Technical and Bibliographic Notes / Notes techniques et bibliographiques

The Institute has attempted to obtain the best original copy available for scanning. Features of this copy which may be bibliographically unique, which may alter any of the images in the reproduction, or which may significantly change the usual method of scanning are checked below.

L'Institut a numérisé le meilleur exemplaire qu'il lui a été possible de se procurer. Les détails de cet exemplaire qui sont peut-être uniques du point de vue bibliographique, qui peuvent modifier une image reproduite, ou qui peuvent exiger une modification dans la méthode normale de numérisation sont indiqués ci-dessous.

- ☐ Coloured covers / Couverture de couleur
- ☐ Covers damaged / Couverture endommagée
- ☐ Covers restored and/or laminated / Couverture restaurée et/ou pelliculée
- ☐ Cover title missing / Le titre de couverture manque
- ☐ Coloured maps / Cartes géographiques en couleur
- ☐ Coloured ink (i.e. other than blue or black) / Encre de couleur (i.e. autre que bleue ou noire)
- ☐ Coloured plates and/or illustrations / Planches et/ou illustrations en couleur
- ☐ Bound with other material / Relié avec d'autres documents
- ☐ Only edition available / Seule édition disponible
- ☐ Tight binding may cause shadows or distortion along interior margin / La reliure serrée peut causer de l'ombre ou de la distorsion le long de la marge intérieure.
- ☐ Additional comments / Commentaires supplémentaires:

- ☐ Coloured pages / Pages de couleur
- ☐ Pages damaged / Pages endommagées
- ☐ Pages restored and/or laminated / Pages restaurées et/ou pelliculées
- ☑ Pages discoloured, stained or foxed/ Pages décolorées, tachetées ou piquées
- ☐ Pages detached / Pages détachées
- ☑ Showthrough / Transparence
- ☑ Quality of print varies / Qualité inégale de l'impression
- ☐ Includes supplementary materials / Comprend du matériel supplémentaire
- ☐ Blank leaves added during restorations may appear within the text. Whenever possible, these have been omitted from scanning / Il se peut que certaines pages blanches ajoutées lors d'une restauration apparaissent dans le texte, mais, lorsque cela était possible, ces pages n'ont pas été numérisées.

THE

CANADA MEDICAL RECORD:

A Monthly Journal of Medicine, Surgery and Pharmacy.

EDITORS:

FRANCIS W. CAMPBELL, M.A., M.D., L.R.C.P., LONDON
EDITOR AND PROPRIETOR.

R. A. KENNEDY, M.A., M.D., MANAGING EDITOR.

ASSISTANT EDITORS:

JAMES C. CAMERON, M.D., M.R.C.P.I. CASEY A. WOOD, C.M., M.D.
GEORGE E. ARMSTRONG, C.M., M.D.

VOL. XIII.

October, 1884, to September 1885.

Montreal:
PRINTED BY JOHN LOVELL & SON.

1885.

CONTENTS.

ORIGINAL COMMUNICATIONS.

PAGE

A Case of Partial Epilepsy. By L. D. Mignault, A.B., M.D., C.M. 193
Antiseptic Midwifery. By Geo. E. Armstrong, M.D. 169
Atmospheric Materies Morbis. By Henry Howard, M.D. 194
Cholera. By R T. Godfrey, M.D 121
Cholera and the Comma Bacillus. By J. B. McConnell, M.D., C.M. 217
Gynæcological Report. By E.H. Trenholme, M.D., 28, 100, 222, 265
Medico-Chirurgical Society, Montreal 241
Notes of Six Cases of Removal of the Ovaries and Fallopian Tubes. By E. H Trenholme, M.A., M.D., B.C.L 25
Notes on Two Cases of Lead Poisoning. By L. D. Mignault, M.D 49
Sycosis and Allied Affections. By Casey A. Wood, M.D. 97
The Treatment of Opium Addiction. By Dr. J. B. Mattinson, Brooklyn, N.Y. 73
Valedictory Address. By A. Lapthorn Smith, B.A., M.D., M.R.C.S. 145
Valedictory Address. By the Rev. J. B. Saunders, C M., M.D. 171

PROGRESS OF SCIENCE.

A Clinical Lecture in Gynæcology 266, 271
A Clinical Lecture on Remedies for Asthma 134
A Lecture on Nettle-rash 258
A Liniment for Earache 225
A Mention of two Forms of Eye Disease frequently met with in Children 281
A Method Proposed to Secure Children Against Attacks of Diphtheria 43
A New Specific for Rheumatism 137
A New, Successful, and Palatable Medicine for the Treatment of Tape-Worm 45
A New Procedure for the Goitre 229
A New Remedy for Diphtheria 230
A New Treatment for Neuralgia 44
A New Treatment for Tape-Worm 43
A Practical Point in the Treatment of Pleural Effusions 227
A Reliable Tæniafuge 93
A Specific for Hiccough 44
A Valuable Remedy for Headache 230
Absence of Vagina, Uterus and Ovaries in an Apparently well-built Woman 227
Administration of Quinine 184
An Address in Obstetrics and Gynæcology 102
Antiseptic Dressings as they are used at the New York Hospital 43
Antiseptic Uterine Injections in Puerperal Septicæmia 114
Arsenic in Gastric Ulcer 45
Artificial Sea Air 227
Asthma 227
Belladonna Injection for Gonorrhœa 161
Boils 115
Calomel in the Treatment of Otorrhœa 253
Camphor Inhalations in Corysa 113
Cancerous Uterus 45
Cannabis Indica in Melancholia and Mental Depression with Sleeplessness 65
Chlorate of Potassium to Prevent Abortion 258
Cholera Infantum 228
Cholera Vaccination 228
Clark: A Letter on the Subject of Hypodermic Injection of Morphia in Infantile Convulsions 29

PAGE.

Clinical Experience with the New Local Anæsthetic—Muriate of Cocaine 60
Cocaine as a Local Anæsthetic 13
Colds 30
Constant Crying in an Infant 160
Constipation Habit 273
Convulsions of Children 92
Diagnosis of Diseases of Children 39
Diseases of the Eye and Ear 280
Doctors who died of Cholera 46
Dyspeptic Neurasthenia 108
Efficacy of Bichloride of Mercury in Ringworm 115
Epilepsy 41
Epilepsy Treated with Hydrobromate of Conia 59
Ergot in the Treatment of Cough 230
Excessive Sweating 46
External Applications of Ether for Vomiting 230
Fissured Nipple 92
Flatulence 155
For Chapped Hands and Frosted Feet 93
Frequent and Painful Urination 32
Goitre 35
Good Remedies out of Fashion—Emetics in Bronchitis, Stomach Derangements 88
Great Surgical Operation 45
Hay Fever—Valer. Zinc and Assafœt 138
Headaches 110
Headache, Spinal Irritation and Sympathetic Nervous Affections due to Eye Strain 157
How to Shrink Hypertrophied Tonsils by Caustic Application 184
Hughson: Note on Hypodermic Injection of Morphia in Convulsions of Children 92
Incontinence of Urine 230
Incontinence of Urine in Childhood 253
Induction of Premature Labor 225
Infant Digestion 277
Ingrowing Toe-nail. Definition 231
Intestinal Indigestion 12
Iodoform in Erysipelas 46
Iodoform in the Treatment of Goitre 155
Iridin in the Treatment of the Sickness of Early Pregnancy 44
Kinner: Remarks on Otornhœa in Children 91
Levis' Metallic Splints for Fracture of lower end of the Radius 156
More about Boils 64
Needless and Useless Coughing 115
New Hæmostatic Agent 283
Notes on Asthma 232
Notes on the Use of Hamamelis in the Treatment of Varicose Veins 61
On a New Method of Treating Sprains 181
On Hæmoptysis and its Treatment 209
On Intermittent Pulse, as a Sign of Disease, and its Treatment 211
On the Treatment of Catarrh of the Respiratory Passages—Acute Nasal Catarrh 178
On the Treatment of Cholera 128
On the Treatment of the Graver Forms of Acute Bronchitis. 225
On the Treatment of Measles 183
On the Value of Certain Single Symptoms in the Diagnosis of Diseases of Children 39
Palatable Prescriptions 132
Pediatric Aphorisms .....

	PAGE
Peptonizing of Milk	114
Pharyngitis	31
Pilocarpine in Erysipelas	227
Pilocarpine in Hiccough	42
Pneumonia	151
Pneumonia in Young Children	223
Pneumonia—An Infectious Disease	150
Simple Inflammatory Tonsillitis	45
Santonin for Gleet	44
Scarlet Fever: How to Limit i's Contagion	113
Septicæmia	114
Sick Headache	158
Simple Inflammatory Tonsillitis	184
Solidified Creasote	91
Specific Treatment of Diphtheria and Croup	160
Sub-Acute Parenchymatous Nephritis	275
Sulphurous Acid in Scarlatina Maligna	88
Suppositories in Piles	92
Surgical Delusions	57
The Chancroid and its Treatment. By J. H. C. Sims, M.D	7
The Cure of Asthma	183
The Gulstonian Lectures on Malignant Endocarditis	251
The Rational Treatment of Dysentery	89
The Relief of Toothache	89
The Treatment of Bright's Disease	111
The Treatment of Carbuncle without Incision	253
The Treatment of Cholera	153
The Treatment of Croup and Diphtheria	10
The Treatment of Pelvic Cellulitis Following Parturition	64
The Treatment of Phthisical Night-Sweats	64
The Treatment of Pneumonia	234
The Treatment of Ringworm	229
The Treatment of Sick-Headache	227
The Treatment of Whooping Cough	159
The Village Doctor	62
Treatment of Cold in the Head by Cold Ablutions of the Feet	42
Treatment of Colds	92
Treatment of Disease of the Stomach	173
Treatment of Earache	90
Treatment of Eczema of the Genitalia; Pruritus and Leucorrhea	184
Treatment of Fistula in Ano	185
Treatment of Ringworm	235
Water for Infants	44
Who Owns the Prescription	226

SOCIETY PROCEEDINGS.

Medico-Chirurgical Society of Montreal	28, 85, 122, 197, 241
Montreal's Prominent Physicians	51
Ottawa District Medical Society	50

EDITORIAL.

Adhesion of the Omentum in Abdominal Surgery	93
American Medical Association	263
American Rhinological Association	288
As Others See Us	67
Baravena Milk-Food	118
Bishop's College Faculty of Medicine	165
Canada Medical Association	262
Care of the Insane	18
Cholera	161, 186
Cocaine Chloride	94
College Announcements Received	240
College of Physicians and Surgeons, Province of Quebec.	70, 213
Committee on Organization of the Ninth International Medical Congress, to be held in Washington, D.C. in 1887	68
Correction	120
Craniotomy	238
Glycerine for Dryness of Tongue and Thirst in Febrile States	188
Gold Medal Awards to United States Products at the International Health Exhibition, London, 1884	48
Illinois State Board of Health	188
Insane Asylum in the Province of Quebec	14
Local and General	20, 94, 141, 166, 188, 284
Local Anæsthetic	188
Medical Journal Addresses	215
Medico-Chirurgical Society of Montreal	20
Mellin's Food for Infants and Invalids	188
Montreal General Hospital	214
Montreal Sanitation	116
McGill University Annual Convocation	166
Nævus treated successfully by Local Application of Liquor Arsenicalis	48
Obituary	143
Pamphlets Received	264, 288, 240
"Peptonized" Cod Liver Oil and Milk	48
Personal	70, 96, 120, 168, 191, 216, 239, 286
Physical Education	19
Physiological Experiments on Digestion, Alimentation and Nutrition	118
Precautions against Cholera	162
Prevalence of Measles and Whooping Cough	141
Privy Vaults	140
Proper Time for taking Medicine	264
Relative Diastasic Activity of Malt Extracts	20
Removal of the Kidney	266
Reviews	24, 70, 96, 120, 144, 191, 216, 283
Sewage Fuel	140
Sei-i-Kwai	187
Small-pox	235
Spaying for Uterine Fibroids	236
The Annals of Surgery	118
The Board of Health	139
The Davis and Lawrence Co	214
The Late Alfred Jackson, Esq., M.D., Quebec	238
The Lynam Case	17, 65
The Medical Record Visiting List	70
The Medical Service	237
The Medical Service of the Atlantic Steamships	165
The Montreal General Hospital	47
The Montreal Medical Schools	19
The Third Annual Meeting of the American Rhinological Association	288
Treatment of Ringworm	235
Vaccination	215
Victoria and Laval	19
Victoria Medical School	115
Volunteer Military Medical Officers	185

CORRESPONDENCE.

Correspondence	143
Our New York Letter	130

see conduct [illegible] p. 288

THE CANADA MEDICAL RECORD.

VOL. XIII. MONTREAL, OCTOBER, 1884. No. 1

CONTENTS.

SOCIETY PROCEEDINGS.

Medico-Chirurgical Society of Montreal..... 1

PROGRESS OF SCIENCE.

The Chancroid and its Treatment, 2.—The Treatment of Croup and Diphtheria, 10.—Intestinal Indigestion, 12.—Cocaine as a Local Anæsthetic, 13.—Glycerine as a Remedy in Indigestion, 24.—Intestinal Obstruction from Charcoal..... 24

EDITORIAL.

