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# THE CANADA MEDICAL RECORD.

Vol. X.

MONTREAL, JUNE, 1882.

No. 9

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## *Original Communications.*

### ABSCESS OF ANTRUM.

Communicated by Dr. C. E. NELSON, of New York.

In bringing the following case before the readers of the RECORD, I wish to draw attention to two points: First, the grave mistake in the original diagnosis, and, second, the ingenious nature of the operation which was subsequently performed.

A gentleman in the prime of life suffered from an extensive swelling of the face with extrusion of the eyeball, caused by an abscess of the antrum. Believing that the trouble was mainly in the eye, he consulted a celebrated New York oculist, who advised immediate removal of the eyeball. Subsequently he consulted Dr. George P. Miles, a New York dental surgeon, who diagnosed abscess of the antrum from a diseased molar tooth. He believed the eye to be uninjured, and gave it as his opinion that, when the pus was evacuated and the swelling reduced, the eye would return to its normal situation.

Instead of extracting the decayed tooth and puncturing the antrum with a trochar, as is usually recommended in such cases, Dr. Miles drilled through the tooth and socket into the antrum, and through this small opening perfectly evacuated the abscess cavity, the swelling rapidly subsided and

the eyeball returned to its normal position. The decayed tooth was subsequently treated, and the patient eventually made an excellent recovery without loosing either eye or tooth. The importance of accurate diagnosis in such a case is self-evident.

## *Progress of Medical Science.*

### DIPHTHERIA.

By J. SOLIS COHEN, M.D., Physician to and Lecturer on Clinical Medicine in Jefferson Medical College Hospital, etc.

How are we to manage our cases of diphtheria? This is the all-important question. We cannot cure it. It has certain stages of evolution through which it must pass which no specific can arrest; and our duty is to guide the patient through them as safely as may be, and sustain him if we can. Some cases recover spontaneously, there is no doubt, but we can rarely trust to the unaided efforts of the system. The two main indications in my estimation are to keep up a supply of nourishment and stimulants, and to provide for the detachment and discharge of the morbid accumulations when they threaten to occlude the air-passages. Depleting measures, formerly recommended in croup, are no longer resorted to in diphtheria; another clinical point, to my mind, strongly indicative of systemic difference between the two affections. We must bear in mind, as I have indicated, that there is an adynamic blood disease to be resisted, and a local product to be watched. Let us discuss these two

points separately. The blood is the liquid flesh, so to speak, in which all recuperative power resides. The healthier the condition in which it can be maintained, the surer the prospect of recovery from the disease. Hence efforts should be made to regulate all contaminating influences that are within our control. We should provide for systematic disinfection of the sick-room in particular, and for disinfection of the whole house likewise. This can be done by the free use of sprays of carbolic acid or of sulphurous acid. Solutions of sulphate of iron or some other disinfectant should be kept in all the vessels to be brought into the sick room to receive the discharges, soiled clothing, refuse food, and slops of the patient. In this way we guard against additional contamination of the poisoned blood from the emanations and discharges of the patient himself. At the same time, too, and what is of the utmost importance prophylactically, the attendants of the patient and the remaining inmates of the household are protected in part from direct contagion, and from impairment of reserve vigor, which might render them particularly liable to that contagion.

As to the patient himself, assiduous cleansings of mouth, throat, and nasal passages, should they become fouled from retained secretions, with ample supplies of digestible food, and the administration of a tonic remedy, than which none, perhaps, is more serviceable than tincture of the chloride of iron, will be all that will be required anterior to the appearance of the local morbid product; unless there should be such indication of profound septicæmia or collapse, which would call for large doses of quinia, or alcoholic stimulation, respectively.

And right here, gentlemen, let me direct your attention to a significant clinical fact, the truth of which you can verify by your own studies and observation. It is this: Chlorine compounds, whether administered internally or applied topically, are more frequently efficacious in diphtheria than any other remedies. Read the records of writers and you will see extolled tincture of the chloride of iron, which I place for you in the first rank, chlorate of potassium, chloride of ammonium, chloride of mercury, chlorine mixture, hydrochloric and nitro-hydrochloric acids. Other remedies, similarly extolled, have this in common with the chlorides, that they have disinfectant properties. This adds to the list sulphurous acid, sulphites and hyposulphites, carbolic acid, benzoate of sodium, and other drugs of similar qualities. But it is not my intention to enumerate the various modes of treatment lauded in diphtheria. The vaunted success in many instances has been due to the misapprehension that prevalence of common membranous sore throat was prevalence of diphtheria. It will suffice to fix your attention upon those remedies which, in my judgment, are most entitled to confidence. We return, then, to the tincture of the chloride of iron. It must be administered at frequent intervals and in large doses. The object is

to make as profound a beneficial effect on the health of the blood as practicable. Hence we give from five to twenty or even thirty drops according to the age and vigor of the patient, *every second hour, hour, or half hour*. It may be given in glycerine and water, or in diluted syrup of lemon, or in any pleasant way with which you may become acquainted. It is quite probable that the alcohol in this preparation has some beneficial influence constitutionally; for, as will be stated to you presently, alcohol is of the utmost efficacy once the constitutional vigor begins to manifest rapid or steady deterioration. The frequent deglutition of this remedy, in addition, brings it in frequent contact with morbid products accumulating upon the deglutitive tract; and exerts a desirable physical impression upon those products, akin to that specially sought for, when, as I shall mention shortly, it is resorted to as one of our most trustworthy agents in topical medication.

Chlorate of potassium is extensively administered as a constitutional remedy in diphtheria; frequently in the form of the *chlorine mixture*, which is prepared with an equal number of grains of the chlorate and of drops of hydrochloric acid in plain or aromatic water, infusion of quassia, and so on. The dose of the chlorate varies from two to fifteen grains, according to the age of the patient, every third or second hour, or more or less frequently, as may be. It is quite common to combine this remedy with the tincture of the chloride of iron, and in the same mixture. A better plan is to have the two drugs prepared separately, and then combine the mixture, at the bedside, so that the quantity of one drug may be varied, if required, without affecting the dose of the other. Let me caution you about an immoderate use of chlorate of potassium. Look out for evidence of renal irritation, and suspend its administration until such untoward symptoms subside. In view of the normal tendency to albuminuria and to renal disintegration in diphtheria, it is important that no abnormal load be laid upon the kidneys, whose excretory offices are fully taxed as active participants in the elimination of the poison from the system. The local action of the chlorate of potassium on the mouth and throat, and its excretion through the salivary and pharyngeal mucous glands, enhance its efficacy as an internal remedy in diphtheria. It may be given in lozenges or in compressed pills, and allowed to dissolve slowly in the mouth, so as to prolong its contact with the diseased surfaces.

Quinia is a remedy much employed in the treatment of diphtheria; in part as a tonic, in part as an apyretic, in part as a neurotic, and in part as an antiseptic. As it is desirable to combine important remedies when practicable, to avoid too frequent dosing, and as chlorine compounds seem to be especially serviceable in diphtheria, in fact in affections of the respiratory organs generally, I prefer the hydrochlorate of quinia to the sulphate.

It is fully as efficacious, incomparably more soluble, and can be manufactured at much less expense. It is given in decided doses until there is abundant evidence of constitutional impression. When deglutition is painful or difficult, it may be given by enema, with proper augmentation of the dose. Under similar circumstances, it is better to persevere in giving the iron and potassium by the mouth, as their topical effect upon the throat is of certain significance.

Alcohol, in the form of strong wine, or as brandy or rum, is of the utmost importance when the system begins to give way; and its free administration should not be delayed after the earliest manifestations of decided loss of vigor. At this stage it is of more importance for the time being than any other remedial agent. From half a drachm to an ounce of brandy, or its equivalent, proportionate to the age of the patient, may be given at suitable intervals to keep up the effect, be the intervals three or four hours or but fifteen minutes. Indications for its continuance or suspension will be promptly afforded by the general condition of the patient. As long as it is well borne, it may be given to any extent appearing necessary, short of producing actual alcoholic intoxication, especially so when sufficient nourishment cannot be taken. Children readily take a sort of syrup of brandy made by burning it beneath a lump of sugar which becomes melted in the process.

Though other internal remedies are often valuable in diphtheria, especially under varying circumstances, I feel like stopping with the short list just commented on. It is proper, however, to mention a new treatment, highly lauded of late years in Teutonic Europe, but not sufficiently endorsed at present to justify unqualified approval. It consists in the administration of large doses of benzoate of sodium, the use of which is based on the opinion that it arrests the development of the diphtheritic cryptogamia. As considerable attention has been directed to this subject, which has not yet become incorporated into general professional literature, it may be well to mention the formulæ used by Letzerich, the promulgator of the method. Five grammes of pure benzoate of sodium are dissolved in forty grammes each of distilled water and peppermint water, to which are added ten grammes of syrup of orange peel. To infants less than one year of age, two teaspoonfuls of this mixture are given every hour; to older patients the mixture is given in tablespoonful doses, the amount of benzoate of sodium being increased from five to seven or eight grammes for children from one to three years of age; still further increased to from eight to ten grammes for children between three and seven years of age; still further increased to from ten to fifteen grammes for children above seven years of age; and increased to as much as from fifteen to twenty-five grammes for adults. In addition to this internal administration of the drug, the false membranes are dusted over with powdered benzoate of sodium, two or three

times a day in mild cases and every three hours in severe ones. The drug is also administered in gargles; a five per cent. solution being sufficient for older children. I have no experience with this treatment, nor any personal knowledge of it whatever.

I may add, too, a few words as to carbonate of ammonium, sometimes a remedy of great value at moments of sinking. From two to ten grains may be given in syrup of acacia, or other vehicle, to be repeated whenever indicated; and in case of difficulty of swallowing, it may be administered by the bowel in quadruple quantity. In cases of threatening accumulation of fibrin in the right heart, large doses are indicated theoretically on the basis of observations which have shown that its admixture with blood preserves the fluidity of the latter for some time. It is possible, too, that intravenous injections of the solution of ammonia may be resorted to with temporary, if not with permanent benefit at moments of collapse; but I have no data in illustration of the value of the inference.

What shall be done for the sore throat? what for the swollen and painful glands? Pellets of ice placed in the mouth, and renewed more or less continuously, are as grateful and soothing a means of local relief as lies at our command. Iced compresses are used externally by some prominent practitioners; but they cannot always be employed with impunity; and their use should be discontinued if not promptly serviceable. It is often better to apply warm cotton-batting, spongio-piline, or an actual cataplasm. Inunctions with oil, lard, cosmoline, are often useful; care being taken to use nothing which might favor abrasion of the cuticle, lest local infection further complicate the disease. Great pain requires the use of morphia in effective doses by stomach, bowel, or skin, as may be most available. Prompt discharge of the morbid products as they accumulate has been indicated as an important object in the management of our case of diphtheria. How shall this be secured? Shall it be by removing them bodily whenever they are favorably located for detachment and withdrawal? To those who regard the local product and its extension as the more important feature of the disease, such a method seems highly desirable. If there be a circumscribed patch undergoing spontaneous detachment, there can be no objection to its extraction. Indeed its removal is indicated, as getting rid of effete material, the decomposing elements of which are being drawn into the lungs at every inspiratory movement; thus adding additional contamination to the blood.

It is quite possible, in favorable cases, to keep the morbid product diffuent by maintaining a warm and equable temperature in the sick-room, which should be well ventilated without exposing the patient to direct currents of air, and provide an excess of humidity of the atmosphere by hanging wet cloths around, or keeping up a moderate evolution of steam near the patient. The moister the products, the more readily they can be expecto-

rated. When they remain dry and adherent, there is no objection, if fully within the reach of instruments, in making an attempt, by a thorough topical medication, to arrest their further progress, and thus remove the local source of danger; but should the first application fail in this object, no repetition should be made. The practice of cauterizing the uninvaded tissue is reprehensible, because the local product is likely to appear on abraded surfaces. Of all the local agents of which I have any bedside experience, the tincture of the chloride of iron has been by far the most efficacious. It should be applied with a swab of cotton or sponge, which is pressed with considerable firmness against the pseudo-membrane, so as to favor thorough contact. After the application, attempts should be made by gargle, spray-douche or syringe, to remove the deposit; but forcible removal is not judicious, unless it is already partially detached. Lime-water is the best solution to use in the douche or syringe. So much for the accumulations in pharynx and nasal passages.

When the larynx becomes invaded, then the best plan I am familiar with is to keep up a constant evolution of steam passing over the face of the patient; and, in addition, to slake a few pieces of lime the size of the fist, by the bedside every hour or two, or whenever the respiration becomes obstructed; covering the vessel with a hood of stiff paper, so as to direct the steam and particles of lime towards the mouth of the patient. I do not subscribe to the opinion that the lime vapor is capable of dissolving the membranes *in situ*; but I believe that the particles of lime inhaled act mechanically, becoming insinuated beneath them at numerous points, and thus affording minute inlets for the watery vapor, which detaches them, and facilitates their expectoration by cough.

