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CONTENTS.

Original Communications.

MALARIA, AND ITS RELATION TO OTHER DISEASES.

By J. L. Bray, M.D., Chatham, Ex. Pres. Coll. Ph. & S., Ont.

MR. PRESIDENT AND GENTLEMEN OF THE CANADIAN MEDICAL ASSOCIATION:

I stand before you to-day to deliver the address on medicine, and the only thing I regret is that some one more worthy and competent to perform the task assigned me had not been selected.

However I take it as one of the highest honours that could be conferred on any member of the Association to be asked to deliver this address before the Profession of the Dominion in this its chief city, and can only attribuIe my being thus honoured to the great kindness of your President, and to his limited knowledge of my capabilities, and must crave your indulgence for any shortcomings on my part in the performance of this duty, and will endeavour in a very plain manner to give you my views and experience on malaria. Instead of going over the whole domain of medicine, which if I were equal to the task, would only worry and bore you, and further I feel it will better serve the object and interests of this Association to give a few practical points for discussion in order to bring out the opinions of the members present to-day, as I consider we have too many papers and too little discussion in this and every other medical society. Most medical journals are full of papers which only represent the author's ideas, while a short practical paper, which I trust you will find this to be, elicits criticism, and the flaws are pointed out and condemned while the good things (if any there be) are approved and endorsed by men of experience and ability.

Perhaps in no subject connected with medicine have more theories been advanced or divergence of opinion expressed than that of malaria, and I must confess that I know very little of its etiology after reading most of these theories, aided by an experienee of nearly thirty years practice in a malarious district. But scientists and investigators of the present day are approaching more nearly the solution of this knotty question.

It is a generally recognized and acknowledged fact that three things are necessary for the production of malaria, viz., heat, moisture and vegetable decomposition, and unless these three causes combine we can have no malaria.

Modern research has sohwn that vegetable decomposition of organic matter in the soil is due to the vital activity of living organisms, and we are indebted to such

men as Laveran, Carter, Councilman, Steinberg, Osler and others for their original investigations and untiring efforts to solve this problem, and it is to them, particularly the former, that something like a conclusion has been arrived at that micro-organisms in the blood if not the cause of malaria, have an etiological relation to it, and are beyond doubt a diagnostic mark of its presence in the system.

Laveran's theory has come to be the one generally accepted by the profession as communicated to the Paris Academy of Medicine in 1881 and '82, and afterwards published in 1884.

He found in, as characteristic elements of the blood of persons attacked with malaria, first, crescentic pigmented bodies; second, pigmented bodies in the interior of the red corpuscles which underwent changes in form described as amœboid; third, a pigmented flagellate organism.

The following brief summary of the important facts relating to these organisms I take from a monograph by Osler:—1st. In acute forms of malaria there exists within certain of the red corpuscles amœboid bodies usually pigmented, which undergo a definite evolution, increasing in size, gradually filling the entire corpuscle, and which prior to and during the chill undergo a remarkable segmentation. To this form the term "Plasmodium Malaria" has been given. There are also in some cases free pigmented bodies; occasionally in acute forms flagellate bodies are seen free in the blood, presenting from three to eight long actively moving cilia. According to Councilman these are much more common in blood withdrawn from the spleen. 2nd. In more chronic cases, particularly in the forms of remittent fever which are so apt to be taken for typhoid, the corpuscles do not so often present the intercellular forms, but there are remarkably ovoid rounded and crescentic bodies deeply pigmented. These are in all probability related to and developed from intercellular forms. From certain of these, particularly the ovoid and rounded forms, the flagellate bodies may be seen to develop.

We know these organisms are in the blood. But how they got there, and from whence come they is a question that to my mind is difficult of solution.

Do they exist as an element of the blood and are only developed when persons are exposed to certain influences supposed to be of a malarial character? Or are they, on the other hand, given off from the soil, the result of decomposition of organic matter and taken into the blood directly through the lungs, or are they taken into the stomach through the saliva or otherwise and thence to the intestines, where they undergo changes and enter the circulation through the lymphatics there to develop as has been demonstrated, in the red corpuscles.

I cannot but think that these malarial germs or organisms, or whatever they are, enter the system both by the lungs and stomach, or why do they produce, as they often do, diarrhœa and dysentery in place of the typical intermittent or remittent fevers. My idea is that when this occurs the germs are carried directly into the stomach through the water we drink, or the saliva we swallow, and thus reach the intestines. In proof of which I quote Steinberg, who says "the human intestine has a microscopic fauna and flora almost equal to a city gutter. The mouth with its uniform temperature, free access of oxygen and constant supply of pabulum (the salivary secretion) is an admirable culture apparatus. Hence, therefore, there is constantly going on a struggle for existence among a number of minute parasites, most if not all of which are harmless, and the same may be said of the bacteria which habitually infest the human intestines. Then why should not other species, whose normal habitat is external to the body in swamps or elsewhere, when introduced into the intestines, as they often must be in

large numbers, give rise to special kinds of fermentation, and to the production of special products which are not harmless."

Now, I am of the opinion that the malarial germ often takes this route and this is why we have diarrhœa and dysentery that can only be cured by clearing out the intestines and giving quinine; other remedies, such as ipecac, opium, etc., have had no curative action in my hands in the endemics of dysentery, undoubtedly malarial, that we sometimes have in the western district late in the season after a hot and dry summer and the well water very low.

This to me is a very strong proof that these germs or organisms are carried to the intestines and these undergo changes which make them dangerous.

Again, on the other hand, I think it is clearly demonstrated that the germ which produces this plasmodium as found in the red corpuscles of the blood is taken directly into the lungs through the air we breathe and enters the circulation causing those typical cases of intermittent pneumonia, and aggravating and often producing periodical attacks of asthma.

Now, Mr. President and gentlemen, I am not going further into the consideration of the origin and development of these organisms, as if I did I would only be giving you the opinion of others, as I have not investigated this part of my subject to such an extent as would warrant me in inflicting my views on you, and your time can be much better employed by looking into the works of Laveran, Councilman and Osler, which are well worthy of perusal.

Before considering the different types of malaria, I would ask why do we have malaria in winter when the temperature is very low if it depends on vegetable decomposition due to heat and moisture, as no doubt it does.

I have seen no theory advanced to account for this, and shall give you my own as expressed in a short paper read before the Sanitary Convention in London in November, 1883. It is this: There are three great receptacles for the malarial poison, viz., the earth, water, and the human body that have a supply in store as it were laid up for the winter, which under favorable circumstances manifests itself in the shape of intermittent or other forms of malaria. The water in the wells is perhaps the greatest source of supply, particularly when the ground is frozen hard for a long time and the water gets low.

The second reason is the poison escapes from under houses and spots of ground protected from the frost, and the third source is that some people living in a malarious district have a continual supply in the system only waiting to be developed when it finds a good opportunity; such as exposure, sudden changes of temperature, over fatigue, loss of rest, mental strain, or anything else that will cause the system to run down, thus reducing and impairing the vital resistance of the nervous system. One very strong proof that these organisms are latent in the system is that a man may have lived for fifteen or twenty years in a malarious section without ever having had ague or any other form of malaria. But let that man cross the Atlantic or go where malaria is unknown, and he is liable to an attack of it. I have known many such instances, which to me is a very strong proof of the latency of this germ in the blood or some of the organs of the human body.

It is true the type of malaria is milder in winter, and for the reason that the sources of supply are limited in comparison to summer, and is principally confined to localities where it is endemic. In other words, there is not enough escapes for the organs to carry it to any distance in sufficient quantities to produce its pathological effects, if indeed it could survive the frosts it would have to encounter on its journey. This, then, is my theory as to why we have malaria in winter. It may be erroneous, but I think the investigations of Laveran and others as to the organisms found in the

blood corpuscles gives strength to this view, and if this is correct goes to show that these organisms are not only a diagnostic mark but also a factor in the production of malaria. Another reason that convinces me that these are stored up in the blood or organs is this: Speaking from personal experience, a sudden fall of temperature in hot weather invariably brings on in me symptoms of malaria, such as lassitude, stretching, yawning, aching of the muscles; particularly of the back, and neuralgia, which a few doses of quinine will relieve in a short time; the same thing occurs in cold weather on a sudden rise of temperature, and I can only account for this by having stored up somewhere in my system a supply of these, I was going to say, infernal germs or organisms. I speak feelingly and I think with some weight, as I have been a sufferer in this way for over a quarter of a century.

Now as to the types of malaria. We have the quotidian, tertian, quartan and remittent forms.

Why these different types should occur is hard to explain, nor has it hitherto been satisfactorily accounted for, and is a field well worthy for further study by our pathologists.

By some it is claimed to be due to individual idiosyncracies, and they offer as proof of this that in a number of people exposed to the same malarial influences we find one having quotidian, another tertian, and a third quartan ague, as is exemplified in individuals exposed to cold under identical circumstances, one will have pneumonia, another rheumatism, and a third diarrhœa.

There may be some truth in this theory, but I think that temperature as well as the intensity of infection has more to do with the different types than has individual peculiarities.

My experience and investigations have led me to believe that early in the summer we have the tertian and quartan forms. When the heat is great and the eminations from the soil reach their maximum intensity we have quotidian, double quotidian and remittent. Later, when the temperature is lower and decomposition has almost ceased, we go back to the quartan and tertian varieties, and still later when the temperature gets much lower we have dysentery, the reason for which I will presently endeavour to explain. My conclusions are, then, that it is more to temperature and date of intoxication that these different types are due than to individual idiosyncracies. In proof of which it is well known and shown by statistics that in India and other tropical countries, persons that go there who have hitherto been free from malaria will have the quotidian or remittent type, while those who have lived there for years and have been exposed to and poisoned by malaria, will have relapses at longer intervals and these only when subject to exposure or sudden change of temperature. This is I think important, and goes to prove that date of infection and temperature have much to do with the character and type of malarial attacks, and my own observations bear out this view. Thirty years ago almost the only form of malaria prevalent in the western district was of the quotidian and remittent variety. The latter was called bilious or bilious remittent fever, and the reason I assign for this is that the low country was almost constantly covered by water, undrained, and was being settled by immigrants who hitherto knew nothing of malaria. The land was being cleared and tilled allowing the germs to escape for the first time, so that those people got the full effect of the poison liberated from the virgin soil which had accumulated from the decayed and decaying organic matter, and as a consequence were attacked with regular old-fashioned shaking ague that made the dishes on the table and the tins on the walls clatter. So much was this the case that it was no uncommon occurrence to find whole families laid up at once and at the same hours leaving no one to give an-

other a drink of water. All this is now changed and we rarely if ever see a case of shaking ague, but have instead chill fever or dumb ague, intermittents, neuralgia, diarrhœa, dysentery, malarial coughs, lassitude, anæmia, heart murmurs, albumen and oedema, simulating Bright's disease, hæmaturia, enlarged spleen, rheumatic pains, and congestions of nearly all the organs, besides many other affections obscure in their nature but undoubtedly due to malarial organisms. Now, how is this change in the type of malaria to be accounted for. For nearly thirty years I have been a close observer of the changes that have taken place in the forms of malarial diseases that are endemic to this section, as well as of the climatic influences which effect the character of this poison, and to my mind there are three reasons for this change: The first and chief one is better drainage; the second is the forests have been cut down and the country cleared up lessening the amount of organic decomposition, and the third one is that nearly all the virgin soil has been cultivated over and over again, thus liberating and getting rid of nearly all the organic matter that had been for years accumulating and stored up under the sod. I said I would try and explain why dysentery should be produced by malaria after vegetable decomposition had ceased, and will now endeavour to do so. My explanation is this, continued exposure to malaria engenders a cachætic state of the system by reducing the globular richness of the blood, perverting the nutritive processes of the tissues and impairing the vital resistance of the nervous system, thus rendering its victims especially liable to attacks of specific febrile diseases and to splenic, hepatic intestinal and other local congestions; one of the structures most liable to be affected is the mucous lining of the intestinal canal. Taking then the perverted state of the blood and tissues, the congested condition of the intestines together with the malarial germs infesting the canal undergoing changes by fermentation, and acting locally on the mucous lining as well as constitutionally through the blood and we have made plain the reason why dysentery follows continued exposure to malarial influences, and why the mortality from this disease at such a time is far above what it would be if the malarial element had not existed. We hear and read of typho-malarial fever. Now, I do not believe there is any such disease, and the name is a misnomer.