Insane Asylums in the Province of Quebec, 14.—The Lynam Case, 17.—Care of the Insane, 18.—Victoria and Laval, 19.—The Montreal Medical Schools, 19.—Physical Education, 19.—Medico-Chirurgical Society of Montreal, 20.—Relative Diastasic Activity of Malt Extracts..... 20

Local and General, 20.—Reviews. 24

Society Proceedings.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

Stated Meeting, May 23rd, 1884.

T. A. RODGER, M.D., President, in the Chair.

Dr. R. L. MACDONNELL exhibited a patient with *Keloid Tumors*, supposed to be of idiopathic origin. The patient, under 40, had been under treatment at the Out-patient Department of the Montreal General Hospital for a tubercular syphilide upon his forehead, which is now rapidly disappearing under the iodide of potassium. It was found that he had two keloid tumors upon his body together with the remains of a third. The first of these appeared upon the buttock, when he was 15 years of age. It was at first painful, but as it enlarged became less sensitive. After ten years it began to shrink. Nothing now remains of it but an elongated scar. Upon the breast, lying horizontally across the sternum, just below the junction of its first and second pieces, there is a tumor which is well defined, raised above the surrounding skin, firm, smooth and elastic, and of a pink and white color. It is 7 inches long, ½ to 1 inch wide, and consists of two masses, each about half the size of an egg, connected by a band of tissue which resembles greatly the cicatricial bands seen in large scars. It made its first appearance fifteen years ago, and has been steadily growing ever since. It is more itchy than painful, and is by no means tender on pressure. A third tumor exists upon the left shoulder. It is but 4 inches long, but of exactly the same shape and appearance of that over the sternum.

Dr. HINGSTON said he had never seen idiopathic keloid; never saw keloid disappear. In traumatic keloid the skin is never movable, as in this case.

PATHOLOGICAL SPECIMENS.

Dr. SUTHERLAND exhibited the following specimens:

Kidneys and Heart from a case of Chronic Bright's Disease.—Symptoms; shortness of breath for one year; frequent micturition at night for several years. Before death, developed acute pericarditis and effusion into right pleura. Suppression of urine for 36 hours before death. Suffered acute dilatation of right heart. Kidneys reduced in size; weigh 100 gms., and are typical specimens of cirrhotic kidney. Heart shows slight degree of pericarditis: no effusion. Dilatation of both ventricles, especially of right, which extends 1½ inches to right of sternum. Tricuspid orifice greatly enlarged. Muscle substance pale and fatty but unusually tough, especially about papillary muscles.

Right Kidney, from a case of Chronic Bright's Disease, having the appendix vermiformis and cœcum attached to it.

Cirrhotic and Fatty Disease of the Liver.—Dr GEO. ROSS gave the following description of this case;—G. N., hard drinker past ten years; attack of acute nephritis three months before death; no dyspeptic symptoms till just before admission to the hospital. *On admission*—Skin moderately jaundiced (not noticed till that day); great distension of abdomen by fluid; legs œdematous; fever and delirium; severe diarrhœa, stools quite

colorless; albumen and bile-stained epithelial casts in urine. Breathing very distressed; pulse weak. Aspirated abdomen, with some relief to respiration. Died comatose in five days, jaundice persisting. At autopsy, large quantity of fluid in abdomen; liver about normal size—good example of cirrhotic liver, which is somewhat fatty; obliteration of cystic duct by old inflammation; hepatic and common ducts free; intense duodenal catarrh especially around papilla. Kidneys large, fatty and bile-stained; vermiform appendix large, and bound tightly to lower extremity of right kidney by old adhesions, which have become organized.

Myoma of Cervix Uteri, size of small orange—Removal—Recovery.—Dr. GARDNER exhibited the specimen, which he had removed from a lady aged 52. Patient had suffered from hemorrhages and pelvic distress for 6½ years. The tumor was sessile, and dilated the cervix. The diagnosis was difficult, as there were adhesions all around between the tumor and the cervix, with the exception of posteriorly, where was an opening through which the sound entered the womb. The uterus was retroverted. The tumor was removed without much difficulty, being shelled out with the finger. There was very little bleeding. Out of 74 cases Dr. R. Lee had only seen four situated in the cervix. Dr. Gardner said that this was the fourth sessile tumor he had removed within a year, all the patients recovering. He made this statement as Mr. Tait. in his last edition, advocated the removal of the ovaries in these cases, as he had found that 50 per cent. of deaths followed removal of sessile myomata from the interior of the womb.

Dr. HY. HOWARD exhibited under the microscope, a slide given him by Dr. Spitzka of New York, shewing the origins of the roots of the 6th, 7th and 8th nerves from the medulla of a cat.

Varicocele of the Spermatic Veins.—Dr. RODDICK read a paper on this subject.

Dr. HINGSTON said the subject was interesting, as this trouble was very often seen. He prefers, when the operation is necessary, that of tying the veins and dividing between the ligatures. He had only operated three times, and now almost questioned the necessity of ever-operating. The trouble comes on, as a rule, about the age of 23, and goes away after a couple of years. He was of the opinion that it was not a cause of emissions, as the testicle is often atrophied, and therefore not so active. The mind was more affected, as a rule, than the scrotum. The ring or a truss or suspensory bandage, were often useful. He had never seen a case requiring castration.

Dr. F. W. CAMPBELL endorsed Dr. Hingston's views regarding this very common condition.

Dr. FOLEY said that Mr. Jonathan Hutchinson's treatment was purgation and elevating the testicles.

Dr. GEORGE ROSS thought the operation ought not to be swept away, for it has proved to be free from danger, and ought to be resorted to where the distress was very great. He has found palliative measures, such as the soft metallic ring, to be all that is necessary in most cases. He has not found either the truss or suspensory bandage to give satisfaction.

Dr. HY. HOWARD said there was no such thing as hypochondriasis. If the patient complained of pain there must be some physical cause. He believed that at times the operation was justifiable.

Dr. KENNEDY asked why so much fear about interfering with veins. He believed that where the operation is indicated it ought to be performed without hesitation.

Dr. RODDICK, in reply, said that the danger of working with veins was considerable. The writer of the article on this operation in "Holmes' Surgery" says that he had a case where two joints were lost from pyæmia following the operation.

Stated Meeting, June 13, 1884.

T. A. RODGER, M.D., President, in the Chair.

Dr. R. L. MACDONNELL exhibited the following anatomical specimens made from a frozen subject—1st, Cross section of the thorax; 2nd, cross section of the abdomen on level with first lumbar vertebra; 3rd, vertical section of the pelvis.

Erysipelas of the Face, followed by double Cerebral Abscess.—Dr. ARMSTRONG narrated the case. F. F., æt. 17, a student was first seen Feb. 15, 1883. For past three weeks, from over study, has been running down in health. Has suffered from vertex headache. To-day the bridge and both sides of the nose are red, swollen, hot and painful. 18*th*—Erysipelas has extended over both cheeks and upwards over the lower half of forehead; had slight chill this morning; temperature 104°. 20*th*—Pain at top of the head still very severe, preventing rest and sleep. He answers questions correctly, but speaks in a slow,

drawling manner. Says he hears nothing with right ear. Temperature 100°; pulse 56. *23rd*—Pulse 68, and intermittent; temperature 103.5°; opened pocket of pus in forehead. *24th*—Mild delirium present. Let out pus at root of nose. *25th*—Had good night; pulse 66; temperature 101.8°; answers questions rationally, but slowly. *26th*—Gave exit to pus at inner and upper angle of right upper lid. *27th*—Dr. Proudfoot made an incision into the orbit quite to the apex to let out pus. *March 1st*—Has had very restless night; much pain in the head; pulse 54; temperature 101.8°. *3rd*—No headache; is more intelligent. *5th*—Has had paroxysms of intense headache; Cheyne-Stokes breathing. *8th* — Constantly moaning, no delirium; pulse 60; temperature 97.8; extremities cold. *10th*—Troubled with vomiting; emaciation extreme. *20th*—Growing worse. Dr. Proudfoot made three openings around the right orbit to relieve pus, which was pushing the eye forward. *30th*—Much the same; vomiting continues. *April 14th*—Patient died of exhaustion after an illness of eight weeks and two days. At the *post-mortem* the membranes of the brain were found normal, with the exception of that portion of the dura mater covering the petrous portion of the right temporal bone; here it was of a very dark color, thickened and softened. The arachnoid and pia-mater were normal. An abscess the size of a walnut was found in each hemisphere, and similarly situated on either side. They occupied the centre of the occipital and part of the parietal lobes. They were not congested. The longitudinal sinuses were healthy. Many of the symptoms usually looked for in cerebral abscess were wanting. There was an entire absence of epileptiform seizures, rigors, paralysis, or disordered sensibility; the prominent symptoms being severe headache, delirium, vomiting, a slow, defective articulation, slow pulse, and slow, intermittent respiration. The last two symptoms were evidently due to pressure.

Dr. Ross thought the abscesses were caused from the suppuration in the orbit. In the few cases of cerebral abscess which he has had, two were in the cerebellum. The absence of typical symptoms in cases of tumors and abscesses of the brain was not uncommon.

Dr. Hy. Howard mentioned a case of supposed abscess following erysipelas of the face. He thought that all organs were liable to be affected by inflammations of the skin covering them, even when bony walls intervene.

Dr. Shepherd had seen several cases of abscess of the brain, but all from ear disease. He was of the opinion that in this case it was due to pyæmia.

Dr. Proudfoot said he had often seen this patient with Dr. Armstrong, and that there had been very little ear trouble all through—nothing, in fact, to indicate disease of the ear itself. Believed the abscess was due to the erysipelas. Had examined the eye several times with negative results.

Dr. Armstrong, in reply, said why one would think the abscess due to disease of the ear was because this was so frequent a cause, and besides, the dura mater was dark and necrosed over the petrous bone. Deafness was also present, without pressure on the auditory nerve.

High Specific Gravity of Urine.—Dr. Foley said that lately he had examined a specimen of urine of a clear amber color, containing neither sugar nor albumen, and yet having a specific gravity of 1035.

Dr. Ross said this was not very unusual. Lately he was attending a child of three years of age, who, from over-feeding, had become ill. She had an enormous appetite, but steadily emaciated. Diabetes was suspected. The specific gravity of urine was from 1037 to 1038, but contained no sugar. Examination for urea showed this present in abnormal amount. She soon recovered under appropriate treatment.

Dr. Stewart said that in all cases where there was deficient oxidation—that is, in all cases of azoturia—a high specific gravity would be seen. Correction of the diet will cure this condition.

Hysterectomy on an Insane Woman.—Dr. Trenholme read a paper on this case, of which the following is an abstract:—

Mrs. R. M. W., of London, Ont., aged 30, was married at the age of 15, previous health being good. Shortly after marriage pregnancy ensued. Excepting heartburn, nothing unusual occurred until her delivery in the spring of 1873. During labor two severe epileptoid convulsions occurred, necessitating instrumental delivery, the child being still-born. Vomiting followed, then blindness, which latter remained for some days; she eventually recovered. Again becoming pregnant, was delivered naturally of a living child in the latter part of the same year. Epileptic fits now

set in, especially at menstrual periods. On account of the rapid recurrence of these fits, a vaginal examination was made, ulceration of the o diagnosed, and treatment adopted, with improv e ment in local condition. No improvement in the fits. Patient took to alcohol for relief, and at last became insane. In 1882 she was sent to the asylum, and entered as an incurable epileptic, with erratic symptoms. Dr. Midford of Portland, who saw the patient, recommended öophorectomy, but this Dr. Bucke did not think necessary. The patient was taken out of the asylum, womb and ovary reported contracted and ovary attached. Vaginal öophorectomy was performed on 10th April, 1883; one ovary was found cirrhosed. Recovery took place, and patient menstruated at usual time, and has continued to do so ever since. No improvement mentally or with the fits, the patient was returned to the asylum. It being considered essential that the tubes should also be removed in these cases, and by abdominal incision this was decided on. This was for the purpose of exploring the pelvis for any supernumerary ovary or remains of ovarian tissue, and if the uterus was diseased, to remove it also. The operation was performed April 23rd, 1884. There was no trace of an ovary or ovarian tissue. The uterus was enlarged and densely indurated, and tubes hypertrophied. The uterus and tubes were then removed. The operation lasted less than one hour, and was well borne by patient; vomiting was somewhat severe afterwards, the patient, however, apparently doing well for the first 36 hours. After this time patient steadily continued to fail; pulse 140, and temperature 102; death ensuing 59 hours after the operation. The report states that "ever since the operation, her fits (slight ones) have been very frequent, but at no time has there been a single unfavorable abdominal symptom, and on examination after death the wound seemed to have been almost healed by first intention. Cause of death, continued and progressive shock." In speaking of this case, Dr. Bucke told me the patient had a series of epileptic fits lasting for 11 hours almost continuously, and that as she had two such attacks while in the asylum, during each of which she nearly died, he felt convinced this last attack, coming on toward the close of the second after such a severe operation, "had a great deal to do with the fatal termination." The following points connected with the operation itself are perhaps worthy of note: 1. The abdominal walls were divided in the exact median line, so that the peritoneum was reached without dividing a single muscular fibre. 2. The uterus was carried upward and retained there by means of a large rectal bougie passed up the vagina and pressed against the os uteri. 3. The uterine arteries and other vessels were secured by fine hemp ligatures, which embraced the folds of the broad ligament corresponding to each tube and ovarian ligament. 4. The uterus was divided at the inner os by a V-shaped incision, and the amputated surfaces brought together by five catgut ligatures in such a way that a simple linear incision resulted. The deeper parts of the opposed surfaces were then more closely approximated by means of quilting them with catgut, about five double or shoemaker's stitches being thus employed. 5. The deep abdominal sutures were inserted so as to carefully avoid any portion of the muscular tissue. 6. No abdominal bandage or long plaster was employed with the object of strongly encasing the abdomen, a practice fraught with no possible good, and often potent for much evil.

