

## Technical and Bibliographic Notes / Notes techniques et bibliographiques

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

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

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

Continuous pagination.

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

# CANADA LANCET.

WILLIAM EDWARD BOWMAN, M.D., EDITOR.

WHOLE No. 17.

MONTREAL, JULY 15, 1864.

SECOND YEAR.

## PERMANGANATE OF POTASH IN GONORRHOEA.

BY JOHN G. RICH, M.D., BEAUVILLE, CANADA WEST.

For the last two years I have frequently employed the permanganate of potash as an injection in the treatment of gonorrhoea, and the constant success derived from its use has been extremely satisfactory.

My usual method had previously been to administer, first, a hydragogue cathartic, then to give a mixture of cubeba, copaiva, nitre, &c., with injections of sulphate of zinc, tannic acid, &c. But since employing the permanganate my treatment has been much more circumscribed, for with this remedy alone, I have frequently cured very bad cases in forty-eight hours, and this too without being followed by any evil effect from the sudden arrest of the discharge.

My usual mode of treatment, however, is as follows:—

R Potassæ Bistart. ℥j.  
Podophyllin; gr. j

In chartulas quadratæ dividendus  
S. One every two hours until free catharsis is produced  
After which :

R Potassæ Permangan. gr. vj  
Aque Fontan. ℥j.

S. To be used as an injection three times a day.  
I direct, at the same time the free employment of mucilaginous drinks, as althoea, ulmus, acacia, &c. and put the patient upon a non-stimulating regimen.

Out of sixty-four registered cases this course of treatment has failed in but two instances. And I find that recent attacks usually become arrested by after from three to six injections. I have found it advisable to continue the demulcents for at least a week after the cessation of the discharge. In none of all these cases was the injection continued after the fourth day.

When accompanied by chordee, I usually employ the following:—

R Lupulin ℥jss.  
Oly Camphoræ ℥j.  
Miccæ Panis, q. s.

ft. mass in pilulis, xvi. dividenda.  
Two, three, or four on going to bed

I think that the permanganate of potash is a remedy deserving of more notice than physicians hitherto give it, and hoping that my experience may produce for it a more extended trial in cases of gonorrhoea. I remain, &c. J. G. R.

## THE CALABAR BEAN.

HYOSOTIGMA VENEROSUM.

The want of a remedy has long been felt which would more thoroughly act as an antagonistic to atropine and other mydriatics than opium or ergotine, in producing contraction of the pupil; This agent has been found in the Calabar bean. The drug was first mentioned by Christison in 1827; but only its action when taken internally had then been examined. Professor R. Fraser, also of Edinburgh, drew attention eight years afterwards to the myotic qualities of the remedy. And we copy the following from his remarks:

The plant from which the beans obtained is a runner growing wild in West India and is gathered by the negroes, who employ it as a ordeal for criminals. The population of Calabar is estimated at one hundred thousand, and of these upwards of 12 are reckoned annually to be sacrificed by this poison.

These so called beans average rather more than an inch in length, and are irregularly reniform, having the appearance of a somewhat flattened fusiform body bent on one of its edges.

As obtained from Calabar, the beans have a grey colour, and are encrusted with earthy matter; this is readily removed by washing, and a somewhat shining integument is exposed of various shades of brown, ranging from a light coffee to an almost perfect black.

While the other parts of the plant are indifferent, as it seems, to the animal organism, the beans have strongly poisonous qualities. According to the missionaries, those who have eaten them, first feel a violent thirst; afterwards, the poisoned individual cannot swallow; mucus flows from the mouth; convulsions; and also cramps in the muscles of the back, come on, &c. During all this, the patient is conscious of everything, and even the language remains up to shortly before death, which may ensue within half an hour. Sometimes vomiting occurs, after which the heat diminishes; and, except headache, all other symptoms disappear.

Small doses, (up to 12 grains) with which Christison made his experiments, soon caused an increasing pain in the epigastrium, with retching, a sentiment of dyspnoea, cramps in the muscles of the breast, vertigo and weakness in the limbs, great secretion of saliva, and irregular, slow motion of the heart, so that in one case the pulse made only 20 beats.

Applied locally to a rabbit, the alcoholic extract produced loss of contractility. And when the intestines were painted over with a solution, they ceased to move.

In order to examine the local action of the remedy on the eye, Robertson prepared an extract from the pulverized bean, which he dissolved in alcohol in three different concentrations. The

Amongst other statistical information concerning newspapers, collected with much care by the editor of the Athenæum, we notice the statement that the number of the medical and chemical journals from the City of London alone, now amounts to an aggregate of fifteen thousand per week

weakest solution was produced by extracting 30 grains of the bean by alcohol, evaporating to desiccation and dissolving the rest in one drachm of water. Thus a dirty light red-brown fluid was obtained. By further extracting and evaporating, a four times and an eight times stronger extract were obtained. After R. had examined his eyes, and found that his pupils were 2 lines in diameter each, and that with each eye Jäger's No. 1. was read at 5 inches distance, he put a drop of the weakest solution in his left eye, which did not produce any more irritation than a drop of water. After 10 minutes, objects at a distance of one foot became indistinct; at the same time all objects seemed larger and nearer. There existed also a sensation of tension in the eye, as if very minute objects had been assiduously looked at. Both pupils were yet equal in size. After twenty minutes the left pupil had only a diameter of 1 line; objects further distant than 9 inches appeared dim; every thing looked at seemed larger and nearer. The right eye was normal. After 30 minutes the left pupil was only  $\frac{3}{4}$ , the right one  $2\frac{1}{2}$  lines in diameter. The far-point of the left eye 8 inches. After 50 minutes the left pupil was  $\frac{1}{2}$  and the right one 2 lines; a sensation of pressure and fatigue became manifest, when the subject of the experiment attempted to read; objects at 10 yards distance were recognized with difficulty. After 6 hours the left pupil was 1 line, the right one  $1\frac{1}{2}$  lines; both reacted on light. After 12 hours the left pupil was  $\frac{1}{2}$ , the right one  $2\frac{1}{2}$  lines in diameter. The following morning both pupils showed yet a slight difference and the left eye was somewhat weak.