A person may have malarial organisms in the system and at the same time be attacked with enteric fever, as a consequence there may be and often is a chill followed by a greater rise in temperature, and then a remission but never an intermission. On examining the blood of such a patient the plasmodum will likely be found. By giving a few good doses of quinine the chill is arrested but the fever goes on and runs its regular course. Again, a person living in a malarious district having typhoid, and when convalescing may be attacked with malaria owing to the perverted condition of the blood and impaired state of the nervous system due to the long illness and after the enteric fever proper has run its course, but in neither of these cases can this be properly called typho-malarial fever. The bacillus of typhoid and the organism of malaria are separate and distinct poisons, and are not produced from the same causes although they enter the body by the same channels. But it has yet to be proved that the germ that produces malaria will cause typhoid, or that the bacillus that attacks the mesenteric glands and peyer's patches will induce malaria in any form, and I think the sooner we recognize this fact the better.

My observations have taught me that if we have a continued form of fever withstanding quinine and mild laxatives lasting over seven or ten days we are safe in pronouncing it typhoid, and just here let me say that the examination of the blood corpuscles in this class of cases is one of the most

valuable diagnostic marks we possess, at the same time this alone cannot be relied on, particularly where malaria in endemic, for I have seen numbers of cases, undoubtedly typhoid, where in the early stage the characteristic plasmodum was found in the blood but after giving quinine for a few days they disappeared, but the fever continued and proved to be enteric, and I would impress strongly on the profession the necessity of caution in giving a diagnosis in these cases. It is much better for the physicians to say I cannot tell for a few days what course this fever will take, than to give a snap diagnosis and say this is typhoid when in the course of a week the patient will be well and at work; or on the other hand say, oh, this is only a case of malaria when it turns out to be typhoid. In this case he will try to square himself with the friends by saying it was malaria but has run into typhoid, or in the former instance take to himself great credit for cutting short and curing a case of typhoid in a week. I have met with examples of both cases more than once.

One more point and I have done. It is this, malaria I am convinced is not confined to certain localities as it was twenty or thirty years ago, but is spread over nearly all parts of the Dominion and is much more general than is usually supposed, and this is a very important point that must not be overlooked. Why you may ask is this the case when you have already proved or tried to prove that in the home of malaria, by drainage and other means before mentioned malarial diseases have greatly decreased. My answer is this: The very means (or some of them) taken for lessening the supply at the fountain head has, while accomplishing this object to a certain extent, caused it to be carried by wind, water and rail to the homes of thousauds who before were strangers to this disease.

The country having been cleared of its forests (themselves great consumers of these eminations) allow the winds to have free sweep wafting the germs miles and miles from their original lair.

The water in the new-made drains carries the poison to streams and rivers to be used in many a household.

The railways conveying as they do thousands of passengers long distances from the source of malaria, many of whom have these organisms latent in the body, which are only developed on reaching their destination owing to climatic changes or other causes, are great distributors of this disease introducing it in this way to localities where perhaps hitherto it had been entirely unknown; and while the types of malaria are not so well marked as was the case when confined to certain districts, (the poison being less concentrated) only makes its diagnosis more difficult, and often accounts for the seeming obscurity of many affections that puzzle and perplex the busy practitioner.

Progress of Science.

MINOR UTERINE SURGERY.

By Charles P. Noble, M. D. A paper read before the Philadelphia Obstetrical Society, December 4, 1890.

For several years the attention of gynecologists has been so largely occupied with abdominal surgery, and particularly with the diseases of the Fallopian tubes, that but little has been said concerning the diseases peculiar to the uterus. It may be supposed by some that the reason so little has been heard of the uterus and its diseases, is that the labors of the past have placed our knowledge of these subjects upon an enduring basis. I am satisfied, however, that the true reason has been indicated above, and am the more convinced of it by the recent appearance of a paper absolutely denying the truth of the teachings of the past concerning, more especially the treatment of diseases of the uterus, and attributing evils to the measures employed greater than the good they have been designed to accomplish. In view of the immense strides which have been made in our appreciation of the diseases of women, especially those of an inflammatory character, in the last ten years, and of the very different light in which diseases of the uterus now appear as contrasted with former years, it has seemed to me that it will be profitable to review the subject at this time. The

ground to be covered is so considerable that I shall present my views concisely and of necessity somewhat dogmatically, so as not to consume your time unduly. Presented in this way, I hope the subject will elicit full discussion, as I consider it one of the most important and suggestive in gynecology.

Before treating of the individual diseases of the uterus requiring surgery, it will be well to consider the diseases of the uterus as a whole. It cannot be too strongly insisted upon that a very sharp distinction should be made between diseases of the uterus themselves and diseases of the uterus complicating, or complicated by, diseases of the uterine appendages. This is the key to the situation, and upon a right appreciation of this fact depends success or failure, or even disaster, in the management of this class of cases. Uncomplicated disease of the uterus, barring neoplasms, seldom or never threaten life, and belong to the minor ailments of women. Where the uterine malady is complicated by inflammation of the uterine appendages, the conditions are essentially different. The disease of the appendages overshadows the disease of the uterus, which must be nearly or quite disregarded. For were it possible to cure the uterine malady without modifying the disease of the ovaries or Fallopian tubes, little would be accomplished, as the more serious disease would remain. But this is not all, for experience has amply shown that to tamper with the uterus, particularly by operation or by intra-uterine applications, in the presence of complicating tubo-ovarian inflammation, is a most dangerous thing, liable to set up acute pelvic or general peritonitis. Hence it should be laid down as a rule that operation upon or manipulation of the uterus is contra-indicated in all cases in which tubo-ovarian inflammation exists. The contra-indication becomes the more absolute the greater the gravity of the complicating disease of the appendages.

The experience of the past has shown the truth of the foregoing statements, and the knowledge of the present concerning the nature of pelvic inflammation has rendered the whole subject easy of comprehension. Formerly, various explanations were offered, some of them quite fantastic, as to the occurrence of pelvic inflammation following manipulation of or operation upon the uterus when "fixed," or in the presence of "cellulitis" or of "thickening." Now we know it is due to the rupture of intra-peritoneal adhesions and the escape of septic material from the diseased appendages.

The Uterine Sound.—I have but little to say in commendation of the uterine sound. Unquestionably it does far more harm than good as used to-day. I believe that its field of usefulness is very limited. For the purposes for which the sound is ordinarily used, it is an unnecessary instrument. Bimanual examination teaches the size, shape, position and mobility of the uterus far more accurately than the sound, and without injury to the patient. The text-books say that the use of the sound should be preceded by bimanual examination to determine the above questions and the presence or absence of pelvic inflammation. If this be so, and the facts be determined, what is to be gained by the use of the sound? More or less uterine colic, and perhaps an acute salpingitis, when a dirty sound has been passed into a healthy uterus, or a clean sound passed with some force into a uterus in the presence of tubal inflammation. Unquestionably, the use of the sound has no place in the determination of the foregoing facts concerning the uterus. Likewise, I would condemn the use of the sound as a uterine repositor. Mobile uteri can be reposited by Schultze's method, and fixed uteri should be left alone. The sound is useful in determining the potency of the uterine canal when this is in doubt; and may be useful in the differential diagnosis of obscure morbid conditions in the pelvis, but I am convinced that the facts apparently determined by its use are often illusory, and that the practitioner who least relies upon it will make fewest mistakes in diagnosis. The sound may be used to determine the presence of fungosities within the uterus; but the history of uterine hemorrhages and leucorrhea, with the absence of disease outside the uterus, makes the diagnosis so certain as to obviate the necessity for its use. The diagnosis and cure can be made with the curette.

Intra-uterine Medication.—I feel convinced that intra-uterine medication has been much abused, and that the cases are extremely rare which require or are benefited by the application of a medicament within the internal *os uteri.* Intra-uterine applications have been recommended for chronic endometritis and chronic metritis. When uterine leucorrhea established the diagnosis of endometritis, and the same, with enlargement and tenderness of the uterus, not due to subinvolution or neoplasms, established the diagnosis of chronic metritis, these diseases were said to be very common—indeed, the most frequent diseases of women. Hence, intra-uterine medication became a routine practice. If I am to judge from my own experience, uncomplicated chronic endometritis and metritis are not frequently met with. As an illustration, by going over a hundred cases in my case-book, and selecting uncomplicated cases, I find seven. If the cases of laceration of the cervix, with erosion, etc., were added, the list would be considerably increased. But in by far the largest number of cases these morbid conditions exist in relation with inflammatiory affections of the uterine appendages, preceding and causing the tubo-ovarian disease, and later being kept up by it.

In the presence of the tubo-ovarian inflamma-

tion it is now generally accepted that intra-uterine applications should not be made. They can do no good, and may do great harm. Fungoid endometritis and septic endometritis following incomplete abortion, require the curette. Excluding the foregoing, and cases of endometritis and metritis complicating laceration of the cervix, few cases remain for intra-uterine medication. And I am far from convinced that this small class cannot be more efficiently treated and more quickly cured by the dilatation of the cervix under anesthesia with thorough curetting of the uterine canal with the sharp curette. During the past year I have thought it advisable to make applications to the whole uterine canal in three cases. One, a case of chronic endometritis in a virgin, was cured. The second, also a case of chronic endometritis in a woman the victim of syphilis years before, was improved by intra-uterine medication, and was cured when mercury and iodide of potassium were given by the mouth, in addition. The third, a case of small fibroid tumor, with menorrhagia, was made distinctly worse.

Looking back over my past results, I feel less and less inclined to make intra-uterine applications. Formerly I made applications of Churchill's tincture of iodine and solutions of nitrate of silver to the endometrium almost daily. Before I appreciated the dangers of the practice and its contra-indications, salpingitis and peritonitis were "lighted up" in a number of cases. Fortunately, no deaths resulted. Since I have abandoned the routine use of intra-uterine medication in disease of the pelvic organs accompanied by uterine leucorrhea, my patients have been far happier (as uterine colic is only a memory), and I am satisfied that the influence of treatment has been more favorable than in former years.

Dilatation of the Cervix.—Dilatation of the cervix is advised for the cure of obstructive dysmenorrhea and sterility due to flexions of the uterus (usually so-called congenital anteflexion), or to stenosis of the cervical canal, congenital or acquired; also as a step in the removal of polypi, small fibroid tumors, and the retained products of pregnancy, and as a preliminary to the use of the curette. In selected cases I am heartily in accord with this advice. It is not possible to discuss these questions now; but the important thing is that cases of uterine disease are to be selected for dilatation, and not cases of tubo-ovarian inflammation. In such cases, when done with full antiseptic precautions under anesthesia, dilatation of the uterus is practically without danger, immediate or remote, and has given very satisfactory results in my hands.

The mistake of regarding cases of so-called acquired anteflexion, due to peritoneal adhesions or shortening of the utero-sacral ligaments, as cases of uterine disease, is particularly to be guarded against, The folly of expecting to benefit inflammation of the peritoneum or of the uterine appendages by dilating the cervix is apparent; and I am convinced that all the disasters following dilatation of the cervix are to be attributed either to this error in practice or to poor antisepsis.

Rapid dilatation with steel dilators has always been employed, the pattern of Goodell having been commonly used. I have never seen a tent introduced into the cervical canal; nor have I seen the hard rubber dilator used.