Upon examination of the parts removed, the Fallopian tubes were found to be occluded for about an inch from the horns of the uterus, and also very firm to the finger. The uterus was hard and about twice as large as it should have been. The cavity of the body was almost entirely obliterated, admitting the point of the probe for about a quarter of an inch only. This condition prevented any communication whatever between the tubes and uterus. Menstruation must have been from the cavity of this neck.

I much regret the issue in this case, because some two months ago I removed the ovaries and tubes from a patient who had been suffering at her menstrual periods with increasing severity up to about six months before the operation, when suicidal mania supervened, and the monthly disappeared. I had a letter from her medical adviser a few days ago, in which he says; "Miss C. is doing well, and her mental condition much improved, though hardly up to par." It may be that there are few cases of insanity which would be cured by removal of uterine appendages, yet, doubtless, there are some cases where the cessation of all sexual activity holds out the only hope of ameliorating their sad fate. Two classes of cases would seem to warrant the performance of the operation, viz., 1st, those cases of *imperfect sexual development* where the nervous energy is diverted

and expended in fruitless attempts to perfect its growth and maturation. Here may we not hope that the removal of the uterine appendages will be found to improve the mental condition, and, perhaps, in some cases restore to sanity. 2nd, Again, in an opposite class of cases, where the activity of the sexual organisation dominates the mental powers, may we not hope that the cessation of this controlling force will be followed by a calm and such a change in behavior as the results of castration in the lower animals would lead us to expect. I think these points are worthy of careful study, and hope they will be tested so as to afford statistical data for future guidance.

Stated Meeting, June 27, 1884.

T. A. RODGER, M.D., President, in the Chair.

Crushed Hand treated by dry and infrequent dressings.—Dr. SHEPHERD exhibited a patient who, some two weeks before, had received a severe crushing injury of the hand. The palm of the hand was deeply incised from one side to the other, and all the short muscles of the thumb were torn out and lying exposed in the palm. The back of the skin of the hand was enormously distended with effused blood and serum. The extended muscles were replaced, a drain inserted on the thumb side, and the wound stitched up. The back of the hand was deeply incised over each metacarpal bone to allow the effused blood to escape, and the whole dressed with iodoform and pads of naphthalized jute, covered with washed gauze, and firmly bound with an antiseptic gauze bandage. Owing to the oozing of blood the dressing had to be changed next day, at which time the drainage tube was much shortened. It was redressed as before, and as there had been no elevation of temperature, discomfort, or pain, the hand had not been disturbed since that time. Dr. Shepherd now removed the dressings before the Society, and showed that the condition of the hand was most favorable; there was union by first intention everywhere; except where the drainage tube was, the hand had quite a normal appearance, and the dressings were only stained with a little bloody serum. Dr. Shepherd remarked that this case was an example of many he had treated in the same way, and which showed the benefit and simplicity of dry and infrequent dressings.

Dr. RODGER said that he treated compound fractures from railway accidents with dry dressings of absorbent cotton and iodoform.

Sarcoma of the Skin and Cellular Tissue about the Ankle—Amputation—Recovery.—Dr. SHEPHERD read a paper on this case, and exhibited both the foot and slides from the diseased structures. The following is an abstract of the paper, which was published in full in the *Medical News* of Sept. 20, 1884:

E. M., a delicate-looking youth, aged 18, came to hospital in April last, suffering from an ulcerated swelling above the left ankle. The ankle was first injured six years ago by a fall, from which he recovered so as to walk as well as ever, although a slight swelling remained. A year after it became painful and more swollen. An unsuccessful incision was made for pus, which opening never healed. Three years ago he was kicked on this ankle by a horse, which increased the trouble. The joint itself, since the first hurt, was apparently never affected, but the swelling on the inner side slowly increased, and at different points sinuses would form. On entering hospital, the parts about the inner side of the left ankle were of a shiny, dusky red color and considerably swollen. At the upper part were several sinuses, and near the centre a small ulcer. Pressure, which gave a semi-elastic sensation, was not painful. A free incision was made. After cutting through very thick infiltrated skin, pockets of a tissue like granulation-tissue were opened up. A neoplasm was suspected, and some of the substance from the pockets was sent to Dr. Wilkins for microscopical examination. He pronounced it a very good example of the round-cell sarcoma. Dr. Shepherd at once amputated the leg at some distance above the disease, dressing the stump with iodoform and pads of sublimated jute. Decalcified bone drains were tried, but had to be given up, as they collapsed. The case did well, the temperature after the third day never reaching 99°. The case was instructive, chiefly on account of the difficulties it presented for diagnosis and the importance of its being correct, as sarcoma, especially the round-cell variety, unless removed, is a fatal malady.

Dr. GEO. ROSS asked what was Dr. Shepherd's experience with decalcified bone tubes, and why they failed in this case.

Dr. SHEPHERD, in reply, said that these tubes had been kept in carbolic oil, which made them too soft, spirit being the better fluid to keep them in. They use these tubes in New York, but have difficulty in getting them just right. Some become absorbed too soon; others never absorb.

Dr. FENWICK had found the india-rubber tubes to give entire satisfaction; in some of his cases of excision of the knee, the dressings were renewed but three times in all.

Dr. RODDICK said he made some decalcified bone tubes, and used them twice, but they became clogged. He said McEwen experienced this same trouble, and now passes horse hair through the drain. This he finds prevents clotting. Another objection to them was that the bone tubes sometimes become absorbed too fast, and leave a pocket of pus undrained.

Dr. STEWART exhibited a case of *Multiple Cerebral Sclerosis, having an Apoplectiform mode of onset, and where Syncopal and Apoplectiform attacks frequently recur.* The patient, a man aged 47, hotel porter, came under observation three months previously, complaining of obstinate constipation, difficulty in speaking, and dimness of vision. He gave the following history: Three years ago, while in the enjoyment of his usual health, he was seized, while seated on the driver's seat of an hotel 'bus, with giddiness. He was at once carried home, and almost immediately afterwards passed into a state of unconsciousness, which lasted twelve hours. After the return of consciousness, he passed, in a few minutes, into a delirious state of a few hours' duration. For some three weeks afterwards, his wife says he was "weak and useless," and "his speech was so curious that it was difficult to understand what he said." In the course of a few months he was able to speak much plainer, but not so plain as he could do previous to the attack coming on him. In the autumn of 1882 he spent some weeks in the General Hospital, and while there was under the care of Dr. Ross. Through Dr. Ross' kindness I am enabled to compare his state at that time with what it is at present. With the exception of syphilis, he never had any trouble up to the time of his present affection coming on. He formerly drank to excess, but not since the commencement of his present illness. His father died of what he calls "liver complaint." His mother and only brother are dead, but he is ignorant of the cause in either case.

Present state—Nervous system.—There is a considerable degree of mental weakness, which has only been apparent during the past year. It is progressively becoming more and more pronounced. He frequently loses his way in the streets. He is extremely emotional, laughing and crying without an apparent cause. His memory for recent occurrences is very poor, but good for trifling events of many years past. He has a very exaggerated opinion of his own cleverness. As he never received any education, he is unable to write. His speech is markedly slow, monotonous, and syllabic. The voluntary power in both upper and lower extremities is good. When he undertakes to perform any movements, the muscles commence to tremble. This tremor, however, is not always marked; very frequently it is absent, especially in the afternoon and evening. It is very pronounced immediately after getting out of bed in the mornings. The nutrition of the whole voluntary muscles, except the tongue, is normal. The patellar and superficial reflexes are present. The co-ordination and muscular sense are not interfered with. There is no disorder of sensation. There is no paresis of the bladder or incontinence of urine. There is no obstinate constipation. Dr. Buller has examined his eyes. He finds simple atrophy of both discs. Vision is *nil* in the right eye, and almost so in the left. There is no paralysis of any of the ocular muscles. Hearing, taste and smell are good. There is paresis of the respiratory branches of both facial nerves, as is evidenced by the expressionless aspect of the lower half of the face, the obliteration of the naso-labial folds, the dribbling of saliva from his mouth, and by his inability to whistle and to show his upper teeth. The soft palate is very slightly paretic. When the mouth is opened, the lower jaw trembles. He has difficulty in protruding his tongue, and when he attempts to do so it commences to tremble. There is not only difficulty in protruding the tongue, but there is difficulty in keeping it protruded. The tongue is very slightly wasted, but it is not the seat of any fibrillary twitchings. There is no impairment of either the motor or sensory divisions of the trigemminus. He has no difficulty in swallowing. He complains much of giddiness, especially when walking; objects, he says, are constantly turning around him. He is subject to both syncopal and apoplectiform attacks; both coming on suddenly, without warning,—the former lasting a few seconds, and attended with paleness of the face; the latter lasting several hours, and attended with suffusion of the face and an elevated temperature. His pulse is constantly beating between 40 and 45 times in the

minute, and at times it is irregular in rhythm. His urine is free from both albumen and sugar.

The patient's present condition was then contrasted with what it was when he was in the General Hospital, 18 months previously.* At that time the symptoms present were purely bulbar. Since that time the bulbar symptoms have gradually increased in severity, and, in addition, we have involvement of the optic tracts, cerebrum, and in all probability the cerebellum also. Although the giddiness may be explained otherwise, it is probable that its mode of causation in this case is the formation of sclerotic nodules in the cerebellum. Whether the slow pulse is a proof of the implication of the vagus nucleus, it is impossible to say. If so, it is necessary to suppose an irritative lesion of the cardiac inhibitory nucleus. The case is undoubtedly one of multiple cerebral sclerosis, commencing in the pons and medulla and gradully extending into the cerebrum, cerebellum, and optic tracts. There is no evidence of the pyramidal columns being affected either primarily by the sclerosing of their structure or secondarily by a descending degeneration. Neither is there any proof of any other portion of the cord being involved. The case is therefore one of pure cerebral sclerosis. It is noteworthy for its peculiar mode of onset, and for the apoplectiform and syncopal attacks to which the patient is liable. Another interesting feature in this man's case is the intermittent presence of tremor. In the great majority of cases of disseminated sclerosis, tremor on voluntary movement is the most constant and most characteristic symptom present.

Dr. GEO. ROSS said he had not seen the patient since he reported the case to the Society. At that time he had recently had an attack, apoplectiform in character, which he believed to have been due to a hæmorrhagic clot.

In reply to Dr. Roddick, Dr. STEWART said his patient had taken iodide of potassium.

Dr. HY. HOWARD said that these cases of sclerosis vary so much that it is difficult to group the symptoms so as to tell positively whether the brain or the cord was affected primarily. Erb says that out of 200 cases, 171 were syphilitic, and the cord was first affected. Dr. Howard's own observations showed that 7 out of 10 had syphilis. A man in the asylum denied having had syphilis till the marks were found; his first symptom was impotency. He (Dr. H.) had never seen a case cured. Insanity in those cases of progressive paresis was caused by reflex action from the cord where it is diseased to the higher nervous centres, which are the lowest organized.

Cancer of the Stomach; rapid growth of the tumor.—Dr. CAMPBELL related the following particulars of this case:—Had been sent for early in May to see Mrs. L., aged 41, who was complaining of pain over the stomach, but not very severe. As her mother had died of cancer, he was pretty sure this would prove to be the same trouble, although no tumor could, as yet, be made out. Within a week vomiting set in. *June 1st*—Rather worse. *5th*—Could keep nothing on her stomach. On the 7th, could feel a nodule, which, in 48 hours, increased wonderfully from being the size of the top of the thumb to that of a walnut. The vomited matters were the color of bile—never bloody. The patient died a week later. The pylorus and lesser curvature were implicated. There was stenosis, but not much dilatation of the stomach. Pain, which was never very severe, was less toward the end. There was no cachexia present.

Dr. TRENHOLME said he had had two similar cases. In one, there were no symptoms till within three or four days before death, although a cancerous mass the size of a turnip existed, which involved the stomach; the other was that of an old gentleman, who ate well up to the last, and had very little pain.

* A detailed report of his then state will be found in the Society's Transactions recently published. Dr. Ross gave an account of his condition at the meeting held on December 1st, 1882.

Progress of Science.

THE CHANCROID AND ITS TREATMENT.

By J. HENRY C. SIMES, M.D.

The question of the treatment of any venereal sore is one which has of late years given rise to two methods of therapeutics. On the one hand we have those who advocate, as a rule, the application of some destroying agent to the lesion, and, on the other, those who are opposed to any form of cauterization.

To consider the subject in a satisfactory manner, it becomes necessary that an understanding of the nature of the lesion should be at least approximated, since much will depend upon the opinion we hold in regard to the affection.