Bowman, who has also experimented on his own eye, as stated by Wells, says that after 5 minutes he felt a strong tension in the neighborhood of the ciliary body, as if something crept about there. After 10 minutes this sensation had yet increased, and he felt also some lancinating pain. After 15 minutes the near-point was at the left side 6 $\frac{1}{2}$  inches, while in the right eye, to which nothing had been applied, it was removed to a distance of 15 inches. The far-point seemed equally distant in both eyes. After 20 minutes No. XVII Jäger was seen at 15 feet, but the letters oscillated: they disappeared and returned alternately. The left pupil was then contracted to the size of the head of a pin, remained in this state for 18 hours, and in the course of three days again became normal. With this dilatation the reaction of the pupil on light again became noticeable on both eyes. Twenty-five minutes after the application there existed astigmatism: the vertical staffs of a window appeared perfectly distinct at a distance of from 6 to 10 feet, while the horizontal ones seemed dim and angular. This was remedied by a concave cylindrical glass of 14 inches focus. With a cylindrical glass of 50 inches focus distant objects appeared palpably smaller. This astigmatic state was yet found 18 hours after the application.

De Graefe has tested the new myotic on 8 healthy persons. The average time for the setting in of contraction was 14 minutes with the weak, 12 minutes with the strong solution; the duration of contraction with the former 2, with the latter 3 days; the maximum of contraction lasted from 6 to 18 hours. The altered state of refraction, i. e. the cramp of the muscle of accommodation and the approach of the near-point, lasted much less in Graefe's experiments: it reached its height in 10

minutes, and remained there but from 10 to 24 minutes. The apparent increase in the size of objects and change of illumination were also observed; the acuteness of vision was reduced from 1 to  $\frac{1}{2}$ . Ophthalmoscopically there appeared no change of circulation. In a patient who had no iris, but good vision, the action on the ciliary muscle was also manifest. Experiments on birds, showed the action of the drug on the pupil of these animals to be very brief; on amphibia and fish, the remedy remained without influence. De Graef also satisfied himself that atropine is a much more powerful irritant in an opposite sense than the Calabar bean. The latter is not capable of contracting the pupil after it has just been dilated by atropine; the action of the latter also again appeared, when in an atropinized eye the Calabar bean had for a short time produced a medium degree of contraction. When the pupil had first been contracted, atropine always acted, but somewhat slowly. The remedy acted also on the iris, when it was abnormal but not totally atropic, in glaucoma and in a case of fistula of the cornea.

From all hitherto published experiments, it results that the Calabar bean first produces a subjective sensation of tension in the ciliary body, which may be recognized also by the determination of the near-point and the range of accommodation, that it also causes contraction of the pupil; the contraction reaches its height in the course of an hour; that the iris loses during that period its contractibility; and that the dilatation to the normal size from this contracted state requires less time than the contraction of the pupil, when dilated by atropine (the latter circumstance probably depends on our incapacity up to the present time to extract entirely the active principles of the bean). Simultaneously with the tension of the ciliary body occur the symptoms of myopia with a small range of accommodation, and of astigmatism. The remedy therefore, acts by producing a cramp, by irritation of the ciliary branches of the oculo-motorius, & the ciliary muscle and sphincter of the pupil: it does not paralyze the dilator pupillæ, as otherwise it could not produce complete contraction in a previously dilated pupil. It is, consequently, so far an antagonist of atropine as the latter irritates the dilator of the pupil.

Therapeutically the remedy will find the following applications: 1. Perhaps in retinitis, with sensibility to light, in order to moderate the admission of light. 2. In mydriasis, consecutive in some cases to debilitating diseases (typhus, diphtheria etc.), and to injuries. 3. In ulcers at the margin of the cornea, in order to avoid incarceration of the sphincter of the pupil after perforation. 4. In artificial mydriasis, in order to do away with the dazzling, which is very disagreeable to patients after having been examined by the ophthalmoscope, particularly if they have but one eye. (To these indications may be added the following: 5. In those corneal opacities with a transparent centre, which produce, when the pupil has its normal size, dazzling by diffusion of light. 6. In similar circumscript opacities of the crystalline body, situated near the centre of the latter, and in dislocation thereof. 7. In abnormal mobility of the lens, with a tendency to fall into the anterior chamber. For the discovery of simulated amaurosis, the pupil being dilated with atropine. 8. In wounds of the cornea and sclerotic with a recent prolapsus of the

peripheric part of the iris. 10. Perhaps in diseases of the ciliary body.]