The Curette.—The uterine curette is a most valuable instrument and is indispensable in the treatment of uterine fungosities and for the removal of the diseased endometrium in certain cases of menorrhagia. I believe it capable of rendering good service in the treatment of certain cases of congestive and obstructive dysmenorrhea—in which the seat of pain is in the uterus, and the cause, morbid processes taking place therein—by removing the endometrium, particularly near the internal os. After incomplete miscarriages, and in septic puerperal endometritis, the curette is useful to remove necrotic tissue; but in these cases its use should be preceded by the finger, used as a curette, by which alone can the state of the uterine cavity be determined. In such cases the finger is the best curette. In all cases I precede the curetting with dilatation of the cervix and follow it with the intra uterine douche and intra-uterine iodoform gauze packing, which acts as a capillary drain.

In cases of chronic endometritis without complication, dilatation and curetting will either effect a cure or greatly facilitate subsequent intra-uterine medication.

In curetting, full antisepsis should be maintained, and the same care be used to select uncomplicated uterine cases. Anesthesia is essential to thoroughness. The curettes of Martin and Schrœder have been used. The dull curette should be regarded more as an instrument of diagnosis. It is useful in cleaning the uterine cavity of debris before using the douche. It also finds a place in puerperal septic endometritis.

Laceration of the Cervix.—Probably no subject in gynecology has excited more discussion than that of the pathological importance and the treatment of laceration of the cervix. I am in accord with those who regard laceration of the cervix as a lesion of importance in the causation of pelvic disease, and the operation devised by Emmet for its repair as a useful addition to surgery. Certainly many lacerations of the cervix, occurring during labor, heal spontaneously during the lying-in, and are of no practical consequence to the puerpera; others heal more or less perfectly, and, involution of the uterus taking place fully, no ill consequences follow. But the history of laceration of the cervix in many cases is very different. The laceration

does not heal, the cervix gapes open, involution of the pelvic organs does not take place, pelvic congestion is kept up, and uterine catarrh and menorrhagia follow. The general health is more or less affected, depending upon the vigor of the particular constitution, and the duration of the local disease. In some cases extensive reflexes are developed; but the conservative man will ever bear in mind the possibility of overlooking neurasthenia and hysteria in this class of cases.

Local and general treatment will effect a cure in many of these cases without operation. Rest, tonics, regulation of the bowels, ergot, hot water, vaginal douches, the application of glycerine tampons, painting the cervix with Churchill's tincture of iodine, together with scarification of the cervix, will frequently improve the condition so markedly as to effect, practically, a cure. But often this treatment proves ineffectual and operation is necessary. Another indication for trachelorraphy is the existence of laceration of the cervix as a complication of retroversion or retroflexion of the uterus. Not infrequently the malposition cannot be corrected until the intra-vaginal cervix is restored by operation. It is important that endometritis, existing as a consequence or as a complication, should be cured before closing the laceration. Where this is difficult or impossible, and in all cases in which uterine hemorrhage is a feature, the trachelorraphy should be preceded by dilatation of the cervix and curetting of the uterus. Trachelorraphy done under these conditions has given very satisfactory results in my hands. When done for supposed reflex effects, due to cicatricial tissue, the outlook is not so promising.

It will be observed that the operation has been recommended only for uterine disease. When the uterine diseases exist in connection with inflammatory disease of the appendages, the operation is contra-indicated. Under these circumstances, there is great danger of causing acute peritonitis; or, this failing, drainage from the uterus is interfered with and subsequent acute attacks of salpingitis promoted. In a neglect of this contra-indication lie most of the dangers and disappointments of trachelorraphy.

The relation of laceration of the cervix to tubal disease is a subject worthy of careful study. That laceration of the cervix is a frequent cause of subinvolution of the uterus and endometritis is generally believed. That endometritis causes salpingitis by extension is also true. Hence, it appears probable that laceration of the cervix sustains an important relation to salpingitis as one of its predisposing causes. The relation between laceration of the cervix and cancer also is probably more than accidental. These considerations are further inducements to repair all lacerations of the cervix which are causing active symptoms.

I believe that trachelorraphy, done under the conditions laid down, is a perfectly safe and very valuable operation; and that the present tendency to decry its usefulness arises from a failure to observe its proper indications, or to carry out the principles laid down by its inventor for the operation itself. Of lateral and posterior incision of the cervix I shall say but little. I believe that the field of usefulness of these operations is limited, but that in exceptional cases they may be valuable.

I hope I have made it clear that my own experience has made me a firm believer in the value of minor uterine surgery for uterine disease. It seems equally clear to me that the cause of disappointment in the past when it has been met has been a failure to properly study the cases; and thus uterine surgery has been employed for other than uterine disease. Also that the disasters of uterine surgery have been due to insufficient antisepsis; or to the fact that operation has been done in the presence of disease of the uterine appendages, more especially pyosalpinx and abscess of the ovary.

When it was believed that inflammation of the appendages was cellulitis, which was caused by, and kept up by, disease of the uterus, and only to be cured by curing the uterine malady, it was perfectly logical to attack the uterus with our therapeutic resources. But experience has shown the dangers as well as the futility of this method, and modern pathology has brushed away the apparently rational basis upon which it rested. It is upon this ground that I have opposed useless and dangerous uterine treatment in complicated cases of pelvic disease.—*Memphis Jour. of Med. Sciences.*

REMARKS ON THE TREATMENT OF THE PYREXIA OF PHTHISIS.

By C. Theodore Williams, M. A., M. D., F. R. C. P., Senior Physician to the Hospital for Consumption and Diseases of the Chest, Brompton.

Pyrexia is often a most troublesome symptom in both acute and chronic phthisis, though it is not a necessary accompaniment—certainly not of the chronic forms—and it has been known to be absent even in the acute ones. It is, however, in a large proportion of cases, the principal unfavorable symptom. When it is persistent it is impossible for the medical man to give a hopeful prognosis, and when it subsides the case assumes a most hopeful aspect. Its absence has generally been assumed to indicate quiescence of tuberculous disease, and its presence, activity; and while the latter proposition is usually true, the former is not to be always relied on, for in many cases tubercle forms and undergoes excavation without pyrexia.

The pyrexia of phthisis never reaches very high figures—a record of 105 degs. F. is very seldom attained, and the charts rarely run higher than 103 degs. A chief feature is the uniformity of the afternoon rise. On the other hand, the temperature descends, as in the early morn-

ing, very low indeed, and I have registered a reading of even 91.6 degs. The case was one of acute lung excavation, and the range of temperature in twenty-four hours amounted to 10 degs.

A rise of temperature above 100 degs. in a case of phthisis ought always to lead to a careful search for the cause of such elevation, and it generally is to be found in extension of tuberculous disease, or in softening and excavation of old tuberculous masses, or, if a cavity be present, in its further extension; or, again, it may be traced to commencing tuberculosis in some other organ, as the lymphatic glands, the joints the testicles, or the intestines. In a very few cases it is due to pulmonary congestion, generally affecting the bases of the lungs, though pulmonary congestion in phthisis means, as a rule extension of tuberculation.

Various theories have been put forth of late years to explain the processs of fever, and, on the whole, I am inclined to adopt that of Dr. Donald McAlister, as best meeting the many difficulties which surround the subject, and as being particularly suited to the requirements of phthisical pyrexia.

Dr. McAlister divided the factors of fever into three: 1, the thermolytic or heat-discharging mechanism; 2, the thermogenic or heat-producing mechanism; 3, the thermotaxic or heat-adjusting mechanism.

Heat is discharged throughout the whole of fever—during its rise, its continuance, and its defervescence, the discharge taking place through the skin by evaporation, conduction and radiation in the ratio of 80 per cent., and through respiration in the ratio of about 20 per cent.

Heat is produced in the body by the oxidation of tissues, chiefly of muscles, which may be regarded as the furnaces of the body, the heat-producing or thermogenic function of muscle being quite independent of the contractile function, and continuing during rest, though in some degree increased by contraction. This thermogenic metabolism of muscle continues as long as blood and nerve supply are intact. If the nerve be stimulated, muscular contraction outlasts heat production. When a muscle is poisoned with curare, which abolishes the function of the nerve endings, and thus blocks the way for the transmission of impulses from the nerve trunks to the muscle, both effects are lost, and the thermal behavior of an animal, whose thermogenic tissues are thus cut off from the influence of the nervous system, is remarkable. The vasomotor system is intact, but the animal can no longer maintain its temperature. If plunged into a cooler medium the temperature falls; if transferred to a warmer one, it rises. Moreover, the practical cessation of oxidative metabolism is shown by the consumption of oxygen and the exhalation of carbonic acid falling to a fraction, showing how much these processes are due to the thermogenic action of muscles, and how much this latter is due to their innervation.

Heat production in the muscle is, according to Dr. McAlister, carried on under the influence of a twofold nervous mechanism, the one part exciting to thermogenesis, accompanied by destructive metabolism, and the other part staying thermogenesis and subserving contractive metabolism. The thermogenic tonus is the manifestation of the normal balance between these parts.

Experiments show that by the stimulation of a particular region to the inner side of the corpus striatum the thermogenic function of the muscle is abnormally increased, and this without encroaching on the motor tract, without exciting the motor function, and without any action that can be fairly called vasomotor being brought into play.

The temperature of phthisis is, as I have shown in a paper in the *Medico-Chirurgical Transactions* (vol. lviii), due to a combination of fever and collapse influence. If these are equally balanced, a chart hardly differing from the normal results; if collapse prevails, subnormal temperatures appear, and if the febrile process be in the ascendant, pyrexia shows itself.

The formation of tubercle may not cause great variation in the temperature chart from the normal, but any variations which occur take a particular form, which is visible in apyrexial cases, but is accentuated in pyrexial ones. Thus, the temperature of tuberculization is characterized by a considerable range of temperature, varying from 94 degs. F. to 105 degs. F., by afternoon pyrexia and subnormal early morning temperatures. For tuberculization without fever the curve is similar, but not so marked, the collapse influence prevailing.

Now we may look at the subnormal temperatures as instances of the thermolytic agency, where heat is being discharged in the form of night sweats. Then in the afternoon pyrexia we see the thermogenic influence giving rise to that wasting of tissues, especially of muscle, which is so characteristic of phthisis. When we examine the hectic temperatures of acute excavation we see there all the features of suppurative fever in the afternoon and evening pyrexia, followed by the rapid fall during night and early morning, and the recovery in the later morning hours. Here we appear to have more thermogenic influence in the afternoon and evening, and more thermolytic in the night and early morning, while the whole chart seems sadly to lack the thermotaxic control shown in the thermogenic tonus, and this is still more marked in the records of advanced phthisis.

The treatment of the pyrexia of tuberculization, if the latter be limited in extent and do not amount to acute tuberculosis of the lung, may often be dealt with, and dealt with successfully, by general measures. In some cases the addition of arsenic or quinine to the tonic will

suffice to reduce temperature; in other cases derivative measures in the form of free application of counter-irritation to the chest wall succeed, if combined with the promotion of large secretion from the whole bronchial tract by saline expectorants, to which the addition of aconite or digitalis is often desirable. When regard to counter-irritation, vesication, and specially with the preparations of cantharides, if applied so as to produce a large blister over the affected lung, is far more effacious in reducing temperature than any amount of poulticing or iodine painting. The best form of expectorant in these cases is the effervescing carbonate of ammonia draught, to be given two or three times a day, to which may be added 4 to 5 minims of antimonial wine, and the same dose of tincture of aconite. This, with the ordinary precautions of rest in bed during the fever rise, reduces the heat in a great proportion of cases of tuberculization. Where these measures fail, quinine, given in an effervescing form in 3 to 5-grain doses, just before and during the rise of the temperature, is advisable. Salicylate of soda, or salicin, may also be tried. Professor Jaccoud's plan of giving hydrobromate of quinine in doses of 10 to 30 grains every night for three consecutive nights, which, he states, lowers the temperature in this stage of phthisis for four days, failed entirely in my hands in two cases in which a fair trial was given to it, though cinchonism and great mental excitement were thereby induced.