The use of emetics is indicated in children to provoke expectoration from the air-passages in the act of vomiting; but the same indication does not occur in adults who are able to expectorate voluntarily. If successful, the emetic may be repeated, at intervals of six hours, as long as the indications continue to recur. Alum, ipecac and turpeth mineral are the most reliable agents, and may be tried in the order named: adhering to the alum if it prove efficient. Emesis should not be carried too far, or be repeated if ineffectual, as it exhausts the power of the system without any compensation in the discharge of morbid products.

Should asphyxia be threatened from accumulations in the larynx or trachea, tracheotomy is indicated; and though most frequently unsuccessful in averting death, it facilitates due access of atmospheric air to the lungs, and often saves lives that would otherwise be lost.

The most careful attention is required after tracheotomy to keep the artificial passage clear. The stimulating treatment and the lime inhalations should not be discontinued.

The two main indications for favorable prognosis after tracheotomy are desire for food, and

ability to expectorate. All treatment should be subservient to facilitating these great ends.

Paralytic sequelæ sometimes follow diphtheria. They are to be managed on general principles; and they usually subside without leaving permanent traces.—*Medical News and Abstract.*

## THE TREATMENT OF CROUP.

*A Clinical Lecture.*

By WM. T. PLANT, M.D., Professor of Clinical Medicine and Diseases of Children in Syracuse University, Syracuse, N.Y.

GENTLEMEN: Membranous laryngitis is one of the diseases in which medical treatment has always been most vacillating and unsatisfactory. Our fathers, rightly regarding it as a violent inflammation, fought it determinedly with their deadliest weapons. These, in the words of an old author,\* were "bleeding, emetics, purgatives, and blistering."

Bleeding, first, "so as nearly to produce fainting;" if not relieved, more blood "by several leeches over the trachea." After bleeding, an emetic of ipecac and antimony, to be again and again repeated if the continuance of the disease—and the patient—afforded an opportunity. At the same time—and the sooner the better—"a large blister all across the throat or upper part of the chest" was in order. It was further recommended to keep up brisk purgation with calomel and jalap throughout the entire course of the disease. These sledge-hammer blows were supplemented by frequent smaller doses of tartar-emetic and calomel. To all this was added the "antiphlogistic regimen," which, in those days, meant little nourishment and no stimulants. Unless you call to mind the cat-like tenacity of life inherent in some children, you will be surprised when I tell you that a few survived both the croup and the treatment.

We do not work in that way now. If, as is often the case, we cannot do much good with our remedies, we endeavor not to do harm, and that is more than can be said for the old way.

If the medical treatment is to be of avail, it must be instituted early. In croup, delay is not only dangerous; it is fatal. As soon as a laryngeal cough, an increasing hoarseness, and obstructed inspiration give warning, the child, *volens volens*, should be put to bed. The room should be well warmed; from 80 to 85 degrees Fahr. is not too high. The air should be moist as well as warm. A warm and moist air is relaxing and soothing; a cold and dry air is irritating to the inflamed larynx, and tends to induce paroxysms of cough and dyspnoea. There are different ways of charging a room with moisture. If it is warmed by a cook-stove, vessels of water may be kept boiling. The objection to this plan is that, if the apartment is small, it becomes overheated. Large

\* Thomas' Practice, 1815.

volumes of steam may be generated by dropping hot irons or bricks into a vessel of water. Another plan, and an excellent one, is to curtain the bed with blankets and introduce steam through a tube communicating with a vessel of water standing outside the inclosure, over a gas or spirit lamp. In some children, spray may be sent directly to the inflamed surface by the steam atomizer. From ten to fifteen minutes' steaming every hour or two does much to soften the cough and relieve the dyspnoea. This instrument also affords a ready means of carrying a medicated vapor to the seat of trouble. Just now lime-water is being much used, there being some evidence that it has a solvent effect on the false membrane. Though doubting whether the minute quantity of lime introduced in this way can have an appreciable effect, I would not discourage its use, since the vapor of lime water is at least as good as that of pure water. There are other solvents of pseudo-membranes. Among the best of these is, according to experiments recently made at the New York Foundling Hospital, liquor sodæ, diluted about fifty times with water, or, perhaps better, with aqua calcis; it may be used freely with the atomizer. Feeble solvent power is also claimed for both lactic acid and chlorate of potash. If any of these agents can destroy the membrane, they should *a fortiori* prevent its formation if used early enough.

If not disagreeable to the patient, I think it well to add a little carbolic acid to these atomizing fluids. Unfortunately, some children are so young and many are so perverse, that effectual use of the atomizer is very difficult. But do not fail by some one or all of these methods to furnish to the child for at least a large part of the time a steam-laden atmosphere.

Perhaps something may be gained by the application of mild counter-irritants over the larynx. A slice of salted fat pork, made more irritant by dusting its applied surface with mustard, or black pepper, or powdered camphor, and stitched to a cloth passing around the neck, answers a good purpose. Hot poultices, and cloths and sponges wrung from hot water, are sometimes bound upon the neck. Without great care, they wet the clothing and the upper part of the chest, and do more harm than good. Some practitioners prefer the continuous application of cold, but I have had no experience with this method.

The hoarse dry cough and the tendency to dyspnoea will suggest to you an early resort to emetics and expectorants. It used to be thought, and some are still of opinion, that there is peculiar virtue in the harsher and more depressing emetics, such as antimony and hive syrup. For myself, while not objecting to giving these agents once or twice at the outset for their emetic effect, I am not favorable to their repeated administration. Being powerfully depressant, patients kept under their influence rapidly lose strength, and I doubt if their local action is better than that of lighter

emetics, such as ipecac and alum, and the sulphates of copper and zinc. My preference is for the wine or syrup of ipecac, repeated whenever it becomes necessary to produce emesis. A teaspoonful of powdered alum mixed with honey or syrup is an old and still popular remedy. Very many physicians rely wholly on the sulphate of copper as an emetic. With the act of vomiting some secretion is carried from the larynx and trachea; perhaps pieces and casts of false membrane are thrown out, and considerable relief follows, but it is seldom permanent. Before long, in most cases, the dyspnoea again becomes urgent, driving us back to emetic treatment.

Towards the end, the stomach responds less readily to emetics, because, as I suppose, the functions of the nervous system are in abeyance. I have seen large quantities of nauseants given in the last stages of croup without result.

I had almost forgotten to say that apomorphia has gained some favor as a prompt and non-depressing emetic. As little as .0015 gramme, or the fortieth of a grain, hypodermically, will effect the object.

Because emetics bring some relief to urgent symptoms, there is a liability to their over-use.

Nothing is gained by keeping a child constantly nauseated; on the other hand, appetite and strength are lost, and rapid prostration ensues.

Aside from favoring the secretion of mucus and driving from the windpipe, *occasionally*, the accumulated products of the inflammation, I doubt if anything is to be gained by the use of these agents.

Most authors recommend the warm bath early in croup. It reduces the fever, it relaxes the system, and is a reliable adjuvant to the emetic treatment.

Until a recent date, much reliance was placed on mercury as a remedy in membranous laryngitis on the theory that it abated inflammation and promoted the breaking down and liquefaction of the false membrane; it was used early and late in all cases.

This treatment, once so popular, has fallen into comparative disuetude. I must confess that I am not yet convinced of its uselessness, and that I still continue the practice, partly because it has happened to me to see some recoveries under it, and partly because I would not hastily abandon a remedy that has been held to be of the greatest service by many eminent physicians. I do not believe that mercurials have any effect on the already formed membrane, but I am not certain that they may not so modify and lessen the inflammation that the materials for the manufacture of this membrane are no longer furnished.

But if mercury is to be of any use in a disease of such rapidity, no time is to be lost in bringing the system under its influence. Unless we can so give it as to insure prompt action, we had better not give it at all. I like the plan of small doses often administered. From .01 to .03 gramme—

r-6 to  $\frac{1}{2}$  grain—of calomel may be placed on the tongue as often as every hour or half hour.

In some cases it becomes necessary to guard against diarrhoea, by the use of Dover's powder. Probably a systemic effect can be secured in this way quite as speedily as by inunction or subcutaneous injection. After a day or two of this frequent dosing, we may properly conclude that something of its constitutional effect has been secured. I would then suspend it for a time, or give it much less frequently.

In all instances where the croup is secondary to or a concomitant of, other diseases, and in feeble children, I think it safer not to give mercury at all. Prof. J. Lewis Smith, in his most excellent work on children's diseases, advises a mixture of chlorate of potassium and muriate of ammonium for these cases, and gives us the following formula :

	<i>Grammes.</i>	
R̄. Potassii Chlorate.....	4	ʒj.
Ammonii Muriat.....	2.6	ʒij.
Syrupi Simp.....	fl. 30	ʒj.
Aquæ.....	fl. 60	ʒij.

*Misce.*

R̄. A teaspoonful or two every half hour or hour.

While you are attending assiduously to the details of medical treatment, you will give some thought to the nourishment of your patient. If, in any acute disorder, support is necessary, it is so here. Probably there is little or no appetite, but the fever creates thirst, which should be assuaged, in part, by milk. Beef-tea and other fluid foods may be given, if desired, but milk is of more value than any of these.

Then as to stimulants, I advise an early resort to them. The labored breathing, the restlessness, and the enforced wakefulness, are so rapidly exhaustive, that they may properly be given from first to last. Do not think that the violence of the laryngo-tracheal inflammation contraindicates their use; on the contrary, it creates a demand for them. Some of the authors tell you that when the heart shows signs of failure, *then* resort to stimulants. But why wait for exhaustion? Why not try to prevent it? If stimulants are adequate to rally from a low condition, may they not, if given in time, forestall that condition? I believe it is proper to begin their use as soon as you feel certain that you have to deal with true croup. They may be given at first in small quantity and at infrequent intervals, but when the disease is as its height and the labor of breathing is great, you may use them with unsparing hand. The disease creates a tolerance of them. A child of from two to four years may take daily anywhere from fifteen to ninety fluid grammes, or from one-half to three ounces, of brandy or whiskey with only benefit.

But statistics are heavily against us in this disease, and it is more than possible that, in spite of our efforts, the condition becomes increasingly unfavorable. It is apparent at length that, without the intervention of surgery, the child must die.

The question of a resort to tracheotomy then presents itself and must be promptly decided.

Tracheotomy does not cure croup; it simply admits air to the windpipe below the point of obstruction. With time thus gained, the laryngeal inflammation may subside and the patient recover.

The death-rate having been high, the operation has never been a popular one, but it should be remembered that the mortality has been in spite of the operation, not because of it. As it is never entered upon until death seems to be inevitable without it, and as its performance under ether or chloroform is painless, I think we might well resort to it more frequently than we do.

Reports from some public institutions are quite in its favor. Of ninety tracheotomies in the children's hospital at Prague, nearly thirty-five per cent. were followed by recovery. This is a better showing, however, than most other institutions make, and far more favorable than statistics from private practice.

Age has its bearing on the success of the operation. The older the child, the better is its chance, because, mainly, the trachea and larynx are more developed. Under two years of age failure is the rule, though, like many rules in medicine, subject to exceptions.

There is a proper time in the progress of the disease for operating. You will be in little danger of resorting to surgery while there are still hopes of success through medical means. There is more danger of procrastinating until the patient is moribund. This mistake, has, I think, been sometimes made. As soon as lividity of the lips and fingertips shows that the blood is becoming surcharged with carbonic acid, then, and not much later, is the time for tracheotomy.

The probabilities of recovery after the operation are much lessened if there is coexistent bronchitis or pneumonitis; and, unhappily, one or the other is often present. Not only that; these diseases are often consecutive to the tracheotomy, and, in case of death, are prime factors in its causation.

To prevent the occurrence of these pulmonary troubles after the operation, attention must be given to the temperature and humidity of the air to be inspired. Since it is no longer warmed by passing through the nose and mouth, it should be warmed artificially from 85° to 93° Fahr.

A competent nurse should be constantly at hand, by night as well as by day, to regulate the temperature, to give necessary attention to the tube, and to administer proper nourishment at proper times. The difficulty of obtaining such help at an hour's notice constitutes one reason why tracheotomy in private practice compares unfavorably with the same operation in public institutions.—*Phil. Med. News.*

#### QUININE ENEMATA.

In a lecture on the treatment of malarial fever, published in the *Detroit Lancet*, Dr. Alonzo

Clark, of New York, with regard to the methods of administration, observes :

I have not become a lover of the hypodermic injection of quinine, for it so very generally has made sores in instances where I have seen it used. If the druggist can prepare it in such a way that there will be no irritation I would be less inclined to object to it ; but I know it is effectually administered by injection into the bowel, and given in this manner it acts, at least, in an innocent way. But it must be given in large doses to be effective. The doses that were employed four or five years ago would seem only to inflame the fever and not to reduce the temperature. It must be used in ten grain doses, three times a day, and you will find that injecting it into the bowel will be just as efficacious as if it were taken by the mouth. The old account of the matter was that a double dose should be given when the medicine should be administered by injection. I do not think so, and I feel quite sure that I can make five or ten grains of quinine, properly dissolved, do just as much for the general system, when injected into the bowel as if it were taken into the stomach. It may not be true of a large circle of medicines, but I am confident that it is of this.—*Med. and Surg. Reporter.*

### ON THE USE OF CHIAN TURPENTINE IN CANCER.

By Professor JOHN CLAY, Obstetric Surgeon to the Queen's Hospital, Birmingham.