E. Hert recommends a solution of the extract of such a concentration that one drop shall contain the extractive matter of three grains of the crude drug. He furthermore says that the alcoholic extract is soluble in glycerine, and that this solution is more durable than the watery one, which after a few days becomes decomposed.—*Geissler. Am. Jour. Ophthalmology.*

### TRICHINA SPIRALIS

**TRICHINIASIS.**—We published in our last number an extract from the *British Med. Journal* relating to the whole-sale poisoning of a large assembly at Hettstadt, Germany. The fatal agent used was *Trichina Spiralis*, served in hog's flesh at a feast. Disregarding the injunction in Leviticus concerning swine, "Of their flesh shall ye not eat, and their carcase shall ye not touch; they are unclean to you," eighty-three persons ate and died, and there can be no doubt that many instances of death attributed to poison or mysterious disease are due to the same cause. It would really seem as if the pig were created to serve as a foul nursery for the most loathsome parasites which infest man, and as an aversion to him, which long ago amounted to complete abstinence from pork in every form, is now increased tenfold by the recent information that the encysted trichinae, which are occasionally found in the muscle of man on dissection and which we knew were derived from the muscles of swine, instead of being the harmless parasites we have theretofore considered them, produce one of the most deadly diseases known. Unfortunately there are no symptoms of trichiniasis in the pig after the encysted stage; and the presence of the capsules which contain the worms would hardly be noticed in its flesh on account of their near resemblance in colour, and the amount of fat with which the latter is saturated. The disease has never yet been met with in any herbivorous animal, and, according to Langenbeck, trichinae have been found in great numbers in earth-worms (as many as 500 or 600 in a single worm), which form part of the food of swine when at liberty. A committee, consisting of Virchow, Romak, Gurlt, and others, has been appointed by the Berlin Medical Society to investigate the whole subject. We add for the further information of our readers an interesting account by M. Davaine, from the same journal, of the symptoms produced in man by this disease.

When trichinae exist in great numbers, their presence in the muscles or intestines produces severe and sometimes fatal symptoms. These symptoms may, in animals experimented on, present three successive, more or less distinct phases. The first phase is characterized by intestinal disorder, produced by the development of the larvae in large numbers, and their adhesion to the mucous membrane of the intestine. In this stage, M. Davaine has seen rabbits die with intense diarrhoea; and two cats, which he fed with trichinized meat, had diarrhoea for at least a fortnight, but survived. Five or six rats fed on a similar diet, one only, which was pregnant, died of diarrhoea, after abortion, on the eighth day. According to Mr. Leuckart, the passage of the embryos of the trichinae through the intestinal walls sometimes produces trichiniasis. This intestinal phase often becomes blended with the next; it may be relieved by the

expulsion of the worms by means of the diarrhoea, or may cease with the natural death of the worms.

The second stage presents general symptoms—muscular pains, &c. These phenomena are dependent on the introduction of the trichinae into the muscles; they rapidly acquire their maximum intensity, and have not a long duration. The appearance and duration of this stage are in complete relation with the development and length of sojourn of the trichinae in the intestines; in fact, in this entozoon oviposition is not slow and of long duration as in many nematoid worms; the genital tube is rapidly formed, and the ova in its whole length are developed almost simultaneously, so that the embryos, arriving soon at maturity, are at once thrown out in large numbers into the intestine, and the mother trichina dies exhausted. If it be remembered that the embryos do not escape before the eighth day, that a certain number of days are required for their arrival in the muscles, and that new ones are not produced after six or seven weeks, it will be understood that the first symptoms of this stage can scarcely appear until the end of a fortnight after ingestion of the diseased food, that they must continue four or five weeks, and that after this they may disappear. This course of events is observed in animals; and in man, the symptoms of this stage have shown themselves and become aggravated from the third to the sixth week after infection. Most animals die during this stage; rabbits rarely survive; rats, on the contrary, generally resist it.

If the animals do not die of the general symptoms or local disturbances proper to these two stages, the inflammatory symptoms cease, respiration becomes natural, and order is re-established. But, in some cases, the number of cysts formed in the muscles are sufficiently great to impede the proper exercise of their functions, and hence arise general debility, a kind of consumption which persists or becomes aggravated, and the animal dies of marasmus. M. Davaine has noticed this in rabbits, but especially in a rat.

Recovery from these phases of trichinal infection may be apparently perfect. A rabbit, which M. Davaine kept during five months, became large and fat, although it had a large number of trichinae in its muscles; a rat which had had these entozoa in considerable numbers during six months was to all appearance in good health. Hence he concludes that the trichinae produce symptoms only when they are in the intestinal canal and when they are entering the muscles. Having become lodged in their cysts among the muscular fibres, they may remain harmless for an indefinite time. In every case, except one, down to 1853, trichinae have been found in the bodies of persons who have died of disease (generally chronic) or by accident, or in the dissecting room in bodies regarding which the previous history could not be obtained. In most cases, the cysts contained a cretaceous or fatty deposit, showing that they had probably existed for several years.

The observations which have been made on the human subject in regard to the symptoms caused by trichinae show that they belong, as in animals, to the initial period of infection. They consist in intestinal and muscular lesions: the latter coincide with the entrance of the parasite into the muscles, and are truly traumatic. In Zenker's case, the intestinal symptoms present were swelling and pain:

in a case described by Friedrich, diarrhoea was present. In all cases, the most remarkable symptoms were violent rheumatoid pains in the muscles, not in the joints, which were considerably aggravated by attempts to extend the half-bent limbs. The other symptoms have been variable, but have had a strong resemblance to those of typhoid fever. In several cases there has been abundant sweating; and in one there was a very remarkable miliarial and furuncular eruption. The animal heat was diminished in Friedrich's case; and in those observed in Voigtland by Freytag, the temperature never exceeded 102° Fahr.

"The progress, duration, and severity of the disease in man are in relation to the number of trichinae taken into the digestive canal. Of sixteen patients observed at Plauen by Drs. Boehler and Koenigsdorfer, eight, who were moderately affected, recovered in a month; four, more severely diseased, were ill two months; of four others, one died with ascites and colliquative diarrhoea at the end of two months, and three recovered slowly at the end of three or four months. Recovery does not imply the death of the trichinae; it follows their inclosure in cysts.