The treatment of the pyrexia of softening and excavation of tubercle is encompassed by far greater difficulties, as here we have to heal with suppurating surfaces out of surgical reach, from which reabsorption of pus and septic products with our old enemies, the tubercle bacilli, is continually taking place, and consequent infection of fresh tracts of the lung, so that we have to treat suppurative fever and the pyrexia of tuberculization in the same individual.

Small wonder is it that our efforts to reduce such fever result, for the most part, in temporary, and rarely in permanent, success. The temperature falls under treatment, but rises directly that treatment is suspended, and generally the pyrexia only subsides when excavation is for a time complete, or a cavity has still farther extended and the patient's vital powers have become more and more collapsed.

The number of medicines which have been tried to reduce the temperature of this stage is an almost endless list, which I shall not attempt to exhaust, but will enumerate those of which I have most experience. *Quinine*, in doses of from 5 to 20 grains dissolved in acid, undoubtedly will temporarily reduce temperature, but as cinchonism is soon produced, it is impossible to persevere for any length of time. The effervescing quinine draught before mentioned, combined with digitalis tincture (10 minims) is far more effectual because it can be continued longer, and I have had the best results from this antipyretic. Heim's pills, often called Niemeyer's containing a grain of sulphate of quinine and digitalis, combined with half a grain of opium, given three or four times a day, also exercises a good temporary effect. Salicylate of soda and salicylic acid reduce temperature, but cannot be continued long on account of the lowering influence of the drugs. Of the two, salicylate of soda is preferable, and, when given in 20 grain doses every four hours, sc n has the desired effect, and may be afterward ...en twice in the afternoon to control the pyrexia.

Salicin, if added in 10 grain doses to the effervescing carbonate of ammonia draught already mentioned, considerably strengthens its antipyretic effect.

Iodoform, in doses of 3 to 5 grains, three or four times a day, I tried in a number of cases, but with no good result whatever.

Kairin and *chinoline* were both so nauseous that I cannot say I succeeded in persuading the patients to make a fair trial of them.

Antipyrin I have used very largely, and for a long time it was my principal febrifuge. It generally reduces the temperature if given for a few days in 15 to 30 grain doses every four hours, by inducing perspiration, but if persisted in, is followed generally on the eighth day by a measly rash, which disappears on the drug being omitted. Anorexia and vomiting, and sometimes collapse, have been noted in cases where antipyrin has been continued for a lengthened period, as is necessarily the case in phthisical pyrexlia.

Its action is very rapid, the temperature often falling within an hour of the first dose, and the fall is often very great. I have known the thermometer fall from 103 deg. F. to 96 deg. F. in a few hours, where 20 grains were administered every two hours for a day, but it rose again when the doses were only required every six hours. This is the great difficulty—we have often to choose between pyrexia and saturating the patient with antipyrin, and in the end generally prefer even the former.

Resorcin, a derivative of benzol, in 10 to 25 grains has a similar effect to antipyrin, and was very successful in reducing the temperature of one case of acute consumption under my care.

Thallin is a very powerful antiseptic derivative of coal tar, of which I have used the sulphate and tartrate in two cases for reduction of temperature according to the recommendation of Ehrlich and Laquer.

In a case of cavity with high pyrexia, which hydrobromate of quinine had failed to reduce, but which had temporarily subsided under antipyrin when carried to the extent of producing the measly rash, after its omission thallin was tried in 1-grain doses every hour, with speedy reduction of temperature from 101.5 deg. F. to

97 deg. F., but, unfortunately, with symptoms of collapse, rigors, and a feeble pulse, and the thallin had to be discontinued.

In another cavity case one grain was administered every two hours, and the temperature was lowered in eight or ten minutes. The medicine was continued in one and one-half grain doses three times a day, but here again collapse fol lowed, and the drug had to be omitted. For rapidity of cooling action thallin, even in small doses, surpasses all other drugs, but its effects are nearly as alarming as those produced by pyrodine, which I strongly recommend all members to have nothing to do with.

Antifebrin or *phenylacetamide* has given me, on the whole, good results in phthisical pyrexia. Its action is rapid, and the lowering of the temperature appears due to diaphoresis, which is sometimes long continued and may be exhausting. The great advantage of antifebrin over antipyrin and other antipyretic coal tar derivatives are (1) the small dose (five to seven grains dissolved in warm water, it being insoluble in cold), and (2) the few doses required in the twenty-four hours—as a rule, two doses a day, given at noon and 4 p. m., will suffice to keep the temperature within moderate bounds; (3) that it can be easily suited by the patient to his or her own requirements. A record of the temperature is kept, and if the chart rises above 100 deg. F. or 101 deg. F. a powder is at once taken, but if the record remains below this it is omitted. Much has been said about the danger of antifebrin in causing collapse of the circulation; all I can say is that I have administered it in the above doses to hundreds of consumptives without the slightest evil result; and I regard it, on the whole, as one of the best antipyretics available for the pyrexia of phthisis. It speedily lowers the temperature 2 or 3 deg. F, which effect remains as long as the antifebrin is taken.

Phenacetin has been found useful in some few cases where antifebrin failed. The dose is smaller and the sweating not so profuse. I once tried hypodermic injections of *carbolic acid* of strength varying from 1 in 30 to 1 in 50, in accordance with the advice of M. Leon Petit, of Paris, who informed me that the reduction of phthisical pyrexia by these means was complete. Two female patients, with well-marked third stage pyrexia, were selected, and 15 minims of a 5 per cent. solution of carbolic acid were injected before the fever rise every day for a fortnight, the dose being gradually increased to 30 minims. The result was purely negatives, but the patients did not complain of the proceeding.

In another case the hypodermic injection of *guaiacol* was performed on a hospital patient of mine by a German physician, who reported most satisfactory results from this treatment in his own country. The dose was 18 minims of an alcoholic solution, and it was injected under the skin of the thigh, the temperature being then 101.8 degs. The patient complained of a slight burning pain over the puncture spot, which soon passed off. Half an hour later she felt very hot and perspired profusely, the temperature falling to 97.4 deg. Two hours later symptoms of collapse came on, and for two hours the temperature was so low that the thermometer failed to register it. By 10.30 p. m., under stimulating measures, the patient had recovered, and the temperature rose first to 96.4 deg., and by 12.30 to 101.4 deg. I need hardly to say the experiment was not of a character to encourage or justify repetition.

Cold Applications.—Some eighteen years ago I published three cases of pyrexia of phthisis treated by cold baths, where consumptives with high fever were immersed in water at 90 deg. F., which was rapidly cooled to 60 deg. F. The reduction in all cases was very decided, and in one case amounted to 6 deg. In all three cases the temperature rose again, but in two of them the bath seemed to be the starting points of improvement in appetite and strength, breathing, and physical signs, and moreover, in thess two, the records were never so high after the bath, and the pyrexia gradually subsided. The third case was an advanced one, with double cavities, and the temperature was lowered, but not permanently. In neither of the patients was any congestion of the lungs or bronchial catarrh induced by the baths.

However, cold baths are at best a clumsy arrangement, and quite inadmissible in many instances, and so I next tried tepid sponging of the body in several cases, with great refreshment to the patient. The ice pack was also tested in some instances of severe pyrexia, and found effective for reduction of temperature, though difficult of frequent application. Finally at the suggestion of the late Dr. Wilson Fox, I tried Chapman's spinal ice bags, arranging that the patient, should wear one of these for a few hours each day whenever the temperature rose above 100 degs. F. This reduced the temperature decidedly for the time, and added greatly to the patient's comfort.

A natural question arises here: Is it advisable to reduce the pyrexia of phthisis at all? We do not thereby stop the tuberculous process; and as regards the wasting, I have shown elsewhere that pyrexia in phthisis is compatible with gain of weight, provided the diet be of sufficiently abundant and nutritive character. In most cases the reduction of temperature is attended with a certain degree of comfort to the patient. But even to this statment there are exceptions, for occasionally patients, when the pyrexia is reduced by antifebrin or antipyrin, experience such uncomfortable sensations—chiefly of oppression—that they prefer the high fever to the effect of the antipyretic.

Two agencies which sometimes prove power

ful antipyretics must be mentioned. One is confinement to bed. This I have seen by itself reduce temperature to the extent of 2 deg. or 3 deg. F. The other is sleep, which will reduce temperature 2 deg. and more at a time without any medicines.

My conclusions as to the treatment of pyrexia in phthisis are:

1. The pyrexia due to tuberculization is best dealt with by derivative measures, such as counter irritation, salines promoting secretion from other organs, and assisting expectoration.

2. That in the treatment of the pyrexia accompanying softening and excavation, measures which hasten these processes are found to be most successful, especially if combined with antiperiodics, such as quinine, salicin, salicylate of sodium, to moderate the fever.

3. That the use of medicines solely directed to lowering the temperature of the body without promoting increase in the natural secretions is generally inadvisable.

4. That our object in the treatment of phthisical pyrexia should be, not the reduction at all hazards of the temperature, but its lowering to the limits compatible with the comfort and well-being of the patients, and for this end that much may be done, in addition to the discriminating use of medicines, by the simple means of frequent food combined with stimulants and rest in bed.—*British Medical Journal.*

FIFTY REMEMBERS FOR DRUGGISTS.

By H. M. Whelpley, M. D., PH. G.

1. Remember that saltpetre and sulphur may explode, if pounded in an iron mortar.

2. Remember that powdered camphor can be kept in the pulverulent form by the addition of one-half per cent. of oil of vaselin.

3. Remember that a "want" book is of no value unless used.

4. Remember that sugar added to ordinary ink forms a good copying ink.

5. Remember that quinine will preserve mucilage, paste, etc.

6. Remember that anilin colors fade with age. Records should not be written with anilin ink.

7. Remember that kid gloves can be cleaned by rubbing them with a clean chamois, dipped in sweet milk.

8. Remember that sulphureted hydrogen water is best preserved in glass stoppered bottles, with the stopper protected by vaselin.

9. Remember that cherry laurel water and morphine salts are liable to form the poisonous cyanide of morphine.

10. Remember that powdered rosin may produce spontaneous combustion.

11. Remember that an application of a weak solution of hydrochloric acid, followed by a weak solution of chlorinated lime, will remove logwood stains from the skin.

12. Remember that rose water made with carbonate of magnesium and used to make eye-water by dissolving zinc or lead salts, will form an irritating precipitate.

13. Remember that many celluloid articles can be mended by covering the edge with glacial acetic acid and pressing them firmly together until dry.

14. Remember and mix acids with water, by pouring the acid into the water and not the water into the acid, as the latter process may cause an explosion of steam.

15. Remember that etherial solutions of iodoform are not permanent.

16. Remember that prescription vials are not always accurate measures, and the quantity of liquid to be used should be measured in a graduate.

17. Remember that the granulated gum arabic dissolves more readily than the powdered.

18. Remember that chloral and cyanide of potassium mutually decompose each other, and that hydrocyanic acid is one of the products.

19. Remember not to keep books of reference where you cannot find them.

20. Remember that it is wrong to accept apprentices who do not like the business.

21. Remember and do not permit graduates, mortars, etc., to stand around dirty. It is much easier to clean them immediately.

22. Remember and do not lose your presence of mind when an accident occurs.

23. Remember that a physician's patronage may cost you more than it is worth if you are over-anxious to hold it.

24. Remember that the druggist should be able to detect any adulterations liable to occur in the medicines he sells. Ignorance is indicated by the excuse. "It was sold to me for the genuine."

25. Remember that the official chemicals are not always "C. P." The terms "U. S. P." and C. P. are not synonymous.

26. Remember that the antidotal treatment for the most common poisons should be familiar to druggists. It is not sufficient to know where to find them.