More than two years have elapsed since I commenced treating cancer of the female generative organs with Chian turpentine. By the courtesy of the conductors of *The Lancet* the results of my first experiments were published in the number for June, 1880. The paper attracted considerable attention, both professional and general, and provoked much adverse criticism ; indeed in certain quarters this plan of treating cancer of the uterus in particular was declared useless. An enlarged experience, however, has confirmed the statements made in my original paper, and I have now the satisfaction of being able to declare that I have nothing to withdraw or to qualify as regards the statements I then made, as the result of observation, as to the effects of Chian turpentine in uterine cancer. I should be glad to confirm these conclusions by now publishing a number of illustrative cases showing the treatment pursued in different forms of uterine cancer, but consideration of the space at my disposal obliges me to be content with describing briefly the conditions under which a measure of success may be obtained, and the opprobrium of the alleged uselessness of the remedy may thus be removed, to the ultimate benefit of suffering humanity. It appears, therefore, necessary to determine whether Chian turpentine does actually alleviate the distress of cancer or has any controlling influence upon the progress

of the disease, or any pretensions to effect its cure. It is obvious that if either or all of these results can be secured by the use of the drug, in any form or situation of cancer, the remedy cannot be deemed useless. Now, the facts within my own knowledge, derived from my own professional experience, may be summed up as follows : Nine cases of cancer confined to the uterus, which have been under treatment for about twelve months, are so far convalescent that they are no longer under observation. The cancerous growths have disappeared, there is no bleeding on manipulation, and the parts are smooth to the touch, and appear to be covered with mucous membrane. In most of the cases the cervix uteri is shortened from the contraction consequent on the removal of the growth. A number of cases of uterine cancer in private and hospital practice are under treatment, in which freedom from pain, diminution of hæmorrhage, and sloughing of the growth, with improvement of the general health, are prominent features. A number of advanced cases of uterine cancer have been treated for a short time, and the patients have died, but an amelioration of the more severe symptoms took place, although the patients succumbed to the anæmia produced by the previous exhausting discharges. The disappearance of the cancerous growth was verified in three cases where an examination was made after death. One case was complicated with cystic disease of each ovary, one died from dysentery, and in the other the glands in the pelvis and abdomen were extensively diseased. In neither of the fatal cases where the remedy had been exhibited for some time were there any fistulous communications with the rectum or bladder. If we bear in mind the progressive and generally rapid advance of the disease when left alone—as it rarely disappears spontaneously—or when it is treated by palliatives, and compare this with the treatment by Chian turpentine, we find in the latter method a gradual subsidence of the disease, varying as to length of time in proportion to the more solid consistence of the growth, a marked diminution of pain, a lessening of the hæmorrhage, with an increase of the muco-purulent discharge. There is usually an improvement in the general health, but an increased tendency to anæmia is sometimes noticed. From a review of all the cases I have observed, it may be safely asserted that the effects of Chian turpentine in cancer of the uterus are tolerably uniform, and it is more than probable that the remedy effectually removes the cancerous infiltration surrounding the original growth, thereby preventing the extension of the disease. In some instances the treatment has removed glandular complications, and in others it is presumable that these have been averted. It is this controlling action of the drug which probably causes the abatement of the pain and hæmorrhage. The growth gradually diminishes in size, becoming loose and shrivelled, and losing its firm and succulent condition. Whatever may be the termin-



ation of the case, the treatment manifestly affords to the patient such comfort as is not obtainable by any other therapeutical measure.

The earlier the cancerous disease comes under treatment, the greater is the prospect of ultimate relief. The success obtained in recent cases is probably owing to the patients coming under observation before any apparent extension of the disease, or before vital organs are involved. Where the vagina is affected with the disease primarily or secondarily, particularly the latter, the prospects of relief are materially reduced. The treatment should be prosecuted vigorously and persistently, especially at the outset, so as to minimize the constitutional effects of the disease, as it is difficult to decide in what stage these are developed, and perseverance with the treatment should be strenuously encouraged by the medical attendant, as otherwise the patient may be left to die unaided by the only drug that has been found by its internal administration to have any pretensions to resolve a cancerous growth.

In treating a case of cancer of the uterus or rectum, the following procedure is recommended for adoption. It may be premised that it is essential that the genuine drug only should be administered. It is a humiliating statement to make that even now some houses are supplying and dispensing other turpentine for Chian turpentine, and are even guaranteeing the genuineness of the article they supply. It is also necessary that the drug should be given in the form which is most convenient for assimilation. The essence of Chian turpentine, prepared by Messrs. Southall & Barclay, of Birmingham, appears to me to be the most suitable preparation. This is prepared without the sulphur, and evidently does not contain any ether. The drug is in a state of minute supervision, is easily digestible, suitable for all forms and situations of cancer, and is very palatable. One teaspoonful of the essence contains three grains of the turpentine. In place of the sulphur in the essence, Messrs. Southall prepare pills which contain sulphur, sulphate of copper, etc., and which they style, "pil. sulph. comp.," to distinguish them from the Chian turpentine pills. Two teaspoonfuls of the essence, with one or two of the compound sulphur pills, should be given three or four times a day, and after the medicine has been taken for about three months it should be omitted for about three days in every fortnight. The pills or mixture, prepared according to the original formula, may be given instead of the essence and sulphur pills.

The vagina and rectum, even from the first, should be syringed daily with equal parts of vinegar and water. After allowing time for this to drain from the parts, it is advisable to insufflate into the vagina or rectum about ten grains of the following powder: Tannic acid half an ounce, powdered charcoal two drachms, and powdered sulphate of copper ten grains. Messrs. Mappin & Co. of New-street, Birmingham, make a vaginal

insufflator by which the powder may be introduced into the rectum or vagina very efficiently. An insufflator may be improvised out of a vulcanized tube and a two-ounce india-rubber bottle connected with elastic tubing, but such an instrument is apt to become moistened by the secretions, and thus prevent the powder from becoming properly placed. The propriety of excising the os uteri in epithelioma of this part, as a preliminary procedure to the use of the Chian turpentine, may be questioned on reasonable grounds. The cancerous growth as it disappears under the Chian turpentine treatment leaves a shortening of the os uteri which brings the external rim of the os uteri into close proximity with the bladder and rectum, so that if the vaginal portion of the uterus has been removed the subsequent contraction of the lower portion of the uterus drags on the rectum and bladder, causing great pain, with rectal and especially vesical troubles. In large pedunculated epithelioma of the os uteri the larger portion of it is perhaps best removed, taking care to leave the normal uterine tissue intact. In cases where the turpentine has been taken for some months, the dull curette may be used to remove the sloughing mass with advantage. When pain in the sacral or hypogastric regions comes on after the treatment has been pursued for two or three months, the use of morphia suppositories is indicated. To avoid the habitual use of opium, the tincture of Jamaica dogwood (Christy's), in one drachm doses once or twice during the evening, may be prescribed. Hæmorrhage at the monthly periods is best met by giving the liquid extract of ergot in ten or fifteen-minim doses (which may be added to the essence of Chian turpentine), and to use locally the perchloride of iron in solution, or the dried persulphate of iron by means of insufflation. Diarrhoea and dysentery sometimes supervene during the treatment, for which the oil of eucalyptus globulus (in five-minim doses three times daily for a few days only) is a good remedy. This drug may be added to the essence of Chian turpentine. Anæmia consequent upon the occasional hæmorrhages and serous discharges is a serious complication; much of the local treatment here recommended has been suggested to anticipate or prevent the anæmia. To combat this condition, Fellows' syrup of the hypophosphites, in one-drachm doses, may be given during meals, from the commencement of the treatment, in connection with the Chian turpentine treatment.

In cancer of the vulva, Chian turpentine acts slowly, and as the disease frequently extends rapidly, an early excision of the growth, if possible, is necessary, the remedy being given for some time afterwards with a view to prevent a recurrence of the disease.

The use of Chian turpentine in a large number of cases of cancer of the breast shows that it is a remedy of considerable power in relieving pain, of diminishing the size of the growth by causing the removal of the cancerous infiltration, leaving the

more permanent fibrous stroma to be subsequently dealt with. In many instances the growth, although at first it was firm, and seemingly adherent to the chest walls, has become loose and easily movable from side to side, as if it were merely a foreign body, so that if an incision had been made in the skin it could have been pushed out. Several cases of primary scirrhus of the breast have been noticed in which after the administration of the Chian turpentine for some months, the whole of the cancerous mass has sloughed away, appearing as a black gangrenous mass leaving a cavity of considerable dimensions, the walls of which were composed of healthy tissue, and the wound healed with comparative rapidity by granulation. This process, however, is a slow and painful one, and suggests the propriety of anticipating the sloughing process by removing the growth with the knife after it has become sufficiently detached from the surrounding structures by the treatment. Several cases treated by this method have done well, the operation has been materially simplified, and, if the remedy is administered for some time after the operation, the experience gained shows that there is not much likelihood of a recurrence of the disease. In recurrent cancer of the breast the remedy is often found to be of great benefit, and after it has been given for some weeks the application of the crystals of resorcin to the growth facilitates the disintegration of the mass. Resorcin is a powerful and at first a painless application. When its use is attended with much pain it may be mixed with equal portions of tannic acid and charcoal with good effect. Vaseline or chrisma dressing is all that is required after the application of the powder.

In epithelioma of the face and other parts of the cutaneous surface the use of Chian turpentine in conjunction with the powder previously advised (when stating the local treatment of cancer of the uterus), to which three drachms of resorcin have been added, very good results have been obtained. In two cases of cancer of the stomach very beneficial results have accrued from the special treatment. In cancer of the mouth and tongue the results have not been so good, in consequence of the rapidity with which the neighboring glands became involved in the cancerous disease.

I leave these necessarily incomplete observations to the impartial critical judgment of the profession. Enough, I trust, has been stated to show that the Chian turpentine treatment has some ameliorating influence on cancerous disease—how much the future must determine—and therefore I am enabled to claim that the remedy is far from being useless. The facts stated may be considered at least as a distinct addition to our existing stock of knowledge in the treatment of cancer, and I look forward as the almost certain result to their being confirmed, and to candid inquiry leading to further improvements in the same direction.—*London Lancet.*

## OBSERVATIONS ON EXAMINATIONS FOR THE TUBE-CASTS OF BRIGHT'S DISEASE.

Read before the Clinical Section of the Philadelphia County Medical Society, January 31, 1882, by JOS. G. RICHARDSON, M.D., Professor of Hygiene and Demonstrator of Histology in the University of Pennsylvania.

Mr. President and Fellow-Members of the County Medical Society,—I feel almost as if I owed you an apology in advance for attempting to interest you in the subject of the tube-casts of Bright's disease, and my justification is that our energetic Committee on Clinical Pathology has laid it upon me as a duty, with such urgency that I felt bound not to refuse to do my best towards making a few remarks upon this subject not absolutely wearisome.

Of course I need only just remind such an audience as I see before me that tube-casts are solid cylinders formed in the uriniferous tubules of the kidneys during the course of certain acute maladies, such as diphtheria, scarlatina, typhoid fever, or yellow fever, and in the group of more chronic renal affections entitled generically Bright's diseases. These casts differ in size, structure, and general appearance, and constitute, I think, very important aids in recognizing the form and stage of Bright's disease. Their diagnostic value has lately been contested by the famous French authority, Prof. Charcot, and by others, but for reasons which I shall give you presently I think these gentlemen are mistaken in their opinion.

The first specimen I have to submit to your inspection is a section of gouty kidney, beautifully double-stained by my friend Dr. Geo. A. Piersol, which shows numerous casts filling the calibre of uriniferous tubules, and so obstructing them that little or no urine could pass, thus contributing in a purely mechanical manner to the scanty flow of the renal secretion which often occurs in Bright's disease.

There may also be seen a contracted Malpighian corpuscle, the vastly thickened wall of which displays the fibrinous exudation it contains, stained the exact blue tint of the tube-casts which plug the uriniferous tubules. Specimen No. 2 exhibits "small hyaline tube-casts." No. 3, "pale and dark granular tube-casts." No. 4, "epithelial tube-casts." No. 5, "large waxy tube-casts," some three-hundredth of an inch in diameter. No. 7, "granular cast, with pus-corpuscles attached."

The search after tube-casts should be much more thorough than is generally made, and frequently a half-hour's examination will be rewarded with but one or two faint hyaline casts. I have found tube-casts abundant in the urine of a patient with diphtheria two days after the commencement of the attack, so that they do, sometimes at least, give us very prompt warning of the onset of disease. Including a case now under my care, in

which the diagnosis is not positively established, I have seen three cases of Bright's disease in which I detected casts, whilst there was absolutely no albumen in the renal secretion.

The exact diagnostic value of the tube-casts in any particular instance must be determined by a careful consideration of the history, inherited tendencies, general symptoms, etc., as pointed out in the standard text-books upon the subject.