Without entering into a discussion upon the various theories of the duality or unity of the vene-

real sore, I will divide them into two varieties, those which are followed by syphilis and those which are not. That these two kinds of sores are met with, all experience is an evidence of the fact. The doubtful and disputed point is to know where to draw the line, to differentiate between an infecting and non-infecting lesion. That it is possible, in every case, to determine, with absolute certainty, the precise nature of every venereal sore, all writers are agreed in the opinion that such accuracy of diagnosis cannot be reached. There are, however, in most cases of venereal sores, some symptoms which justify us in placing the lesion under one of the two varieties. It is well, in every doubtful sore, never to give a positive opinion of its nature, but wait until the time for constitutional symptoms has arrived, and then all doubts will be removed. Indeed, it may be considered prudent, in no case of venereal sore to commit ourselves to a positive opinion, until we are satisfied the time for systemic infection has passed. Our diagnosis may be correct in ninety-nine out of a hundred cases, but there always exists the possibility of error; and where so much depends upon the opinion of the surgeon, not to the patient alone, but to his family and society, it is imperatively our duty to use every precaution to protect all against such a misfortune as may follow a hasty and wrong diagnosis. The symptoms which accompany the non-infecting venereal sore—the chancroid—may be summarized as follows: The origin of this lesion is usually due to contact with pus from a similar lesion, or to accidental inoculation of the secretion of a chancre upon a person already affected with syphilis. And I am also inclined to believe the possibility of the formation of a chancroid from pus other than that obtained from a chancroid, or, in other words, from pus from other sources. The stage of incubation of a chancroid is so irregular and uncertain that such a period may be regarded as not existing, and is of no value as a diagnostic symptom, except in a differential diagnosis from the infecting sore. The seat of the chancroid is, almost without exception, either upon the glans penis or prepuce. The possibility of a chancroid occurring at any other locality cannot be denied. Writers of unquestionable ability have met and described such lesions. That they are of the greatest rarity must be admitted, since seventy or eighty will cover all the reported cases, while those of the glans penis and prepuce may be counted by the thousands. The chancroid begins as a pustule or ulcer; it is irregular in shape, the edges are sharp cut, and often undermined, its surface is uneven, whitish, pultaceous; it secretes an abundant purulent discharge, which is readily auto-inoculable, and, therefore, the chancroid is usually multiple. Pain is a prominent symptom. There exists no characteristic induration, such as is met with in the infecting sore, but, exceptionally. the lesion is accompanied with an œdematous inflammatory swelling, which, in a measure, resembles the specific induration of a chancre. This is more especially the case when any irritant has been applied to the sore, such as a caustic. It, however, differs from the chancre induration, in that there is no marked limit to the swelling, but it gradually blends with the healthy tissues to which it is adherent; and, finally, it differs from the specific lesion, by disappearing with the healing of the sore. Again, the chancroid has no regular course; it may recover with rapidity, or it may be extremely slow in healing, enlarging and extending over a large extent of surface, in fact, becomeing phagedenic. No protection of the system is afforded against a second attack by a previous infection. Inflammation and suppuration of the neighboring lymphatic glands is a very frequent complication of the chancroid. The histology of the chancroid presents nothing characteristic of the lesions; it is an ulcerative process, due to an inflammatory action, and therefore results in a loss of substance. No distinction can be histologically made between a chancroid and an ulcer due to any irritant which occasions inflammation and ulceration.

A sore with the above history, and presenting the symptoms I have enumerated, may generally be regarded as a local non-infecting lesion and treated as such; but, as previously mentioned, it may possibly be followed by constitutional symptoms, and therefore, while giving all encouragement of a hopeful kind, it is well to be cautious in expressing any positive opinion. A case in point recently came under my observation. Two men had connection with the same woman, in immediate succession. During the following week they both presented themselves to me, and upon both, in the furrow between the glans penis and prepuce, were seen painful, irregular, multiple, and profusely discharging purulent sores. The same treatment was applied to both, and they both progressed favorably for a certain time. Their termination, however, differed; one, he who had connection with the woman first, entirely recovered; the other, about three weeks after the exposure, returned with the sores unhealed, and, upon examination, quite a different state of affairs was seen. There was in the preputial furrow a sore presenting very markedly all the objective symptoms of an indurated chancre; also the characteristic indurated inguinal glands of lymphatic contamination were observed. Here I have no doubt constitutional syphilis will eventually follow in due time; as yet the systemic involvement has not made itself manifest. Such cases, although they are seldom met with, should teach us that caution in expressing our opinion cannot be too rigorously observed.

Fortunately the treatment of the venereal lesions does not, in either case, materially affect the result. That is to say, it matters but little whether we have to do with a simple local venereal sore, or a sore which will be followed by syphilis. In both the same method of treatment is now advised by most writers upon the subject. In both the thera-

peutics is to be strictly local, but it is as to the nature of the local treatment that there arises a difference of opinion. One author advises us to cauterize every case; another rarely employs this method, and only to meet special indications.

The application of cauterizing agents to venereal sores has always been one of the methods of treatment in this affection. The reasons for its adoption can readily be understood, when we remember that, previous to the separation of venereal sores into two classes, the infecting and non-infecting, it was noticed that very often constitutional contamination did not supervene, and it was generally believed that the destruction of the virus contained within the sore by the cauterizing agent had prevented such contamination. Now, however, we know that it was not the treatment which prevented an outbreak of syphilis, but no infection had taken place, and therefore there had been no preventive treatment.

After the division of venereal sores into infecting and non-infecting, the application of caustics has been continued, on the ground that each variety of sore contains within itself a specific virus. That this is true of the infecting variety none deny; but that there exists any specific element in connection with the non-infecting sore is a question which, at the present time, is disputed by a few authors. I do not propose now to enter into a discussion upon the specificity or non-specificity of the chancroid, but may say that a study of the subject has led me to think there still is room for investigation, and that, viewing the subject from a therapeutical standpoint alone, the specific nature of the chancroid, as far as my experience goes, need not be admitted. My reason for adopting this view of the subject is based upon the investigations of a practical kind which I have carried out during the past year. Within this period there came under my observation seventeen cases of chancroid; of these five were treated by caustics previous to coming under my care, thus leaving twelve cases which I saw from the beginning to the end. Among this number the different varieties were met with, as single, multiple, concealed, etc., thus offering a favorable opportunity for my investigations.

From frequent employment of the cauterizing agents in this lesion, I had seen some of the disadvantages they occasioned, and more particularly the pain. This is always severe and at times intense, notwithstanding the use of a local anæsthetic, such as carbolic acid, previous to the caustic application. The administration of ether or chloroform to produce general anæsthesia is, in my opinion, not admissible in such cases, except in rare and unusual circumstances. If, therefore, the same results could be obtained by not applying any such severe means of treatment, it certainly would be a great gain, and from the fact that such a claim had been made, a trial of the method advocated by those who do not employ caustics seemed at least justifiable. Therefore, I determined to omit all cauterizing agents in my treatment of the chancroid, provided no ill-effect arose from the omission.

The number of cases treated, as above stated, were twelve, and in none did I find it necessary to resort to any cauterizing agent, in none did any complication arise during treatment, and in all a favorable termination was the result. One of the greatest difficulties the surgeon will meet with in following out this method of treatment is the patient himself.

Such a firm hold has the caustic treatment, not only upon the medical mind, but equally so upon the public, that the patient is not satisfied unless you "burn" his sore, and you must constantly call his attention to the progress the sore is making towards recovery, in order to reconcile him to the non-cauterizing treatment. Having succeeded without "burning," I doubt if you ever will be able to convince a patient of the necessity of a caustic, if he should be so unfortunate as to contract another chancroid.

It could scarcely have been a coincidence, but it is the fact, that in not a single case in which the cauterization was omitted was the lesion complication by an adenitis. While, on the contrary, in four or five cases which had been cauterized previously to coming under my observation, there was developed, or there existed at the time they presented themselves for treatment, a suppurating adenitis or periadenitis.

One of the most important, and for some the only reason that cauterizing agents are applied to the chancroid, is to prevent auto-inoculation, or a multiplication of the sores. There is no doubt but that a thorough application of a caustic will prevent auto-inoculation. The remedy is very severe, and frequently complicates the lesion by occasioning a very intense local inflammatory action, and also, to my mind, the exciting cause of the sympathetic adenitis in many cases. That such cauterization is unnecessary, and that auto-inoculation may be prevented by other means, is demonstrated from the results obtained in my cases. In none was there any increase in the number of sores after treatment had been commenced.

Those who advocate the non-cauterizing method of treatment of the chancroid, regard the lesion as an ulcer, which may be caused by any irritant, and in this case the irritant is an acrid pus, coming in contact with a special part of the body, which, from its peculiar histological structure, is liable to develope the special form of ulcer characteristic of the chancroid. Therefore, they claim that the treatment applicable to ulcers in general is equally suitable for the chancroid. Thus anodynes, sedatives, astringent and stimulating applications have each their sphere of action in assisting nature to heal the lesion. The kind of medication to be employed will depend upon the symptoms presented by the sore, and judgment in the selection of the remedy is a very important element in obtaining success.

No definite rule can be given for the treatment of every case, but where there is no complication, the sore presenting the typical symptoms, the treatment which I have employed and found satisfactory, may be stated as follows: The discharge from the lesion is, as far as possible, to be prevented from collecting upon and around the sore; this may be done by frequent washings with water. The surface of the sore is kept dusted with iodoform, and is covered with a pledget of absorbent cotton. The simplicity of this treatment is a stromg recommendation, and I can answer for its efficiency. Let me here say, the employment of iodoform is not from any supposed specific action of this drug; but, on account of the favorable impression it exerts upon any ulcerated surface. An objection, and a very serious one, to the iodoform application, is its penetrating, lasting and extremely unpleasant odor. This, however, can in a great measure be obviated by exercising great caution, in its application, not to permit any of the powder to come in contact with the patient's clothing; confine your dusting exclusively to the ulcerated surface, and carefully cover the part with cotton. A few drops of oil of rose added to the iodoform is also of service in masking its odor.

Where the iodoform treatment cannot be used, on account of some complication, such as a contracted prepuce, or intense inflammatory action, or refusal of the patient, then the other forms of medication may be resorted to, selecting such as the symptoms of the sore seem to indicate. I am inclined to think the advantage of the idoform treatment over others is to be found only in the greater rapidity with which the process of healing progresses.—*Philadelphia Polyclinic.*

THE TREATMENT OF CROUP AND DIPHTHERIA

BY INHALATION OF THE FUMES PRODUCED BY *THE COMBUSTION OF A MIXTURE OF TURPENTINE AND COAL-TAR.*

Dr. Delthil, of Nogent-sur-Marne (Seine), in a memoir presented to the Academy of Medicine at Paris, March 25th, 1884,* advocates, in the most enthusiastic terms, the treatment of diphtheria by a method which he claims to be "specific" for diphtheria have been so often and so confidently urged upon the notice of the profession, only to fall into desuetude when tested by more extended experience, and with a more critical spirit than has fallen to the share of their advocates, that physicians will naturally look with suspicion upon what seem *a priori* to be extravagant claims. Nevertheless, a careful perusal of this memoir cannot fail to impress the reader with the modesty, sincerity and accuracy of the author; qualities which, joined to the honorable titles he holds, require at our hands a careful and conscientious consideration of the facts and arguments he sets forth. The writer confesses to having arisen from the study of Dr. Delthil's brochure with a strong prepossession in favor of the author, and a decided disposition to test the practice upon suitable occasion.

Assuming the verity of the theory, "universally held as demonstrated," of the parasitic origin of diphtheria, Dr. Delthil propounded to himself the following question: "What microbicide may we employ, which, with disintegrating powers upon the false membrane, will conjoin the property of penetrating the system by means of the respiratory tract, and which, without danger to the economy, can reach and combat the generalized diphtheritic poison?" After a lengthy series of experiments, he has made choice of essence of turpentine, as combining in itself all the desiderata. Thus, it will detach and disintegrate the diphtheritic exudation (Laboulbene); it is a parasiticide whose virtue needs no more to be demonstrated (Bouchardat); and it can be employed in the requisite quantity without danger to the economy.

The next point to be solved was the best method by which to apply the remedy. His experiments in this direction have been prosecuted more than eight years. He has used nebulizations of turpentine; direct applications to accessible parts; the introduction of liquid turpentine into the larynx by means of a syringe; the evaporation of hydrocarbons from a receiver of turpentine, contained in a waterbath, at a temperature of 50° to 60° (Centigrade). None of these methods proving satisfactory, he resorted for a long while to the following:—

In the patient's apartments were placed several large dishes, each containing a kilogramme of coal-tar seven or eight tablespoonfuls of oil of turpentine and about one hundred grammes of oil of cajuput. This mixture was allowed to evaporate. Besides this, he threw upon hot coals, every hour, a quantity of a powder containing equal parts of benzoin and coal-tar, and subjected the patient to fumigation with the vapors thus produced. In addition, accessible parts were washed with a solution of coal-tar and with lime-water.

He obtained from these methods very satisfactory results, but not sufficiently conclusive to warrant publication. He was struck, however, by the notable diminution in his practice of cases of laryngeal croup necessitating tracheotomy.

The great objection to the practice lay in the fact that, together with the respirable and beneficial vapors, there were also disengaged traces of creasote and of acrolin, disagreeable and unsuitable for respiration, and producing in some instances a sort of suffocation.

For these reasons he was led to modify his procedure; and for the benefit of all interested he has given the unsuccessful and partially-successful plans, as well as that which he now feels warranted in laying before the profession as a specific treatment for diphtheria.

* D'un Traitment spécifique de la Diphthérie, par la combustion d'un Melange d'Essence de Térebenthine et de Goudron de Gaz. Paris, H. Lauwereyns, April, 1884.