27. Remember that pyroxylon should be kept packed in glass and moist with its own weight of water.

28. Remember that glycerine administered in large doses may produce poisonous symptoms.

29. Remember that when alcohol and water are mixed the combined volume is less than the sum of the two separate liquids.

30. Remember that alcohol stains varnished surfaces.

31. Remember that the druggist who makes a failure of his own business knows how to run every other store in the neighborhood.

32. Remember that moistening aconite tubers with alcohol before powdering in a mortar will

prevent the irritating dust from rising.

33. Remember that carbolic acid is combustible.

34. Remember that the National Formulary is the authority for non-officinal preparations.

35. Remember that iodine and iodides precipitate the alkaloids.

36. Remember that scaly iron salts dissolve more readily by adding the scales gradually to the menstruum than by triturating in a mortar.

37. Remember that it is never safe to manufacture a preparation from memory. Always have the formula before you.

38. Remember that acetate of lead loses some of its acetic acid when exposed to the air.

39. Remember that cocaine and borax form an insoluble borate of cocaine, while boric acid and cocaine do not.

40. Remember that black lead is not plumbum, but a form of carbon.

41. Remember that eulyptol is a proprietary preparation and differs from eucalyptol.

42. Remember that the metric system has been adopted for the seventh decennial revision of the U. S. P., and it is time to learn the principles of the system.

43. Remember that five parts of phenol with ninety-five parts of water or five parts of water with ninety-five parts of phenol, forms clear mixtures.

44. Remember that the American Pharmaceutical Association meets at Old Point Comfort, Virginia, September 8, 1891, and that every druggist here should attend.

45. Remember that learning the answers to a set of examination questions does not prepare you for an examination.

46. Remember that Bastin's New College Botany and the fourth edition of Maisch's Organic Materia Medica, are two books which should be possessed by by every pharmacy student.

47. Remember there will be plenty left to learn, even if a clerk studies several text books before he enters a college of pharmacy.

48. Remember that your certificate of registration should be prominently displayed.

49. Remember that many cabinet specimens of drugs and chemicals are easily ruined by rough handling.

50. Remember and eat at regular hours and take the usual amount of time for meals that other business men enjoy. Few things make a person ill-natured quicker and renders him more unsuitable for business than irregular habits about eating. I think that much of the proverbial crabbedness of druggists is due to their habits of eating behind the prescription case where they are frequently interrupted by customers.—*Kansas Med. Jour.*

LOCAL TREATMENT OF THE THROAT IN DIPHTHERIA.

The cruel and useless practice of swabbing out the throat with caustic applications in diphtheria of the fauces has, I think, died out; but this method of applying astringents, such as perchloride of iron, or antiseptics and solvents, still survives. The diphtheria wards in the Hospital for Sick Children afford exceptional opportunities for observing the effects of various methods of local treatment; and, from long observation, I have no hesitation in condemning as injurious to the system of brushing out. And this for several reasons. In the first place, on account of the distress it causes to the patient. In the case of a young child it involves a severe struggle; sometimes the help of two or three persons is required to overcome the fierce resistance, and to open the mouth and reach the fauces. It causes terror, excitement, heart strain and physical exhaustion—conditions most inimical in a disease tending to death by asthenia—and the distressing process has to be repeated frequently if it is to be effectual. Moreover, apart from this matter of the wear and tear involved, the rough treatment of the fauces probably does harm by causing abrasions of the surface, and thus favoring absorption of the local poison. We know how readily fresh raw surfaces of all kinds take up poisons which come in contact with them. Witness, for example, the communication of scarlet fever in surgical operations, the absorption of morphine from a blistered surface. If the diphtherial poison is rendered more available for circulation by the application of solvents, the infective absorption is liable to be still greater. The most rapidly fatal case of diphtheria from profound general systematic poisoning I ever have seen was one in which the throat was cleared of membrane by brushing out with papain.

I am sure that not only are the patients saved great distress, and doctors and nurses much trouble and anxiety, by the abandonment of the brushing-out process, but the results generally have been more satisfactory. Insufflation with iodoform or sulphur, or spraying with boric acid or corrosive sublimate solutions, are far more easy of application and more effectual in antiseptic action.

There are other errors in treatment of which I should like to say something, such as oppressive poulticing of the chest in pneumonia, obstructive to respiratory movement, and tending to increase the body heat; the administration of emetics in diphtheritic croup, which is utterly ineffectual except to depress and exhaust the patient; their frequent repetition in bronchitis and whooping cough when there is no extreme mucous obstruction of the air passage to justify it; the too free purging of rickety children suffering from laryngismus and convulsions, under

the belief that irritant matter in the alimentary canal is the sole cause of evil. But time forbids me to do more than allude to these things. I will merely add this word of advice. In treatment, consider as carefully what not to do as what to do. To avoid doing harm is as important as to affect positive good.—*Dr. W. B. Cheadle in The Practitioner.*

THE THERAPEUTIC VALUE OF CANNABIS INDICA.

The virtues of cannabis indica are well known to neurologists, and especially to asylum physicians, but the profession generally does not appear to have great confidence in the drug. We are therefore pleased to see a letter in the *British Medical Journal* for July 4th, by Dr. C. W. Suckling, professor of medicine in Queen's College, Birmingham, calling attention to the value of cannabis indica in a variety of morbid conditions. He states that during the last few years he has been accustomed to prescribe it in many affections. In one form of insanity, more common in women than in men, and brought on usually by mental worry, often owing to the illness of a near relative, or by a moral shock, the drug acts almost as a specific. In this affection the patient is depressed and apprehensive, and imagines that animals are after her or that some one is trying to injure her. There are great mental confusion and mental loss, the patient is unable to carry on any conversation, and sometimes is unable to dress herself, the condition being one of acute dementia. The author says that he has notes of several such cases that have been cured with cannabis indica within a fortnight. He usually gives ten minims of the tincture three times a day, combined with iron and strychnine. He prescribes also complete rest and plenty of food. The cannabis indica is an essential factor in the treatment, for without it the rapid recovery does not follow; it seems to remove the mental distress and the restlessness.

Cannabis indica has proved very useful in his hands in the treatment of melancholia and mania. He has also found it of great value in the treatment of chorea when arsenic fails. It may be combined with chloral with advantage in such cases. In migraine the drug is also of great value; a pill containing a quarter of a grain of the extract, with or without the same amount of phosphide of zinc, will often check an attack immediately, and if the pill is given twice a day continuously the severity and frequency of the attacks are often much diminished. The author has met with patients who have been incapacitated for work from the frequency of the attacks, and who have been enabled by the use of cannabis indica to resume their employment. The drug is also a valuable gastric sedative in cases of ulcer of the stomach and gastrodynia. It may be combined with nitrate of silver, and it increases the efficacy of the latter. It is also a valuable hypnotic.

Dr. Suckling omits an important practical point in connection with the use of cannabis indica. We refer to the difficulty of procuring reliable preparations of the drug. We have reason to believe that this difficulty exists in England as well as in this country. This fact probably accounts in a large measure for the distrust of the drug felt by many physicians. They have found its action so uncertain and irregular that they have abandoned its use altogether.—*Ed. N. Y. Med. Journ.*

THE DIAGNOSIS AND TREATMENT OF INFLAMMATION OF THE APPENDIX.

In a discussion upon this subject before the Massachusetts Medical Society Dr. John Homans said a diagnosis of inflammation of the appendix should be made by any physician up to the ordinary standard of to-day. It is, however, difficult to recognize those cases that would be fatal if left to themselves and those that would recover without surgical aid. Chronic suppuration or hernia may occur after laparotomy for appendicitis, but this should not prevent us from operating. Rational symptoms should guide us in cases requiring an operation, and if possible it is best to wait until an abscess has formed. In cases where the vomiting ceases a day or two after the first onset, the countenance becomes bright, the temperature falls below 100°, and the pulse is about 80, and the abdomen is soft and not tense—a favorable issue with a convalescence, though often tardy and tedious, may be expected. The patients are better off than if they have to go around for a year waiting for an abscess to close and these abdominal abscesses seldom do close—or a ligature to come away, or a hernia to be cured, or with pains from adhesions. On the other hand, a tense abdomen, great mental anxiety, a rising temperature and pulse, with inability to take food and increasing tenderness in the iliac region, especially with a protrusion into the rectum, urge immediate operative interference and removal of the appendix also, if it is easily found. The varieties of appendicitis may be, classically, divided into four: (1) One in which the appendix is perforated, and, perhaps, the cæcum also, and general peritonitis is at once set up. This class of cases is generally fatal with or without operation. (2) Another variety has perforation of the appendix, with limited peritonitis, soon shut off in an abscess of varying size, but generally rather large and forming a well defined tumor, often quite prominent. This class demands operation and drainage, and is generally cured.

(3) A third variety has the appendix swollen and edematous, but unperforated; and yet the symptoms are severe, and there is generally great anxiety and often distension. The tumor here is ill-defined and small, but there is considerable tenderness, with high temperature, pulse, and abdominal distension. With no improvement in two or three days, laparotomy and removal of the appendix, if easily found, is proper. (4) The fourth variety has a sharp pain at first, soon subsiding. Perhaps one attack of vomiting, or tenderness on pressure, and a swelling in the right iliac region, and without any tumor in the rectum. These cases resume an almost normal temperature and pulse in a few days, and though the convalescence often lasts for four or five weeks, yet health is finally restored. The liability to subsequent attacks, however, is problematical, but operation in the initial attack is improper.—*Boston Medical and Surgical Journal.*

THE TREATMENT OF INSOMNIA FROM INDIGESTION.

Healthful, refreshing sleep probably bears a closer relation to the operations of the digestive process than is generally acknowledged by even physicians. Healthful digestion does not in the least interfere with sleep, but any deviation from this standard is more than likely to disturb at least the amount of real rest thus obtained.

In a late issue the *Boston Medicol and Surgical Journal* makes some important remarks which, while not new, are worthy of being placed in remembrance. First, errors are made as to the quantity of food taken. An excess causes an embarrassment to the digestive organs; decomposition and flatulence set in under unmolested microbic rule. Putrid and more or less toxic gases and ptomaines are generated, and a bilious condition supervenes. That insomnia should attend such a state of things is not surprising. The remedy for this is to reduce the daily rations to the physiological standard. The necessity of eating slowly and deliberately is apparent as rapid eaters are more than likely to over eat. Second, poor food may engender insomnia by inducing anæmia or starvation of the vital organs. It cannot be too much insisted upon that the daily fare contain an adequate mixture of albumen, fats and carbohydrates. Indigestible food produces essentially the same evils as excessive amounts of food. Under this head may be ranked improperly cooked food, unripe fruit, pastries, hot bread, fried pork, confectionery. Foods which alone are digestible may become indigestible if too many kinds are eaten at a meal. The idiosyncracies of the individual must be respected, and articles found indigestible be avoided. Much depends upon the muscular work done. Thus hay makers on the salt marshes need food hard of digestion, so as to yield up force during many hours; food such as baked beans and pork, boiled beef and cabbage, and mince pie. These people sleep well in spite of their hearty fare. The rich diet upsets the brain workers, the persons of sedentary habits. Third, a healthy digestion presupposes a healthy state of the stomach, intestines and accessory organs, and any derangement of these viscera must be corrected by suitable medicinal and dietetic means before normal sleep can be enjoyed.

The hygienic treatment of indigestion includes dieting, exercise, recreation, cold bathing, etc. Equally necessary are change of scene, diversions, and the cultivation of a contented, cheerful frame of mind. Of the medical means for promoting digestion we cannot now speak, but they are important in numerous cases.—*Amer. Lancet.*

BROMOFORM AS A TOPICAL APPLICATION.