The new points to which I ask your attention may seem at first sight too insignificant to be worthy of notice, yet I venture to submit them, because, when combined with other little facts, resulting from your own experience, or that of our professional brethren elsewhere, they may contribute to the advancement of true medical science, for which we are all laboring so earnestly.

First, in regard to mucous casts, which often puzzle or actually mislead beginners in microscopy: these are long, often branched, rarely epithelial in their character, but sometimes having leucocytes attached to their surfaces. In my experience they generally shrink up in the acetate of potash solution, and this may be recommended as a diagnostic test for them. As they are apt to appear in cases of irritation of the bladder, it has occurred to me that they may proceed, when found in the urine of male patients, from the ducts and follicles of the prostate gland and perhaps of the urethral glands.

Second, I propose the use of osmic acid to demonstrate the existence of slight fatty degeneration in cells of renal epithelium attached to "epithelial casts," also the employment of aniline solution to bring into view very faint and doubtful "hyaline casts," which might otherwise escape observation.

Third, I claim that we can, by a careful consideration of the number of the empty "cell-walls" of red blood-corpuscles attached to the various forms of tube-casts, gain important information occasionally as to the activity of the renal congestion in Bright's disease (see *American Journal of the Medical Sciences*, January, 1870).

Fourth, it seems probable that many cases of Bright's disease escape detection every year, simply because no microscope is convenient, at least until after putrefaction renders the examination difficult or unreliable. I, therefore, invite attention again to my method of preserving tube-casts, and advise that in every instance of possible renal disease, where a thorough investigation is not made at once, a couple of fluid drachms of the sediment from the urine should be poured into a small vial containing about an equal bulk of dry acetate of potash, which will perfectly preserve tube-casts, if it happen to contain any, for careful study at any future time.

Fifth, having observed that many tube-casts in the urine of yellow-fever patients are made up partly or wholly of fungous spores (micrococci), and also that the kidneys of some persons dying of yellow fever had their uriferous tubules generally obstructed by plugs of micrococcus, I advanced the theory at Richmond in 1878 that the suppression

of urine so common in fatal cases of yellow fever was more or less mechanically due to this occlusion of the renal tubules. Such a doctrine was rendered highly probable by the observations of Prof. Orth, and gains additional confirmation from the recent very important investigations of Prof. H. C. Wood and Dr. Formad upon diphtheria.

Lastly, believing as I do that some light may be thrown upon nearly one-half of our cases in general practice by microscopic examination of the urine, sputum, blood, etc., and that therefore no physician can honestly do his whole duty to his patients without frequent resort to Medical Microscopy, I urge that every practitioner of medicine should, in default of a better instrument, provide himself with one of Beck's little ten dollar microscopes, which, as I show you here, will display even "pale granular tube-casts" with distinctness. Perhaps this recommendation will be severely criticised, but my excuse for making it is that it is better to discharge a duty imperfectly than to neglect it utterly, and also that every doctor who has once found out how much assistance even such a feeble aid gives him in his practice will very soon resolve to benefit himself and his patients by procuring a good microscope, although he may at first be compelled to borrow the money to pay for it.—*Phil. Med. Times*.

#### SCENTED IODOFORM POWDERS FOR THE EAR.

*Read before the Philadelphia County Medical Society,  
November 10, 1881,*

By CHARLES H. BURNETT, M.D.

Iodoform is stimulant and anæsthetic, and has long been recommended as a local remedy in chronic inflammations of the middle and external ear, attended by discharge from the meatus. Its formula is  $\text{CHI}_3$ ; it belongs to the methyl compounds; contains ninety-six per cent. of iodide by weight; when heated it will liberate iodine and hydriodic acid, and when only exposed without heat it will volatilize slowly, and to this volatilization is due the unpleasant odor. It is doubtless a useful remedy, especially in chronic purulent inflammation of the drum cavity; but the odor of the drug, unpleasant alike to physician and patient and to their respective families, has well-nigh banished it from aural practice. To the writer it is not unpleasant; but so nauseous is its odor to most persons that positive injunctions not to use it have been laid on the surgeon by the patient's family. In order not to lose this beneficial aid from my armamentarium, it has occurred to me to have the iodoform scented with some of the essential oils, balsams, etc., for use in the ear, as has been done by others in ointments containing iodoform to be applied to other parts of the body. Therefore, through the kindness of Mr. Charles

P. Stout, of H. C. Blair's Sons, Eighteenth and Chestnut Streets, in this city, I have had made a number of combinations of iodoform and scents, and in two instances the combinations have been such as to deodorize in a measure the iodoform by forming another, but highly useful, compound, as will be shown later.

These powders are composed as follows :

1. Iodoform, gr. xx ;  
Ol. menth. pip., Miv.
2. Iodoform, gr. xx ;  
Ol. gaultheriæ, Mii.
3. Iodoform, gr. xx ;  
Ol. amygd. amar., Mii.
4. Iodoform, gr. xx ;  
Ol. lavandulæ, gtt. ii.
- \*5. Iodoform, 3 i ;  
Tr. dipteris odorat., f 3 ij.
6. Iodoform, gr. xx ;  
Ol. menth. pip.,  
Ol. lavandulæ, aa Mj.
7. Iodoform, gr. xxx ;  
Ol. amygd. amar.,  
Ol. lavandul. flor.,  
Ol. menth. pip., aa gt. i.
8. Iodoform, 3 j ;  
Bals. Peruvian., gr. iij.
9. Iodoform, gr. xx ;  
Tannin, gr. x.

By thus scenting the iodoform its use is rendered more agreeable, and in the combinations with the non-oxygenated essential oils, like lavender oil or any of the turpentine series, there is probably obtained a good result in the diseased ear by the oxygenation of the essential oil, since in such oxygenation ozone is said to be generated, and this acts as a disinfectant and an antiseptic. As it is asserted that the exhaled odor of cut flowers in a bouquet produces ozone and makes them beneficial in a sickroom, it would seem likely that the exhalation and oxygenation of an essential oil might produce a similar result in a diseased cavity like the ear. On this point, however, it is desirable to hear from the chemists present.

In the case of iodoform combined with tannin, and in the combination with Peruvian balsam, the iodoform is very slowly broken up, and there is formed an iodide of tannin. This prevents volatilization of iodine, and diminishes the odor. Thus in the same powder we have the iodide of tannin, tannin, and iodoform. This powder not only smells the least, but is one of the most efficient in

\* After having read this paper, the writer saw in the *Philadelphia Medical Times*, November 19, 1881, that Mosetig, of Vienna, had endeavored to mask the odor of iodoform by Tonka bean, *Dipterix odorata*.

its healing power. The powder composed of iodoform and Peruvian balsam has the advantage of an agreeable odor, and of possessing at the same time a larger proportion of iodoform than the combination between this drug and tannin, as it requires but little Peruvian balsam to impart the pleasant odor to the mixture. I have used this particular powder, and that composed of iodoform and tannin, with so much satisfaction that to these two I give the preference as iodoform powders for the ear.

In regard to the others, it may be said that they possess all the virtues of iodoform, but, owing to the rapid evaporation of the essential oils, they ultimately possess the characteristic smell, excepting just at the moment of using them, nearly as much as pure iodoform.

All of the powders may be applied to the ear by blowing them in with a small powder-blower, or they may be carried in by means of cotton rolled on the end of a dentist's cotton-holder under perfect illumination of the auditory canal and the drum-cavity by means of the forehead mirror. These and all other medicaments are worse than useless if applied to a running ear by means of cotton, which is allowed to remain even for a short time in the canal, because the discharges are thus retained, maceration brought about, granulations favored, and foulness of the ear certainly produced.

So far as iodoform is concerned in diseased ears, it is best applied so as to produce at most but a thin film over the ulcerated or inflamed surface; and this is efficiently accomplished by smearing it on by means of the dossil on the cotton-holder, as already said.—*Phil. Med. Times*.

## MERCURY IN THE TREATMENT OF SYPHILIS.

PROF. GEO. HENRY FOX, A.M., M.D.

*First*.—In the treatment of syphilis mercury is naturally the most valuable curative agent of which we have any knowledge. The positive results which follow its employment are such as to convince any competent observer as to its efficacy.

*Second*.—Mercury is an overrated remedy. The fact that a remedy will do much is no sign that it will accomplish everything that may be desired of it. It will lessen the manifestations and shorten the natural course of syphilis in most cases, but it will not always produce a speedy and beneficial effect, as most physicians are inclined to believe. Some of the worst cases of syphilis in my practice have occurred in patients to whom I gave mercury for one or two years.

*Third*.—If the profession generally were more strongly impressed with the great value of hygienic measures in the treatment of syphilis, and were less inclined to confide solely in the specific action of

mercury, I am convinced that patients would receive a far greater amount of benefit. Remedial agents often acquire a fictitious value by reason of the fact that patients improve during their administration. We know that mercury is not inert, and have ample proof that it can and does accomplish a great deal. The improvement which takes place in our syphilitic patients when treated is not wholly the effect of mercury. It is due in great measure to the *vis medicatrix*.

*Fourth.*—Mercury is not essential to the cure of syphilis. This disease, like other erythemas, tends to run its course. It may be severe, and, in that instance, terminates fatally. In the majority of cases it is a far less malignant disease than it is supposed to be. If the patient is of sound constitution and the infection is mild, it usually runs its course without injuring the health of the patient. It may be said that such patients will suffer more from severe lesions in later years. I believe that these patients are as thoroughly cured as though they had taken mercury. I have seen hale men of advanced years who have had syphilis in their younger days and have received no specific treatment, so that I cannot believe that mercury is essential to the cure of the disease.

*Fifth.*—The internal administration of mercury is preferable to the inunction, vapor-baths, etc., in every case for the cure of constitutional disease. A somewhat extended trial of mercurial inunction has led me to abandon it. It is but just for me to say that my experience with the vapor-baths and hypodermic injections has been very limited. They possess no advantages over the method of internal treatment which I can recommend, nor can they claim the merit of simplicity.

*Sixth.*—The dose of mercury usually given to syphilitic patients is unnecessarily large. From the time when the beneficial effect of mercury was estimated by the pints of saliva which dribbled from the patient's mouth, there has been a sudden tendency toward diminution of the dosage of this drug. I believe that in the vast majority of cases the very best effects on syphilis may be obtained by the employment of doses which will not incur the slightest danger of salivation. I have no faith in the administration of doses upon the homœopathic principle. The daily dose of one-half to one grain of the biniodide will do more good than two to three grains. Regarding the choice between metallic mercury and the numerous salts, I am not prepared to speak. The protiodide given in the form of trituration will not cause gastric disturbance. In the late stages of syphilis I have followed the custom of changing from the green to the red iodide. In my own experience, I have never observed any benefits result from the combination of various salts, as recommended by Bumstead, or by the frequent change from one preparation to another.

*Seventh.*—The duration of mercurial treatment should vary according to the character of the case. There are cases of mild and cases of severe sy-

philis. Mild syphilis does not demand mercurial treatment.

I do protest against treating all cases of syphilis upon a routine plan. Many writers on syphilis lay down the absolute rule that the disease must be treated during a certain specified number of months or years, without even hinting that, for various reasons, one patient may not require as much treatment as another. In our text-books of the present day the description of syphilis rarely corresponds with the average case in practice, but it is the description of the superior and comparatively uncommon forms of the disease. The question is not what the disease is capable of doing, but what it is likely to do. There are cases of syphilis which demand two, three, or perhaps five, years of treatment. But it seems to me to be utterly impossible to fix a certain time as the duration of treatment for all cases. When the early symptoms are slight and disappear under treatment, I deem it quite necessary to continue the use of mercury for two or three years to entirely eradicate the disease and prevent subsequent manifestations. Late lesions of syphilis frequently do occur after prolonged administration of mercury. My own practice is to give mercury in every case during the existence of any symptom of the disease, whether it occurs early or late. In the early period I continue the use of mercury for six months after the last symptom has yielded. I then stop the administration of the drug and await further developments. If the symptoms reappear, I resort again to the use of mercury, and continue for perhaps two or three months after the disappearance of the latest symptoms. In late syphilis I give mercury to subdue any growing symptom and then stop.—*Med. Record.*

#### ANTISEPTIC INHALATION IN PULMONARY AFFECTIONS.

I. G. Sinclair Coghill, M.D., F.R.C.P. Ed. (*British Med. Journal.*)

The objects of treatment are: 1. To lessen secretions 2. To promote evacuation of what secretion is formed. 3. To disinfect the air which may pass into surrounding or deeper healthy portions of the lungs. Again he says: "Besides acting as disinfectants, antiseptic inhalations promote expectoration by increased energy of expiratory acts. The apparatus is extremely simple. It consists of a space for a pledget of tow or cotton wool, inclosed between the perforated surface of the respirator and an inner perforated plate, which can be raised so as to permit the tow to be saturated with the antiseptic solution. Elastic loops are attached to pass over the ears and retain it in position. The inhaler may be procured either plain or of a slightly smaller size, and covered with black cloth for wearing out of doors. The pledget of tow, which may be changed

once a week or so, sprinkled with from ten to twenty drops of the antiseptic solution from a drop-stoppered vial, twice a day at least, according to the extent to which the inhaling may be carried on. Of this the patient is the best judge, and the length of time and quantity of solution should be regulated by tolerance and effect. The most important times for inhaling are for an hour or so before going to sleep at night, and after the morning expectoration, which leaves the suppurating surface or cavity dry to be acted upon—disinfected, so to speak—by the antiseptic vapor. A great many of my patients have of their own accord come to use the respirator almost continuously day and night from their experience of its good effects. I attach the utmost importance to the mode in which the respiration is conducted while inhaling. The patient should be carefully instructed to respire through the mouth alone, and expire through the nose. In this way the breath is drawn through the saturated tow in the perforated chamber of the inhaler, and passes directly into the lungs laden with the antiseptic materials. Expiring through the nose only, necessarily involves a complete circulation of the medicated air. The breathing should be short at the beginning of the inhalation, but gradually deepened, so as to displace and effect the residual air in the more distant portions of the lungs. This form of respiration itself is not only of great use in favoring the circulation of the blood in the lungs, and thus aiding local and general nutrition through the fluid, but it helps very much the expulsion of the sputa by means of the increased energy and thoroughness of the expiratory acts.