Persuaded that the carbides liberated by the combustion of turpentine and of gas-coal-tar are capable of absorption without danger, and that they penetrate the respiratory tract; believing, too, that this is equally true of the free carbon carried up by the vapors, as demonstrated by the anthracosis of miners, he conceived the idea of setting fire to the mixture of tar and turpentine. This produced the happiest results. Rapidly the false membranes become softened, the catarrhal period is established in a few minutes, and, particularly remarkable, the fumes, though so thick as to obscure the light, do not produce cough.

The volatile hydrocarbons and other empyreumatic products, impregnate the mouth, the nasal fossæ, the larynx, the trachea and the bronchi. The patient seems enveloped in a kind of tarry varnish. The false membranes, softened, disintegrated, and covered with carbon, are easily expelled. Turpentine is essentially assimilable, says Dr. Delthil, by the respiratory mucous membrane, as is demonstrated by the odor it transmits to the urine of painters. Under the influence of these fumigations the urine of his patients acquires, with rapidity, the odor of violets. The drug traverses the whole economy, and is eliminated by the natural filter of the kidneys, playing the rôle of a parasiticide throughout the whole organism.

Five cases of diptheria have come under the author's observation since the adoption of his latest method. Recovery has taken place in all. Two cases are recorded at length. In both of these tracheotomy was necessary; but Dr. Delthil thinks that it should have been a useless operation without the employment of the turpentine and coal-tar fumigations. In one case, that of a child of four and one-half years, at the time he was called in consultation the false membranes filled all the base of the throat, and laryngeal croup menaced the patient with asphyxia. The child was cyanosed, the supra-sternal recession was extreme, anæsthesia pronounced, agitation excessive, the voice was extinct, the croupal cough infrequent. An old wound on the right hand had become covered with diphtheritic exudation. There was albuminuria. Tracheotomy was thought of as a desperate resource, and the time for operation fixed at 11 P. M., it being then 10 P. M. Meanwhile, thinking the fumigations could but prove beneficial, he made resort to them. In less than an hour, such an extraordinary amelioration took place in all the symptoms that it was decided to postpone the operation. The day passed well. Respiration was re-established, the croupal cough resumed its characteristic intensity, but with a decided catarrhal *timbre*. The child was able to take nourishment. A partial extinction of respiratory murmur in the right lung indicating obstruction of the origin of the right bronchus, he began to fear an ascending croup. These fears were verified, and the urgent symptoms returned on the eleventh day of the disease, four days after the first menace of asphyxia, so happily dissipated. Thinking to gain more direct access for the vapors, he now proposed tracheotomy to the family, but they declined. A few hours later, however, they begged him to operate. Though he felt that the case was desperate, as he would find only a canal completely blocked with false membranes, he consented. After having incised two rings of the trachea, it was necessary to incise two more, in order to find entrance for the canula, so abundant was the exudation. The suffocative symptoms were but slightly diminished; under ordinary circumstances death would have occurred after but a brief delay. As a supreme resource he fired his mixture; the fumes became disengaged with an intensity that hid each one in the apartment from the view of the others. In a few moments the false membranes became diffluent, and under the eyes of eight observers a mass of disintegrated, membranous flakes covered with carbon, poured out through the canula. Dr. Delthil feels justified in asserting that in the absence of the fumigations the operation would have been futile, and the child would have been asphyxiated, even at the moment the canula was inserted.

The other case detailed is, in some respects, even more remarkable than this.

Dr. Delthil calls attention to the prophylactic virtue of his fumigations, as exemplified by the uniform escape from contagion of parents and attendants, and the healing without ill-result of a wound received by himself during operation.

He is endeavoring to perfect the apparatus for the employment of his treatment, which is at present very primitive. Meanwhile, he wisely cautions against the risks of fire. The receptacle of the mixture to be ignited must be surrounded by an additional vessel, to prevent accident, in case the first one should be broken by the intensity of the combustion. The two vases must be placed on the floor in the middle of the room. All inflammable objects are to be removed.

The large bottle or other vessel containing the stock of turpentine must be removed from the room; and nothing must be added during the combustion of the mixture. The flames may be extinguished at will by casting over the vessel a woolen cloth.

The proportions recommended by Dr. Delthil are as follows—to be modified according to exigencies: Gas-coal-tar (Norwegian tar will not answer; better use turpentine only), 200 grammes; essence of turpentine, 60 grammes; or the same of turpentine alone. The mixture to be renewed every two or three hours, according to the gravity of the case, and the amelioration produced.

We summarize the following from his conclusions: The fumes are easily supported by the persons in attendance upon the patient, and, indeed, benefit these persons by virtue of their prophylactic influence. Resorted to in time, this treatment will obviate the necessity of tracheotomy; and in old, desperate cases, will transform

that operation from a hopeless last resource, to an almost certain remedial measure.*

Although we cannot accept Dr. Delthil's treatment as a *specific* for diphtheria, the facts before us seem to show that it is likely to prove beneficial in a large number of cases. It certainly deserves trial.—*S. Solis-Cohen in Philadelphia Polyclinic*

INTESTINAL INDIGESTION.

A Clinical Lecture Delivered at the Children's Hospital, Philadelphia.

By Louis Starr, M.D., Lecturer on Diseases of Children in the Post-Graduate Course of the University of Pennsylvania. Reported by Wm. H. Morrison, M.D.

Gentlemen :—The previous history of the little patient before you is very incomplete, since we can learn nothing except that she has been in bad health for some time. She is eight years old, and sufficiently tall for her age, but her face and limbs are thin. The muscles, however, are firm, and the skin is only slightly deficient in softness and flexibility. Her general strength is fair. The cheeks, as you will notice, have a moderately good, red color, and there are no dark rings around the eyes, although, if you will look closely, you will see that the conjunctivæ have a distinctly yellow tinge. Her tongue is perfectly clean, the papillæ normal, and the mucous membrane of the mouth healthy. Her appetite is good, there is no increased thirst, and she has neither vomiting nor eructations of flatus or sour liquid. She does not complain of abdominal pain, and the bowels are said to be opened daily; but I am inclined to doubt this statement, for the belly is very greatly distended, and you will at once be struck with the contrast which this part of the body bears to the rest. While thus markedly altered in size, the abdomen is painless on palpation, and percussion elicits a tympanitic sound, showing that the enlargement is due to gaseous distension and not to the presence of a solid tumor. The hepatic and splenic dulness are not increased. The heart and lungs are free from disease, there is no alternation in the pulse or surface temperature, and the urine is voided freely.

Now, what conclusions can be drawn from the points elicited in this case? In the first place, we can say positively that there is no gastric disorder, for the tongue is perfectly clean, the appetite good and neither eructation, increased thirst, nausea nor vomiting is complained of. Still, the only symptom presented, viz., the uniform, great gaseous distension of the abdomen, indicates deranged digestion; consequently, we must look to the intestinal canal, or its accessories, for an explanation of the trouble. As already indicated, it is difficult to account for the absence of abdominal pain and disordered action of the bowels under the circumstances; but since these symptoms are denied by the patient, let us see if the meteorism can be referred to any other cause than simple intestinal indigestion. The abdomen is uniformly distended, is painless on palpation, there are no indications of a tumor, and very little constitutional disturbance, so that we may at once put intestinal obstruction from intussusception or fecal accumulation, for instance, out of the question. Sometimes, in ataxic cases, the muscular coat of the intestine, sympathizing in the general debility, ceases to afford the normal resistance to the contained gases, and these expanding greatly distend the gut; but this cause cannot be acting here, for the patient is but little below par. Caseation of the mesenteric glands (tabes mesenterica), especially when complicated, as it frequently is, with ulceration of the bowels, has meteorism for one of its symptoms; but there is at the same time diarrhea and all the signs of chronic interference with the nutritive processes. Under such conditions the child wastes and grows pale and feeble, the face looks haggard, the sleep is disturbed, the appetite is capricious, and thirst increased. Dilatation of the abdominal veins is often noticed, and occasionally edema of the feet and legs is met with, while the discovery of an irregularly-shaped, slightly movable tumor in the umbilical region makes the diagnosis certain. These symptoms are entirely different from those presented by this case.

We are entirely justified, then, in attributing the meteorism to intestinal dyspepsia, which is the most common cause of abdominal distension in children.

Let us next study the manner in which the symptom is produced. There are no indications of impaired gastric function, and I think that we can assume that, as far as the stomach is concerned, the work of digestion is well done; but you know that only the albuminous articles of the diet are digested in the stomach, that a part even of this class of food passes the pylorus unaltered, and that the starches and fats are unaffected by the gastric secretions. In the intestine, therefore, some of the albumen and all of the starch and fat of a meal must be digested. This is mainly accomplished by two secretions poured into the upper part of the duodenum, namely, the bile and the pancreatic juice; of these the first takes the lesser part, merely assisting the gastric digestion and helping to emulsify the fats—the bulk of the work falling upon the second.

The pancreatic juice contains four ferments : *a*, trypsin, which converts albuminous matter into peptones; *b*, curdling ferment, which curdles the casein of the milk; *c*, pancreatic diastase, which changes into sugar and dextrine, and *d*, emulsive ferment, which emulsifies and partly saponifies the fats. The major part of digestion is, therefore, accomplished in the intestine, and the pancreatic secretion is the most powerful and important agent;

* Since the above was in type, we notice [*Med. and Surg. Reporter*, Philadelphia, July 5th, 1884, from *Deutsche Med Zeit.*, May 22d, 1884,] that Dr Delthil has employed these fumigations in four additional cases in which tracheotomy had been performed for laryngeal diphtheria. One case recovered. Dr. Féréol resorted to the method in the treatment of one adult, who recovered. This makes, altogether, ten cases, with seven recoveries. In six of the cases tracheotomy was performed, with three recoveries. These statistics, so far as they go, are quite favorable.

consequently, if this gland is at fault, if its secretion is diminished in quantity or poor in quality, more or less of each meal will remain in the intestine undigested, notwithstanding the fact that gastric digestion may be perfect.

You know, from a former lecture, that this undigested food, lying like a foreign body in the gut, irritates the delicate mucous membrane, causing catarrh with its uniform result, a hypersecretion of mucus; and, from what has just been stated, you will infer that starch is one of the substances most likely to be imperfectly digested. There is present, then, a fermentable substance, starch, a ferment, mucus, and one of the encouraging conditions of fermentation, an elevated temperature. Of course but one result can be expected, fermentation is set up, carbonic acid gas is liberated, and the intestine becomes distended.

As this explanation implies a catarrh of the intestinal mucous membrane, it would be interesting and satisfactory if we could find some proof of the existence of this condition in our patient. Constipation and the presence of mucus in the fecal evacuations, the common pathognomic symptoms, are wanting; but look again at the eyes: the conjunctivæ are, as you observe, quite yellow, indicating a slight degree of jaundice. Now jaundice, both in children and in adults, is most frequently catarrhal in its origin. In other words, it is due to more or less complete obstruction of the common bile duct by catarrhal swelling of the mucous membrane with the accompanying increased production of mucus; a lesion which is usually simply an *extension* of a pre-existing catarrh of the duodenal mucous membrane. Here, then, is the evidence which I think establishes the diagnosis.

For the successful management of this case a careful regulation of the diet is important. The starches and fats must be excluded, because they are digested in the intestine, and it is this portion of the digestive tract which we have found to be at fault; the starches are also unsuitable, on account of their liability to undergo fermentation, with the production of gas, and a consequent increase of the abdominal distension. Three meals a day of the following articles of food should be taken. For breakfast, at 7.30 a.m., a bit of fresh fish, or the lean of a mutton chop, or a piece of tender beefsteak, with milk (either warmed or not, according to taste), and a single thin slice of stale bread, without butter. For dinner, at 2 P.M., the soft part of half a dozen oysters, a bowl of meat broth entirely free from fat, or, instead of this, a piece of lean beefsteak, roast mutton or beef, a little spinach, or well-boiled cauliflower tops, and not more than a single slice of thin, unbuttered bread. For supper, at 7 o'clock in the evening, one or more glasses of milk, with a single slice of unbuttered bread. For drink, she must take nothing but filtered water.

The medicinal treatment must be directed to the improvement of the impaired intestinal digestion; and, as this has been traced to an inactive pancreatic secretion, we must endeavor to artificially supply the deficiency. Just as in cases of stomach dyspepsia, due to alterations in the gastric secretion, we administer with the food pepsin and muriatic acid, or supply an artificial gastric juice. Within the past few years a number of preparations have been introduced, purporting to contain the active principles of the pancreatic juice. One of these, Fairchild's Extractum Pancreatis, I have lately used extensively, and so far with very satisfactory results. To obtain these results, however, several things must be borne in mind: first, that the normal pancreatic juice is alkaline in reaction, and that acids greatly impair, if they do not actually destroy, the activity of its ferments; second, that in health, the pancreas throws out its secretion most freely from two to three hours after a meal has been swallowed, or about the time that the food is passing from the stomach into the small intestine; third, that at this time the contents of the stomach are still acid in reaction. These facts show us that, to be of any service, the Extractum Pancreatis must be given at the proper time, two and a half hours after taking food, and must be safely conducted through the stomach, a feat accomplished only by guarding it with a full dose of an alkali, as bicarbonate of sodium.

The proper dose for a child of the age of our patient is 2½ grains. I shall order her the following prescription:

℞—Ext. Pancreatis, gr. xxx.
Sodii Bicarb., ʒ j.
M. et fit., chart, No. xij.

Sig. One powder to be taken 2½ hours after each meal.