Dr. S. Solis-Cohen has recently employed bromoform in a severe case of ozena as a topical application to the nasal mucous membrane after thorough cleansing with hydrogen dioxide. The absence of the severe local reaction anticipated, together with the extraordinary success of the measure, not only in destroying the odor but in controlling morbid secretion, encouraged him to use the same agent as a topical application to tuberculous and other ulcers of the larynx, after cleansing with hydrogen dioxide. Here the agent seemed to exert analgesic as well as disinfectant properties, as pain was relieved and healing apparently promoted. The agent being extremely volatile, the immediate effect is transient, and he has, therefore, followed this application with insufflations of iodoform powder. —*Medical News.*

THE USE OF FUCHSIN IN THROAT AFFECTIONS.

Dr. K. Bogroff strongly advocates the use of the aniline preparations as antiseptic agents. In a case of chronic pharyngitis provoked by a tubercular condition of the lungs and larynx, in which the patient had great difficulty in swallowing, and all treatment had proved useless, a spray of a 2 per cent. boric acid solution saturated with fuchsin cured the patient's pharyngitis. The spray forms an impermeable surface over the epithelial lining and protects the tissues from irritation. It is remarked also that this treatment is especially suitable in cases of tubercular laryngitis, as the fuchsin stains the tissues with which it comes in contact, and thus facilitates observation as to whether or not the right spots were touched.—*Vratch—New York Medical Journal.*

IMPAIRMENT OR LOSS OF THE SENSE OF SMELL AS A MEANS OF DIAGNOSIS.

Mr. W. Spencer Watson says that dyosphresia or impairment of the sense of smell, distinguished from anosuria, or total loss of that sense, is not easily estimated. Dyosphresia is a common congenital defect, and is not of much value as an indication of disease. Still, when the taste for flavors and the sense of smell are strikingly impaired, it is well to look for local obstructing cause. An ordinary catarrh may temporarily deaden the senses of taste and smell. If there is frequent intermittent failure of taste and smell there will generally be found some form of chronic rhinitis, and the most common form indicated by this symptom is that associated with gelatinous polypi. Other forms of nasal stenosis may produce anosuria more uninterrupted. Where no obstruction is found chronic atrophic rhinitis, ulcerations, necrosis and caries may lead to the same symptom, as well as facial paralysis with involvement of the fifth fasiculus. But anosuria is, medically speaking, a more serious symptom when it is not to be accounted for by any local disease of the nostrils. It may indicate intracranial disease or injury. Should the symptoms come on suddenly, after a fall upon the back of the head, it may indicate a separation of the olfactory bulbs from the lamina cribrosa, or the injury may have been more extensive and involve the cerebral olfactory centre, which is situated in the tempero-sphenoidal lobe. Drs. Hughlings Jackson and Beevor presented a case illustrative of this point. Perversion of the sense of smell in this case was noted as a prelude to epileptic fits, which preceded the gradual access of dementia, ending fatally; and in the *post-moriem* inspection a tumor, involving the tempero-sphenoidal lobe, was found. In any case similar to the above, in which the olfactory aura is marked, it is a question whether the case should not be handed over to the surgeon, for the purpose of trephining and endeavoring to find the cause of the mischief. In certain cases there is some hope of remedial treatment, but when this symptom is complicated with epilepsy or insanity, the probability of some tumor or disease in the vicinity of the tempero-sphenoidal lobe will suggest itself. Should there be a syphilitic history, the probability is in favor of a gumma, and treatment, if successful, will confirm the diagnosis. The possibility of optic neuritis being present should not be overlooked, and it should be a part of the routine practice in all these obscure cases to examine the retina ophthalmoscopically. —*Annals of Surgery.*

In an excellent paper on "dose dispensing" by Dr. A. B. Somers (now of Omaha), he says: As the years go by I have more and more reason to respect the effect of small doses of medicine often repeated. If some of my older friends are skeptical on this subject, let them try the effect of small doses of tartar emetic (gr. 1-100 to 1-50) in a case of acute bronchitis, with high fever, repeated every half hour from twelve to twenty-four hours, and see the direct sedative effect it will have on the mucous membrane of the lungs and air passages, accompanied by lessening of frequency of pulse and diminution of temperature; or in case of acute dyspepsia usually denominated bilious attacks with fever, try the effect of calomel gr. 1-10, alternated with ipecac gr. 1-10 and bicarbonate of soda grains ½ to ⅓ every two hours, and see how a single grain each of calomel and ipecac, with less than ten grains of soda bicarbonate, will reduce the temperature and produce even more copious discharges of bilious matter than we are in the habit of getting from large doses of calomel, or vegetable cathartics, and without any of the griping and uncomfortable symptoms usually accompanying the powerful doses; or to illustrate further, try in the first case of hepatic colic, or severe pain you meet with, the almost magical effect you will get from morphia gr. 1-20 to 1-40 combined with tartar emetic gr. 1-50 to 1-100 and administered every five minutes. Hypodermics of morphine in much larger doses are scarcely more effective.—*Western Med. Reporter.*

IODIDE OF POTASSIUM FOR THE DIAGNOSIS OF PHTHISIS.

Sticker renews an observation made by him a few years ago, which he has in the meantime confirmed and successfully used for the diagnosis of doubtful phthisis. He finds that where a lesion exists at the apex of a lung, suspected by an impairment of resonance, and alteration in pitch, or a harsh respiratory murmur, but without rales or blowing murmur, the latter may be produced by giving, for a few days, small doses of iodide of potassium. It seems as if the drug stimulated secretion, especially in the neighborhood of diseased tissue, thus giving rise to rales. If moderate doses of the iodide be administered to a healthy person, no changes can be detected in the lungs; but in a case of diffuse dry bronchitis, in the course of a few days an extensive moist catarrh, with fine and coarse moist rales, results. Similar manifestations appear in the area of circumscribed pleural adhesions or pleuritic roughenings. Not rarely the evidences of local reaction are gradually obscured by the signs of diffuse catarrh. In four cases of suspected tuberculosis, in which repeated physical examination of the lungs proved negative, the administration of the iodide for diagnosis purposes produced distinct signs of localized reaction in one or both apices, with tuberculosus sputa.—*N. Y. Med. Jour.*

INTRA-CRANIAL TUMORS AND THEIR LOCALIZATION.

In a paper read in the course of last year by Dr. Putnam, of Boston, before the New York Medical Association, attention is directed to the value of the commencement of a convulsion as an indication of the position of the exciting cause of the fit. He starts with the Jacksonian dictum that, given an irritation of the arm or leg area, the attack is most likely to begin in the thumb or fingers in one case and in the toes in the other, these parts being the most highly specialized or the most lately evolved in their respective limbs. Considerations are urged by Dr. Putnam which are really corollaries of this proposition. They refer chiefly to the occurrence of convulsions in the limbs as effects of tumor at some distance from the limb areas. Particular reference is made to one case published by the author, in which he himself witnessed a convulsion of several minutes' duration, occurring at the shoulder, and unattended by loss of consciousness. This, however, was the only attack witnessed, although (according to the history) there had been others of a more general character, and it was not considered to furnish sufficient justification for operating. Had an operation been performed, with the indication afforded by the occurrence of this convulsion, the tumor would have been found, for it lay at the posterior end of the middle frontal convolution, and had rolled over the upper edge of the hemisphere toward the falx cerebri, strongly compressing the intervening parts. To sum up, the author concludes that the following list indicates approximately the liability to convulsion by irritation in the neighborhood: (1) Hand, (2) face, (3) toe and foot, (4) elbow, (5) leg, (6) shoulder, (7) trunk, and, conversely, convulsions limited to or commencing in the parts mentioned in the end of the list would furnish much more reliable indications for localizing the irritation than convulsions starting in the hand or face. A similar line of argument is pursued with regard to indications afforded by speech derangement, comprehension of speech in this relation being regarded as the less specialized or evolved condition, and therefore as furnishing by its disturbance a more reliable guide in localizing a lesion than is afforded by disturbance of the more highly specialized power of expression.—*London Lancet.*

EPILEPSY.

The most satisfactory results are obtained by combining the bromides with some vegetable agent of producing cerebral anemia. The combination also tends to produce tolerance. Among the best agents are the calabar bean, belladonna and cocculus indicus or their active principles, combining the bromides tends to prevent bromism, while it increases their physiological action; and while the potassium salt produces diarrhœa the sodium constipates. A very good formula increasing the salts as required is:

℞.	Brom. of ammonium,	grs. v.
	Brom. of sodium,	grs. v.
	Brom. of potass,	grs. x.
	Tinct belladonna,	gtta x. M.
	Aromat Elix.,	ʒii.
	Aquæ puræ,	grs. ʒi.

Sig. Three times a day.—*Kansas Med. Jour.*

THE ETIOLOGY OF ACUTE SUPPURATION.

An interesting review of Steinhaus' exhaustive work on this subject closes with the following paragraph, which is of surgical interest:

"That, so far as our present knowledge is to be relied upon we are justified in believing that suppuration in the living tissues is the result of some certain chemical action, which may be combined with the presence of bacteria, or may be obtained from pure chemical substances without the presence of micro-organisms."

Whether this is merely of theoretic interest or not, and that practically in clinical work all suppuration is due to microbes, is still a question unanswered. It is of especial interest in regard to cold abscesses, whose pathology is still unsettled. Steinhaus also claims to have demonstrated that the action of the same micro-organisms varies greatly in different animals, thus explaining many apparently contradictory experimental results.—*Boston Med. and Surg. Jour.*

TREATMENT OF CHRONIC ENDOMETRITIS.

Philippeau treats this disease by drainage and the application of mild caustics and astringents to the endometrium. Tincture of iodine is to be preferred, although iodized phenol may be used at the beginning. Both of these remedies should be applied by means of an applicator armed with cotton, which is allowed to remain in the uterine cavity for a minute or longer and then carefully withdrawn, so as not to displace the eschar in process of formation. A tampon of cotton impregnated with tannin and iodoform may now be placed against the cervix and the application is complete. The patient should remain quiet the rest of the day; remove the tampon the following morning, and immediately afterward take a vaginal injection of water at a temperature of 45° C. [113° F]. These applications of iodized phenol should be repeated every 4 days until the uterine discharge nearly or quite ceases, when tincture of iodine should be substituted for it and continued for several weeks or even months. Injections should never be employed. A 50 per cent. solution of zinc

chloride is very efficacious and may be applied a few times once in 10 days. It is absolutely necessary, however, to put the patient abed immediately afterward. Of course, the cause, if discoverable, must be removed and the cervix must be freely permeable.—*Gazette de Gynécologie.*

PATHOLOGY AND TREATMENT OF WARTS.

Dr. J. F. Payne, in a clinical note on the contagiousness of common warts, expresses the following theory: Common warts, including the so-called *Verruca vulgaris* and *Verruca plana* (which differ only according to the part of the skin on which they occur), but excluding the small pigmented warts and the pointed condylomata, of which the origin is not so clear, appear to arise by implantation of some contagious material at one or more points on exposed parts of the skin. There is also some idiosyncrasy, for whilst children especially are very liable to warts, others, though living under precisely the same conditions, never suffer from them. From the original wart or warts thus produced, others may by local inoculation be set up, just in the immediate neighborhood. At any period Dr. Payne believes that communication to another person is possible by ordinary contact, though a somewhat close contact appears to be necessary. As to the local treatment of warts, the commonest mistake is to attempt to destroy the wart at once by some powerful caustic, this process being often painful, and, if successful, apt to leave a scar. A better method is to apply several times daily some light caustic, as concentrated or glacial acetic acid, and in this lies the main secret of successful treatment.—*The Brit. Jour. of Dermatol.*

TREATMENT FOR VARICOSE LEG-ULCERS.

Basing his opinion upon numerous experiments and a large number of successful cases, Dr. J. Braun, in the *Allgemeine Med. Central-Zeitung*, May 6, 1891, advocates most highly the treatment of leg ulcers with the following formula:

℞.	Zinci oxid.,	15. 0	grammes.
	Lanolini,	100. 0	"
	Unguent. moll.,	40. 0	" M.