After many trials of the now formidable list of antiseptics, I find that carbolic acid, creosote and iodine, in combination with sulphuric ether and rectified spirits of wine, are the most efficacious and satisfactory. The want of volatility in boracic, salicylic and benzoic acids, and their salts, proves a bar to their employment by this method. Dr. Horace Dobell, who has had a very favorable experience of this treatment, writes to me that he has found thymol, in the form of Shirley's thymoline, very grateful and efficient in many cases where the smell of carbolic acid and creosote was intolerable either to patients or to their friends. Of the three antiseptic agents I chiefly use, I find iodine most useful in the second stage of phthisis, when the expectoration is passing from the glairy into purulent character. I use the tincture for inhaling purposes made with sulphuric ether instead of spirits of wine, and this ethereal solution has a singularly soothing effect on the cough and pulmonary irritation. In combination also with carbolic acid, as carbolized iodine, or iodide phenol, it is extremely useful in the purulent expectoration accompanying the resolution of pneumonia both catarrhal and croupous. In the stage of excavation, whether tubercular or pneumonic, the combination of iodine with carbolic acid and creosote is most potent.

The acid seems to have the greater influence in checking the amount and purulent nature of the sputa; while creosote acts merely as a sedative in the cough, apparently by reducing the irritability of the pulmonary tissues. The addition also of varying proportions of sulphuric ether and chloroform greatly assists in soothing and allaying irritation. These combinations also act frequently like a charm in the profuse expectoration of purulent bronchitis, as also in bronchial asthma.

#### THE LOCAL APPLICATION OF CHLORAL HYDRATE IN THROAT AFFECTIONS.

In a paper published in the *Detroit Lancet*, for July, 1881, Dr. G. A. Collamore speaks of a species of sore throat, characterized by moderate swelling of the tonsils and adjacent mucous membrane, pain in deglutition, and a peculiar cherry-red or purplish-red hue of the tonsils and pharynx. On the tonsils appear spots of whitish or yellowish white color, the size of a grain of corn or less. These are composed of the aggregated secretions of the tonsillar glands, and are readily detachable, leaving the mucous surface unabraded. There is, moreover, a moderate, sometimes high, grade of fever, and decided prostration of the system. The disease is properly a follicular tonsillitis, though the inflammation is not confined to the tonsillar surfaces, but affects the palatine and pharyngeal mucous membrane also, and is liable to be mistaken for and called diphtheria.

In these cases, combined with systematic remedies, chloral acts in a kindly manner as a local application, either as a gargle, a grain or two to the ounce of water, frequently used, or in a stronger solution applied with a camel's hair brush or a swab. A small quantity of the gargle may be swallowed after each gargling, in order to apply it to the lower pharynx. Employed in this way the author has found chloral a very valuable remedy. —*Med. and Surg. Reporter.*

#### HOW TO REMOVE CORNS.

Saturate a small piece of cotton with alcohol, apply it to the corn for a minute, then with a sharp scalpel or knife carefully separate the corn from the healthy tissues, which is easily done by a careful handling of the knife and gentle pulling with forceps, while the parts are being immersed with alcohol. If the alcohol dries away while operating, apply the saturated cotton again, and I frequently find it necessary to apply this several times before the operation is completed. The alcohol not only lessens the sensibility of the parts, but it facilitates the separation of the hard corn from the soft and tender tissues. This cures, and that without drawing a drop of blood or producing any pain, except what results from pulling on the corn with the forceps. After raising one edge, it is about like removing a piece of adhesive plaster. —*American Med. Journal.*

### SOME PRACTICAL POINTS IN THE TREATMENT OF HÆMOPTYSIS.

In bringing forward, in a very brief manner, some practical points in relation to this question, I will, for the convenience of the first part of my object, divide cases of hæmoptysis into three kinds: first, the slight; second, the copious; and, third, what may be termed the explosive.

In the *slight* form, the basis of the sputum is composed of mucus, which is stained more or less deeply with blood, the bleeding vessel being of small size. The most successful remedy for the this form is ergot.

In the second or *copious* variety, the expectoration consists of pure blood, the quantity of which may vary up to a very large amount; and the bleeding ceases gradually until the attack is over. Here, again, the most successful remedy is ergot, and indeed it is in this kind of hæmoptysis that ergot is especially efficacious. In order to prove efficient in hæmoptysis, however, ergot must be given boldly. One teaspoonful of the liquid extract is a suitable dose, and it may be ordered every half-hour, hour, or two hours, according to the urgency of the case. If it is doing good, it is a mistake to leave it off before the sputa are bloodless, although the intervals between the doses will be lengthened as the hæmorrhage abates. In a few of these cases, ergot will fail; not in many, but now and then. If seven or eight doses be ineffectual, it is best to abandon it. The next remedy worthy of confidence is gallic acid, which it is necessary to give freely, in doses of fifteen to twenty grains, at intervals the same as in the case of ergot. Should there be tedious delay in the final clearing up of small traces of blood from the sputa, an acid mixture with quinine is usually effectual; or, if very obstinate, ipecacuanha, in twenty-minim doses of the wine pushed to slight nausea, will generally remove them.

In the third or *explosive* variety of hæmoptysis, the attacks are profuse, sudden in their onset, all at once ceasing, often for many hours, then abruptly bursting out again. There is no gradual subsidence. The lesion is probably a rupture of some aneurismal sac in the wall of a cavity. Now is it in these cases that ergot is hardly ever of much use. In my experience, the best remedy is turpentine internally, with cold applications over the chest. Three half-drachm doses of oil of turpentine may be given, half an hour apart; or, if care be taken to follow it with castor-oil, even more than three. When the turpentine is left off, it is well to follow up closely with a mixture of gallic and aromatic sulphuric acids, sulphate of magnesia, and quinine. It is particularly in this type of case that digitalis is often useful for calming vascular excitement. As the patients often make blood very rapidly, the free use of aperients ought to be enjoined.

Nothing would be easier than to quote a long string of remedies for hæmoptysis, but my present object is to leave prominently on the mind one or two that are to be relied upon, and to indicate

their spheres of usefulness. Nor is it necessary to dwell on certain instructions which apply to all forms of blood-spitting. Constipation must go unrelieved, and is best treated by salines. A quick pulse must be steadied by digitalis, of which perhaps the most handy form is the digitaline granule of Homolle and Quevenne. Cough is to be soothed; the simpler the mode of accomplishing this the better, but it must be done; and nothing answers better for this than a chloroform pad laid over the sternum.

Speaking in a general way, and not alluding to hæmoptysis of cardiac origin, I hold that we should keep before our minds the advisability of stopping all blood-spitting in phthisis without delay. To this rule, perhaps, there are two exceptions. The first is trivial. It is that dirty-red, slimy, bad smelling, never-abundant expectoration which hysterical women with phthisis often exhibit at the bottoms of their spittoons; this may be left to itself. The other exception is a serious one; it comprises those forms of hæmoptysis, usually copious and angry, occurring in advanced and very chronic cases where there is a considerable amount of fibroin induration. In such patients, notable dyspnoea on exertion has for a long time past been a prominent symptom, and respiration has been maintained by a very small extent of lung-substance. These cases are open to a special danger—that of fatal embolism in the right chambers of the heart or the pulmonary artery. Not uncommonly, the course followed is for the bleeding gradually to abate in quantity, remaining, nevertheless, of the same angry red; then urgent dyspnoea suddenly sets in, and death takes place within forty-eight hours. These are cases calling for extremely careful treatment. Can it be right, where only a small surface is available for respiratory function, to contract those few vessels with ergot? Or can it be good practice to pass styptic medicines into a patient's circulation when his cachectic state, his low vitality, and perhaps some febrile movement, render him especially liable to the formation of thrombi? It is wisest to limit ourselves to external applications, chloroform-pads, dry cupping, sinapisms at a distance or other derivative treatment, with appropriate general management.

Perhaps I may be allowed to conclude with two cautions, commonplace they may seem, but both of them the out-come of bedside experience. One is, to have some responsible person in attendance, night and day, on all cases of severe bleeding, till the attack has completely passed away. Death in hæmoptysis is generally sudden, and it is very appalling to discover too late the consequences of omitting this precaution. The other is, to decline positively to examine a patient's chest while there is any hæmoptysis. Irrespectively of the danger of the process, an opinion arrived at by auscultating a chest during or immediately after a bleeding is not a reliable one.—Jas. M. Williamson, M.D., *British Medical Journal*.

## REMARKS ON THE USE OF ICE IN THE PREVENTION OF MAMMARY ABSCESS.

Read before the Philadelphia County Medical Society, January 25, 1882, by M. O'HARA, M.D.

In 1879 I was called to visit a lady entering the eighth month of pregnancy, with a phlegmonous inflammation of the left mammary gland and the surrounding cellular tissue. The cause assigned was a kick of a child which was sleeping on the same bed. There was intense congestion, inflammatory exudation, very great local pain and high constitutional irritation. Fearing premature labor from the severe constitutional disturbance, I exerted speedily all the forces at my command, locally and generally, to abort the inflammation: I used lead-water and laudanum, belladonna, camphor, compression, with aconite, veratrum, and morphia, etc., all without avail. Suppuration ensued, and to relieve tension and agony, the knife was used. Notwithstanding these efforts, premature labor set in, resulting in the successful delivery of a seven-and-a-half-months child. After the incision into the left breast and cellular tissue, both glands took on the secretion of milk, but a mammary fistula occurred, which was so annoying, by the copiousness of the discharge, as to prevent the lady from resuming her household duties. Everything was used, of special or general value, to reduce the secretion of milk and to permit the closure of the fistula, such as iodides, bromides, belladonna, salines, pressure, etc., but all to no purpose. In the third month of lactation rigid dieting lessened the distention and fullness of the breast by reducing the whole amount of the circulating fluid, and the fistula closed naturally. The child nursed thereafter at both breasts and thrived vigorously. The father insisted several times that the child should be weaned, in order to relieve the mother of the soaking of milk about her clothes; but, as the child was puny and undeveloped, and the heat of summer was extreme, I considered it criminal to deny the child the mother's milk: therefore I tried various means to dry up the left breast and leave the right intact; but the effort did not succeed. I thought then that I could not dry up one breast without at the same time arresting the secretion in the other, but I offered to try it with the ice-bag, which was refused; luckily, by low diet, at somewhat of a risk, though, I accomplished the purpose. I have thought often, since that time, that, following the practice of Dr. Corson, I could have averted the whole trouble and pain, and have permitted the patient to recover speedily from the traumatic mammary inflammation, by a speedy use of the ice-bag.

In the same year, Mrs. ——— was delivered at full term of a healthy boy. The nurse was an old family attendant, who by her care of the breasts of females intrusted to her previous to labor could almost warrant that they would never have a

gathered breast. She had had the breast in training for some time. Both breasts gave milk, but not in a very satisfactory manner to the child, for two or three weeks. There was no healthy-shaped conical nipple to either. I expressed my anticipation of a mammary abscess from want of free flow of the milk, due to the condition of the left nipple, some abnormal development of the nipple and some of its outlet tubes, resulting in backward distention of the lobules, milk-accumulation and inflammatory irritation in the milk-reservoirs, then extension to the cellular tissue, and abscess. The larger portion of the gland was thus affected, and there was no option but an artificial opening; due drainage, and the non-use of the organ, set that breast all right.

The right breast had a very small nipple jammed in the breast in a hollow, and somewhat turned upon itself. I kept the baby on this breast for several days. The lower half of the milk-ducts gave milk, but the upper half did not. There was a lump to be felt on the upper portion of the breast, which was a distended lobule or lobules corresponding to the excretory ducts which were occluded. As the breast became distended, signs of suppurative inflammation occurred in this; and two weeks after the other breast was lanced, this one had to be relieved in the same manner, and both breasts became *functus officio*.