"The diagnosis of trichinal infection has several times been made in the living human subject by removing a portion of muscle. M. Davaine thinks it probable that, during the first six or eight weeks of the disease, the diagnosis may be confirmed by searching for adult trichinae in the alvine evacuations, produced naturally or by means of a purgative." (*Boston Med. and Surg. Journal.*)

#### PRACTICAL DETAILS IN OVARIOTOMY.

LETTER FROM T. SPENCER WELLS, ESQ. TO THE BRITISH MEDICAL JOURNAL.

SIR,—In your last number, Mr. Furzeaux Jordan, after a very kind allusion to me, is reported to have said (in a way to imply that I still close the wound in the abdominal wall with hare-lip pins) that wire sutures are preferable. Will you, therefore, allow me to say, it was only in my earlier cases that I used hare-lip pins? I never found the "sloughing" of the tissue included between the pin and the twisted hemp or silk, which Mr. Jordan fears; because I never twisted the silk or hemp tight enough to cause sloughing. But I did very soon find, when the abdominal wall was thick, that it was impossible to bring the opposite divided surface evenly into apposition. I then began to use wire sutures of different kinds—silver, platinum, and iron—as well as catgut, horse-hair, India-rubber, and gutta serena; but I found nothing answer so well as fine, strong, pure silk. It is easily applied, easily removed, and, if not drawn too tight nor left too long, causes no sloughing of the circle of tissue which it encloses. I seldom leave the sutures more than forty-eight hours, and often remove them at thirty-six or forty. Dr. Keith of Edinburgh has recorded one case in the *Edinburgh Journal* for October 1863, which so strikingly shows one of the great advantages of silk over wire, that I make no apology for asking you for space for his account of the *post mortem* examination. He says:

"On carefully examining the line of incision, which had been secured by seven wire sutures passed through the whole thickness of the abdominal wall, including nearl. half an inch of peritoneum, it was observed that the peritoneal line of union was so uniformly perfect that it was impossible to tell

where the line of incision had been. The wires were felt under the peritoneal surface; and on cutting one of these from the outside, in order to see how the cut extremity of the wire would behave when passing over this freshly united serous surface, I was surprised to find, though it was withdrawn with the utmost gentleness, and the point kept as much as possible against the upper surface of the wall, that the point of the wire tore the peritoneal membrane right across, leaving it ragged, and allowing a drop of matter which lay along the track of the wire to appear on the peritoneal surface.

It is the fashion to sneer at "petty details"; but a fact like this shows that it may be of immense importance to a patient whether her wound has been closed by wire or by silk.

Nothing is more likely to lead to error than statistical conclusions based upon a small number of facts. It is assumed that, as one operator who generally returns the tied pedicle into the abdomen only lost four cases out of twenty, this great success implies some superiority of this practice over the use of the clamp. In reply, I may say that between June 1862 and March 1863, I had twenty-three cases of which only two died and twenty-one recovered—and in twenty-two of these cases the clamp was used.

The question, "what to do with a short pedicle, is one of the most important which can engage our attention; but it can only be determined by the experience of a large number of cases accurately observed and faithfully recorded. I am, etc.,

T. SPENCER WELLS.

Upper Grosvenor Street, June 11, 1864.

P.S. As some of your readers may wish to know the result of my entire practice of ovariotomy, I may state that I did my hundredth operation on the 2nd of this month. If the patient recover (which in all probability, she will, though both ovaries were removed), the result will be sixty-six recoveries and thirty-four deaths.

#### PROFESSOR MILLER OF EDINBURGH.

We regret to announce the death of Mr. James Miller, Professor of Surgery in the University of Edinburgh, which took place at Corstorphine on Friday last, at the age of fifty-two. The deceased gentleman was the son of the late Rev. James Miller, minister of Monkik, in Forfarshire. He studied medicine at Edinburgh, and was the favourite pupil of Mr. Liston, with whom he resided for fifteen years, for five years as his assistant, and who, before leaving Edinburgh for London, introduced him to all his patients. In 1842, on the death of Sir Charles Bell, Mr. Miller was unanimously elected by the Town Council to fill the Chair of Surgery in Edinburgh University, where he was a very popular and successful teacher. Mr. Miller was also Professor of Pictorial Anatomy to the Royal Academy, and was Surgeon-in-Ordinary to the Queen, for Scotland. As a consulting surgeon his services were highly esteemed, and both in the scientific and practical parts of his profession he maintained a high reputation. He was the author of "The Principles and Practice of Surgery," which has passed through several editions in this country, and been several times reprinted in America. He was also the writer of the article "Surgery" in the "Encyclopædia Britannica"; and the author of "The Surgical Experiences of Chloroform," and other works.

published a considerable number of tracts on temperance, of which he was a strenuous advocate. In philanthropic and religious agitations he took a very active part, both on the platform and through the press; and as an elder in the Free Church was an ardent supporter of its politico-ecclesiastical views, and of its missionary schemes. He was a man of lively and generous sympathies, and of kindly temper, and he enjoyed the affection and esteem of a wide circle of friends, accompanied by no small degree of popularity in public life. He was a man of fine physique, and the sudden breakdown of his constitution gave a shock of surprise to many who had admired his manly vigour and earned his robust health. A few weeks ago he was seized with congestion of the brain, which, notwithstanding the most watchful care of his professional friends, entirely prostrated his strength, both mentally and physically, and rapidly led to a fatal result. Professor Miller married in 1831 a daughter of the late Major Gordon, of Rosburn, Aberdeenshire, who, with a numerous family, survives him. — *Medical Circular.*

**HARVARD UNIVERSITY.**—It will be gratifying to all interested in medical education and the College, to learn that a professorship of the Physiology and Pathology of the Nervous System has been established by the Corporation, and that the greatest teacher in this branch of medicine of the day, Dr. E. Brown-Séguard, has been appointed to fill the Chair. This distinguished physiologist here, we are pleased to say, left London and fixed his residence permanently among us. We doubt not that this addition to the many advantages now offered by the medical faculty of the University, will be duly appreciated by students from all parts of the country in selecting their winter course of lectures.—*Boston Med. and Sur. Journal.*

#### TARTARISED ANTIMONY IN STRUMOUS OPTHALMIA.

By EDWIN CHESHIRE, F.R.C.S., Senior Surgeon to the Birmingham and Midland Eye Hospital.  
(From the *British Medical Journal.*)

I have so frequently prescribed tartar emetic, generally in combination with opium, (but often alone), in strumous ophthalmia, as well as in acute corneal and conjunctival inflammations, and with such marked success, that I have no hesitation in suggesting to my professional brethren a more extensive use of the remedy in the treatment of those obstinate, and frequently protracted, affections of the eye.