The ulcer should first be carefully washed and dried, and the above salve, thickly spread upon a piece of linen, applied, and covered with light bandage. The patient should be kept in bed. Almost immediately after application of the ointment all pain and itching will disappear, and the copious discharge will soon lessen.

According to Braun, this salve forms a protective covering over the ulcer, and the lanolin absorbs the purulent discharge, while further suppuration is checked. The ulcer will therefore become dry and heal. In discolored ulcers the salve should be applied four or five times a day. In about three or four days the ulcerated surface will assume a healthy appearance and cicatrization will begin. The author has even seen deep and extensive varicose ulcers heal in this way, without any transplantation of skin being necessary. After healing, the author advises that an elastic bandage should be worn for some time over the seat of the ulcer.

This same salve has been found by Braun to be of great service in eczema, and as an application to any granulating surface. In eczema capitis the addition of a little bichloride of mercury will be found excellent.—*Med. and Surg. Rep.*

SUGGESTIONS RESPECTING SCIATICA.

Dr. G. Eliot (*N. Y. Med. Jour.*) says:

A large proportion of cases of sciatica are neuritis, and not simply neurlagia.

Temporary relief of suffering should be secured by hypodermic injections of morphine, atropine, or of theine.

Among the curative agents salicylate of sodium and iodide of potassium are especially valuable —the former in acute, the latter in chronic cases.

Considerable benefit may often be derived from the administration of the more purely neurotic drugs—aconite, belladonna, and gelsemium.

Cantharidal blisters are of very great service in promoting the cure of the disease, when used in conjunction with appropriate internal treatment.—*Pittsburgh Med. Rev.*

ICHTHYOL.

Unna employs the following preparation in the treatment of skin diseases:

℞.	Ichthyol,	ʒ vi
	Carbolic Acid,	℈ ii
	Starch,	ʒ iss
	Water,	ʒ vss

The ichthyol and carbolic acid are dissolved in the water while hot, and the starch added.—*Medical News.*

RESORCIN IN ACNE.

Isaak recommends the following:

℞.	Resorcin,	ʒ i
	Zinc Oxide Powder,	
	Starch,	aa. ʒ iiss
	Liquid Vaseline,	ʒ v—M.

S.—Rub on the part affected, at night, and remove in the morning with sweet oil.—*Jour. Amer. Med. Assoc.*

THE PROVINCIAL MEDICAL BOARD.

The semi-annual meeting of the Provincial Medical Board was held at Quebec on Wednesday, 30th September. There were present Drs. R. E. Rinfret, M. P., Alfred Morissette, F. G. Austin, Jules Prévost, E. P. Chèvrefils, l'Hon. M. Marcil, H. A. Mignault, J. M. Beausoleil, Robt. Craik, L. J. A. Simard, Geo. Ross, Côme Rinfret, A. Lagenais, Thomas Larue, L. J. E. Desjardins, J. H. L. St. Germain, L. T. E. Bousseau, Léonidas Larue, P. Laberge, A. Vallée, C. E. Lemieux, écr., J. Lippé, P. M. Guap, M. P., F. Trudel, L. H. Labrecque, C. S. Parke, F. W. Campbell, and A. G. Belleau, secretary.

In the absence of Hon. Dr. J. J. Ross, President, the chair was taken by Dr. A. F. Rinfret, M. P., Vice-President

After the adoption of the minutes, the report of the examiners for the preliminary examination was read, giving a list of students entitled to registration. The committee on Credentials made their report. The question of reciprocity with Ontario was left over until the next meeting. The committee for examination for license was appointed as follows, viz.: Surgery, Dr. C. E. Lemieux; Med. Jurisprudence, Dr. Vallée; Medicine, Dr. Geo. Ross; Mat. Medica, Dr. Jules Prévost, and Obstetrics, Dr. H. A. Mignault. One candidate only presented himself and was rejected.

The following holders of the Bachelor's degree were sworn and admitted to the study of medicine, viz.: MM. Bernard Miville dit Déchêne, B. S., St. Paschal, Kamouraska: Jean Marie Arthur Rousseau, B. A., St. Casimir, Portneuf; Gustave Augustin Côté, B. L., Ste. Anne des Monts; Félix G. Fortier, B. A., Quebec; Evariste Gélinas, B. A., St. Barnabé and St. Maurice; Jos. H. Richard, B. A. St. Maurice; R B. Mackay, B. A., Montreal; Jean-Etienne-Jos.-Ph. Landry, B. A., St. Roch, Quebec; Joseph F. X. Bossé, B. A., St. Onzsime; Calixte Alp. D. Masson, B. L, St. Anicet, Huntingdon; Ernest Cyr, B. A., Maria, Baie des Chaleurs; Walter J. LeRossignol, B. A., Montreal; Joseph Lapierre, B. S., St. Jerome; Aurélien Constantineau, B. S., Montreal; Alexis Lagacé, B. A., Montreal; J. A. Lortie, B. S., St. Justin de Mewlon; W. J. A. Derome, B. A., St. Jean Chrysostome; E. C. Campeau, B. A., Vaudreuil; Wm. F. Deeks, B. A., Montreal; Isaac L. Hargrave, B. A., Eden, Man.; Thomas Nelson Walsh, B. A., Ormstown.

A unanimous vote was passed congratulating the President upon his elevation to the Senate.

It was moved by Dr. Mignault, seconded by Drs. Craik and Parke. That the Governors of the College of Physicians and Surgeons of the Province of Quebec desire to express their regret at the loss which the College has sustained by the death of Dr. Thomas A. Rodger, one of the governors representing the district of Montreal. His influence amongst the members of this Board was deservedly great, being endowed with unquestioned talent, as well as of unchangeable good nature, as is admitted by all who came into contact with him. He always devoted himself heartily to maintaining the honour and best interests of his profession, of which he was a distinguished member. That this Board expresses their profound sympathy with the bereaved family.

The following graduotes were sworn and received their license to practice, viz.: Roch Auguste Paradis, Lotbinère; Albert Aubrey, St. Stanislas de Kostka, Beauharnois; Joseph N. Perrault, St. François du Lac; George R. Fortier, Quebec; Alfred Arsenault, St. Bonaventure; C. J. M. Verge, jr., Quebec; Achille Chandonnet, St. Pierre les Becquets; Pierre V. Faucher, St. Foye; Gédéon Blanchet, St. Dominnique, co. of Bagot; Alexis N. Bellemarre, Yamachiche; George Eugéne Guillemette, Bay St. Paul; Joseph L. M. Genest, St. Bernard; Chas. E. Augé, Drummondville; Georges Cloutier, St. Georges, Beauce; Camille Gariépy, St. Casimir; Arthman Bruère, Montreal; Elizabeth Walker (nee Bruère), Montreal (M.D University of Paris); William Dougan, St. Catharines, Ont.; Jas. P. McIntosh, Connecticut, U.S.; John E. Molson, Montreal; Alexander Dewar, Winchester, Ont; H. B. Ford, Morewood, Ont.; Achille Dagenais, Montreal; Antoine Chopin, Montreal; Charles Wilfrid Beaudoin, St. Bridget, Iberville; Jos. Poupore, Montreal; George Sheriff, Huntingdon; William Fawcett Hamilton. Montreal; Joseph Elie Landry, Stanhope, Quebec; Ovide Normandin, Ste. Philomêne; Alex. A. McCrimmon, Montreal; Neil Malcolm Watson, Williamson, Ont.; Thomas Beeth, Otenaw, Man.

A letter was read from Messrs. Martigny and Montpettit, representing the students of Laval, complaining of the paucity of subjects and the high price charged for them by the Inspector of Anatomy. Another from Mr. George DeFoy offering to furnish bodies for dissection for $5 apiece.

It was moved by Dr. Dagenais, seconded by Dr. Beausoleil: That this Board recommends the Goxernment to repeal the present law concerning the Inspection of Anatomy, and that an amendment to the Medical Act invest this Board with power to govern the inspection of anatomy. Carried.

Moved by Dr. Craik, seconded by Dr. Marcil: That whereas certain holders of the degrees of B.A., B.Sc. and B.L. have, through ignorance, neglected to have their degrees registered at the proper time, resolved—That to rectify this omission all who have so graduated since the promulgation of the Act up to the present date, and who have signified their intention to this effect, be considered as having been registered students of medicine from the date

of the irrospective degress. Lost by a vote of 7 against 15.

Dr. J. J. Dugdale was named assessor for Bishop's College in place of the late Dr. Rodger.

Dr. John A. McDonald, of Montreal, was elected a governor of the College in place of the late Dr. Rodger.

Dr. Lippé presented a scheme for a system of mutual life assurance amongst all the physicians of the Province, but no action was taken.

Dr. Beausoleil presented the Report of the Committee on Legislation. This will be printed circulated amongst the members, and considered at a special meeting of the Board to be held on the last Wednesday in October, at Montreal.

COMMENCEMENT, DURATION AND METHOD OF TREATMENT OF SYPHILIS.

Leloir, speaking before the Tenth International Medical Congress, says that mercury should not be given until secondary symptoms appear, and then, according to the intensity. Inunctions of from 2 to 4 gms. should be used for 15 days. The patient then rests from 15 to 21 days. In the latter periods a general tonic treatment is undergone and the local symptoms treated in the usual way. After 6 to 10 months the inunctions are again employed for 10 day periods, with intervals of from 6 weeks to 2 months of no treatment. Later the iodides are used. After 2 years, if the patient has had no manifestations of the disease, then inunctions twice or thrice daily of 2 to 3 gm. of the blue ointment for 10 days, and a period of rest between of 3 months. After this, a few weeks of the iodides. If marked secondary symptoms appear, the treatment must be more vigorous and the periods of rest shorter. At the expiration of the third or fourth year, if the patient for an entire year has had no manifestations, then inunctions of 10 days duration are to be repeated semi-annually; and after each period of inunctions a month's treatment with the iodides. Large doses are deprecated, as he has seen severe neurasthenia intervene. Hypodermic injections of mercury are to be used only in hospital practice.—*Journ. des Maladies Cut. et Syphil.*

BOULTON'S SOLUTION.

The following is the formula for this solution:

R.	Tr. iod. comp.,	m xx;
	Acidi carbol., (cryst).,	m vj;
	Glycerinæ,	ʒ vij;
	Aq. destillat,	℥ v.

S. Place in water bath of 100° in tightly corked bottle, until solution becomes colorless, then filter. Use in atomizer.—*Columbus Med. Jour.*

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EDITORS:

A. LAPTHORN SMITH, B.A., M.D., M.R.C.S., Eng., F.C.S., London
F. WAYLAND CAMPBELL, M.A., M.D., L.R.C.P., London.

ASSISTANT EDITOR
ROLLO CAMPBELL, C.M., M.D

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MONTREAL GENERAL HOSPITAL.

