounced at the anterior and outer surfaces. And

extends from the junction of the upper and middle thirds of the thigh nearly to the crest of the ilium; laterally from the middle of the groin in front to the great trochanter behind.

The tumor is smooth and uniform on its surface and its boundaries apparently well defined. The skin covering it contains a plexus of dilated veins; no adhesions exist between it and the tumor. It is hard and resisting above but soft and semi-fluctuating below and at the outer side. There was no evidence of secondary growth in any of the serous viscera.

July 15: Chloroform was given and an incision about five inches long was made over the outer surface of the tumor when a large cyst cavity was opened which was found to contain masses of gelatinous material together with new bone formation. The upper extremity of the femur was found extensively eaten into and very soft, so that a good part of it readily came away by aid of an ordinary table spoon. The cavity was packed with iodoform gauze and the thigh sutured and dressed antiseptically. Parts of the tumor being examined microscopically it was found to be of the nature of mixed celled osteosarcoma with cystic degeneration.

July 21: Dr. Ferguson decided to operate to-day. The patient took a hearty breakfast and a light dinner. Later on she was given an enema of brandy and peptonised milk and before the operation a hypodermic of morph. sulph. and atropine was given. Ether was given and the leg prepared. All the blood of the extremity was driven into the body by an Esmarch's bandage and hemorrhage was guarded against by Jordan Lloyd's tourniquet, also an assistant endeavored to control hemorrhage by means of both hands grasping around the thigh tightly. The large vessels were caught and ligatured as soon as possible. The operation was performed very rapidly and the amount of hemorrhage was small.

The stump being dressed she was removed to a warm bed and given stimulants by hypodermic injection freely, but died from shock 2 $\frac{1}{2}$  hours after the operation; first having only rallied very

slightly from the anaesthetic. No autopsy.

TRAUMATIC GANGRENE.

CASE 3.—J. B., aged 32, lumberman, was admitted to the Winnipeg General Hospital under Dr. Ferguson, July 1st, 1890, suffering from fracture. On the 29th prox. about midnight while hauling at the towline of a moving tug (Lake of the Woods) the patient got his left foot entangled between it and the boat, bending it nearly at right angles with the leg and causing a compound fracture of both bones in their lower third. He went to Rat Portage as soon as possible, where he was attended by a physician, the leg being put in a box splint and cold fomentations applied. The patient arrived at the hospital early this morning much chilled and fatigued from his long journey. He complains loudly of pain in his foot and leg. On examining the leg a compound fracture of both bones in the lower third was made out; the fibula protruding through the skin: the leg is much swollen at the seat of the fracture, and appears cold. It is dark red in color, which discoloration gradually disappears going up the leg. The toes and foot are cold and blue. No pulsation can be made out in the arteries below the site of the fracture. The patient is a strong well nourished man, pale and looks care-worn. The pain being severe hypodermic injections of morphia were given when required. Ex; amputation of organs with negative result; temperature 99°-100° F.; pulse 100 regular and full. The box-splint was removed and the leg put in the most favorable position and hot fomentations applied. After continuing with the fomentations for nine hours there was seen to be no hopes of re-establishing circulation in the foot, so amputation was decided on. At 5 o'clock p.m. chloroform was administered. The leg having been prepared, an Es-march's bandage and tourniquet was applied about the thigh. All the tissues below the knee being involved a Carden's operation was performed. Bone drains were used and the stump dressed antiseptically. July 5, the patient complain-

ed of pain in the stump; temperature ranging between 98.5° and 101° F. The dressings were removed when a few vesicles with clear serum were found on the anterior flap. A few stitches were removed and the stump re-dressed. The patient did not rest very sound at night-time for the next week and several times removed his dressings during sleep. A small slough formed on the anterior flap near its centre which was subsequently removed leaving an ulcer over the end of the bone. He left hospital August 14th in this state. About three weeks later Dr. Ferguson found it necessary to remove a second piece of the lower end of the femur and close up the ulcer, after which the leg healed rapidly and the patient began to go about.

MANITOBA MEDICAL ASSOCIATION.

An extraordinary meeting of the Manitoba Medical Association was held in the Council Room of the City Hall, kindly lent by the Mayor for the occasion. Drs. Steep and Hutton were elected members of the Association. The following is the President's address, which, owing to unavoidable circumstances, he was unable to read at the meeting.

Gentlemen:

I thank you sincerely not only for the honor you have conferred upon me by electing me for your president, and also for the pleasure which it affords me of offering you all a most cordial welcome to this our first meeting as the Medical Association of Manitoba.

I also express this earnest hope that the present as well as subsequent meetings of this Association will be full of interest and profit to the medical profession of this new Province, individually and collectively, in advancing the cause of medical science, in upholding the honor and dignity of the profession, and also the advantage of the mutual improvement of its members by discussions on the various interesting subjects which will from time to time be discussed. I look upon a meeting like the present, as a great

exchange, better by far than exchanging gold for silver or silver for gold, but an exchange where gems of thought and jewels of scientific research of the most brilliant lustre are exchanged for others of equal brilliancy and intrinsic worth, each contributor giving and receiving an amount of good which cannot be estimated.

I will beg your indulgence if I now refer to the position of our noble profession as it now stands throughout our Province. At no period of the history of our country, since its accession to the British Crown, has the medical profession been in a more favorable position than at the present day. At no period of its existence has it been so well organized especially in Manitoba and Ontario and consequently so well prepared for dealing with all questions affecting our future work for the public good. In the question of medical education I would venture to say that in no other province of the Dominion is a higher standard of medical education required than in Manitoba, and the M.D. of our University, which is accepted by our medical council is a sufficient guarantee. Its holder is qualified technically, though not legally, to practice in any part of the Dominion or of the Empire or United States, I might say at once in any part of the world where the English language is spoken.

I might here suggest that some action be taken with a view to secure a uniform license for the Dominion to which we would be willing to agree if it were made on equal footing. It seems strange that a graduate of Manitoba University who wishes to practice in British Columbia or in Ontario should be obliged to pass another examination and pay another registration fee as well. If each province were represented by its medical council on the Board of Examiners probably a way would be found of overcoming the difficulty, honorable to all and to the advancement of the medical profession. The older provinces would be more benefited by a reciprocity in this respect than Manitoba, as probably a much larger number of medical men would be found desiring to reside and practice in this

province from other portions of the Dominion than would be found of Manitoba medical men desiring to practice elsewhere.

I will venture further to assert that in no other country is there such an amount of self denying zeal shown by medical practitioners in order fully to prepare themselves for the performance of their duties to their patients by keeping abreast with the very latest and most advanced methods of treatment. Every year finds some of our men journeying to England, France and Germany to study the methods adopted by those great master minds of the medical profession either as general practitioners or specialists. Others take advantage of the clinics of New York or other places of celebrity. All honor to such men in this or any other part of our Dominion who voluntarily sacrifice so much time and means to qualify themselves for the general public good. No other learned profession can show such a life of self denial and so much self imposed labor to qualify them to relieve pain, heal the sick, prevent disease and advance the happiness of the human race. It is a matter of regret that a post-graduate course is not within the reach of all medical men. I would suggest the necessity of a Provincial medical library and museum, for the benefit of the profession. The medical library lately established by the Ontario Medical Association has been highly appreciated by the medical men there. I hope to see a similar establishment here in Manitoba with the addition of a museum to assist in pathological research. Here again we refer to our idea of exchange. The gold miner works down in the mine digging up the ore, it passes from one workman to another until the die is struck upon it and it is put in circulation. So in the ever-advancing progress of medical science with its yearly gaining of activity we find the miners in every department searching for new materials, proving new facts, or testing new applications; we find some at the dissecting table with microscope and scalpel tracing out the most minute structure of the human body; others searching

for remedial agents to cure disease, and remove pain; and all combined to discover the cause of disease.