I believe the trouble in the right breast might not have amounted to an abscess but for the extra filling by reason of the cessation of the function in the left. I saw that some of the tubes were not open or not allowing an outflow of milk; but, being filled with milk, the additional afflux of blood seemed so to congest the erectile tissue about the nipple as when in a state of erection to kink up and prevent other excretory ducts from emitting their contents, and distention of the lobules was of course imperative. I may say here that I tried by shields and traction to modify the condition of the nipple, not using any violence, but concluded there was some abnormal condition of the nipple and tubes, whether congenital or acquired. In this case I should fear the same condition would be gone over again, if proper means were not taken during the pregnancy to develop the nipple, and, failing that, to forbid the use of the breast. One might be tempted, in the interests of the child, to get as much use as possible of the breasts, and depend on the ice-bag, which I believe could be successfully used at the moment of imminent signs of suppuration occurring. I feel warranted in saying this by my experience in the next case to be related.

I attended Mrs. O'C. three years ago. She had a typically normal left breast and nipple, but the right nipple was flat, depressed, and distorted. The child did not care to use this breast, and no amount of pulling out or countersinking the nipple with a shield could bring it out. Neither could it be freed by the pump, which, when used, gave very much pain. Gradually, from the distorted,



kinked, or strictured nipple-tubes, milk-accumulation, inflammatory irritation, and mammary abscess occurred. She suffered some weeks of agony, which I desired to spare her by an early incision, which she refused until it pointed, when I opened it. She had a tedious recovery from the agony and prolonged drain of pus, and the breast was left damaged considerably, and also a much worse nipple was left.

She was confined again four months ago. The day after the birth she told me she wanted no more gathered breasts. I examined the damaged breast. It showed above nipple a veteran scar, was cocked upward, and promised no future as a nursing organ. The other breast was good. That belonged to the child, and I had no right to meddle with it. Yet even now the right breast was painful and swollen, with pain felt in the arms and under the clavicles. I told her my idea was that I could not keep the left breast for the baby; that I must dry up both. She said I must do it, for doctors must have some means of doing anything they wanted.

It then occurred to me to try the ice. I put on a circular plaster of the india-rubber combination of extract of belladonna, with a hole cut through which the nipple protruded. I filled a thin rubber bag with ice, and gave directions to keep it constantly applied. She kept it constantly applied, not always on one spot, but changing it from the upper part of the breast to the lower, sometimes towards the clavicle, and sometimes on the side of the chest. She shifted it from the breast to the contiguous territory, admonished to change it by her own desire of relief from pain, which would recur in various parts around as the inflammation attempted to pursue its course. She seemed to understand that the breast was furnished with its blood from many arterial branches, and when the irritation from one region was subdued, had to get at another. The application of the ice-bag was immediately followed by a relief of pain, and she was enthusiastic in its praises. It was kept in use night and day for six days. On the third day the milk came in the other breast, and the baby has used it from that day to the present. There was no interference with the general system, except favorably, in abating the rather high constitutional irritation due to the mastitis of the right breast.

On the fourth day she complained of severe local peritonitis. She had been kicked by her elder child in the abdomen, and the inflammation appeared to localize itself in the broad ligaments. The use of morphia, leeching to twelve ounces, and the use of the ice-bag to the abdomen, relieved this feature in twenty-four hours.

On the sixth day the breast presented the appearance in size and to touch of the same organ prior to pregnancy, and there has been no complaint of it since.

There was much interference by officious neighbors, who told them the ice had caused the peritonitis; but the patient bravely held on to it, and

the ice-bag has won a victory in that neighborhood. I wondered that it produced so little disturbance to the organism, and I began to think that Dr. Hiram Corson was not over-enthusiastic in his statements as to its virtue in the prevention of mammary abscess and even arresting the process of suppuration. I think it ought to be more in use in the prevention and cure of inflammations of the breast.

Dr. Goodell read Dr. Corson's paper before the Philadelphia Obstetrical Society, November 4, 1880, and it is reported in the Proceedings of the Society for that year. He has used ice for mammary abscess for many years. It appeared from the debate upon his paper at that time to be unknown as a mode of treatment to Philadelphia physicians then present. The causes of mammary abscess are numerous, and I have not gone into them. Dr. Corson has given many, but neither he nor the members of the Society in that debate appear to have spoken of the cases dependent upon obstructed nipple-ducts or deformed nipples. Dr. Ingham expressed the opinion "that mammary abscess is undoubtedly generally the result of fissured nipple." I have seen very many cases of fissured nipple without this result, and if you get a normal breast and well constructed in its delivery-tubes you can often treat fissure successfully. But you will hardly escape abscess in the cases alluded to in this paper.

"Byford, in his "Diseases and Accidents incident to Women," says, "Anatomical causes of inflammation of the breast exist to a great extent. They are sometimes congenital, sometimes hereditary, but I think for the most part brought about by improper dressing. The flat, undeveloped, or retarded nipple is one form which prevents the perfect performance of suckling. Nursing is often impracticable." He speaks of a very broad but extremely short nipple entirely too large for a child's mouth and too short for prehension; another, a breast with scarcely a trace of the peculiar warty tissue-like nipple; another, a very small nipple where the milk-tubes seem to be bound in such a contracted bundle as not to allow free egress to the milk. He mentions a type in which I would place my second case (the right breast), a nipple large enough to be easily taken by the child and drawn but the milk-tubes on entering turn too acute an angle, and a little swelling of the sub-areolar tissue from the retention of the milk will stop them entirely, so that the milk will not pass out, and if the gland continues in full function we must have inflammation and abscess. It would be interesting to discuss whether these are rudimentary nipples or due to tight lacing and the faults of female clothing, and whether physicians ought not to teach patients how to avoid them if preventible. If anything can be done for the improvement of the defective organ, it must be during the pregnancy. I is too late to do anything after the labor. On this I should like to hear the experience of others.

If we do try after the gland is in function and

fail, we have no right to be censured, and shall not be, if we explain correctly to the patients, and, seeing the storm coming, we can, I think, by the use of ice prevent an abscess from this cause or other causes.

My experience of ice only goes to preventing abscess by drying up the breast. We are not allowed to try many experiments on our patients, yet I think it would be very judicious treatment to use coils of india-rubber tubing, with a constant current of water of the temperature we choose, and draw the line exactly by experience between due physiological and pathological congestion of the breast, and not as in these cases I have referred to, where from necessity we are forced to annul the function of lactation; for when we determine that the nipple is useless the woman ought not to be compelled to go through the agony of a gathered breast.

The time allowed me is so short that I cannot quote from Dr. Corson, but I must notice a criticism of Dr. Corson's treatment, by Dr. G. B. Funderberg.\* He says that, for various reasons, he considers other measures preferable, especially the use of belladonna and pressure. Pressure is the prime factor, belladonna the auxiliary. By pressure, "a tight body" compressing both breasts for forty-eight hours, and the use of 3 ij of extract of belladonna to ʒ ss of glycerin, he reports successful results. Now, I have tried compression in many cases with belladonna, and there is no comparison between the two modes of treatment. I have not the slightest faith in belladonna in any shape in a severe form of mammary inflammation, and in future will have no reliance on it. This is the result of experience in these cases just mentioned and many others. It will do in mild cases, but they would probably get along as well by themselves. But as Dr. F. speaks of compression, that is serviceable. And where can you get better means of compression than ice? Ice carries its compressing power deep into every cell and every fibre of the tissue; compression otherwise is only superficial, and cannot go to the intimate depths of every little cell. Compression will not act on the afflux of blood; ice will. Compression is painful; ice is anæsthetic. The sensation is blunted and pain relieved; an inflamed breast bears badly compression. Ice constringes everything,—blood-vessel, nerve-fibre, muscle, and cell, wandering or fixed,—and stops the active formation and progression of the leucocytes, and it is a very simple, easy, and efficient mode of compression. I think those who use it freely will accord it the merit of being a perfect agent of pressure.—*Phil. Med. Times.*

#### EXAMINATION OF CHILDREN.

By W. T. PLANT, M.D., Professor of Diseases of Children, etc., Syracuse University, New York.

For the proper examination of sick children both time and tact are necessary. The work can-

not be forwarded by haste and impatience. It is important, at the outset, to win the confidence and good-will of the little one. If the patient is a stranger and old enough to be observing, be careful how you approach it. "First impressions are lasting." Avoid brusqueness. Better, at first, talk about the child than to it. Get the history of the sickness from the mother, and while receiving that, you may notice the child without seeming to. A trained observer can see a good deal in a short time. The first glance will show whether the child is very ill, and may even indicate the probable character of the ailment. Notice the physiognomy first. The features of a child under three or four months have little expression, but beyond this period they may be taken as an honest declaration of its feelings. It has not yet learned the art of hiding trouble under a tranquil mien. In acute diseases attended with fever the cheeks, and perhaps other parts of the face, are flushed from congestion. If the redness is circumscribed and transient, appearing on one or both cheeks, the forehead or the ears, soon fading into paleness to reappear after an uncertain time, we have in this a reliable sign of serious brain trouble. Drooping of the upper lids, squinting, rolling of the eyeballs, fluctuating or unequal pupils, or a steady gaze on vacancy, associated with fever, are symptoms that point in the same direction. A small, pinched face, overtopped by an enormously enlarged head, characterizes hydrocephalus. Rapid out and in movements of the *alæ nasi*, with flushed and anxious countenance, attend severe inflammations of the respiratory organs. I know of no disease that will change the physiognomy of a little child so quickly as a diarrhoea, with copious watery dejections. I suppose that full three-fourths of the weight of a child's body is water; and its rapid abstraction by an intestinal flux may, in a few hours, work such changes in a plump and ruddy face that it is scarcely recognizable.

Notice also the voice. You know the clear, ringing, exuberant tones of healthy childhood. In sickness they are changed. Diseases that produce great debility render the voice weak and plaintive. In pneumonitis and peritonitis it is restrained, because its exercise causes pain. Fits of loud crying are evidence of the absence of these diseases. In croup, and other affections of the larynx, the voice is apt to be hoarse and brassy. Hoarseness is also an early sign of congenital syphilis. Some cases of cerebral inflammation are attended by an occasional solitary piercing cry, a cry so peculiarly expressive of agony that it is not easily forgotten. This is the "hydrocephalic cry" of the old authors. Sighing is a symptom frequently seen in like cases.

Cough is very frequent in children, and its character varies with the cause. After taking cold, the most frequent cause, the cough is dry at first from diminution, but becomes moist at length from an increase of bronchial secretion. The cough of pneumonitis and pleuritis is apt to be restrained,

\* Pittsburg Medical Journal, October, 1881.

That of whooping-cough is always paroxysmal after the first stage, though the whoop is not always present. The cough that accompanies some forms of heart disease is dry, stuffy, and frequent. A laryngeal cough is peculiarly loud and resonant—clarion-like. Stomach and intestinal irritations, as from worms or undigested food, also cerebral and spinal irritations, often give rise to a persistent, dry cough, from reflex nervous influence. Lastly, continued fevers in children are often attended throughout their course by a hacking cough, difficult to subdue, and more annoying than dangerous.

Notice, again, the position and movements of the patient. If very weak it lies upon its back without much movement of its limbs. If the head is retracted and cannot be brought forward without pain, if the body is rigid, and there are muscular spasms and twitchings, this condition points strongly towards cerebro-spinal irritation or inflammation. If any of the abdominal viscera are inflamed, the child prefers to lie on its back with the limbs drawn up. In colic the prone position is chosen because pressure gives relief. Children often carry the hand to the seat of pain—to the forehead in headache, to the ear in earache, to the gums when teeth are coming. Rubbing the nose and upper lip is popularly regarded as a sign of worms. It may be due to these, or to any other irritant in the alimentary track, to a cold, or a dose of Dover's powders or other opiate. In spinal and hip diseases children instinctively assume positions so characteristic that they are of great diagnostic value. In all conditions of the respiratory organs, in which the need of air is urgently felt, there is apt to be extreme restlessness.

Inspection of the surface of the body will frequently lead to a correct diagnosis without other examination. All the exanthemata may be known in this way. Congenital syphilis is wont to betray itself by coppery discolorations of the surface and eruptions around the anus. In infants the first stage of intermittent fever is seldom attended with shaking, as in older people, but by lividity and paleness of the skin and a characteristic goose-flesh appearance. Jaundice, a frequent ailment in the newly-born, imparts a yellowish tinge to the surface.

In grown people we make much of the pulse; not so with children. It is usually absent at the wrist for a week or ten days after birth, and throughout infancy it is feeble and very rapid. Its average during the first year is about one hundred and thirty (130). It is considerably slower during sleep, and much faster during active movement. Gradually it becomes less rapid, and at the fifth year it is about ninety. During the whole of the child life it remains somewhat faster than in the mature. At puberty it is about eighty. The infant pulse is liable to great acceleration from slight causes. A cold, the coming of a tooth, or any transient emotion of joy or grief, may affect its rate as much as a serious illness. You will natur-

ally infer that a rapid pulse is of little significance in very early life. A prematurely slow pulse is of more importance, being one of the ordinary accompaniments of serious brain disease. The difficulty of counting the pulse, owing to the incessant movement of children, still further detracts from its value.