Nux vomica is also indicated, partly to give tone to the muscles of the intestine, which must be in some deeree weakened by the constant distension, and partly to encourage proper glandular action. I shall therefore order three drops of tincture of nux vomica with a teaspoonful of compound infusion of gentian, before each meal.

Finally, to assist in the reduction of the abdominal distension, it will be well to rub the belly thoroughly twice a day with a stimulating liniment, such as turpentine and olive oil, one part to three. —*Archives of Pediatrics.*

COCAINE AS A LOCAL ANÆSTHETIC.

Dr. Koller, of the Vienna General Hospital, has quite recently discovered in cocaine a valuable agent for the production of local anæsthesia. He found that the introduction of from one to three drops of a two per cent. watery solution of cocaine into the corneal chamber rendered both the conjunctiva and cornea completely insensitive, so that, for instance, the cornea could be partially gouged without exciting any reflex action or sense of pain. The same fact was demonstrated by Drs. Brettauer and Becker at the recent Ophthalmological Congress. Koller in his first report mentioned the employment of the same agent in the production of anæsthesia of the larynx.—*Lancet*, October 4, 1884.

THE CANADA MEDICAL RECORD

A Monthly Journal of Medicine and Surgery.

EDITORS:

FRANCIS W. CAMPBELL, M.A., M.D., L.R.C.P. LOND.
R. A. KENNEDY, M.A., M.D.

SUBSCRIPTION TWO DOLLARS PER ANNUM.

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

MONTREAL, OCTOBER, 1884.

INSANE ASYLUMS IN THE PROVINCE OF QUEBEC.

Among the many distinguished men who visited Canada, to attend the meeting of the British Association for the advancement of Science, was Dr. Daniel Hack Tuke, editor of the *Journal of Mental Science*, and an alienist of acknowledged celebrity. As was natural, he was desirous of seeing how the insane were treated in Canada, and as Montreal was the place where he first sojourned for a limited period, the Insane Asylum at Longue Pointe, within a few miles of the city, was the first Institution for the reception of the insane which he visited. He was accompanied in this visit by Dr. Henry Howard, the Government Visiting Physician to the Asylum, and Dr. George Ross, editor of the *Canada Medical and Surgical Journal*. He subsequently visited the Asylum at Beauport, near Quebec, and as he journeyed through Ontario he visited several of the Asylums in that Province. The opinion which he formed of the treatment which the insane were receiving at both Asylums in the Province of Quebec was, that it was lamentably behind the age, and calculated to bring us into great disrepute,—that of the Asylum near Montreal being especially of a character to be condemned. Indeed, as he detailed to his medical brethren from the British Isles what he saw, we know that the universal expression was one of astonishment that such a state of things could possibly exist among a community showing in everything else an advanced state of civilization. On his return home he embodied what he saw, and his opinion thereon, in the form of a report, which he forwarded to the Provincial Secretary of this Province. Such a report was in its nature entirely gratuitous, and its preparation clearly shows how deeply Dr. Tuke felt the unfortunate position we occupied in this matter. This report was published first by our contemporary, the *Canada Medical and Surgical Journal*, and subsequently has appeared, either complete or partially, in nearly every journal in the Dominion. Its publication has created immense excitement. We do not publish the report entire, but make room for a few extracts. After giving a general description of the building, and stating that the cleanliness of the hall, reception rooms, and *apothecaire*, were such as to attract attention he says:

"It is as we ascend the building that the character of the accommodation changes for the worse. The higher the ward the more unmanageable is the patient supposed to be, the galleries and rooms become more and more crowded, and they look bare and comfortless. The patients were for the most part sitting listlessly on forms by the wall of the corridor, while others were pacing the open gallery, which must afford an acceptable escape from the dull monotony of the corridor. The out-look is upon similar galleries in the quadrangle at the back of the building; and to a visitor the sight of four tiers of palisaded verandahs, with a number of patients walking up and down the enclosed space, has a strange effect. These outside galleries are, indeed, the airing courts of the asylum. There are no others. If the patients are allowed to descend, and to go out on the estate, they do so in regular order for a stated time, in charge of their attendants, like a procession of charity school children. Those who work on the farms must be the happiest in the establishment."

"In the fourth tier were placed the idiots and imbeciles—a melancholy sight necessarily, even when cared for and trained in the best possible manner, but especially so when there is no attempt made, so far as I could learn, to raise them to a higher level or educate them. If, however, they are kindly treated and kept clean, I should feel much less regret for educational neglect than I should feel pained by the state of the patients and their accommodation in the parts of the establishment next described. Far be it from me to attribute to these Sisters of Charity any intentional unkindness or conscious neglect. I am willing to assume that they are actuated by good motives in undertaking the charge of the insane, that they are acute and intelligent, and that their administrative powers are highly respectable. **** It is the

farming out of *human* beings by the Province to these or any other proprietors against which I venture to protest."

"It is impossible to convey an adequate idea of the condition of the patients confined in the gallery, in the roof, and in the basement of this Asylum. They constitute the refractory class—acute and chronic maniacs. They, and the accommodation which has so long been provided for them, must be seen to be fully realized. To any one accustomed to a well-ordered institution for the insane the spectacle is one of the most painful character. In the course of seven-and-thirty years I have visited a large number of asylums in Europe, but I have rarely, if ever, seen anything more depressing than the condition of the patients in those portions of the Asylum at Longue Pointe, to which I now refer. I saw in the highest story that in the roof, an ill-lighted corridor, in which sixty to seventy refractory men were crowded together; some were walking about, but most were sitting on benches against the wall or in chairs fixed to the floor, the occupants being secured to these restraint-chairs by straps. Of those seated on the benches or pacing the gallery, a considerable number were restrained by handcuffs attached to a belt, some of the cuffs being the ordinary iron ones used for prisoners, the others being leather. Restraint, I should say in passing, was not confined to the so-called refractory wards for instance, in a lower and quieter ward, a man was tightly secured by a straight waistcoat. Dr. Howard had him released, and he did not evince any indications of violence. It was said he would tear his clothes—a serious matter in an asylum conducted on the contract system! The walls and floor of the corridor in the roof were absolutely bare. But if the condition of the corridor and the patients presented a melancholy sight, what can be said of the adjoining cells in which they sleep and are secluded by day? They are situated between the corridor and a narrow passage lighted by windows in the roof. Over each door is an opening the same length as the top of the door, and 3 to 4 inches in height, which can be closed or not as the attendant wishes. This aperture is, when open, *the only means* of lighting the cell. The door is secured by a bolt above and below, and by a padlock in the middle. In the door itself is a *guichet* or wicket, secured, when closed, by a button. When opened, a patient is just able to protrude the head. There is, as I have intimated, no window in the room, so that when the aperture over the door is closed it is absolutely dark. For ventilation, there is an opening in the wall opposite the door, which communicates above with the cupola; but whatever the communication may be with the outer air, the ventilation must be very imperfect. Indeed, I understood that the ventilation only comes into operation when the heating apparatus is in action. What the condition of these cells must be in hot weather, and after being occupied all night, and, in some instances, day and night, may be easily conceived. When the bolts of the door of the first cell which I saw opened were drawn back and the padlock removed, a man was seen crouching on a straw mattress rolled up in the corner of the room, a loose cloth at his feet, and he stark naked, rigorously restrained by handcuffs and belt. On being spoken to, he rose up, dazzled with the light, and looking pale and thin. The reason assigned for his seclusion and his manacles was the usual one, namely, 'he would tear his clothes if free.' The door being closed upon this unfortunate man, we heard sounds proceeding from neighboring cells, and saw some of their occupants. One, who was deaf and dumb as well as insane, and who is designated *'l'homme inconnu,'* was similarly manacled. In his cell there was not anything whatever for him to lie or sit upon but the bare floor. He was clothed. Some of the cells in this gallery were supplied with bedsteads, there being just room to stand between the wall and the bed. When there is no bedstead, a loose paliasse is laid on the floor. In reply to my enquiry, the Mother Superior informed me that it was frequently necessary to strap the patients down in their beds at night."

"Passing from this gallery, which I can only regard as a 'chamber of horrors,' we proceeded to the corresponding portion of the building on the female side. This was to me even more painful, for when, after seeing the women, who were crowded together in the gallery, on benches, and in fixed chairs, many of whom were restrained by various mechanical appliances, we went into the narrow passage between the cells and the outer wall, the frantic yells of the patients and the banging against the doors constituted a veritable pandemonium. The effect was heightened when the *guichets* in the doors were unbuttoned, and the heads of the inmates were protruded in a row, like

so many beasts, as far as they could reach. Into this human menagerie what ray of hope can ever enter? In one of the wards of the Asylum I observed on the walls a card, on which were inscribed words to the effect that in Divine Providence alone were men to place their hopes. The words seemed to me like a cruel irony. I should, indeed, regard the Angel of Death as the most merciful visitant these wretched beings could possibly welcome. The bolts and locks were removed in a few instances, and some of the women were seen to be confined by leathern muffs, solitary confinement not being sufficient. One of the best arguments in favor of restraint by camisole or muff is that the patient can walk about and need not be shut up in a room, but we see here, as is so often seen, that unnecessary mechanical restraint does not prevent recourse being had to seclusion. A cell, darkness, partial or total, a stifling atmosphere utter absence of any humanizing influence, absolute want of treatment, are but too often the attendants upon camisoles, instead of being dispensed with by their employment. When such a condition of things as that now described is witnessed, one cannot help appreciating, more than one has ever done before, the blessed reform in the treatment of the insane which was commenced in England and France in 1792, and the subsequent labors of Hill, Charlesworth and Conolly. But it is amazing to reflect that, although the superiority of the humane mode of treating the insane, inaugurated nearly a century ago, has been again and again demonstrated, and has been widely adopted throughout the civilized world, a colony of England, so remarkable for its progress and intelligence as Canada, can present such a spectacle as that I have so inadequately described as existing in the year of grace 1884, in the Montreal Asylum."

"Before leaving the Asylum, I visited the basement, and found some seventy-men and as many women in dark, low rooms. Their condition was very similar to that already described as existing in the topmost ward. A good many were restrained in one way or another, for what reason it was difficult to understand. Many were weak-minded, as well as supposed to be excitable. The patients sat on benches by the wall, the rooms being bare and dismal. A large number of beds were crowded together in a part of the basement contiguous to the room in which the patients were congregated, while there were single rooms or cells in which patients were secluded, to whom I spoke through the door. The herding together of these patients is pitiful to behold, and the condition of this nether region in the night must be bad in the extreme. I need not describe the separate rooms, as they are similar to those in the roof. The amount of restraint and seclusion resorted to is of course large, yet I was informed that it was very much less than formerly."

Writing of his visit to the Asylum at Beauport he also complains of the system of restraint followed there, and condemns many of the architectural arrangements of the building. He then says:

"But it is needless to describe in more detail an institution which, however willingly I may praise where praise is due, is so radically defective in structure and so fundamentally different from any well-conducted institution of the present day, in the matter of moral, to say nothing of medical, treatment, that no tinkering of the present system will ever meet the requirements of humanity and science. I regret to say thus. It is a thankless task for a visitor, courteously treated as I was, to criticize any institution which the officers permit him to inspect. But I write in the hope of helping, in however humble a way, to bring about a reform in the injurious practice of the State contracting with private individuals for the maintenance of its insane poor."

In this last sentence Dr. Tuke has struck the chord responsible for all of which he complains. There is no use for us to attempt to hide the matter now. This is not the first time that public attention has been called to this state of things, but as it came from persons residing here, it did not excite the public pulse. Now, without any exaggeration, throughout the entire civilized world, we are held up as being a Province most lamentably behind the age in the treatment of our insane. It is absolutely useless, and folly of the most senseless description, for any one to attempt to bring into this matter—as has been done by a few French newspapers—the fact that Dr. Tuke, being a Protestant, wrote with a view of injuring the nuns. There are but few Protestants in the present day who do not hold these estimable ladies in the very highest respect. But such an opinion is quite compatible with the belief that to farm out to them the insane poor is folly of the worst description. One can hardly imagine nearly, if not quite, one thousand insane,

huddled together in a building totally inadequate, according to Dr. Tuke, for such a number; all these really under the sole direction of a lady—the Superioress,—endowed with administrative ability possessed by but few—but totally destitute of that peculiar information so necessary for one at the head of an Insane Asylum. The medical attendance at Longue Pointe is also totally inadequate, and not of a description to receive public confidence. The visiting physician, Dr. Henry Howard, is not referred to by this statement, for his powers are not medical, but administrative. Place that gentleman in a position at the head of an Asylum, with supreme authority, and we are satisfied, from what we know of him, he would give us an asylum that would be an honor to our Province. We do, however, refer to Dr. Perreault. He is a physician doing a practice in the neighborhood, and is thoroughly qualified for general practice. But the day for a general practitioner to also practice as an alienist is passed. This gentleman should either devote his whole time to his insane patients, for which he should be adequately paid, or he should give up his appointment. To attend to one thousand patients, and give the time necessary for the study which such a position entails, is even more than one man can accomplish, so long as a day only counts twenty-four hours, and seven or eight hours of it are required for sleep. If this is not done, we cannot but express the opinion, that the medical attendance will be unsatisfactory. Indeed such an Institution requires at least one medical superintendent with at least three medical assistants. The system is the cause of all the trouble—we farm out our insane poor. We do not know of any other country that does. We must make a change—humanity and the good name of our Province call aloud for reform. We know there are difficulties in the way; a contract exists which has ten years to run, but during that time much might be done to improve the condition of things. An editorial article is not the place in which to suggest these, but, if our Government has not the money with which to purchase the two Asylums, take them under their own management, and compensate the sisters for loss, then it should find the means for a medical commission. This commission would be able to make suggestions, the adoption of which would perhaps make the farming system at least endurable till the time the contract expires. Then beyond a doubt, we should wipe out the blot which now attaches to our fair Province of Quebec. To accomplish this, the Government will require the support of the entire population. So far as the Medical Profession is concerned, we believe it can rely upon receiving it.