The scientist with crucible and test tube analyses every remedial agent and even testing their effects on living animals, to prove their action on living men. Others again are searching for antiseptic lotions and surgical dressing for wounds, the better to promote healing and prevent infection. From labors such as these mentioned the gems are mined and prepared. They are put in use by the great army of workers, at the sick bed of the old and young, by the side of the wounded, by night and by day, throughout the whole civilized world. The sick, suffering or unfortunate receive the benefit of every new discovery in the science of medicine and surgery. The ratio of mortality of many diseases have been very materially reduced. Fertile sources of disease have been removed, and by improved sanitary arrangement the danger of sweeping epidemics in a great measure averted, and the homes of thousands in our large cities rendered as safe and healthful as country vilas. Much as has been done by the vast strides of medical science in the last two decades there yet remains much to be done in our beneficent field of labor. How important then for each of us to contribute to the general fund of knowledge some useful facts from our own observation and study. Meetings such as the present give us the opportunity. The love of our profession affords the stimulus, and the benefit to suffering humanity is our reward for what we may do in advancing our science or increasing our usefulness. The labors of medical associations in England, the United States and Canada have been eminently successful as a means of unifying and ennobling the profession in those spheres of labor. We hope to achieve the same measure of success here.

Dr. Good read the following paper:

I propose making a few remarks on the subject of posterior pharyngeal growths, variously known as pharyngeal adenoma adenoid tissue situated in the upper part of the posterior pharyngeal wall and

vault of the pharynx, hypertrophy, of the pharyngeal tonsil of some authors. Symptoms are as follows: The child has a vacant look, the mouth standing open nasal respiration being imperfect or absent. Eating and drinking are done rapidly, the patient interrupting the process frequently in order to take a long breath through the mouth. Sleep is much disturbed and snoring very commonly present, the mouth standing wide open, the secretions of the mouth drying on the teeth, micrococci accumulate and favor the development of dental caries. The voice is characteristic of nasal obstruction. Deafness is commonly present. Intellectual torpor is frequently present. The soft palate is rigid and fixed. Posterior rhinoscopy reveals the presence of the growths. Where this can not be practised the introduction of the finger removes all doubt.

Treatment: Removal by finger, ring knife or Lowenberg's forceps modified by Woakes.

The finger is unsatisfactory, the ring knife suitable in many cases but in the large majority the careful use of the sharp forceps guided by the finger yields the best results. All violence should be carefully avoided and great care taken to not injure the pharyngeal orifices of the eustachian tubes which may cause permanent deafness. The galvano-cautery has yielded some good results. Some after-treatment is generally needed as the application of nitrate of silver or alcohol and tannic acid and not unfrequently the use of Politzer's bags, in order that the deafness may be relieved. I have operated on cases ranging from nine months to eighteen years.

In reply to Dr. Higginson, Dr. Good said he did not lay any special weight on the use of nitrate of silver as he sometimes used tannic acid and had no doubt the intelligent use of any astringent would yield good results. His results from the nitrate were, however, so satisfactory that he had a great liking for its use. The galvano-cautery used subsequently in those who could tolerate it would, however, give more positive and satisfactory results.

Dr. Higginson said in regard to Dr.

Good's paper he deprecated the use of nitrate of silver in chronic cases of pharyngitis as he always found it to produce acute congestion. In the acute stage he knew no better astringent than nitrate of silver.

#### SURGICAL HINTS AND CASES.

BY DR. A. H. FERGUSON.

Mr. President and Gentlemen.—The recent advances in surgery have been so rapid, broad and deep, that to keep track of grasp and fathom, needs the undivided attention of a surgeon.

New facts are constantly supplanting old theories, improvements in the technique of surgical procedures are almost of daily occurrence, and aided by the allied sciences particularly that new branch—Bacteriology—many a dark medical corner has been so illuminated as to be accessible to surgical interference. An attempt therefore to present to you intelligently all the advances in surgery that has come even under my own notice the last few years, would make a very lengthy paper and take up more of your valuable time than could be allotted to me on this occasion.

I wish, then, to limit my effort to a few practical hints, and to the report of a few cases, that I have recently managed.

**SURGICALLY CLEAN.**—What do I mean by this term "surgically clean?" It has a social, relative, and a scientific meaning, varying with the mode of living, customs, habits, and with the surgeon's early scientific and professional training, some of which I do not wish to discuss.

I well remember, however, when a boy at school, of my teacher sending the same children home again and again, to wash their hands and faces before being allowed to sit with the rest of us. They invariably protested against the charge of being dirty, and thought they were being harshly dealt with. "Would that we could see ourselves as others see us," applies to the medical man who attempts to carry out antiseptic surgery without a thorough knowledge of the subject. It is not long since I witnessed a physician operate. So many breaks were made in the antiseptic chain, that I ventured to

ask him if he were taking antiseptic precautions. "Oh, yes," was the reply, "I received my antiseptic instructions twelve years ago," so saying he dropped an artery forceps in a dirty basin and placed one hand on the operating table. I afterwards learned that the wound healed by second intention, with the formation of good laudable pus, and no wonder, when that same dirty hand and instrument without being cleansed were used to complete the operation. "You see," says another, "that I am taking every precaution against sepsis,—my instruments are placed in a solution of carbolic acid, 1 in 20, and I use sublimated water, 1 in 2,000 for irrigation, but while thus addressing a class, his moustache received the full attention of his left hand, and his right was poked in his pocket for a knife, and without paying further attention to them, he began to operate; pus formed. Still a third said, "I can't see how that septic trouble could spring up? Why I almost invariably—yes, invariably dipped those instruments into the carbolic solution, and they were clean from the instrument room. Gentlemen, I might enumerate these grave mistakes, but suffice it to say that the comparison with the school children who did not know when their hands were unclean is not invidious.

I am more, and more convinced that any one who wishes to do surgical work—operate, assist or nurse, should take a course of training in Bacteriology. No one without such training can realize how easy it is to infect his agar or gelatine in course of preparation, and in a moment spoil the work of days. It is just as easy to inoculate an open wound, infect the peritoneum, or spoil an operation.

It is only by a special practical study of the nature of bacteria that all necessary precautions can be intelligently carried out. I am told by Dr. Hutton, late house surgeon to the Garfield Memorial Hospital, D.C., that Dr. Halsted, Prof. of Surgery in Johns Hopkins University compels his head nurse to take a practical course on Bacteriology, that she may know, and teach those under her, the whys and wherefores in connection with antiseptic surgery.

It is not sufficient, for instance, in

dealing with the hands to wash them thoroughly with soap and water, then in some solvent of fat, and an antiseptic solution, but they must be kept aseptic. Should it be imperative to handle anything that has not been rendered surgically clean, they should at once be washed in an antiseptic solution, before touching the wound, instruments or dressings, and should not be allowed to get dry.

The instruments are best and most easily prepared by boiling them in water for not less than forty-five minutes. An instrument may be required that has not been properly prepared, or a surgeon may be called upon to operate without previous notice. Under these circumstances if they are thrown into absolute alcohol they are rendered surgically clean in a few seconds.

*Sponges* are being less used than formerly. Gauze has the advantage that it can be sterilized, and need not be used a second time.

*Silk* prepared with sterilization or antiseptic solutions has very materially taken the place of catgut, except in some special operations.