The thermometer, an instrument of the greatest value in our work among grown people, is comparatively of little worth when we are dealing with young children. Often the child is refractory and must be held down in order to keep the instrument in the axilla long enough to take the temperature. This is of the less consequence, since its revelations are of much less value than in adults. For, in children, the temperature, like the pulse, is liable to sudden increase from slight and transient causes. A fit indigestion, or even an outburst of anger with hard crying, will cause the temperature to mount to  $103^{\circ}$  or  $104^{\circ}$ , and the case might seem to wear a serious aspect; but an emetic or a dose of oil for the indigestion, and such wholesome correction in the other case as shall restore the calmness of an obedient spirit, will soon bring the body heat down to the normal standard. When the thermometer is used, it should be remembered that the temperature of the young child is a little higher than that of mature age, though the difference is but the fraction of a degree.

The respiration in young children differs in some particulars from that of mature age. In the very young infant the breathing is frequently intermittent and irregular. There may even be pauses of such considerable length between the inspirations that the mother fears the cessation of the function. From an average of about forty respirations per minute, during infancy, the rate decreases as the child grows older. At the tenth year the average is about twenty-two. Like the pulse, the breathing is liable to great disturbance from slightest causes. Exercise, emotional excitement, or a transient fever, may increase it as much as more serious ailments. In capillary bronchitis and pneumonitis the respiration is quickened. In acute pleurisy, and in peritonitis it is short and difficult from the increase of pain to which the movement gives rise. In all acute febrile affections in the young child respiration is apt to be rapid and panting. This, with the cough to which I have before alluded, often renders parents apprehensive of lung disease. In acute encephalic inflammations the respiration as well as the pulse may be abnormally slow and intermittent. In obstructive disease of the larynx and trachea, as croup, inspiration is prolonged, and, if the obstruction is considerable, is accompanied by a peculiar wheezing sound.

In affections of the chest in infants, you will have frequent occasion to resort to auscultation and percussion; and you will be more fortunate than I have been, if, owing to the uneasiness of the child, to the small size of the chest and to the faintness of the respiratory murmur, you do not

fail of that diagnostic precision which is so easy of attainment in the adult. Some things, however, may be learned by these means from the youngest and most refractory patient. We may always know by auscultation whether the lungs are freely and equally pervious to air, and by percussion whether there is any considerable dullness in any part of the chest. If a stethoscope can be used without frightening the child, it is preferable to immediate auscultation, because with it the sounds are collected from a restricted area, while adventitious noises from the nares, the larynx and the stomach are excluded. It is my habit to begin this examination at the back to avoid frightening the child. The young auscultator should have a care not to mistake the naturally harsh breathing of youth for a condition of disease.

While you have been bringing the examination to this point, some chance opportunity of inspecting the tongue and inner side of the mouth has probably presented itself. If not, this part of the investigation had better be made last, since it is pretty likely to provoke crying and a lusty resistance, which occurring earlier would interfere with and retard your work. To examine these organs the patient should be brought in front of a good light. While the nurse holds it and controls its hands, the mouth may be opened by pressing the chin downward. The tongue being in view, notice the condition of its upper surface. If coated, observe the color and depth of the fur, and whether there is any undue prominence of the lingual papillæ. In infants, examine the inner side of the mouth for aphthous sores; also, if at an age when teeth may be coming, pass the index finger backwards over the gums and ascertain their state as to heat and turgescence. If there is ground for the least suspicion of throat trouble, do not neglect to make an examination. This is easily accomplished by steadying the head and passing the handle of a teaspoon over the dorsum of the tongue, nearly as far backwards as the circumvallate papillæ and making downward pressure.

—*Obstetric Gazette.*

### TREATMENT OF TYPHOID FEVER.

Dr. H. V. Ferrell (*St. Louis Clin. Record*) says: The treatment of typhoid fever is quite satisfactory, the mortality in my experience barely exceeding two per cent. In the treatment there are three fundamental rules to be kept in view.

1. Put the patient to bed early, and enjoin the most absolute rest throughout the whole course of the disease. In all cases of doubt in the diagnosis I advise the patient to take his bed. If it is not typhoid, rest is not apt to hurt him, and if it is, it may be the very means of saving his life. In every one of my fatal cases this rule was not observed. In two cases of death from perforation, one had been about with the fever on him for two weeks, the other three. In the one from hemorrhage, the

young man tried for near three weeks to wear the fever out. I have lost no case where the patient took to bed early.

1. Early and judicious alimentation: by early I mean within the first forty-eight hours. The aliment should be highly nutritious, easily assimilated, in a liquid form, and given at regular intervals.

3. Use drugs only to meet indications, and with a well defined purpose, and no longer than that purpose is subserved. The German specific treatment I believe to be utterly worthless, if not worse. If the temperature runs high, use quinia and digitalis in large doses, sponge the surface freely and frequently with equal parts of whiskey and water, to which may be added a little muriatic acid. To control the bowels and to correct the offensive odor of the discharges, bismuth and carbolic acid, or bismuth and liq. sod. chlorinati. For the vomiting, which is sometimes very troublesome, oxalate of cerium in 10 gr. doses, or calomel in doses of the 1-10 or 1-12 of a grain. For restlessness or sleeplessness, codeia has answered my purpose best. For intestinal hemorrhage, hypodermic injections of ergotine, or what answers just as well Squibbs' Fluid Extract of Ergot. For great muscular or nervous weakness I have seen *tr. nucis vomicæ* produce excellent results.

Finally, I have no sort of doubt as to the utility of alcoholic stimulants early and judiciously administered.

### PICROTOXINE IN NIGHT-SWEATING.

Dr. F. R. Henry (*Med. and Surg. Reporter*). I have exclusively employed the active principle of *cocculus indicus*, picrotoxine, in the treatment of night-sweating in phthisis and other diseases. My success with this substance has been decidedly superior to that previously obtained by the mineral acids, belladonna and ergot, singly and combined.

My attention was first called to this use of the drug by a quotation from an article in the *Practitioner*, by Dr. Wm. Murrell. The dose used by Murrell was from gr. 1-80 to 1-60; the latter amount, four times a day, being the largest dose administered by him. My custom has been to give a pill containing gr. 1-80 at bedtime, which dose may be repeated once or twice during the day in obstinate cases.

As above intimated, I have not employed this drug solely in the night-sweats of phthisis. I recall a case of chronic pleurisy in which the effusion having been absorbed, convalescence was unaccountably retarded and prostration was so extreme that a latent, incipient phthisis was suspected. The skin was bathed in perspiration during the greater portion of the twenty-four hours, and this being the only discoverable morbid condition, I resolved to treat it with picrotoxine. It was promptly checked and convalescence set in immediately.

I have employed the drug in nearly one hundred cases.

## PROCEDENTIA UTERI—MARTIN'S OPERATION.

By P. V. SCHENCK, M.D.

[After giving various methods used in treatment of this disease, the writer says]: Martin, of Berlin, if there be an elongation of the cervix, amputates it; he then denudes an ovoid surface on anterior wall, uniting with deep and superficial sutures; he then draws down the posterior wall, holding by ball forceps; the columna is noticed as a ridge; this ridge he circumscribes by an incision, and dissects off the flap, letting it hang down; covers the denuded surface by alternating deep and superficial sutures, bringing the edges together; the same on the other side. Next, circumscribes the (*introitus*) entrance by an incision beginning at bottom of flap, running up to one-half of labia, thence along the edge of the mucous membrane to median line, ending in front of the anus; then denudes, removes the flaps already left in this denudation, puts in deep and superficial sutures.

Having been in charge of a public charity hospital especially for women, I have had a large number of cases of prolapse of the womb in the third degree to treat, and I have tried many of the operative plans proposed, and, as the following has been so satisfactory in quite a number of cases, I take pleasure in calling attention of the profession to it. If the cervix uteri be hypertrophied and elongated, and there be laceration, take (of course preparatory treatment has been already employed) a Nott's vulcellum, place it in the cervix, which draw well out, and perform hysterotrachelorrhaphy; then replace the womb and perform Martin's posterior operation. There is no doubt but that surgical operations must some day take in this lesion the place of all other treatment. Localization, says Virchow, is the principle of modern medicine. By this operation the perineum is repaired, the columna and rugæ with furrows restored (all other operations cut these away); an effectual obstacle is placed so that it is impossible for the cervix to turn under the pubis, involution will go on in the vagina, and its recreative power be displayed; the cervix uteri is nominally restored, and the womb takes up the wondrous tale and continues the story of birth. You need have no fear of the anterior wall; it depends upon the posterior for support; its prolapse is the result of, not the cause of prolapse of the womb. The dermoid condition of the vagina will rapidly change and the epidermis be replaced by soft epithelium, and thus a normal influence is spread from one pole of the sexual system to the other. The success and result of this operation is far in advance of anything we have yet had. That it is not perfect is an inducement for further study; but so far, as I believe, it is superior to any other mode, better in its success, and fails less in its failures. The operation in Martin's hands has been successful in 18 cases out of 20; in mine, in five cases out of seven.—*Med. Journal, St. Louis, Mo.*

## TREATMENT OF NASAL CATARRH.

The case presented itself at the clinic December 1st, with nasal catarrh of two years' standing. The discharge was thick, yellow, occasionally mixed with blood and scabs, and excoriated the nostrils. He was directed to cleanse the nostrils thoroughly with warm salt water twice daily, using both the anterior and posterior nasal douche, and immediately afterward the following, used in the same way:—

℞. Ammonii chloridii..... ʒ iv.  
Aqua..... Oj. M.

Sig.—Tablespoonful to douche.

When the nostrils become accustomed to this, use a chlorate of potash sol. of the same strength; then after a time stop these and alternate between the two following prescriptions:—

℞. Glycerini..... ʒ ij  
Acidi tannici—add as long as it will dissolve.

℞. Cupri sulphatis.  
Ferri sulphatis..... a a ʒ j  
Aqua..... ʒ ij. M.  
Ft. sol.

Sig.—Begin (with each of the above) with 5 to 10 drops in each douche of warm water, and gradually increase strength.

After alternating between the last two for a time, he may use the following:—

℞. Iodoform. pulv. .... ʒ j  
Extract. geranii..... gr. x  
Acid. carbolic..... gtt. xv  
Vaseline..... ʒ j. M.

Ft. unguentum.

Sig.—Saturate absorbent cotton with it and apply up the nostril at night.—*Prof. A. W. Calhoun in Atlanta Medical Register.*

## THUMB-SUCKING.

Dr. Goodwillie of New York City, at American Medical Association, reported a case and illustrated it by a wax model. The treatment consisted in breaking up the habit by applying a leather pad to the elbow, preventing the hand from coming to the mouth; and nasal catarrh is to be treated by douches and the application of powder blown into the nose, proper food, clothing and rest. His conclusions were as follows:

1. Thumb-sucking is more disastrous to the health of the child than the sucking of the other fingers; for the thumb, once in the mouth, it more readily remains during sleep.

2. It interferes with the child's proper rest, which should be continuous and undisturbed, and so becomes a source of nervous irritation and exhaustion.

3. It interferes with the natural respiration through the nose, and sets up abnormal conditions.

4. It malforms the anterior part of the mouth and affects proper mastication.—*Va. Med. Monthly.*

# THE CANADA MEDICAL RECORD,

Monthly Journal of Medicine and Pharmacy.

EDITORS :

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SUBSCRIPTION TWO DOLLARS PER ANNUM.

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

MONTREAL, JUNE, 1882.

We have recently been informed that Messrs. Reed & Carrick and the New York Pharmacal Association of New York city have opened a branch house in Toronto under the management of Mr. H. P. Gisborne, who has been associated with them for many years. We note the announcement with pleasure, as evidencing that the sterling claims of their respective preparations, viz., Mal-tine and Lactopeptine, have been appreciated by the profession in Canada, and we trust that the enterprise of these representative houses will meet with substantial recognition, particularly as they invariably keep their medicinal products in the hands of the Medical Profession. Mr. Gisborne announces that samples and circulars will be forwarded upon receipt of application at Canada Branch, 10 Colborne Street, Toronto.

## OBITUARY.

The late Dr. GEORGE W. CAMPBELL.