In cases of strumous ophthalmia, where there was excessive photophobia, I have found the internal administration of tartarised antimony, in doses varying from one-twentieth to one-twelfth of a grain, according to the age of the patient, to be attended with the most decided benefit; and its efficacy has been singularly marked, where quinine, steel, arsenic and cod-liver oil, had each, in its turn, been tried and failed. No remedy that I know of so completely or so permanently removes the photophobia, which is such a distressing symptom in strumous affections of the eye.

In pterygeal ophthalmia, and in vascular cornea or pannus, uncomplicated with a granular condition of the palpebral conjunctiva, or with inversion of the cilia (trichiasis), a continued course of tartar emetic, in small doses, arrests the progress of the affection most effectually, and with it may be com-

bined the early use of local stimulants, a combination which may be continued, if necessary, for a lengthened period without injury to the general health; in fact, the patients who have taken tartarised antimony under my care, both at the Eye Hospital and in private practice (and I have prescribed it very extensively), have almost invariably told me how much stronger and more energetic they felt during the time they were taking the remedy. I am aware it has long been the practice of ophthalmologists to administer a single emetic dose of tartarised antimony, as a beginning to the treatment of strumous ophthalmia; and that it has occasionally been given in combination with bark and quinine; but it does not appear to have been resorted to as a remedy, *per se*, for the cure of strumous affections of the eye. It is quite true, in the case of the little strumous patients, while under treatment, that they were usually placed on milk diet; and when the photophobia was severe, attention was paid to the exclusion of light, which would probably assist in promoting a favourable result; but the same diet was generally resorted to, and the same care to exclude light was taken, when the treatment had consisted of cod-liver oil, quinine, etc., and yet often with an unsatisfactory result.

D. J. Garnham, Esq., House Surgeon to the Lincoln Dispensary, in another communication, after speaking highly of this agent, remarks:

The idea of the use of tartarised antimony in such a disease, I first received from my much respected friend and teacher, Mr. J. W. Wakem, of London; and he (I believe I have heard him state), in his turn, first saw it used in the practice of some practitioner of former days in Cornwall.

It has been my habit to administer it in slightly nauseating doses of from one twentieth to one twelfth of a grain, or more, according to age, usually combining it with a saline purgative, in just sufficient quantity to act slightly upon the bowels. Its effect upon the patient speedily becomes apparent; and the distressing intolerance to light is one of the earliest symptoms to receive relief.

From the administration of emetic doses of tartarised antimony in this disease, I have not seen good results follow.

In one treatment, as in another, of course, it would be needless to say, exclusion from light is equally necessary.

I trust that these few remarks may assist to strengthen the practice advanced by Mr. Cheshire, and also lead others to try the same.

A third communication is from the pen of Wm. Price, M.D., Surgeon to the Metropolitan Infirmary for Scrofulous children; and Surgeon to a similar institution at Margate for adults, who remarks:

During the past six years, 109 cases of strumous ophthalmia, occurring in children under 15 years of age, have been admitted into the Metropolitan Infirmary at Margate. Out of this number, thirty-eight suffered with photophobia; and twenty-five had either vascular cornea or pterygeal ophthalmia. They had been all, or nearly all, treated by the administration of tartarised antimony in small but repeated doses; and, save in a few instances, with the most marked and decided benefit.

My attention was first directed to this plan of treatment in the Paris schools, and the success I there witnessed attending its employment, induced

me early to forsake the more routine practice of giving cod-liver oil and tonics. It must not be supposed that I have overlooked the beneficial effects of sea-air and a liberal diet on the London poor when removed to this salubrious climate; for the cases mentioned have been generally those in which the children had resided some short time by the sea-side. Amongst a large number of private cases annually coming under my care, I cannot call to mind a single instance in which tartarised antimony has been prescribed. From this circumstance I gather, too, that surgeons rarely resort to, or do not sufficiently appreciate its singular efficacy in certain cases of ophthalmia occurring in scrofulous subjects, in the adult as well as in the child.

#### POST-PARTUM HÆMORRHAGE.

We continue our extracts from Dr. J. L. Earle's able treatise on Post-Partum Hæmorrhage, now publishing in the Medical Circular, for which his position as obstetric surgeon to the Queen's Hospital, Birmingham, so eminently qualifies him.

When a woman suffers from a cough during labour, it is the best plan to give her fifteen drops of Batley's solution of opium immediately on delivery, (unless there should be some symptom present contra-indicating its use) and to repeat the dose in half an hour if the cough be not relieved. I have noticed that if a patient suffers from a cough during labour, it is generally worse for two or three hours after delivery. The loss of blood is nearly always free in such cases, from the violent jerking and straining to which the cough gives rise. The cough, in the greater number of instances, is merely sympathetic: very little mucus is secreted, and although it is troublesome for a few hours after the termination of labour, it generally disappears altogether in a day or two.