*Dressings* should be antiseptic or aseptic by sterilization. For general minor surgery and cases of emergency, it is best to have some prepared antiseptic dressing on hand. When a carbolated or sublimated dressing is applied in a moist condition, a dermatitis is almost certain to be caused in children, and the adult does not always escape it. This disadvantage is most marked in abdominal cases, as the pyrexia caused thereby gives rise to needless alarm. I have experienced this in a number of cases at the Winnipeg General Hospital. The father of antiseptic surgery—Sir Joseph Lister has quite recently produced to the profession a dressing which I here show you. It is claimed to be efficient and non-irritating. The words of that gentleman are "I have for some time past employed for this purpose a combination of the two cyanides of zinc and mercury, which appears to fulfil the requisite conditions of antiseptic efficiency and due storage of the agent in spite of free discharge together with absence of irritating prop-

erties."—(*Br. Med. Journal*, Aug. 16th, 1890.) Were it not so expensive I should use it extensively. My experience with it is confined to about a dozen minor cases, the largest being a lacerated wound at the wrist joint, produced by a circular saw partially severing the flexor tendons, which healed under one dressing without any irritation.

For hospital work sterilized gauze is efficient and non-irritating. It has the disadvantage that it must be removed as soon as it becomes saturated with the discharge from a healthy wound. If left on for even a day or two after this it is liable to act as a culture medium for germs and become contaminated throughout, and secondarily infect the wound. Antiseptic dressings are very extensively used in Britain, while in Germany the aseptic material is more employed. How long should the first dressing be undisturbed? This practical point gave me many a time no small amount of anxiety and trouble. It depends upon the kind of material used, antiseptic or aseptic; upon the nature and locality of the wound; upon whether a non-absorbable drainage tube or none at all is utilized; upon the amount and character of the discharge; but when put up with no drainage tube, or one that is readily absorbed, it then depends upon the absence or presence of constitutional or local symptoms. I have had to remove a dressing within a few hours, and again I have left one on for three months.

When an operation is performed on any part of the body where thorough antiseptic precautions can be carried out, union should take place by first intention under one dressing, e.g. amputations of the extremities, breast, etc. Should pus form, the surgeon can almost invariably trace the cause to some defect in his precautions. When a large bone is gouged out for caries or necrosis, quite recently Schede, of Hamburg, allows the cavity to fill with a blood clot, sews the skin over it, or, if this can't be done, simply covers it with oiled silk, over which an abundant dressing is applied, which is not disturbed for one, two or three months. I have tried this in one case, J., whose tibia (upper third) I gouged out on the 17th



of Sept. ult., and applied an antiseptic dressing which I do not intend to disturb for some time. It is now twenty days since and no bad symptoms has arisen.

On March 13th, last, I packed a very large cavity, exposing the upper surface of the astragalus, with decalcified bone, a medium much used by Macewen and Senn, and its dressing was not removed for three months, when it was found all healed over, but still quite soft in the centre. This case, George Reid, is still in the hospital, and improving. I might say by way parenthesis that he had a suppurating synovitis of the knee joint which is now quite well by free drainage, and a pñimosia which was remedied by circumcision. No positive rule can be laid down suitable even to the majority of cases, but every case must be considered by itself, and experience alone teaches a surgeon when a dressing should be removed.

*Drainage Tubes* are becoming less and less used except in such wounds as are unavoidably irritated by manipulations, as in the abdomen or those subjected to strong antiseptic solutions, after which a profuse discharge is sure to follow.

The secret of dispensing with the drainage tube, I take it to be, is in the lessening of the discharge. It is universally used in Britain, but in Germany it is almost completely discarded. Last year I was very much struck with the large wounds closed by German surgeons without a drainage tube, *e. g.* in all amputations and excisions. I have heard it said that Lister is behind in Listerism, and in this connection, it appears to be true. Let me quote from his address before the International Medical Congress, at Berlin, this year.

"In many small wounds, where we used to think drainage imperative, we omit it altogether, and in those of larger extent we have greatly reduced it. Thus, after removing the mamma and clearing out the axilla, I now use one short tube of very moderate calibre, where I used to employ four of various dimensions. But it would be a grand thing if we could dispense with drainage altogether."

Sir Joseph Lister could not have known that the German surgeons, to whom he was thus speaking, had already successfully abandoned the drainage tube.

In a few major cases I have succeeded without drainage. In fact, it has proved successful in every case in which I tried it. In November, 1889, I performed a double amputation of both legs, which healed under one dressing without drainage. In two amputations of the breast, where the axillary glands were cleared out, no drainage tube was inserted, and both healed under one dressing by first intention.

The first of these was a thin, spare woman, operated on at the Hospital, on the 3rd of September last. The dressing was changed on the 10th and found healed. There appeared to be a small amount of serum beneath the skin at one point, but it soon passed away without any oozing. I am not sure that there was any accumulation. The second case, Mrs. D., in the practice of a brother practitioner, was a very fleshy lady, weighing upwards of 200 pounds. The wound was necessarily very large. The operation was performed on the 16th of September, and healed in eight days, without drainage. For about a week longer serum oozed through a slit left for that purpose. While performing these operations I paid close attention to, (1) strict antiseptics; (2) rapid work; (3) the use of no water or solutions of any kind to the wounds, and (4) the wounds handled as little as possible and dried with antiseptic gauze.

Any large wound, that is irrigated, slushed with hot water, or roughly handled, should not be put up without drainage.

I shall now, with your permission, report a few cases:

*Hernia.*—The recent work in connection with hernia, has been directed to effect a radical cure. I shall only mention the two operations of which I have had experience: Namely, that of Macewen, of Glasgow, and McBurney, of New York. I have operated for the radical cure of hernia, five times during the last year, with one fatality. The history, conditions and circumstances of this case were remarkable, and to do justice to it and to

the operation I performed, would make a lengthy paper in itself. I propose reporting it fully at some future time.

Two of the five cases were strangulated and both have been successful and I have the pleasure of exhibiting them to you on this occasion. The one, Mr McLeod, aged 30, was reported in the *NORTHERN LANCET* last October. His hernia came down while pitching sheaves and in two hours it evidently became strangulated, for violent and persistent vomiting then began, which continued for 46 hours until relieved by operation at the hospital on the 22nd of October last (1889).

Considering the taxis he gave it himself, that given by a medical practitioner; the long time it was strangulated; and the distance (36 miles) he had come on a lumber wagon, I often wonder how he had stood it all. I performed McBurney's operation for the following reasons: (1) The sac was inflamed and ecchymosed, most likely infiltrated with germs from the gut, and not likely suitable to form a healthy boss if puckered and secured within the internal ring, as in Macewen's operation, and (2) The bowel being in a suspicious condition, the re-establishment of the circulation might prove too much for its safety or vitality, when of course grave constitutional symptoms would certainly follow, and further interference might be imperative. Under these circumstances the abdominal cavity is more easily re-opened when the wound is packed with gauze.

The second case of strangulation, strange to say, occurred in a little boy, who will be only 3 years of age on the 16th of this month. His hernia, a right oblique inguinal, caused by the straining of whooping cough, when 10 months old, descended under an inefficient truss eight hours before I saw him, on the 10th day of last month. It had all the symptoms of strangulation, and under chloroform, I failed to readily reduce it by taxis, consequently I had him taken to the hospital where I performed a McBurney's operation at 10 o'clock, at night. It is much more difficult to operate on a child than on an adult. These two cases will be exhibited to you, the one I consider an excellent radical cure, as he has been able to do

hard manual work, lifting and pitching sheaves with impunity, without a truss; the other is not quite cicatrized, but I feel certain will effect a cure. Both these cases are ruptured on the opposite side and may require surgical interference later on. The chief points of a McBurney's operation are:—

1. To freely expose the internal ring.
2. To ligature the sac, when the peritoneum is drawn quite tense over the finger before cutting it off.
3. To pack the wound thoroughly with gauze and retain it there with sutures for six or eight days, after which the re-packing need not be sewed in place.