The meeting of the Governors of the Montreal General Hospital, which was held on the 11th November, was a comparatively small one, yet there was a decision arrived at, which possibly may act injuriously to the best interests of the institution. We refer to the non-admission of lady medical students. It is true that due notice was given on the usual card sent to the Governors informing them of the meeting. The wording of the notice was however not as clear as we think it might have been, and some at all events who would have liked to have been there, did not recognise that the proposed alteration in the by-laws mentioned on the card, referred to this question. The right of the meeting to deal with it was therefore undoubted, and the appeal of Mr. Watt to postpone its discussion and decision to a larger meeting was unheeded and decide it the meeting did. The decision was not a straight and honest decision to alter the by-laws so as to exclude them from the hospital—but to give the Committee of Management the power to do so if they thought it best. What this committee is likely to do, will be fully understood when we say, that we believe every member of that committee is

opposed to their being allowed to attend the Hospital. One would fancy that this question was a new one, and that the Montreal General Hospital had no precedents to guide it, yet the fact is that in several large hospitals on this side of the Atlantic, ladies are admitted as students—such hospitals are numerous on the continent, and strange to say even our Montreal General Hospital had, during the winter of 1890, one lady student in attendance. Yet in spite of the fact that two of the medical staff who spoke at this meeting admitted that so far, no difficulty had arisen, these gentlemen, for fear of prospective difficulties strongly advised their exclusion. They of course formed part of the glorious seventeen members of the medical staff who came to a similar conclusion. Mr. Wolferstan Thomas magnanimously relegated them to the Western Hospital for their education, forgetting the fact that that hospital has only about thirty-six beds, while the law of this Province demands that students of medicine must attend an hospital having at least one hundred beds. His advice was therefore practically useless. That gentlemen stated that in his opinion ladies should confine their medical knowledge to diseases of their own sex, and those of children, but never suggested that to gain their knowledge in these branches they ought to be admitted to the female and children's wards of the institution. Mr. Thomas' opinion is one held by many friends of female medical education, who, however, admit that even to practice in this particular field a general knowledge of the whole range of medical science is desirable. Mr. D. A. P. Watt, one of the governors, championed the cause of the ladies in a most forcible speech, showing the fallacy and unsoundness of the views of their opponents, but the voice of the large majority of the medical board had spoken against their admission, so their doom was sealed.

Another question which was brought up at the same meeting was a notice of motion to have the resident medical staff appointed by the Committee of Management. Its brief discussion brought out some strong opposition and the motion was not pressed but was allowed to stand over till next meeting. We would advise its mover to withdraw it, though upon its surface it would seem to have some points in its favor. If this is not done, and the motion is brought forward for decision, we hope that the governors will defeat it by a large majority. The Montreal General Hospital is a democratic institution and depends for its success on the good opinion of more than three hundred governors. To give the appointment of the resident staff into the hands of the Committee of Management would, we assert, prevent any young man being elected who is not a McGill graduate. The time is past for any hole and corner business of this kind—it is against the spirit of the age that a monopoly in anything, however good, should exist. Bishop College is to-day a well recognised medical school in this city—it is in its twenty-first session—has in its lecture room about seventy students. During its existence it has supplied the Faculty of Medicine of McGill with six teachers, showing the character of the men who then and therefore presumably now, filled its chairs. It has on the list of governors of the hospital five of its teachers, and many friends, who are equally friendly to McGill, but anxious to give the junior school, to say the least, some show. It has the Dean of its faculty on the assistant hospital staff, whose work as a teacher in the outdoor clinic is admitted to be unsurpassed by any other teacher in the hospital. Has a medical school with such a record as this, no claim to have some of the hospital honors fall to its lot. If McGill can prevent it she will. Her history from her foundation has been one of monopoly. As she opposed the Montreal School of Medicine about 1849, she effectually killed, in 1851, the St. Lawrence School of Medicine. She has tried by every means in her power to crush Bishops Medical College but unsuccessfully. Governors do not give up the right which you now

possess of electing the resident staff. Let us remind you that up to about two years ago the resident staff were all McGill men. A few friends of Bishops then thought that it was only fair that one of these five appointments should be given to one of her graduates, and a candidate was found in the person of Dr. Vidal who was also a graduate of Toronto University. His friends were many and influential and among them were not a few governors of the hospital, They felt that his career justified the belief that he would make a good resident officer and they determined if possible to elect him. His candidature met the most intense opposition from the McGill members of the staff but in spite of it, Dr. Vidal was elected, and his work during the ten months he was in the hospital gave the greatest satisfaction, even to those who opposed his election. This being the case it seemed a not unreasonable thing to hope, that out of five resident surgeons the future might at least show a tacit willingness to give one to Bishops College, who at that time had two of its teaching staff on the hospital staff. If ever the men of Bishops College entertained such an idea, it was soon dissipated when last spring among the candidates for the residential medical officers was Dr. Tatley, a graduate of Bishops College. This gentleman, though the son of one of Montreal's best and most prominent citizens, was opposed as determidly as was Dr. Vidal, but in spite of all the opposition he stood third on the *elected* list. Has his so to speak forcible election. against the wishes of the majority of the medical staff, been detrimental to the interests of the hospital ? On the contrary, to-day Dr. Tatley is undoubtedly the best of the resident staff, an honor to the college from which he graduated, and an honor to the institution which he is serving. The resolution of Mr. Watt, if it became law, would be sure to operate in the way we have indicated. We sincerely hope therefore, that the spirit of fair play which always animate this gentleman, will induce him to withdraw his motion.

BOOK NOTICES.

DIPHTHERIA, ITS NATURAL HISTORY AND PREVENTION; being the Milroy Lectures delivered before the Royal College ol Physicians of London, 1891. By R. Thorne Thorne, M.B., Lond., F. R. C. P., Lond., F. R. S., assistant medical officer to Her Majesty's Local Government Board, etc., etc. London, Macmillan & Co., New York, 1891.

This valuable collection of lectures on such an interesting subject, and one of such vital importance to every practicing physician cannot but prove most acceptable to all who are in any way concerned either in the prevention or treatment of this altogether too prevalent disease. A careful perusal of the contents of this little volume will more than fully repay the time thus occupied, and we would heartily recommend it to all physicians. The binding, paper and letter-press are done in Macmillan & Co.'s usual first class style.

ESSENTIALS OF BACTERIOLOGY; being a concise and systematic introduction to the study of Micro-Organisms, for the use of students and practitioners. By M. V. Ball, M.D., late resident physician German Hospital, Philadelphia; with 77 illustrations, some in colors. Philadelphia, W. B. Saunders, 913 Walnut street, 1891. Price $1.00.

This little book forms part 20 of Saunder's Question Compends and is in all respects up to the standard of its predecessors. As bacteria are at the present day looked upon as being the exciting cause of many common diseases the appearance before the medical public of this little work on bacteriology will doubtless prove most gratifying both to the busy general practitioner, who has no spare moments to search for information in more ponderous volumes, and also to the overworked medical students. The price is within the reach of all and none should be without it.

THE URINE; THE COMMON POISONS AND THE MILK. MEMORANDA, CHEMICAL AND MICROSCOPICAL, FOR LABORATORY USE. By J. W. Holland, M.D., Professor of Medical Chemistry and Toxicology, Jefferson Medical College of Philadelphia. Illustrated, 4th edition, revised and enlarged. Philadelphia, P. Blakiston Son & Co., 1891.

The practical little work is intended, as the preface informs us, to be used as a syllabus for the laboratory. The text is made brief and to the point, so as to make a pocket volume, handy for reference. Pages have been left blank for calculations, memoranda, or more extended notes to be made by the student. For the convenience of those whose course of study is very short, the most important matter is printed in the large type. Provision is made for more thorough study by the explanations and quantitative processes given in the small print. Numerous woodcuts are dispersed throughout the book and the general "get up" of the little work is excellent.

SURGERY; ITS THEORY AND PRACTICE. By William Johnson Walsham, F.R.C.S., assistant surgeon to St. Bartholomew's Hospital, etc., etc. Third edition, revised and enlarged, with 318 illustrattons. Philadelphia, P. Blakison, Son & Co., 1012 Walnut street, 1891.

This practical little volume has become so

thoroughly well known since its first appearance before the medical public, that it is not within our power to add anything to its already fully appreciated practical contents. When the first edition appeared some years ago we secured a copy and at that time fully mastered its contents, and were more than pleased with the concise, clear and brief manner in which it placed matters for your perusal. We have since that time had many occasions on which we were compelled to refer to it, and its practibility was only the more thoroughly demonstrated by its continued use. We can in all sincerity recommend it to the medical student.

A Short Manual of Analytical Chemistry. Qualitative and Quantitative—Inorganic and Organic. Arranged on the principle of the course of instruction given at the South London School of Pharmacy. By John Muter, M.A., Ph.D., etc., Public Analyst and Author. First American from the fourth English edition, edited by Claude C. Hamilton, M.D., Ph.G., Kansas City, Mo. Philadelphia, P. Blakiston, Son & Co., 1891.

This is a neat and comprehensive exposition of a most interesting subject. There is no doubt but that this book fully covers the ground its title would indicate. It is very practical as a guide for the medical student, giving both the organic and inorganic work in a very thorough and systematic manner. The tabular arrangement for the detection of unknown salts is particularly to be commended. Typographically the work is above the average. For the busy practitioner who finds it necessary to make an occasional analysis we would recommend this volume as complete and reliable.

Medical Diagnosis: A Clinical Text-Book for Physicians and Students. By Dr. Oswald Vierordt, Professor of Medicine at the University of Heidelberg; formerly Privat Docent at University of Leipzig; Professor of Medicine and Director of the Medical Polyclinic at the University of Jena. Translated, with additions from the second enlarged German edition, with the author's permission, by Francis H. Stuart, A.M., M.D., Member of the Medical Society of the County of Kings, N. Y.; Fellow of the New York Academy of Medicine; Member of the British Medical Association, etc. 8vo., pp. 716. Numerous coloured and wood engravings. Price, cloth, $4; sheep, $5. Philadelphia, W. B. Saunders.

This is the most complete work of its kind hitherto published. It is distinctly a clinical work by a master teacher, characterized by thoroughness, fullness and accuracy. It is a mine of information upon the points that are so often passed over without explanation. The student who is familiar with its contents will have a sound foundation for the practice of his profession. This treatise meets the wants of the physician most admirably. The work is exhaustive, and the systematic and complete consideration of each system leaves nothing to be desired either as a text-book to the student, a guide to the young practitioner, or a work of reference for those longer engaged in practice.

The arrangement is systematic, as shown by a glance at the contents of the book, as follows: Part I contains two chapters—chapter I, Introduction; chapter II, Examination of Patients. Part II has reference to points to be considered in General Examinations. Part III is devoted to Examination of the Respiratory Apparatus, of the Circulatory Apparatus, of the Blood Vessels and the Blood. In this section the Digestive Apparatus, the Urinary Apparatus, and the Nervous System are separately handled. The work has been carefully done, especially that of the translator, who deserves much credit, particularly for the additions inserted by himself. Copious illustrations, many of them coloured, add to the value of the work. We predict for this work a good reception by the medical profession, as it is well fitted to aid the practitioner in his daily work. The volume is well printed and of very attractive appearance, and will prove a valuable addition to any physician's library.

Diseases of the Nasal Organs and Naso-Pharynx. By Whitfield Ward, A.M., M.D., ten years surgeon to the Metropolitan Throat Hospital. G. P. Putnam's Sons, New York and London, 1891.

This is a highly interesting little volume, especially so, as within the past decade catarrhal affections of the nose and throat have apparently become more frequent, whether this be due to our mode of living in over-heated houses and on overstimulating diets we do not propose to say, but assuredly at the present time the specialists in this line have ample scope for experience. Within the past few years great progress has been made in the treatment of the many diseases so frequently found in the nasal cavaties. This has been especially marked in those affections for surgical operations, many improved methods and many new instruments having been invented for their better performance. The author states that in this little book he has endeavoured to present the subject as clearly and concisely as possible, seeking to view the matter from a practical rather than from a theoretical standpoint. The contents are well selected, nicely put together, and form very agreeable reading. The price ($1.00) is within the reach of all.

NEWS ITEM.

The next meeting of the Medical Society of the State of New York will be held at Albany, Febuary 2nd 3rd 4th 1892, Dr. Seneca D. Powell, No. 12 West 40th Street, New York. Dr. James D. Spencer, of Watertown, and Dr. Farnklin Townsend, No. No 2 Park Place, Albany, have been appointed the Business Committee. Any Communications regarding papers or any matter pertaining to the business of the Society which should properly come before the Business Committee should be addressed to Dr. Seneca D. Powell, 12 West 40th Street, New York, City.

A. Walter Suiter,
President.

F. C. Curtis
Secretary.