Tightening the binder after the birth of a child, acts beneficially in stimulating the womb to contract upon the placenta, but should the former feel soft and flabby, we ought not to trust to the pressure of the binder. In such a case it is better to leave it unfastened, and to place the hand next to the skin over the fundus of the uterus. No kneading action should be used with the hand, because it may induce irregular contraction, or separate only a portion of the placenta, and bring on severe hæmorrhage. The pressure should be but a little more than the weight of the hand, and equally over as large a surface of the fundus as possible.

Slight and equable pressure on the uterus is as useful in the prevention of hæmorrhage, as strong pressure is in the treatment of flooding.

The delivery of the placenta is the most important and anxious part of a natural labour. Women regard that accoucheur the most skillful who brings the child into the world most quickly; whereas, if they knew better, they would judge his skill rather by the way he managed the delivery of the placenta than that of the child. Many women have had their cheeks blanched, their constitutions more or less injured, or have lost their lives, from mere want of care, on the part of the attendant, in the management of the delivery of the placenta.

The uterus after labour usually contracts with merely sufficient force to detach the placenta, partially or entirely, but not to expel it. While the placenta remains attached in its whole extent, the patient is safe from hæmorrhage; not so when it becomes detached: it then acts as a foreign body,

and prevents the uterus from contracting to its minimum, which is Nature's great and chief means for arresting the flow of blood through the uterine vessels.

The placenta and membranes should always be well examined to see that they have come away perfect. If a large portion of the placenta is missing, or the membranes are known to be left behind, an attempt should be made to remove them at once, rather than allow the patient to run the risks of flooding and puerperal fever. In speaking of clots of blood he says:

Place the left hand next to the skin over the uterus, and while pressing the fundus down, pass the index finger of the right hand into the vagina, and remove any that are obstructing the os uteri. In removing the finger, I generally push on the posterior wall of the vagina, at the same time pressing the uterus outside, and telling the patient to bear down. By these means, if there should happen to be a clot *in utero*, it very often slips out. It is very important to remove any clots obstructing the os uteri, for a clot in that situation is in many cases a primary cause of post-partum hæmorrhage. As I stated before, it prevents the blood from flowing away from the uterus as fast as it is poured out, and the result is that the blood distends the uterus and coagulates in its cavity. Hæmorrhage is brought on by the clots preventing the uterus from contracting to its minimum. I know that some practitioners consider the presence of clots *in utero* as beneficial. How they can hold such an opinion, even after moderate experience, is to me perfectly incomprehensible.

Having found the uterus contracted, and any clots obstructing the os being removed, a pad, made by folding up two or three napkins, should be placed partly over and partly above the fundus of the uterus, and the binder again introduced tightly. While the placenta was *in utero*, the bandage acted sufficiently alone as a stimulant, but not so when the placenta has been removed; the uterus is now small, and therefore, in order to apply direct pressure to that organ, it becomes necessary to add the hand. If, instead of finding the uterus contracted, it feel large and soft, the binder ought not to be tightened: as, in the case of an uncontracted uterus, there is no safeguard equal to the hand, which should be kept on the uterus until due contractions sets in, and then, and not until then, ought we to relinquish the pressure of the hand for that of the binder.

The medical attendant ought not to leave the house until an hour has elapsed since the delivery. If the patient should go on for an hour without flooding, with proper care there is not much likelihood of serious hæmorrhage occurring afterwards. A large number of cases might be, and are left short time after delivery without any harm arising, but it is very unsafe to do so. Some of the most experienced writers on midwifery emphatically recommend this precaution. Gooch may be mentioned especially, as he took great interest in the subject of post-partum hæmorrhage. As Dr. Arthur Farrer used to say, in his admirable lectures at King's College: "If you stay with your patient an hour after their delivery, you will very rarely be called back again: if you don't, you may lose a patient from flooding." I very nearly lost two cases in consequence of my having left soon after the delivery of the placenta.

When the patient has been confined an hour, and

there is no hæmorrhage, she may have the wet things removed, including the binder, which is generally soiled, and the clean things be drawn down. Goobch recommends us not to move the patient for two hours. This advice is very good; but the reason I do not follow it in ordinary cases is, because I do not feel satisfied unless I ascertain the condition of the patient *after* she has been placed in bed, and I prefer applying the binder myself. It is important to feel the state of the uterus, and ascertain the amount of discharge after the patient has "been put to rights," as the pulling off the wet clothes and drawing her higher up in the bed is sometimes quite sufficient to bring on flooding. Amongst the poor, most of whom, if allowed, will be confined in their stays and numberless petticoats, it is not uncommon for hæmorrhage to set in after they have been undressed and placed in bed. The greater the difficulty is removing the clothes, of course, the more the mother has to exert herself, and the more liable is she to flood. Directions should be given to the nurse to move the patient as little as possible, and not to let her sit up for one moment. The wet things should be drawn away gently, and then the clean things drawn down. All these points can be effected much more easily and with more safety by two than by one; it is as well therefore, to have another woman to assist the nurse. When the patient has been placed comfortably in bed, the medical attendant should examine the pulse, and pass his hand over the uterus to feel whether it be of proper size and contracted; and the patient should be asked whether she feels much loss. These three points being satisfactory, a good wide calico binder should be passed under the hollow of the back, and with the assistance of the nurse drawn under her, so that the lower edge of the binder extends down to the trochanter major. Two napkins should be placed over the fundus of the uterus, and then the binder pinned tightly on the right side of the patient.