To closely follow a Macewen's operation, one should see himself perform it. The various steps, designed to counteract the pathological conditions of a hernia, are so complete that when I heard the reasons, and then saw him operate, I was perfectly convinced of his method being a radical cure, even before I saw the excellent results he had obtained. Although not suitable to all hernial cases, still in selected ones, I think, it is the most rational and scientific operation yet produced. To do it well, requires this special catgut which I secured from his wards; and these special needles, which I brought from Glasgow.

#### *Dermoid Ovarian Cyst.*—Operation—Recovery.

Bella B., aged 26, referred to me by Dr. Fleming, of Brandon, ten years ago, had puerperal inflammation, and ever since has not been free from pain which was greatly exaggerated during the menses. Previous to Dr. Fleming's examination, who at once correctly diagnosed left ovarian tumour, she had undergone all sorts of treatment, douching, tamponing, burning, cauterizing, etc., without the slightest benefit. I shall not trouble you with the details of the case, nor with those to be found in almost any recognized work on ovarian tumours, but briefly relate and discuss the most interesting and instructive features.

In connection with the diagnosis and indications for operation, the wisdom of passing a small aspirating needle into the mass per vagina was mentioned by one of the consultants, and rather emphatically

said that if pus were found, "at once pass a knife up and there's an end to it." Had this been done quite fluid sebaceous matter, identical in ocular appearance to pus, would have been withdrawn, which would be very misleading and result in a terrible blunder should it be opened per vaginam. But even if an abscess of the broad ligament, I am convinced the proper treatment is abdominal section for removal and drainage.

Upon cutting down through the *linea alba*, a thick roll of fat, the size of one's finger, and closely resembling the omentum, had to be cut away before reaching the peritoneum. I never met with the like before.

After removing the ovarian tumour the question of taking away the right ovary was considered, even though to sight and feeling it appeared normal. I decided, however to follow the advice of Lawson Tait, that if only one ovary is apparently diseased and demands removal, the other also ought to be taken away, because the same process is most likely invading it too. It is well I did so, for here in the specimen you can see the seat of a small cyst, probably sebaceous, which would very likely cause trouble if left undisturbed. Before operating, and while on the table, I judged her condition to be due to the former inflammation she had suffered. But when I opened the large cyst and finding it filled with hair, fluid sebaceous matter and also a tooth in it, I began to doubt my former conclusions, because dermoid cysts are said to be congenital. By far the most interesting feature of the case came up after the operation. The operation was on the 25th of July last. On the 27th, just 54 hours afterwards, her temperature rose to 103° F. As soon as the pyrexia began a brisk saline purge was given, which had only a temporary effect. The abdomen had been closed without a drainage tube, and the only suspicion of septic infection was the using of two sponges, whose condition, I afterwards learned, to have been doubtful. I at once thoroughly flushed the peritoneal cavity under chloroform; with warm sterilized water with two fingers in the abdomen, the adhesions just beginning to form, were broken down by gently moving the float-

ing bowel and omentum, to and fro, up and down until the water returned clear. The ligatured stumps were also felt and found secure. The abdomen was left almost filled with the clean water. A glass drainage tube inserted and the dressing renewed. Three hours after the flushing, her temperature was 105° F.: the abdomen flat; the water absorbed; face flushed; skin dry; restless; heat dyspnoea; but there was no depression; pulse good and not proportionately high; was cheerful, and her general appearance very favorable.

Five grains of antipyrine soon had effect and in a short time she was again normal, and went on to recovery without any disturbance worthy of notice. I believe the temperature would have lowered of its own accord; but to what was it due? It might be accounted for in several ways: (1) The water was fully the temperature of 105° F., and it was all absorbed in a short time. (2) The fibrin forming elements and likely ptomaines were carried to different parts of the peritoneal cavity than where they were forming, thus affording a better opportunity for their ready absorption and causing septicæmia: or, (3) It might be partly reflex in origin. Indeed, I fully believe, that all I have mentioned, were combined factors in its production.

In two months she was able to go to service.

I believe the best after treatment, after every abdominal section, except when the bowels are penetrated, to be, as the patient has recovered from the anæsthetic, and before vomiting from adhesions, tympanitis or other disturbances has had time to set in, to administer saline purgatives. Early purgation has the advantage of starting peristalsis in the right direction, and drains the abdomen of recently formed and accumulating exudations, carrying with them any germs accidentally admitted during operation before they have time to multiply or form ptomaines; it cannot do any harm, and may prevent the necessity of flushing. Although not recommended by any surgeon, that I know of, I can testify to its harmlessness, in my last three cases of abdominal section. Try it.

*Discussion.*—Dr. Good relates his experience in hernia and antisepsis, and asserted forty (40) per cent. of failures according to Bull, of New York, in cases of operation for radical cure of hernia. Macewen, of Glasgow, and McBurney, of New York, had many failures. The operation is on trial. Jacobson says, "forty per cent. of Macewen's cases wear trusses at present." He, (Dr. G.,) performed four operations with one death, and in one case, one testicle sloughed away. Cases cannot be considered as cured till the lapse of 18 months. If there be no return of the hernia in this time, the case may be considered as successful.

Dr. Higginson remarked that after operating for the radical cure of hernia, all patients should wear a support of some kind afterwards, for the following reasons:—

1st. It is a weak point, that is the aperture through which a hernia comes.

2nd As we are depending on a new tissue to make strong that part, and as it requires about 12 weeks for complete cicatrization and as the gut presses forwards during walking, coughing and expiratory efforts, is it not well to give this part some support? thus preventing recurrences.

Dr. Macdonnell stated that in the summer of 1889, at the Winnipeg General Hospital, he made an autopsy in a case of hernial operation, after Macewen's method, done 7 days previously. The post mortem revealed pelvic cellulitis, with no appearance of peritonitis. If one could be justified in forming a conclusion from one case, in which the dressing goes wrong, that cellulitis is more to be dreaded than peritonitis. It would follow that the resisting power of cellular tissue is less than that of serous.

Dr. A. H. Ferguson replied, stating that trusses should not be applied, inasmuch as pressure caused absorption of the cicatrix, which favored a recurrence of the hernia. In all his cases he forbids the use of a truss. With regard to the statement in Jacobson's work, one must remember that Jacobson is English and Macewen Scotch. Macewen does not recommend a truss; but a soft pad for three

months after the operation. Macewen states that he had only one failure, which he attributed to the patient not following his instructions. The source of trouble in the post mortem, alluded to by Dr. Macdonnell, was undoubtedly septic, hence antiseptic precautions are strongly indicated, particularly in this operation.

## SULPHONAL IN THE DISEASES OF CHILDREN.

Read before the Section of Disease of Children of the American Medical Association, at Nashville, Tenn.

BY WM. C. WILE, A.M., M.D.

In the treatment of many of the diseases of children and especially small children, the practitioner is often put to his wits end to get the little patient much needed rest. As a rule those remedies which are adapted to quiet the nervous irritability in the adult, are in the infant, indeed a source of great danger, as the action is ever so much more rapid and lasting. A dose, small indeed, and well proportioned to the age of the little patient often produces the most alarming effects and at times when least expected. Again the after effects of opium are for the most part of such a grave character that this alone would almost bar its use.