THE LYNAM CASE.

What is now known as the Lynam case has attracted a very large amount of attention not only in the Dominion but in the United States. The details of it are, in brief, as follows:—Mrs. Lynam, living with her husband and children in the city of Montreal, was by the former considered to be of unsound mind and so violent that he believed his life to be in danger. Dr. Henry Howard, visiting Physician to the Longue Pointe Lunatic Asylum, was called upon to examine her, and on his certificate she became an inmate of that Institution. This was a little over two years ago. There she has remained ever since—most, if not all, of the time being confined in the refractory department. Mr. Alfred Perry, in whose employ she had at one time been, from a variety of circumstances became convinced that she was sane, and therefore wrongfully detained. Acting under a recent Act of the Quebec Legislature, he applied to Judge Jetté to have Mrs. Lynam produced in Court for the purpose of having her mental condition ajudicated upon. This order was granted, and in the interval of her appearance a number of medical men visited the Asylum to examine her condition. When proceedings began in open court, Drs. Trenholme, Wanless and Pickup (formerly medical resident at Beauport asylum), of Brockville, Ont., were examined on the part of Mr. Perry, and declared their belief in her sanity. Dr. Perrault of Longue Pointe, who is the medical man employed by the Sisters (Nuns) of the Asylum, as Attending Physician, also stated on oath that from the date of her admission up to the present time he had considered Mrs. Lynam a sane woman; that he had never made any report to the Government on the subject, although he had expressed his opinion to Dr. Henry Howard, who held the contrary view, and that he had not pressed the matter, although he still believed her sane. Dr. Howard testified that in his opinion she was insane, and at times, when excited, actually a dangerous lunatic, and in corroboration of his views produced Dr. George Ross, Professor of Clinical Medicine in McGill

University, and Dr. Cameron, at present Professor of Obstetrics in Bishop's College, but till this year, and for several years past Professor of Medical Jurisprudence in the same Medical Faculty. Both these gentlemen stated that on their first examination they were inclined to believe her sane. An interview being arranged between Mrs. Lynam and her husband, "which they saw, unseen and unknown," they both witnessed her in a state of great mental excitement, and from her conduct at this time they came to the conclusion she was insane. With such evidence before Judge Jetté, no wonder he felt bewildered, and he accordingly put Mrs. Lynam into the witness box, and, before a crowded court, gave her a most searching examination. It is but right to say that she stood the ordeal with wonderful calmness. At the same time those who believe in her insanity claim that, though calm, some of her evidence, as regards certain things she had overheard from the window of the Asylum, were nothing short of mental delusions. Here the case paused for a few weeks, when Judge Jetté announced that he felt himself unable to decide the question. He appointed Dr. Vallée, of Quebec, who occupies the position of Visiting Physician to the Beauport Asylum, to examine Mrs. Lynam, and at the same time suggested that the Quebec Cabinet should name two other experts to act with him. The Government at first objected to appointing the two other experts, but additional pressure was brought to bear, but their decision has yet been confirmed. In the meantime Mrs. Lynam remains an inmate of the Asylum. Thus the case stands at the time of our writing. We fully sympathise with Judge Jetté in the very difficult position in which he has been placed. We believe his determination to leave the case particularly in the hands of experts will, *if three experts* be named, give general satisfaction. Our experience does not enable us to analyse the evidence so as to express an opinion which would be of any value, so we content ourselves with a simple detail of the case. When the case has terminated we may express our views on certain facts which have been brought to light during the course of the investigation.

CARE OF THE INSANE.

THE ONTARIO AND QUEBEC SYSTEMS COMPARED —RESTRAINTS ALMOST DISUSED IN ONTARIO.

The following is a condensation of an interview obtained by a reporter of the Toronto *Globe* with Dr. W. F. O'Reilly, Inspector of Asylums and Prisons for Ontario, on the subject of the report of Dr. D. H. Tuke, editor of the *Journal of Medical Science* of London, Eng., and formerly Superintendent of the York Retreat for the Insane, on the asylums of Ontario and Quebec.

Dr. O'Reilly describes Dr. Tuke as a man of wide information in all matters regarding the insane and their management, and thought it quite impossible that he would misrepresent the case. He stated that the condition of matters existing in Quebec, particularly in regard to the system of restraint, could not occur in Ontario. Restraint there had been all but abolished. After a great deal of discussion, the opinion, a few years ago, began to be held by a considerable number that entire nonstraint might be successfully undertaken. On the side of restraint were ranked men of high standing and experience, but there were men equally high in standing who had put the non-restraint system in operation and had accomplished the most surprising and satisfactory results. When he personally had first entered on his official duties he had been in a general way acquainted with the restraint question, but he had since given the matter careful consideration, and was convinced that the non-restraint system was the best. He had also lost no opportunity of urging this view upon medical superintendents. Quoting from the report of Dr. Bucke, superintendent of the London Asylum, which he had just received, he showed that for fifteen months no mechanical restraint or seclusion had been used at that asylum, and that no sedative drugs had been administered. Dr. Bucke was as much surprised as any one at the success attained. The *morale* of the institution had also been revolutionized, and the basis of treatment in the London Asylum was said to be the employment of patients at whatever they were fitted for, thus securing distraction of the mind, and sleep. This treatment was found to have the result of making the patients more manageable and, so to speak, more civilized. In two years the attendance of those capable of good behavior at chapel had increased from an average of 250 to a regular attendance of over 400.

Dr. Bucke's report also states that the credit of the admirable results mentioned belong first to Dr. O'Reilly, who so persistently urged the non-restraint system upon his attention.

Dr. Metcalf, of the Kingston Asylum, Dr. O'Reilly said, reports that for nearly two years

there had not been an instance of mechanical restraint in that asylum, and the result had been such that they were not likely to go back to such treatment. Sedatives were sparingly given, however, though, instead of increasing by the reduction of mechanical restraint, they were falling off. He likewise based his hope for success in future on the employment of the patients. During the year prior to the abandoning of restraint out of a total of 430 under treatment 194 were employed, while during the past year out of a total of 581, 425 were employed.

To the farming-out system Dr. O'Rielly attributed the unsatisfactory state of affairs in the Quebec asylums. Contractors being paid so much per head for the care of the insane, it was natural for them to make as much money out of the contract as possible. In Ontario no official had any connection with asylums, directly or indirectly, and they were thus precluded from any chance of making money out of their position. The Government pays for evreything, and in the matter of food, clothing, etc., imposes no restrictions as to what shall be used, except that reasonable economy shall be used. The food furnished, while plain, is of the best quality.

In regard to cost of maintenance in Ontario as compared with Quebec, the Doctor said in Quebec the contractors received at the rate of $11 per month per patient, or $132 per year. The average cost per inmate in Ontario was $131, and they had thus an infinitely better system at an equally low rate. In the States the expenditure on lunatics is nearly double what it is here, the buildings and furnishings being much finer, and the attendants being higher paid. Their food, although no better, was in greater variety and more attractively served.

VICTORIA AND LAVAL.

Our readers will remember the difficulty which has for several years existed between those two rival medical schools. In the September number of last year we gave a synopsis of it, so need not occupy space by repeating it. It seemed to drag along as if it would never end,—now one side and then the other claiming that the victory was theirs. But the Apostolic Delegate to whom it was referred was not to be hurried. He seemed determined to make himself master of the situation before coming to a conclusion, and in this he was wise. That conclusion has, however, at last been reached, and we are pleased to say that it is favorable to Victoria. Her school is to continue, and her professors are to have the same control as heretofore at the Hotel Dieu. In a word, Victoria goes on as before. In this decision there is much which must give satisfaction to all in the profession, who know the history of this School of Medicine. Its birth and early life bear witness to the cordial friendship which existed then, and we believe exists to a great extent now, between the French and English members of the profession in Montreal. Its death would have made a breach between the French Medical Profession in this Province that in our opinion a century would not have healed. To have such a calamity averted is cause for much thankfulness, and when the irritation has been calmed down by time, we believe that the supporters of Laval will admit that the decision of the Apostolic Delegate was wise and just.

THE MONTREAL MEDICAL SCHOOLS.

The various medical schools in Montreal opened the first week of the present month, and, so far as we can gather, the attendance at all is about the same as last year. We do not look for much increase in the number attending the English schools, till the senior English medical school here learns that there is not always wisdom in monopolies. Toronto knows this well, and is profiting by it amazingly. We do not grudge that city the success which is attending her Medical schools—she acts fairly by all—and prosperity sits on the banner of each.

PHYSICAL EDUCATION.

A short time ago we noticed in the *Gazette* a letter from our esteemed *confrère*, Dr. Fenwick, reporting the highly satisfactory result of an examination he had made to ascertain the effect of gymnastic exercise in the case of eight members of Mr. Barnjum's Gymnasium. Dr. Fenwick adds the following postscript to the report above alluded to: "I must add to this my acknowledg-
" ment of the usefulness of your system of calis-
" thenics with children and young women, several
" of whom I have sent to you to receive special
" training in cases where special sets of muscles
" had become weak or wasted through disease.
" In several cases that I can call to mind during
" the past few years the greatest benefit has been
" derived from the system of instruction you have

"followed." This testimony is at once valuable and suggestive, as reminding us that in Mr. Barnjum we have a coadjutor of whose assistance we might oftener avail ourselves. In many instances medicine alone, or ordinary exercise (more often prescribed than followed), are inadequate to cure various forms of muscular debility or deformity· and here the aid of one upon whom we can thoroughly depend for faithfully and intelligently carrying out a defined remedial course of exercise comes in most opportunely. There can be no doubt that rationally conducted and systematic, exercise is a necessity for obtaining that full degree of healthy development which is, we regret to say rather the exception than the rule. Physical education, no less than mental education, should be begun in childhood and be carried on gradually and systematically. Were this fact more generally recognized, how much of suffering and deformity might be avoided. There is too great a tendency to cultivate the brain to the neglect of the body. This is a serious error, both should be developed equally. Better a trifle less learning and more health to enjoy and make use of it. It is undoubtedly true that medical men, in a general way, convey such idea to parents. Still there is a lamentable amount of apathy or ignorance prevailing in regard to this matter which calls for judicious and oft-repeated counsel at the hands of those who are amongst the most trusted, if not always adequately valued, friends of those who turn to them for relief when sickness and suffering invade the home circle. We are urged to put this matter strongly because we know of several instances where weak and ailing children placed under Mr. Barnjum's care became strong and healthful. Montreal is exceptionally fortunate in possessing a first-class institution for physical education, conducted by an educated gentleman, and we sincerely hope that his opportunities for usefulness may be largely increased, as the public become more awake to the value of bodily training. This awakening may be materially hastened by medical men.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

On the 10th October the annual meeting of this Society was held in their very comfortable rooms in Phillips Square. The attendance was large, and perfect unanimity prevailed. The following were elected officers for the ensuing year:—*President*, Dr. Roddick; *1st Vice-President*, Dr. Alloway; *2nd Vice-President*, Dr. Trenholme; *Treasurer*, Dr. Molson (re-elected); *Secretary*, Dr. Gurd (re-elected); *Librarian*, Dr. Reed; *Publication Committee*, Drs. Cameron, George Ross, Kennedy and Bell; *Council*, Drs. George Ross, Kennedy and Roger. An able address was given by the retiring President, Dr. Roger. Dr. Osler was elected as honorary member, and it was decided to present him with an illuminated address of deep regret at his departure from Montreal.

RELATIVE DIASTASIC ACTIVITY OF MALT EXTRACTS.

Recognising that the diastasic activity of Malt Extract is probably its most valuable feature, the Maltine Manufacturing Company have taken pains, not only to perfect their preparation in this respect, but also to bring out the fact by indisputable testimony. This has been most effectually done in pamphlet now before us, carrying as, it does, testimony of the highest authorities in the world of chemistry in support of their claim to diastasic excellence. This element secured, no more reliable constructive is at command of the profession for treatment of wasting diseases, notably phthisis. No doubt the pamphlet referred to has been generally circulated amongst the profession, but if any have failed to secure copy they can do so by addressing post card to Mr. H. P. Gisborne, 10 Colborne street, Toronto.

Local and General.

CONDUCTED BY P. A. LAVER, M.D.

A branch of the London (Eng.) Society for Psychical Research has been started in Montreal, and would be pleased to hear of facts bearing upon the theory of the intercommunication of thought or consciousness without any visible medium. Commenting on the aims of this Society a Montreal paper gently chides the profession for not taking an interest in such matters, and predicts that when the study of psychology is more general among the doctors that they will be brought to see the error of their ways. I doubt it. If we are to take as samples of the stories from which the Society draws its inferences relative to spiritual

things those published lately in the Montreal *Witness*, psychical research will not prove very seductive to the average medical student.

Not only is it much more probable that in the majority of cases the circumstances related are merely coincidences than that they have any necessary connection, but the special plea of the spiritualist is only too evident in most of them.