What I have to say of the binder I shall say now, it should be only used as a means of preventing, not arresting hæmorrhage. No one in his right senses would make use of a binder while hæmorrhage was going on. The binder acts like an artificial hand, applying pressure and irritating the uterus into a permanent and equable contraction. It is a safeguard which no prudent practitioner would think of omitting. Besides the binder, the application of a pad over and above the fundus of the uterus is of great value. The binder applies equable pressure over the abdomen, whereas the pad applies direct pressure to the uterus. The pad I use in ordinary cases, where there has been no hæmorrhage, consists merely of two thick napkins—one half placed over, the other half above the fundus. If there has been flooding, a safer pad consists in rolling up three big napkins separately—one should be placed transversely above the fundus; the other two perpendicularly, one at each side of the uterus. The upper extremities of the side pads should lie over those of the upper pad. In this way the uterus becomes enclosed, as it were, in a box; and if the binder be tightened firmly over them, it is almost impossible for the uterus to escape from their clutch. About twenty years ago a very animated discussion arose. I think in the pages of the "Lancet," on the subject of applying a binder after delivery. A few contended not only that it did no good, but actually did harm. One objected to it on the ground that it was liable to bruise the

uterus. Without a pad I believe it would be very difficult to bruise the uterus, let the bandage be applied ever so tightly. We must remember that the uterus is a movable organ, and on that account the actual compression is not so great as it would appear to be. The uterus is pressed downwards and backwards. If the uterus were immovable, it would be easy to understand how bruising of its structure could be produced by a tight binder. Another gentleman gave it as his opinion, that the binder is a prolific source of *prolapsus uteri*. That would be very difficult to prove, and it seems rather curious, that the very application, which generally gives such relief in prolapse of the uterus, should be one of the causes of that distressing malady.

One of the best proofs to my mind of good accruing from the application of a binder, is the comfort it affords to the patient. They generally tell you "How nice that feels!" "Oh, how beautiful!" and other like exclamations.

Dr. Tyler Smith states, in his 'Manual of Obstetrics,' that he has known cases where he had been obliged to attribute a fatal result from hæmorrhage to the neglect of applying a binder after delivery. I can quite credit it; and I am very glad to find that this eminent and practical authority so strongly recommends its application.

**THE NEGROIN DISEASE.**—In the department of the South there are a number of regiments of coloured troops, and it is a well ascertained fact that they are more liable to disease, and that the mortality is greater than among the white regiments. They rarely ever recover from a severe wound, and when attacked by disease they seem to care but little for life, and die in spite of all remedies and attention. These facts are particularly true of the North Carolina and South Carolina coloured soldiers, the sick reports of which are fifty per cent. larger than those of the white troops; and I find, on referring to my notes, that there were, during the months of November and December, thirty-eight deaths from disease in thirteen regiments, three of which were coloured. The latter lost seventeen men of the thirty-eight. The coloured troops recruited in the Northern States do not suffer to the same degree. *Dr. Goss. in American Medical Times.*

**REDUCTION OF STRANGLED HERNIA BY MEANS OF ELASTIC BANDS.**—M. Maisonneuve relates that, ten years ago, he formed the idea of applying india-rubber for this purpose, first using it for impacted hernia only. The success of the attempt was such, that he subsequently employed the same means for strangulated ruptures. In large inguinal and umbilical herniæ, where they were pediculated so as to be enveloped by the elastic band, the success was as complete as possible, so that cases which would not yield to prolonged taxis returned in a few minutes with the caoutchouc without accident or violence. M. Maisonneuve has now succeeded in applying this elastic method to other forms of hernia, having invented the *hernial reducer*, which can be applied to small ruptures. Thanks to these plans, an operation, the mortality of which amounts to sixty per cent., will be rarely required. The former method, applicable to the large and pediculated form of hernia, is carried out in the following way:—First, three or four circular turns of an elastic band are made round the pedicle.



The turns are then passed over the tumor itself, which should be regularly enveloped by covering it with a series of oblique turns, which, by their number, exert at last a very powerful but even pressure, under the influence of which the hernia gradually returns with surprising rapidity, seldom exceeding two or three minutes. The second process by the *hernial reducer* is applicable to small hernia. The lumbar plate of the reducer is placed under the loins. The reducing pad, armed with the transverse rod, the extremities of which correspond to the lumbar plate, is next placed on the hernia. The corresponding extremities are then to be fastened together, by means of turns of an elastic band. This alone exerts strong pressure, which may be increased by turning a screw attached to the pad, and passing through the transverse rod. The theory of this method is based on this principle; that in strangulated hernia it is not the orifice which causes strangulation, but the swelling of the parts protruded. It follows, therefore, that if by a methodic compression the tumefied organ can be restored to its normal condition, it is always possible to return it by the orifice through which it protruded.—*Australasian Med. and Surg. Review.*

**INGUINAL ANEURISM TREATED BY COMPRESSION.**—An officer came under the care of M. Rizzoli, with an aneurism of the left groin, the result of a fall. As the tumor reached into the pelvis, compression could only be applied below it. At the end of three days, in spite of interruptions of the treatment, fibrins had been deposited, and the aneurism so far hardened and reduced in size that it became possible to apply pressure above it. This was at first done by means of the finger; but, although Valsalva's method of treatment was also followed, only an imperfect effect was produced. Electro-puncture also produced merely an incomplete and temporary result. As the aneurism, although diminished in size, continued to pulsate at the end of forty days, M. Rizzoli had an instrument used by which pressure could be more easily and exactly applied to the artery where it passed over the bone. At the end of two days, this pressure, which had been maintained sometimes by the patient himself, sometimes by an assistant, caused pulsation to cease, not only in the aneurism, but in all the arteries of the limb; the temperature of which, however, remained normal. The pulsation gradually returned in the arteries of the foot and leg. The aneurism remained hard and free from pulsation; and at the end of thirty-five days, the patient left the hospital cured. (*Act. della Scienze dell' Institut. di Bologna, and Bull. Génér. de Ther.*)