The bromides, beside being difficult to administer, are too uncertain to be depended upon in certain periods or great emergencies. Unlike its action in the adult, the infant resists proportionately large doses, and the remedy is given in ever increasing quantities and with the feeling on the part of the doctor, that it is bordering on the dangerous. In fact the use of bromides in early childhood has not been attended with satisfactory results; and has almost gone out of use. In Sulphonal, however, we have an ideal hypnotic for children, and it is certainly and entirely harmless. In a very considerable experience, in its use, both with babies and small children in the last year, I am prepared to say that I have never seen a single instance of bad effects arising from its use. To illustrate how tolerant the system of the child is to the action of

Sulphonal, I will briefly narrate a case a which occurred not one month from this date. I was called in the early evening to the house of a neighbor to see a child who was in convulsions. The child was one and a half years old, and was large for its age. On my arrival I found the baby in a severe convulsion, and I at once administered a ten-grain dose of sulphonal, finely powdered, unloaded the bowels with a large enema and gave a hot bath. The convulsions ceased for half an hour when I told the patient's parents to give another powder in another half hour if he was not quite free from spasms. They had procured six of the ten-grain powders from the drug store, on the prescription and I only intended the child to have two, but the baby continuing restless, the mother kept giving it at frequent intervals until all were taken, and the first knowledge I had of the fact was when the father knocked at my door at four a.m., asking for a prescription for more of the powders, as the envelope in which they had come had been mislaid, and could not be found. In answer to my questions he said the child was not entirely quiet, and had had no more convulsions, but he thought that he needed some more of the powders. I was naturally somewhat alarmed at the dose taken, and at once hastened to the bedside of the baby. I found him in a gentle but profound sleep, from which it was impossible to waken him; though his pulse and respiration were normal, and his temperature a fraction elevated only. He did not arouse from this condition for twenty-four hours though I did not make any very strenuous efforts to get him awake as I considered his condition not at all alarming. When he did awake he cried for something to eat. It is unnecessary to state that he had no more convulsions, and as far as the family and myself could discover did not have any ill effects from the large dose of sulphonal, which had unintentionally been given him. This is analogous to a case published recently in the journal of the A. M. A., where the little patient took large doses, with no other effect than a prolonged sleep. Given in the proper dose and according to the age of the patient, it will quiet the irrita-

bility of teething; prevent oftentimes convulsions, aid in controlling the same; relieve nervous excitement and irritability; and produce peaceful sleep at the will of the doctor. It does not constipate, leaves no sequelae, does not depress the system, nor impair the appetite. In fact, it is accompanied by none of these phenomena which are sure to accompany opium, chloral and the bromides. For the relief of this class of cases, which are the bane of practice, it will produce the best results.

#### INTERNATIONAL MEDICAL CONGRESS—BERLIN.

*Milksickness.*—Dr. J. A. Kimmel, of Findlay, O., read a paper descriptive of milksickness, a peculiar disease met with in the Central Western States of the Union. The cause of the disease is not known, but it seems to prevail in parts of the country newly opened up to settlement, and to disappear from those where the soil has been brought to a high state of cultivation. Animals seem to be more liable to contract the disease when they pasture late at night or early in the morning. The affected animals usually remain immovably in one place, or wander around over a limited area slowly, and holding the head close to the ground. The appetite disappears, and obstinate constipation is the rule. A little later the animals begin to tremble, and this continues for three or four days, at the end of which time they usually die, although the disease is not invariably fatal. Oxen and bulls only are affected, cows being immune as long as they give milk. The virus of the disease is apparently eliminated through the mammary glands, for the disease is contracted by men and other animals that drink the milk from the cows in an infected herd. The symptoms of the disease in man are very constant, and the diagnosis, as a rule, is an easy matter. The first symptom is a feeling of great fatigue, a languor which the patient, no matter how active he may be by nature, is wholly unable to overcome. Following this are anorexia, nausea and vomiting, pyrosis and obstinate constipation. Excessive thirst is a prominent symptom. There is

no elevation of temperature, indeed the latter may even be subnormal, and the pulse is usually unchanged. The skin is dry, tongue moist and coated at the tip. Respiration is difficult and sighing. The thirst is intolerable, but every drop of water that is swallowed is immediately rejected. The abdomen is retracted but is not tender on pressure. Delirium is rarely observed. Little by little the prostration becomes more marked, the patient can move neither hand nor foot, even the eyelids become immovable, and finally the patient dies in coma. The duration of fatal cases is from fifteen to twenty days, as a rule, but when recovery takes place it usually does so in from five to ten days, but convalescence is apt to be very prolonged and tedious. Milk sickness is clearly distinguished from typhoid fever, malarial affections, and gastro enteritis by the entire absence of fever. It is possible, however, to have malarial fever exist as a complication, and then, of course, pyrexia would be present. The treatment usually employed consists in the administration of quinine, alcohol, and other stimulants. The disease in man can in almost every instance be traced to the use of milk, or butter made from it, coming from a cow pasturing with other infected cattle. The pathogenic micro-organism of the disease, if such exist, has never been isolated, but Dr. Kimmel believed that the disease was of microbial origin, and that the infecting parasite was similar to that of malaria, since the disease in cattle was contracted in a manner very similar to that of malaria in man.

#### BRITISH MEDICAL ASSOCIATION.

OPERATIONS ON THE LATERAL VENTRICLES.—Mr. Mayo Robson, of Leeds, read a paper on "Tapping and Draining the Ventricles in Certain Cases of Brain Disease." Looking at the success which has attended opening and draining the abdomen in cases of chronic peritonitis, he had come to consider the question, with what degree of safety can we open the skull cavity in cases of a somewhat similar nature. Thanks to the labors of Ferrier, Goltz, and others, many cases of

brain disease were capable of being accurately localized and successfully treated. In those cases of brain disease, such as meningitis, which were not so definitely localized, and which on the supervention of coma become absolutely hopeless, could we not attempt some surgical treatment with a prospect of success? We opened the abdomen and the pleura, why should we not open the skull and tap or drain the ventricles?

He quoted the following cases which had come under his charge. A boy, aged ten, with symptoms of inflammatory brain mischief, he had a temperature of 103° F.; right hemiplegia and aphasia; twitching of limbs of right side of body; double optic neuritis, etc. He suspected cerebral abscess or basal meningitis, and decided to adopt surgical measures. A.C.E. mixture was administered and the cranial cavity opened with a 1½ inch trephine over the motor centres on the left side. The brain was non-pulsatile, and no puss could be found. He pushed the needle into the lateral ventricle and drew off ten drachms of clear fluid. Healing went on satisfactorily and the patient showed continual improvement. Six months later he was in good health, but had some convulsive seizures of the right arm. These were relieved by bromides, and the patient is at present apparently in perfect health. Drainage could be continued over longer or shorter periods, as long as the wound was maintained perfectly aseptic. He had drained the spinal canal successfully in several cases of syringomyelocoele. He entered into the details of his manner of operating, but these do not differ materially from those usually adopted in operations on the brain. He referred to a case of hydrocephalus which he had treated in a similar way, but without success.

In the discussion which followed, Mr. Bruce Clarke, of London, said he thought the removal of a large quantity of cerebrospinal fluid a dangerous proceeding. He had drained several cases, but they had all proved fatal, and death had resulted in his opinion from the effect produced on the cerebral circulation by the removal of the fluid. He had operated on two cases of purulent basal meningitis, but he

thought that, unless we could devise some means of washing out the cranial cavity, we should not meet with success in these cases. He had given up using the spray and, in fact, did not use any antiseptics at all during the operation, although he did so to the parts previous to commencing.