We are sure that we but re-echo the sentiment of the profession of this Dominion when we express our deep regret at the somewhat sudden and unexpected death of Dr. George W. Campbell. This melancholy event took place at Edinburgh, Scotland, on the 30th of May last; and although far from home his last moments were watched over by the loving tenderness of two of his daughters. Dr. Campbell left Montreal on the 31st of March last, sailing from Halifax for England two days later. For several years he had suffered much from chronic bronchitis, induced originally by a wetting he received on being upset in his canoe on the Marguerite, while salmon-fishing. This bronchitis was every now and again aggravated by slight attacks of pneumonia, which warned him of the necessity of care in the exposure of his person. Unfortunately on his arrival in London, the weather

was anything but favorable for him, and he had a sharp pneumonic attack. This he apparently recovered from, and he was removed to Edinburgh in an invalid car. We understand that he recovered sufficiently to get out, but the east winds of Edinburgh, so keen and penetrating, relight the attack, and although the best skill of that great seat of Medical learning did all that science could do it was of no avail, and, far away from his home, he passed to his rest. By the death of Dr. Campbell, the profession of the Dominion loses its most distinguished member, one who for almost half a century has been identified with it, and assisted not a little in raising it to the high position it now occupies. Early identified with the efforts made to give Medical education to the youth of Canada, he had the satisfaction of seeing his efforts crowned with success, and knowing that all over this continent are scattered a small army of Medical men who received a portion of their knowledge from his hands. He loved the Medical Faculty, of which he was so long a prominent member, with a loyalty and a devotion which did much to assure its success, and to replace him is well nigh, if not impossible. Commencing practice when Montreal was but a petty town he saw it grow to a magnificent city of two hundred thousand inhabitants, and with its rise and extension grew his reputation and influence. All the prominent men of to-day were his contemporaries, and on his medical opinions, political and otherwise, they placed implicit confidence. In this respect, no one can ever hope to replace him, for with the growth of the city diverse medical interests have been created; each of these have their leader, but we question if all combined could influence the public mind as he did. Strong and decided in his opinions, those who felt it their duty to oppose him found in him an open and manly opponent. When the struggle, so to speak, was over, none was more ready than he to extend the warm hand of personal and professional friendship. It was this example of his which has done so much to make the entire English Medical profession in Montreal feel kindly toward each other, and this in spite of much strong Medico-political feeling. May his influence extend to all future time! In all our local Medical charities he took a warm personal interest; the Montreal General Hospital especially bears witness to much of his fostering care. Dr. Campbell was as successful financially as he was professionally, and with most of our large monetary corporations he was closely identified. For

years he had been a director of the Bank of Montreal, and latterly its vice-president. He was also a director in the Montreal Telegraph Company, Montreal Gas Company, Loan and Mortgage Co., and several others. In all of these his judicious counsel was well recognized. Dr. Campbell was born at the Clachan House, Rosneath, Scotland, his father being chamberlain to the then Duke of Argyle. He received his professional education at the University of Glasgow, where he graduated in honors in 1831, the late Dr. Norman McLeod being his fellow student and intimate friend. After still further pursuing his studies in Dublin and elsewhere, he came to Canada early in the summer of 1833, and began practice, opening his office on the corner of St. Gabriel and Notre Dame Streets. In 1835 he was appointed to the Chair of Surgery in McGill College, and this he held for forty years, having retired from it in 1875. As a lecturer he was not brilliant, but the subject matter of his lectures was everything that a student could desire. As a diagnostician he excelled, and as an operator he was brilliant, and this in spite of an ankylosed right wrist. His reputation as a surgeon extended throughout Canada, and his surgical consultation practice was very extensive. In 1860 he replaced the late Dr. Holmes, as Dean of the Medical Faculty of McGill University, and shortly after the University conferred upon him the degree of LL.D. The position of Dean he held up to the time of his death. Dr. Campbell did much to establish the fame of the Village of Cacouna, on the south shore of the Lower St. Lawrence, as a watering place, and he witnessed its progress from that of an insignificant fishing village to a fashionable watering place, containing many beautiful residences (among them his own), and visited yearly by thousands in search of or the maintenance of health. He was a keen salmon fisher, and for years had been the lessee of the Marguerite, a river emptying into the Saguenay, and on its beautiful waters he passed many weeks each summer. A few months ago, by the death of his brother, Dr. Campbell succeeded to the family estate of Peatoun, on the shores of Loch Long, and it was in connection with it that he visited Scotland. By this same event he became heir it is believed to a baronetcy which had been extinct many years. The writer of this article was permitted, a few months ago, to examine some of the facts connected with his hereditary claim, and feels satisfied that care and perseverance would have

established it beyond a doubt. Naturally of a retiring disposition he shrank at first from unearthing his claim, but we have reason to know that forced by friends he had taken the initiatory steps towards doing so. While the addition of a title would have been gratifying to his many admirers, it could not have given him a higher place in the estimation of his professional brethren and fellow citizens, who now mourn his loss. He has left behind him the history of a life remarkable in many respects, and well worthy of imitation.

The MEDICO-CHIRURGICAL SOCIETY of Montreal, at its meeting held on the 2nd of June, passed the following resolution :

"That the Medico-Chirurgical Society of Montreal have heard with deep regret of the unexpected death of the late George W. Campbell, A.M., M.D., LL.D., Emeritus Professor of Surgery and Dean of the Medical Faculty of McGill University, and for many years a member of this Society, and its first President since its re-organization. A practitioner of medicine for nearly fifty years in this city, he acquired the confidence, the respect, and the regard of his professional brethren of the past and the present generations, by his eminent qualifications as a physician and surgeon, by his loyalty to and respect for the interests of the colleagues he met in consultation, and by the consideration and kindness with which he invariably behaved toward all, and especially the younger members of the profession.

That it is with profound sorrow that this society tenders its sincere sympathy to Mrs. Campbell and her family in the severe affliction which the loss of such a husband and father implies, and desires to assure them that the members of the medical profession of this city and country feel it to be an irreparable loss to them."

At a meeting of the Medical Faculty of McGill College, held on June the 1st, the following resolution was passed :

That the Medical Faculty of McGill University has heard with profound regret and sorrow of the unexpected death in Edinburgh of their beloved and respected Dean, the late George W. Campbell, A.M., M.D., LL.D., Emeritus Professor of Surgery in the University.

An active member of this Faculty since 1835, he contributed very greatly, by his distinguished abilities as a teacher of surgery, to establish the reputation of its medical school ; and as its Dean since 1866, by his administrative capacity, his de-

tion to the duties of his office, his wise counsels, his unvarying kindness and consideration for his colleagues, and his high personal character, he not only increased the efficiency of the department of the University over which he presided, but secured the cordial co-operation of all its members in the advancement of its interests, and attached them personally to him as their most valued friend and most distinguished and honorable colleague in the teaching and practice of the medical art.

And, further, that this Faculty tenders to the bereaved family of their beloved Dean its deep-felt sympathy in the irreparable loss which has so unexpectedly befallen them, the profession to which he belonged, and the community in which he so long, so lovingly and so successfully labored.

At a special meeting of the Medical Board of the Montreal General Hospital, held on the 2nd instant, the following resolutions were unanimously passed:—

Moved by Dr. MACCALLUM, seconded by Dr. REDDY,—That the Medical Board of the Montreal General Hospital have heard with feelings of the deepest sorrow of the death of their beloved and honored chairman, the late George W. Campbell, M.D., LL.D. Appointed to the staff of Visiting Physicians of the hospital in the year 1835, he, by his distinguished abilities as a surgeon, laid the foundation of that great reputation which this hospital has long enjoyed as a practical school of surgery. Endowed with rare powers of observation, with a powerful intellect and a cultured mind, his decisions as to the nature and proper treatment of the cases of disease that came under his notice were singularly prompt and correct; and his opinion was always invoked and held in the highest respect by his colleagues. Invariably generous and considerate to his colleagues and the medical staff and to the junior members of the profession, kind and encouraging to the student of medicine, and just and honorable to all with whom he was in any way associated, he was regarded with an affection and esteem rarely accorded by men to their fellows, and in his death we all mourn the loss of a dear and valued friend.

And, further, That this Board tender their deep and heartfelt sympathy to the bereaved family of their late beloved Chairman, so suddenly plunged into the very depths of sorrow by the unexpected loss of a devoted husband and father, with the earnest prayer that He who was "a Man of sorrows and acquainted with grief" may sustain them in this their hour of affliction.

The remains of Dr. Campbell arrived from England by *S.S. Polynesian* on the 14th, and on the 16th June they were interred in Mount Royal Cemetery. The funeral *cortège* was one of the largest seen in Montreal for years.

#### THE LATE DR. MUNRO.

By the death of Pierre Antoine Conefroy Munro the Montreal School of Medicine and Surgery loses the last survivor of its founders. The deceased gentleman was well known in Montreal, having begun his professional career when our city was far from what it is at present. He was a son of the late Dr. Henry Munro, who died in 1856, and who was for several years Surgeon to the North-West Company. The father of Dr. H. Munro was a U. E. Loyalist, and a descendant of the Munros of Fowlis, Ross-shire, Scotland. He lost all his property in the State of New York on account of his views on American independence, and settled in Canada, where he became a Legislative Councillor. Dr. Pierre Conefroy Munro, his grandson, was born in 1811, and was licensed to practice medicine in 1834. In 1837 he became one of the attending physicians to the Hotel Dieu, a post which he occupied till his death, though latterly age and infirmities prevented him from attending to the duties of it. During nearly half a century he was a daily visitor to the sick wards of the Hospital, and his regularity had become proverbial. He had, besides, a large private practice, and enjoyed in his day an enviable reputation as a physician and a man. In 1848 he founded the Victoria Medical School, along with Drs. Horace Nelson, Sutherland and others, and filled the chair of Surgery till very recently. Though the career of a medical man may offer to his biographer but few facts of public interest, still, as with all who work honestly and faithfully, though in seclusion, for the general good, the greatest meed of praise may be given in the words: "he did his duty." This Dr. Munro ever did, and thereby he merits at once the remembrance and the gratitude of his fellow-citizens.

At the last regular meeting of the Medico-Chirurgical Society of Montreal, the following resolution, moved by Dr. Hingston and seconded by Dr. Howard, was passed:—"That this Society has learned with deep regret of the tragic termination to a long and useful life, in a moment of mental disturbance, as a result of long and severe physical suffering, of Dr. P. A. C. Munro,



one of the most distinguished surgeons and anatomists Canada has produced, also one who gave evidence during his life of the highest moral character."

We notice with regret the death of the following eminent members of the profession in Great Britain:—

Dr. George Budd, F.R.S., formerly of King's College Hospital, London, at the advanced age of seventy-five years.

Dr. T. B. Peacock, physician to St. Thomas' Hospital, London, who died suddenly on June 1st.

Professor Spence of Edinburgh, the rival and former colleague of Lister.

#### PERSONAL.

Dr. Frank Hamilton of New York was in Montreal the middle of June. He visited both the Hotel Dieu and the Montreal General Hospital.

Dr. Henderson, formerly of the Montreal General Hospital, has received the appointment of surgeon on board the SS. "Deserade," of the Canadian and Brazilian line of steamers, which sailed from Montreal on the 21st June bound for the West Indies and Brazil. He expects to be back by the 1st September.

Dr. O. C. Edwards of Montreal has gone to the North-west. The prospect is that he will permanently locate there.

At the regular meeting of the Medico-Chirurgical Society of Montreal, held on the 26th of May, Dr. O. C. Edwards tendered his resignation as Secretary, on account of his removal to the North-West. The Society thereupon unanimously passed the following resolution: Moved by Dr. F. W. Campbell, seconded by Dr. Roddick, "That this Society accepts with regret the resignation of Dr. O. C. Edwards. In doing so, it deserves to place on record its full appreciation of the valuable services he has performed during the four years he filled the position which he now resigns. In parting with him the members of the Society desire to express the hope that in his new home in the North-West he may meet with that success which his professional skill and kindness of disposition fully merit."

Dr. Edwards was then elected a corresponding member of the Society.

#### EARACHE.

In the American Medical Association, Dr. Jacobi remarked that closing the mouths of

infants and children, and simply blowing into the nose, is often a very valuable method of relieving severe earache, and that in a number of cases he had obtained most excellent results from this procedure, the cause of the trouble probably being a catarrhal affection of the Eustachian tube.

#### THE PHARMACEUTICAL ASSOCIATION.

The first meeting of the newly-elected council of the Pharmaceutical Association of the Province of Quebec was held on the 23rd June in the rooms of the Association, corner of Notre Dame and McGill streets, when the following gentlemen were elected office bearers for the present year: Alexander Manson, President; H. F. Jackson, 1st Vice-President; Roderique McLeod, Quebec, 2nd Vice-President; John Kerry, Treasurer; Wm. Ahern, Secretary and Registrar, provisionally; Board of Examiners: J. D. L. Ambrosse, Montreal; F. E. Gauvreau, Quebec; Henry R. Gray, Montreal; Roderique McLeod, Quebec; H. F. Jackson, Montreal, and Alexander Manson, Chairman of the Board, *ex-officio*.

#### DIARRHEA OF TYPHOID.

The New York *Medical Record* says that the excessive diarrhea of typhoid is said to be remarkably controlled by the administration of twenty drops of turpentine every two or three hours.

#### REVIEWS.

*How we Fed the Baby*, to make her healthy and happy; with health hints. By C. E. PAGE, M.D. 144 pages. Paper, 50 cents; cloth, 75 cents. New York: Fowler & Wells, 753 Broadway.

This treatise heralds a new departure in the alimentation of infants, and gives every evidence of conscientious and intelligent study on the part of an author of broad experience, familiar with all the details of the nursery. The central feature of the work represents the infancy of the author's own daughter, whose first months were happily made free from the common inconveniences, not to say horrors, popularly supposed to be unavoidably connected with this period of life. Our author makes plain how infantile diseases may, in great measure, be avoided, and infant life made as free and joyous as that of the most fortunate among the lower animals. We know this manual will be welcomed by many mothers in all parts of the land, as one of the most important questions with parents is *how* to feed the baby, to promote its health, its growth, and its happiness. The hope of the children must be found in an enlightened motherhood, and every effort in this direction should be welcomed. *Physicians* will know how to prize the work of a specialist in this particular branch of medicine.