I would suggest that the committee of organization bear in mind a certain essay of Professor W. K. Clifford ("Ethics of Belief") while estimating the value of the evidence given by our local story-tellers. The following sentences might serve as a beneficial corrective for some of the witnesses:

"In order that we may have the right to accept a man's testimony as grounds for believing what he says, we must have reasonable grounds for trusting his *veracity*, that he is really trying to speak the truth as far as he knows it; his *knowledge*, that he has had opportunities of knowing the truth about the matter; and his *judgment*, that he has made proper use of those opportunities in coming to the conclusions which he affirms." I would also seriously recommend as a text-book for this new class in science the lecture of Tyndall on "The Scientific Use of the Imagination."

Mr. Lawson Tait, in his admirable address before the C. M. A., speaks of the custom prevalent in his time of making the grand tour of continental schools of medicine, and he, in the warmth of his heart perhaps, expressed his belief that in the future the eyes of the searcher after medical truth would be turned westward rather than to European centres of education. Are we also not too prone to consult the wise men of the East in this year of grace? The types of disease that prevail here are essentially American. Such modifications of disease brought about by climatic and race differences may be small in most instances, but they should not be ignored, and I think it is unseemly in a profession that calls itself liberal to submit to this worship of German and French authority because it *is* German and French. Does the Sun of our Science rise on the Seine and set near the banks of the Spree?

A brilliant idea has at last come to the Board of Health of this city. Hitherto vaccination of the children of the poor has been done by five public vaccinators who received about $200 each per annum, from the Corporation.

There are, doubtless, some objections to this method, but on the whole the scheme has worked well. The men appointed did their work in the neighborhood where they lived, and their knowledge of the people and the limited area assigned to each gave them a fair chance of reaching all suitable cases. Now, however, it is proposed to replace these five men by another, an assistant medical health officer, who, in addition to other duties, will be expected to do the whole work of the five who are to be dismissed.

Every Montrealer knows how worn and threadbare is this old, old story. Ever since the days of Dr. Carpenter (and his enquiry into the cause of the high infantile death-rate prevailing in this city) all sorts of testimony, lay and professional, have been given, and all kinds of remedies suggested. If the city authorities will give us a properly regulated Health Office, and if the citizens will support them in carrying and supporting effective health by-laws much may be done. Then let private enterprise supply a summer hospital or sanitarium on some accessible spot near the city and Montreal will no longer be obliged to bear the onus of being one of the most unhealthy cities (*quoad* its children) on the continent.

Yet, in spite of the "dry light" of science, the fog of sentiment occasionally obscures the mental horizon of even the medical *litterateur*.

Some time ago the critic of the *Canada Medical and Surgical Journal* was really quite shocked at the materialistic views of a writer which he was reviewing. A medical journal is hardly the place to discuss questions of religion, but it seems rather late in the day for one doctor to get lachrymose over the dreadful heterodoxy of another. I am sure we all agree with Dr. Holmes that the truth is wanting in the Latin proverb, "*Ubi tres medici ibi duo athei*," but something may be said in support of even materialism.

At the banquet given by the Profession in Montreal to the members of the Canada Medical Association Consul General Stearns gave one of those happy speeches for which he is so generally and so justly celebrated.

His reference to the dangers and drawbacks of specialism was well received by the assemblage,

and I am sure many a medical man there felt with him that the usefulness and the influence of the profession as exhibited by the "good-all-round" doctor—"the doctor that is good for everything"—are in considerable danger.

His belief that if the public are to be directed to this man for a nasal catarrh, to that one if their digestive apparatus suffers, and to the other doctor if they have a cough a great stimulus will be given to the already alarming trade in quack medicines. There can be no doubt but that certain departments of medicine and surgery will, in the large cities of populous countries, be given over to specialists, but I do not see how we can afford much of that sort of thing in a new and sparsely-settled country like Canada. More than that, I believe that, if persevered in, and if it receive the support of any large section of the profession, a few men will reap a fat harvest to the detriment of the general good.

As Dr. Sullivan (in his Presidential Address, C. M. A.) and others have pointed out, the death-rate of this province is needlessly high. This modern holocaust mainly takes the shape of an annual "slaughter of the innocents" in the cities. Dirty houses, crowded together as tenement rows, with foul-smelling drains and small yards—many of them the common receptacle of garbage and domestic rubbish for half a dozen families—all these make personal cleanliness difficult or impossible. Add to these causes the heat and discomfort of our long, hot summer days and the close stuffy atmosphere of small stove-heated rooms and the source of infantile mortality in Montreal is explained.

There is one exasperating form of Teutonomania which shows itself in the proneness of writers of a certain class to offer (and I suspect of their readers to accept without question) the unsupported dictum of some man with a German name.

And then, if it be desired to clinch the argument, let the original text be given. This is also very effective and awe-aspiring in a paper read before some Medical Society. As not more than five per cent. of the magazine readers and of the medical audience have a faint idea of what the writer is talking about in the particular instance the value of the whole argument is of course very much enhanced!

Far be it from me to undervalue the debt which we all owe to Virchow, Koch, Erb, Ziegler, Ziemmsen, and to a host of others whose names are to us as household words, but it cannot be denied that it is not to Germany any more than to France, England, or even to despised America, that we have to look for *permanent* additions to our storehouse of medical and surgical knowledge.

"Natur hat weder Kern noch Schale
Alles ist sie mit einem Male,"

says Goethe, and the observant *physician* shall not fail to discover the truths of nature whatever language he may speak or wherever he may live.

It is greatly to be regretted, for the honor of Canadian Surgery, that Mr. Lawson Tait was on board the Quebec boat when the young woman cut her brachial artery. I wonder if he considers the two doctors (one French, the other English) who vainly tried to ligate the severed vessel to be fair samples of the men to whom a too-confiding public entrust their valuable lives. Let us, however, not be too censorious, it may be that the gentlemen in question were not of those who pay *particular* attention to surgery—of the blood vessels.

What the Health Department wants, to begin with, is a respected and responsible medical chief. If the City Council would pay a man a respectable salary they would get the worth of their money in educated experience, the sort of thing needed to carry out intelligently and effectively *any* scheme of sanitary reform. As it is, the officers and employees of the Health office are at loggerheads; the work of the Department is done in a perfunctory and spasmodic fashion, and the public health suffers.

This reminds me of the story wherein a newly-fledged M.D. determines to make a specialist of himself, and in looking round for some unoccupied field of labor comes to the conclusion that the only ground left him for pre-emption was the scar caused by the wound which remained when the cord dropped off. He therefore announced that he would in future "pay special attention to diseases of and injuries to the umbilicus!"

September 30, 1884.

PERSONAL.

Dr. Wesley Mills is delivering the course on Physiology and Pathology this Session at McGill College.

Dr. Molson, of Montreal, we understand, has no intention of removing to Philadelphia, as stated last month by the *Canadian Practitioner*.

Dr. John J. Gardner, late house surgeon of the Montreal General Hospital, has been appointed Demonstrator of Anatomy in the Medical Faculty of Bishop's College.

The Glee Club of the Medical Students of Bishop's College, assisted by a few amateurs, gave a concert in Farnham, Que., on the 31st of October, in aid of a church fund.

The many friends of Dr. J. Leslie Foley, late Professor of Anatomy in Bishop's College, will regret to learn that his illness has become so serious as to necessitate his entirely giving up practice.

Dr. Osler, late Professor of the Institutes of Medicine in and Registrar of the Medical Faculty of McGill University has been elected Professor of Clinical Medicine in the University of Pennsylvania, Philadelphia, rendered vacant by the transference of Professor Pepper to the chair of Practice of Medicine. Dr. Osler has accepted the position, and left Montreal on the 7th of October, to enter upon his duties. Previous to his departure the Medical Profession of Montreal entertained him at a farewell dinner at the Windsor hotel. All the Medical Schools in Montreal were represented at the dinner, and warm expressions of regret at Dr. Osler's departure were uttered by the various speakers. The line of teaching which Dr. Osler has assumed is somewhat new to him. His friends, however, hope that he may be as successful a teacher of Practical Medicine as he has been of Physiology and Pathology. Since his arrival in Philadelphia, Dr. Osler has been warmly welcomed by his new colleagues. His departure is a serious loss to the Medical Faculty of McGill, of which he was a very active member, and it will create a vacancy on the attending staff of the Montreal General Hospital.

THE LATE DR. GEORGE W. NELSON.

Dr. Stern, of Panama, writing to us, says :

"The death of Dr. George W. Nelson, late Resident Surgeon to the Central Hospitals of the Panama Canal Company, has removed from the ranks of the Medical Profession a bright and promising ornament. During the brief period that the Canal Company had the benefit of his services he proved himself an earnest worker, painstaking and observant. He had made valuable use of his time, and had he been spared would have manifested what good sound medical training, backed by industry and careful observation in a large field of practice, can effect. He has died 'with all his music in him' at the early age of 26 years.

His death took place in California, whither he had gone in the hope of recovering his health. He succumbed to his malady, tubercular phthisis, on the 2nd of October.

In the but too few years allotted to him on earth he hath done his work faithfully and well; and the longest life is all too short if this be no achieved."

The Panama *Star* and *Herald* says:—

"The late Doctor Nelson came of a family of doctors, he being the ninth in direct descent. He was the second son of the late Dr. Horace Nelson, of Montreal. With his brothers, he was a student of the Medical Faculty of Bishop's College, Montreal, graduating in 1879, with honors in his primary and final years, taking the final prize. Still being a minor he had to wait nearly a year for his diploma, when he became a member of the College of Physicians and Surgeons of the Province of Quebec. While waiting for his degree he practiced as Assistant to Dr. H. Cotton, at Mount Forest, Ontario. Later, he established a successful practice at Marbleton, P.Q. The drudgery of the life told severely on his health, and the hereditary enemy of his family for many generations singled him out. In December, 1881, he passed through this city on his way to California, in search of health. He remained there a year, returning to this city in December, 1882. He practised with his brother, Dr. Wolfred Nelson, until March, 1883, when the Canal Company offered him an appointment. He filled the latter ably, and amassed a valuable collection of clinical notes, particularly on the fevers of the country. A series of meteorological observations conducted by him will throw some valuable light on the influence of atmospheric conditions on yellow fever. They will be published for the benefit of the profession that he loved so well. In April

last, in rapidly failing heath, he sailed for California, proceeding to Tucson, Arizona. He returned to Santa Barbara, accompanied by his brother, Dr. Francis J. Nelson, where his career closed at the early age of 26 years.

REVIEWS.

The Student's Manual of Chemistry. By R. A. WITTHAM, A.M., M.D., Professor of Chemistry in the University of Buffalo. New York, William Wood & Co.

This is just such a book as is needed by the class for which it is intended. General works on the subject of chemistry contain too much which is of little importance to medical students. In the work now before us special attention is paid to these portions of chemistry which are of direct interest to medical practitioners, while as far as possible those portions are excluded which are of purely technological interest. Descriptions of processes of manufacture are therefore very briefly dwelt upon, while chemical physiology and the chemistry of hygiene, therapeutics and toxicology, are fully explained. We strongly recommend this work to the attention of all teachers of chemistry in our medical school. No better text book can be selected.

The Physician's Visiting List. P. S. Blakiston, Publishers, Philadelphia.

This, the first visiting list in the field, maintains its reputation, in spite of many rivals. We cannot say more to recommend its use to our readers. It is prepared for 25, 50, 75 and 100 patients weekly.

AMERICAN JOURNAL OF OPHTHALMOLOGY.

This journal—the only one published on this continent in the interest of this specialty, is issued at St. Louis, Mo. It contains a large amount of interesting matter, and should receive the support of those for whose benefit it is published.

GLYCERINE AS A REMEDY IN INDIGESTION.

The editor of the *Medical Index* has found the exhibition of glycerine to be attended with satisfactory results in two forms of indigestion, particularly: 1st, in that form of irritative dyspepsia, which is the common result of rapid eating and imperfect mastication. The usual symptom in such cases is distress coming on half-an-hour or an hour after meals. There is also duodenal catarrh and dyspepsia, with perhaps, slight jaundice and other symptoms, referable to, and explained by, the irritated mucous membrane of the stomach and duodenum. The indications in such cases are well-defined. The food must be prevented from undergoing mischievous chemical changes before it can be acted upon by the enfeebled digestive organs, and a remedy must be given, which shall exert a local soothing effect upon the irritated mucous surface. Glycerine, theoretically, from its preserving and emollient properties, fulfils these indications, and in practice our contemporary has not been disappointed in its use. A somewhat similar condition to the above is met with among children shortly after birth, after a trial of feeding them solid food has been followed by colic and soothing syrup. In such cases the child is apt to have greenish discharges, occasionally specked with blood. Glycerine will be found an admirable remedy in these cases.

INTESTINAL OBSTRUCTION FROM CHARCOAL.

A patient who was lately under my care, suffering from chronic obstruction in the intestinal canal, probably in the descending colon, took, on his own account, freely of charcoal powder, often a drachm a day, to relieve flatulency. The result was an all but fatal obstruction. Fortunately, under the use of enemata, coupled with persistent but gentle abdominal friction, relief was obtained, although stercoraceous vomiting once occurred. The excretions causing the obstruction were coated with carbon, and portions of carbon also passed in the free state. This is the second case in my practice in which charcoal powder has caused intestinal obstruction.—*Asclepiad, October*, 1884.