Mr. Kendall Frank, of Dublin, thought that, as much benefit was derived from simply incising and draining the peritoneum, the same ought to be the case in the brain. He quoted a case in which he tapped the lateral ventricle and drained it, for supposed middle-ear brain disease; the patient died on the fourth day. On making a postmortem examination he found the ventricle almost empty, containing a little bloody serum, but there was basal tubercular meningitis.

Mr. Wheelhouse, of Leeds, spoke strongly against the practice of tapping the ventricle in chronic hydrocephalus. It had fallen to his lot to do it once in the case of a child, who after it steadily sank and died, and he certainly should never do it again. He thought the three cavities referred to were placed under totally different circumstances. After removal of fluid from the peritoneum the abdominal walls accommodate themselves to the altered condition, and the lung fills up the pleural cavity; but the brain cannot expand to fill up the deficiency left by the withdrawal of fluid, so that we cannot hope for the same success in applying the same kind of treatment to similar conditions of the brain.

Mr. Mayo Robson said that he did not mean his remarks to apply to cases of chronic hydrocephalus, but thought that the treatment was justifiable in those cases which ended in coma, and which were otherwise quite hopeless. He said there were many cases recorded in which cerebro-spinal fluid had drained without any fatal result; it was merely a question of gradual instead of sudden withdrawal. He always used antiseptics, and although he did not think the spray essential, he preferred using it in large public institutions, whereas he dispensed with it in private houses. In referring to Kendall Frank's case of tubercular meningitis, he thought

that, as long as it had not reached the purulent stage, there was hope of treating it successfully by surgical proceedings; but once purulent, he could not see how the puss could be washed away. *Medical Record.*

**HYPERTROPHY OF THE PROSTATE.**—Prof. Bottina, of Pavia, read a paper on this subject before the International Medical Congress, in Berlin. After giving some account of his earlier experiences on this subject, he stated that he operated now on any case of enlarged prostate, provided there was difficulty in urination. He had operated on over sixty cases and had lost five. His operations had been on the whole good in their results, but in some instances they required repetition. He displayed his battery and his instruments, together with the method which he adopted, and showed that he could limit the galvano-cautery action to the special part that he was operating on by holding the other parts of the instrument in his hand. The same experiment was tried by others, conclusively showing that the surrounding parts were not cauterized. The instruments were shaped like a lithotrite, and the male jaw was made of platinum—was in fact, a platinum knife, which cut through the opposing piece of prostate. It resembled Mercier's instrument for prostatesctomy, after which it was evidently modeled.—*The British Medical Journal*, August 16, 1890, p. 408.

**INTESTINAL OBSTRUCTION.**—Dr. Clauß mentions two cases of intestinal obstruction which were successfully treated, after ordinary methods of treatment had failed, by injecting as high as possible into the bowel, by means of a long India-rubber tube, a mixture of three ounces (90 cubic centimetres) of sulphuric ether with twelve ounces (360 cubic centimetres) of mineral-water. The injection produced a feeling of warmth all over the body, with eructation of gas smelling strongly of ether, immediately after which a copious stool was passed, and all the symptoms of obstruction came to an end.—*The Lancet*, August 16, 1890, p. 365.

## THE NORTHERN LANCET AND PHARMACIST.

AN extraordinary meeting of the Manitoba Medical Association was held in the City Hall on the 13th ult. Several interesting papers were read and discussed, and it may be now fairly considered that the Association is launched on a sound basis. It remains for the various country districts to form local branches, as there will be but one general meeting of the Association yearly, which will be held at different points in the Province, and it is most desirable, both in a Professional and social aspect, that medical men practising in the country, should meet together as often as possible. Steps are being taken to arrange a monthly meeting of the Winnipeg branch, and every practitioner interested in the welfare of his Profession should give the movement his most cordial support. There are some medical men in the city who affect to regard these meetings as useless, but they are not in touch with the spirit of the age, and we cannot help thinking that a conscious and probably well founded doubt of themselves, when brought into collision with their fellow practitioners in debate, has much to do with their holding aloof from these professional gatherings, and their endeavor to throw cold water on the formation of a professional association in this province. However, the formation of a Provincial Association is now an established fact, and that it is the most important step taken by the profession here, since the establishment of the Medical College, all who are conversant with the great value of these societies in other places will readily admit. A young but vigorous association has been formed in the North Western Territories, and it would be well

if arrangements can be made with the members of this Association and our brethren in British Columbia to have a general yearly meeting which would be more convenient than membership with the Association in the east. We would urge that at all meetings of the Association or its branches that students should be invited to attend. Our very efficient and pains-taking secretary, Dr. Jones, will afford every information concerning the Association on application being made to him.

### LODGE PRACTICE.

A correspondent of the *Canadian Practitioner* writes that journal as follows: "While agreeing in the main with your editorial remarks in your issue of 16th August, and with those of Dr. McKinnon in that of 1st September, allow me to say that exclusion of those who engage in such practice from the Ontario Medical Association, is something they themselves have brought upon themselves, and that with their eyes open. It is not 'a drastic measure,' as you say, that they were not aware of, would or could be applied, because the Association's Code of Ethics (Art. viii, § 3) reads:—

"Neither societies for mutual benefit, for the insurance of lives or for analogous purposes, nor any profession or occupation, can be admitted to possess such privilege," namely, "valid claims for gratuitous services."

Those who wish to engage in such practice should have such section either erased or amended. Not one of several to whom I have mentioned the subject defends for a moment the practice, but agrees in deploring its prevalence. From this, I infer that a proper presentation of its enormity and wrong, will at once secure a promise from every honorable member of the profession that he will, if not resign forthwith, at least not renew his contracts when his present term expires. There is nothing "drastic" about that—he simply stays in the fold, or goes out, of his own action.



It is well enough known that most of these societies are wealthy and have funds invested. Such then should not receive our services as paupers or mendicants. Their membership and successful working are largely due to their furnishing medical attendance free. That is the main consideration for members to join.

Those physicians who serve them do so as an indirect means of advertising (at the expense of the profession at large). Hence the committee on Ethics did well to put their objections to lodge practice and newspaper advertising and puffing on the same level, and condemn both in the same breath and in similar terms. If one kind of advertising is tabooed so should the other; for, of the two, accepting lodge work is the more insidiously sneaking and underhanded. The result will then be that only the most degraded sort of practitioners will be willing to accept such dirty and degrading work.—GALEN.

#### PHARMACEUTICAL ASSOCIATION OF MANITOBA.

The quarterly meeting of the council of the Pharmaceutical Association of Manitoba, was held on the 17th of September, at the office of Messrs. Hough & Campbell, Winnipeg, G. W. McLaren, Esq., President of the Association, in the chair.

Mr. Flexon was elected a member of the educational committee in the place of Mr. W. J. Mitchell.

The treasurer, Mr. A. Moncton, submitted the quarterly statement, shewing a balance of \$1027.55 on hand at the end of the quarter.

The register, Mr. J. K. Strachan, submitted his quarterly report shewing, amongst other things, that during the quarter, Dr. F. J. Coulding, Dr. W. M. Scott, Mr. A. A. Campbell, and Mr. E. R. Finch, had been registered as pharmaceutical chemists; and that two prosecutions for offences under the Act had taken place and convictions obtained.

Mr. Geo. Graham, of Morden, applied to be registered as a certified clerk, and Mr. Graham possessing the requisite quali-

fications, the registrar was directed to place his name upon the register.

Dr. Simpson, Dr. Hutton and Prof. Neelds were appointed the lecturers for the association for the 1890 and 1891 course, which commenced on the first inst.; and the registrar was instructed to insert an advertisement of the lectures and forthcoming examinations in the *Manitoba Free Press*.

After the transaction of general business the council adjourned.