**USE OF SULPHURIC ETHER.**—Sulphuric ether is a most valuable remedy in detecting various diseases simulated by soldiers. Its slow and insidious action enables the surgeon to easily detect the feigned deformity or sickness. In aphonia, chronic rheumatism, anchylosis, incontinence of urine, and numerous other complaints the soldier selects often to deceive his medical officer, the exposition under its influence is complete, and hence its advantage over chloroform, the action of which is too sudden and dangerous to be employed with impunity.—*American Med. Times.*

Dr. Rudolph Leuckhart, in his recently published book on human entozoa, *Die Menschlichen Parasiten*, reckons the number of species of parasites which infest man, at fifty.—*British Medical Journal.*

**To Correspondents.**

- 1.—The Hair Restorative you mention is prepared as follows:—(1) tincture, 1 drachm, diluted nitric acid, 1 drachm; tr. cantharides, 1 oz.; balsam Peru, 2 drachms; alcohol, 4 oz.; water 2 oz.; mix &c.
- 2.—*Syr. Cherry Pectoral*.—Acetate of morphine 16 grs.; tr. bloodroot 1 oz.; wine of opiac, and antimonial wine, of each 1/2 oz.; essential oil of bitter almonds, 12 minims, previously mixed with a drachm of alcohol; simple syrup, 12 oz.
- 3.—*Florida Water*.—ells lavender, bergamot, and lemon, of each 2 drachms; oil neroli, 1 drachm; oil melissa, 30 drops; otto of roses 10 drops; alcohol, one quart.

**Medical Works published in Great Britain from the 1st June to the 1st July, 1864, with their sizes, numbers of pages, London Publishers' names, and prices in sterling.**

- Harber (George), The British and London Pharmacopœia 2nd edit revised and enlarged, 15mo, 112 pages. (Simpkin) 2s 6d.
- Harwell (Richard), Guide in the Sick Room. New edit 12mo, 152 pages (Marrillan) 3s 6d.
- Besham (W. R.), On the Significance of Dropses as a Symptom in Renal, Cardiac, and Pulmonary Diseases being the Croonian Lectures for 1864, delivered before the President and Fellows of the Royal College of Physicians of England. 8vo, 34 pages. (Churchill) 7s.
- Chambers (Thomas King), Lectures, chiefly Clinical, 8vo, 620 pages. (Churchill) 10s 6d.
- Contington (F. T.), Tables for Qualitative Analysis. 2nd edit. Post 8vo. (Longman) 2s 6d.
- Draper (H. N.), Manual of the Medicinal Preparations of Iron. Post 8vo. (Hasthulke) 2s 6d.
- Jago (James), Entropies: with its uses in Physiology and Medicine. Post 8vo, 200 pages. (Churchill) 6s.
- Jones (C. Handfield), Clinical Observations on Functional Nervous Disorders. 8vo, 602 pages. (Churchill) 10s 6d.
- Parvira (Jonathan), Sobora & Prescriptions: Selections from Physicians' Prescriptions. With Key and Literal Translation 14th edit. 2mo, 320 pages. (Churchill) 6s.
- Squire (Peter), A Comparison of the British Pharmacopœia, comparing the Strength of the various Preparations with those of the London, Edinburgh, and Dublin, United States, and other Foreign Pharmacopœia; with Practical Hints on Prescribing. 8vo, 210 pages. (Churchill) 5s 6d.
- Swan (Joseph), Illustrations of the Comparative Anatomy of the Nervous system. 2nd edit 4to 200 pages. (Simpkin) 32s.
- Swan (Joseph), Delineations of the Brain in relation to Voluntary Motion. 4to 70 pages. (Simpkin) 21s.
- Brathwaite (W. & J.), Retrospect of Medicine for the last half year, vol. 43, 12mo, pp. 450. (Simpkin) 6s.
- Brathwaite (W. & J.), A Commentary of Midwifery at the Diseases of Women and Children, for the last half year. 12mo, pp. 120. (Simpkin) 2s 6d.
- Napper (Albert), On the Advantages derivable to the Medical Profession and the Public from the Establishment of Village Hospitals: with general instructions concerning Costs, Plans, Rules, &c. and an appropriate Dietary, by (Lewis) 1s.
- Post (Julius) The Principles and Practice of Medical Designated chiefly for Students of Indian Medical College. 8vo, pp. 603. (Churchill) 11s.
- Hankin and Hanciliffe, Half Yearly Abstract of the Medical Science, vol 33, post 8vo, pp. 344 (Churchill) 6s 6d.

**Periodicals received since 15th June.**

- London Medical Circular to 22nd June. British Medical Journal to 25th June. London Medical Times to 25th June. American Medical Times to 9th July. Boston Medical and Surgical Journal to 7th July. Christian Medical and Surgical Journal to 11th June. Philadelphia Medical and Surgical Reports to 11th June. Philadelphia Dental Cosmos, July. Canadian Medical Journal, July. Chicago Medical Journal, July. Buffalo Medical and Surgical Journal, June. London Pharmacological Journal, June. American Drug and Chemical Journal, July. New York Medical Independent to 9th July. London Publishers' Circular to 1st July. London Circular and Druggist to 15th June.

**Subscriptions received since last issue.**

- Dr. Ross R. Bunting, Philadelphia, 6s.; Dr. T. A. De Ford, St. Marc, 6s.; Dr. J. G. Rich, Beachville, 6s.

The Canada Lancet is published monthly at the rate of one dollar, (or four shillings sterling) per annum. Remittances may be made to W. F. Bowman, M.D., Editor and Proprietor, or to Mr. John Lovell  
Agent, 8, Maw & Son, 11 Aldergate st., London, E.C.  
PRINTED BY JOHN LARLELL, ST. NICHOLAS ST., MONTREAL