#### PHARMACY.

**TONSILITIS**—The following has been a very useful gargle in the treatment of tonsillitis, and is highly recommended:—

R Tr. guaic. ammoniat.,  
Tr. cinchonæ comp., aa f ʒ iv  
Potassii chlorat., ʒ ij  
Mel. desp., ʒ iv  
Pulv. acacie, q. s.  
Aque, q. s. ad. f ʒ iv M.

Sig. Use as a gargle, and take a teaspoonful every two hours.

**ATOMIZERS** are being so generally used in all throat and nose troubles, particularly in this country where catarrh is so prevalent, both the physician and druggist will be glad to know that an atomizer cheap and durable is being manufactured by Messrs. Ellis & Golttermann New York. This atomizer is simple in its construction, and easily cleaned. Their advertisement with cuts of the most popular ones will be found on the first page.

Messrs. Johnson & Johnson, of New York, in the introduction of their gentle ointments and emulsions, show another evidence of their enterprise. These ointments are put up in collapsible tubes, and are thus conveniently applied. By the use of various shaped nozzles, supplied with each tube, the emulsions can be carried to the anterior surface of the organs desired to be reached. They have been warmly endorsed by our leading dermatologists, and are likely to take the place of the old system. They can be removed by washing with cold water. We would call attention to their advertisement in this number.

**CHLORALAMID HYPODERMICALLY.**—Schmidt employs chloralamid hypodermically, the solution used being 13 grains of chloralamid dissolved in five drams of distilled water. Sixteen minims of this subcutaneously is usually a sufficient dose, and acts more rapidly than larger doses given by the mouth.—*Medical News.*

**TO SECURE TONGUES OF FLIES FOR MOUNTING.**—A correspondent of the *Scientific Enquirer* says that the best and most humane method of killing flies for the sake of mounting the tongues, is to drop them in alcohol. They die with this organ protruded. We do not know whether this method is considered humane because so many human beings die by the same means.—*National Druggist.*

**A MUSTARD PLASTER WHICH WILL NOT BLISTER.**—If you want a mustard plaster which will not cause a blister to form, no matter how long it is allowed to remain, mix the mustard with the white of an egg instead of water, and you will have it. The plaster will be just as efficacious in drawing the blood to the surface, and the patient will not be annoyed while waiting for a blister to heal. If the mustard is too strong add flour.—*V. E. L., Med. World.*

**THE PURIFICATION OF GLYCERINE.**—Recent investigation, says the *Pharmaceutische Zeitung*, have shown that all the patents taken out in Germany for the purification of glycerine up to the end of 1888 have been allowed to lapse, a proof that none of these processes have been able to stand the test of practical experiment. The problem how to free glycerine from impurities in a manner at once cheap and practically useful is, therefore unsolved, and offers a tempting opening for chemical investigators.

**CODEIA IN PELVIC PAIN.**—Freund, in *Medical Chronicle*, May, 1890, confirms Lauder Brunton's recommendation as to value of codeia in disease of women. In pains which proceed from the uterus it gives relief, and in ovarian troubles it is of great value, while in exudations of pelvic peritoneum and connective tissues and affections of tubes, it is inert. He gives half a grain three times a day,

which promptly relieves ovarian pain, whether functional or inflammatory. He claims its action is local, and does not impair the appetite, stupefy, or constipate.

**ARISTOL.**—Boymond, experimenting in skin diseases, thinks this new remedy will replace iodoform, iodol, and sozoiodol, because of its harmlessness, its energetic action, and its freedom from odor. It consists of a voluminous, amorphous reddish-brown precipitate, which results from the mixture of a watery solution of iodine in iodide of potassium with thymol dissolved in caustic soda. It is insoluble in water or glycerin, slightly soluble in alcohol, easily soluble in ether. For use it is combined with oils or ointments, or sprinkled dry upon wounds or burns. It is not absorbed, and has no toxic properties. It is as efficacious as chrysarobin in psoriasis, and does not color the skin nor provoke conjunctivitis.—*Medical Analectic.*

**HOW LONG IT TAKES TO BECOME A PHARMACIST.**

The following table from the *Chemist and Druggist* shows the minimum time in which a pharmacist can be produced in the countries named:—

Country.	Years passed in a Pharmacy.	Years passed as a Student.	Total No. of years required.
France.....	3	3	6
Belgium....	2	2	4
Germany....	5 to 6	1½	6½ to 7½
Austria....	5	2	7
Russia.....	5 to 6	1½	6½ to 7½
Italy.....	1*	3	4
Switzerland.	4	3	7

\*The year is passed in a pharmacy after the three years university course.

"CAN I use your telephone a moment?" asked a lady, stepping into a drug store. "Certainly," said the polite drug man, and he engineered her to the back part of the store, past counters and bottles, to the telephone itself. "I cannot reach it," she said, anxiously. "Can I telephone for you?" asked the druggist, with one eye on his store. "Y-e-s. Please call up Smith & Blank's drug store, and tell them to send Mrs. --- a box of mustard leaves and a porous plaster. I have an account there," she kindly explained to the paralyzed druggist.

MESSRS. Johnson & Johnson, of New York, deserve much credit for the great many improvements they have made in the manufacture of antiseptic dressings. "Moist antiseptic dressings" originally introduced by them have almost entirely supplanted all others. Even Prof. Lister, the originator of the antiseptic method of treating wounds and of the dry method of preparing antiseptic dressings, now uses and commends moist dressings only. Their new gauze can is also a great convenience. It allows the gauze to be drawn from the can as required without removing the roll and also prevents drying and deterioration.

#### PILOCARPIN IN DRYNESS OF THE TONGUE.

—Extreme dryness of the tongue is, under any circumstances, a very distressing symptom, and one which does not readily yield to treatment while the concomitant cause remains in operation. The sucking of ice or sipping of bland fluids, gives but temporary and inadequate relief, and the same may be said of glycerine employed as a paint. In this condition Dr. Blackman has successfully used pilocarpin, one-twentieth to one-tenth grain, in the form of a gelatine lamel allowed to dissolve on the tongue previously moistened with a sip of water. This small dose quickly establishes a moderate flow of saliva which persists for at least twenty-four hours, and is unaccompanied by excessive perspiration. The altered state of the mouth is often described by the patient as being delightful. Due caution in the use of so potent a remedy is advised.—*British Medical Journal*.

#### GURJUN OIL AS AN EXPECTORANT.

Gurjun balsam, or wood oil, is a balsamic exudation obtained from the trunk of *dipterocarpus turbinatus* and other species growing in the East Indies, by incision and the application of heat. It is a transparent liquid, like olive-oil, of an opaque, dingy, greenish-gray color, as seen by reflected light, and having an aromatic odor and taste not unlike that of copaiba, but without its acidity. Some years ago it was brought into notice as a remedy for leprosy. In the present instance it was given by Dr. Murrell, for

its expectorant qualities, in the treatment of bronchitis and winter cough. At first he prescribed it in doses of one or two drachms three times daily, in combination with liquor potassæ, spirit of nitrous ether, mucilage of acacia, and cinnamon water; but this was not a very inviting preparation, as it had a tendency to "curdle" and produce a rash during its elimination through the skin. After a time he gave it with extract of malt—two drachms of the balsam to one ounce of the extract—three times a day, and this was taken without any difficulty. The chronic bronchitis reported that it acted admirably as an expectorant, "clearing the chest" and easing the cough. In several cases pilocarpine was given at bed-time, to produce sweating, but no eruptions resulted. Dr. Murrell concludes that gurjan oil has all the advantages of copaiba as an expectorant, without the grave disadvantage of exciting an eruption.—*The Lancet*.

WATKINS (T. J.) ON A CONCENTRATED SOLUTION OF MAGNESIA SULPHATE AS AN ENEMA, ETC.—The advantages of this enema are:

1. Its action is local producing diffusion.
2. Its action is free and seldom fails.
3. Time of action is short.
4. The bulk is small, causing but very little, if any, discomfort.

5. It is as unirritating as a simple enema. Its certainty of action has become so well recognized in the New York Woman's Hospital that it has been used in nearly all the operative cases, as the cathartic preparatory to operation, for the last six months.

It is best administered with the patient in Sim's position, the hips being elevated by a pillow; and when much tenderness exists it is best given through a large gum elastic catheter passed well up into the bowel. The patient is to be instructed to allow the abdominal muscles to remain lax, and the nurse is to keep up pressure over the anus, if necessary, to cause it to be retained for at least fifteen or twenty minutes. If the bowel should fail to expel the exuded liquid, a rectal tube had better be inserted in order to

allow it to escape. It has not produced any bad results when two ounces have been retained, but Christiansen reports a case of death in a boy ten years old where two ounces were taken by the mouth without causing any purging. In my cases it probably was excreted by the kidneys nearly as fast as it became absorbed. Where it is retained the sphincter ani is likely to be strongly contracted, and great relief will follow paralysis of the sphincter by forcible dilatation under an anæsthetic, which will also have a good effect over the chronic constipation usually present.

The following is the formula I use:

R Magnesii sulph. .... 2 oz.  
Glycerine ..... 1 oz.  
Aque ..... q. s. ad. 4 oz

#### MISCELLANEOUS.

VERY large doses of iodide of potassium in inveterate syphilis have long been employed by American physicians. In the *Semaine Medicale* Dr. Wolf, of Strasbourg, reports a number of cases in which ordinary doses having proved useless, as much as an ounce and two thirds per diem was administered. The patients promptly improved under these heroic doses, and their body-weight is said to have considerably increased while taking pounds of the iodide.

Dr. A. C. BERNAYS, in *Medical Mirror*, unhesitatingly recommends the use of Campho-Phenique in preference to Iodoform as a finishing dressing over all sutured wounds. During the operation, carbolic acid, bichloride of mercury, boric acid, salicylic acid or any of the usual dilute solutions may be used to wash and irrigate the wound, but as a finishing dressing, one which can be left alone longer than any other, possessing more powerful germicidal qualities, which are not readily lost by evaporation, the gauze or cotton or lint moistened with Campho-Phenique is superior to anything he has ever tried.

**FATAL POISONING WITH SALOL.**—Dr. Hesselbach reports, in the *Fortschritte der Medicin*, the case of a young man, suffering with rheumatism, who took by mistake two drachms of salol. Coma resulted,

with great dryness of the tongue, anuria, and death on the second day. At the necropsy the kidneys were found to be soft anæmic, and of a pale yellow color; microscopically, the glomeruli were full of embryonic cells and leucocytes. The convoluted tubes were tumefied, and fatty degeneration had begun, the tubuli were filled with degenerated epithelium. There were no other lesions attributable to the drug. The toxic principle was the carbolic acid that is generated from salol in the system, and the author believes it should be prescribed carefully, and the conditions of the kidneys as indicated by the urine, carefully watched.—*The New York Medical Journal*, August 30, 1890, p. 245.

**MASSAGE IN THE TREATMENT OF FRACTURES.**—M. Lucas-Championniere devotes a whole number of the *Journal de Medicine et de Chirurgie* to the discussion of massage and mobilization in the treatment of fractures. He advises a gentle, painless, medical massage in the direction of the venous circulation, followed by movement of the neighboring joints, and gives detailed instructions of the method to be pursued in different cases of fracture. He finds the treatment adapted to all cases, the only counter-indication being the tendency of movement to create a deformity which it is impossible to counteract. Small wounds may be avoided during the manoeuvres, and will not prevent massage being performed if conducted gradually and prudently. Massage relieves pain, rapidly diminishes swelling, and favors the quick formation of callus. The muscles are preserved, and there is no cellular induration; the joints are not stiff. Whilst the limb regains all its functions, the general health does not suffer, which rarely happens if immobilization be practiced.—*Provincial Medical Journal*, June 2, 1890, p. 361.

**THE SURGICAL TREATMENT OF PERITONITIS.**—Dr. G. Frank Lydston of Chicago, in a paper read before the recent meeting of the American Medical Association at Nashville, raised a plea for early operative interference in cases of peritonitis, and referred especially to the so-called "idiopathic" peritonitis of children

(*Journ. Med. Assoc.*, June 28th). He denies that the affection is ever truly idiopathic, pointing out that in children the peritoneum is very readily injured, and that in them also slight injuries of the abdomen are more dangerous than in the adult. Many cases apparently idiopathic are also secondary to perityphlitis, which is comparatively common and often overlooked. He attributes the profound prostration and cardiac inhibition characteristic of peritonitis to (1) tension of the peritoneum produced by inflammatory products, with consequent reflex inhibition of the heart; and (2) mechanical interference with the heart's action. He maintains that there is no logical objection to surgical interference, the operation being almost invariably palliative, if not curative—enhancing the chances of recovery to a great degree. No case, unless in *articulo mortis*, should, he says, be allowed to die without such intervention. The incision need not be a large one, and except where perityphlitis is diagnosed (when it is best made along the line of incision for ligature of the common iliac), a median incision, with flushing of the abdominal cavity, is sufficient. He disclaims any intention of discouraging the use of opium, and states that his remarks apply especially to fulminant attacks, and these, although less acute, resist ordinary measures of treatment.

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#### PERSONAL.

DR. JAMES KERR'S many friends, in Winnipeg and the Northwest, will be pleased to learn of his increasing prosperity in Washington, D. C. Evidencing the esteem in which his skill and attainments are held there, comes the word that he has just been appointed chief of the surgical clinic of the Emergency Hospital and Central Dispensary of that city. This is considered the highest surgical appointment in Washington. The institution is supported by Congress and is to immediately occupy its new quarters—a fine building, completely equipped and thoroughly modern in all its details. Dr.

Kerr is also surgeon of the Garfield Memorial Hospital and to the Womens' Dispensary, of Washington.

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#### LIBRARY TABLE.

Messrs. Blakiston, Son & Co., 1012 Walnut St., Philadelphia. The essentials of *Medical Chemistry* by Woody and *Quiz Compend.* *Equine Anatomy and Physiology*, by Ballow. There is a vast amount of information condensed into comparatively few pages in both these little works, and they are admirably adapted for the student's perusal. Dr. Woody's work is of especial value as it places before the reader what it is essential for him to know before being able to pass a chemistry examination, and to cull which from large text books would take much time and study.

Forty-fifth Annual Session of the Medical Department of the University of Buffalo.

Baltimore University.—School of Medicine Annual Announcement.

The Suppression of Consumption, by C. W. Hambleton, M.D.

Ninth Annual Announcement of the College of Physicians and Surgeons of Chicago.

A Practical Splint for Inflammatory Joints, by C. F. Stillman, M.D., Chicago.

A NEWSPAPER DIRECTORY FOR CANADA — Messrs. A. McKim & Co., Advertising Agents of Montreal, are preparing what will be the first comprehensive newspaper directory of this country.

Canada is now quite large enough and its journalistic interests of sufficient importance to require its own annual Newspaper Directory and there are several new features of the proposed work which will make it a valuable hand-book for all seeking information concerning the Canadian Press.

We bespeak for this enterprising, firm the hearty support and co-operation of Canadian publishers generally.