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# CANADA

# MEDICAL & SURGICAL JOURNAL

**JULY, 1885.**

Original Communications.

## CASE OF CÆSAREAN SECTION.

BY JOHN L. BRAY, M.D., CHATHAM, ONT.

*(Read before the meeting of the Ontario Medical Association, June 4th, 1885.)*

On the 27th of February last I received a telephonic message from Dr. Abbott to go at once to Comber and bring obstetric case. On arrival at Stony Point, I found a man waiting to drive me to his house, about six miles south, where Drs. O'Keefe of Tilbury and Abbott of Comber were awaiting my arrival. The former had been called that morning at three o'clock to attend Mrs. G. in labor. She was about 27 years of age, 5 feet 6 inches high, well proportioned, and the mother of one child, 5 years of age. She had a tedious, but not serious, delivery of her first child, which terminated without artificial aid in about 24 hours. Some three years ago she was the victim of an accident which proved to be the cause of her present trouble. At that time a corn crib fell on her, fracturing the right ileum, and producing the deformity in the pelvis which eventually caused her death. There was nothing externally to show that any deformity existed, and it was only on attempting to apply the forceps that this was discovered.

As I said before, Dr. O'Keefe was summoned at 3 am., and found the os high and but slightly dilated. He waited some time, during which she was having strong labor pains, and the os becoming more dilated, with no advance of the head, he thought it best to apply the forceps. He attempted to do so,

but found it impossible, as the foetal head was thrown forward over the pubic arch; and although he could apply one blade, it was impossible to introduce the other, as there seemed to be a wall of bone on the right side of the pelvis, forming, as it were, a shelf, upon which the foetus rested. After several unsuccessful attempts he sent for Dr. Abbott, who also failed. They then sent for me, and when I arrived, about 3 p.m., I found the os dilated, the foetal head very high, labor pains strong and continuous, and the patient cheerful. On attempting to introduce the forceps, I had no difficulty in getting the left blade into good position, but there my success ended, as the shelf or projection of the ilium on the right side was an effectual bar to the application of the right blade. I then tried this blade first, but found it would always fall back of the foetal head towards the sacrum, and assume a position resting on the perineum. After a consultation with Drs. Abbott and O'Keefe, it was thought best to perforate, although I was afraid, from the nature of the deformity, that it would be useless, as, if we succeeded in bringing the head down, it would be impossible to extract the child's body. And my fears proved to be correct, for after perforating, which was performed with the utmost difficulty, owing to the non-fixtured position of the foetal head, and it being so far forward and so high up, it was impossible to extract, as the bones of the head could not be crushed, for all our attempts to apply the craniotomy forceps or cephalotribe were unsuccessful, and although we nearly emptied the skull, still we could not introduce any of the above-named instruments to crush and extract. We succeeded in getting the blunt hook into the foramen magnum, and used all the force possible, but could not budge the head, so we had another consultation, which resulted in sending for Dr. G. W. Jenks of Detroit, who arrived about 9 p.m. the same day. He tried the forceps, cephalotribe, etc., as we had done, but with no better success, as he found it was impossible to apply more than one blade.

Now, what was to be done? After having exhausted every known means of delivery by the vagina (I might say that I had previously tried to pass my hand up and get the feet, with the

view of turning, but in this I also failed), and the patient being yet strong with forcible pains, we concluded the only thing remaining was abdominal section. And this we decided on. At about 2 a.m., or about 24 hours from the commencement of labor, the patient having been removed from the bed to a table and placed under chloroform by Dr. O'Keefe, Cæsarean section was begun by Dr. Jenks. Commencing about two inches above the umbilicus, he continued his incision a little to the left till below that point, when he kept down the mesian line to about three inches above the pubis, when it was found impossible to go any lower, as on cutting through the abdominal walls and peritoneum he came upon the bladder, which was full (notwithstanding a catheter had been previously introduced). The neck was tightly wedged between the uterus and bones of the pelvis, so that the catheter could not have entered the bladder. This was, of course, a serious drawback, as it was found impossible to push it down out of the way, consequently the uterus had to be opened very high near the fundus, and to make matters worse, on cutting through this organ, the placenta was severed, and you can imagine how appalling the hemorrhage became—in fact, we thought it would prove fatal—but Dr. Jenks quickly finished the incision and removed the foetus and placenta in less time than it takes me to describe it. Of course the moment this was accomplished, owing to the strong uterine contractions, the hemorrhage ceased, but in removing the foetus the uterus was torn near the neck, which gave us some trouble, owing to a good deal of blood oozing from this rent. One of the most troublesome things connected with the operation was the difficulty of keeping back the intestines, and when they did come out, to keep them warm. This we endeavored to do by means of napkins dipped in hot water applied to them. We tried to keep the room at a temperature of 80°F., but you can imagine how difficult that would be with the thermometer about zero, and with no assistants other than the medical gentleman named. The cut edges of the uterus were brought together, and two deep and four or five superficial sutures of carbolized silk were put in, which, when done, completely closed the opening. The

abdominal cavity was sponged out, and, singular to say, the sponges were hardly colored, so little blood found its way in owing to the pressure made on the abdominal walls by the assistants. The abdominal wound was then closed by means of two deep and ten superficial silk sutures, the deep ones, of course, embracing the peritoneum. By this time the patient had completely rallied, and had come from under the influence of the chloroform. She was removed to bed, and hot water bottles placed all around her. A quarter of a grain of morphia was injected into her arm with the hypodermic syringe, and she appeared very comfortable. The extremities and body soon got warm, and she fell into a nice sleep. The temperature was normal and the pulse 120 when we left.

I did not see her again, but Drs. O'Keefe and Abbott were in constant attendance, and from them I learned she progressed nicely (with the exception of occasional vomiting) till Monday morning about one o'clock, when she began to get very weak. In a short time she became comatose, and died about 6 a.m., just 48 hours after the operation. There was no post-mortem, so we could not tell exactly what caused death. It certainly was not shock. It was almost too soon for peritonitis. It might have been hemorrhage into the intestinal cavity, owing to the giving way of some of the sutures caused by the vomiting, or, what in my judgment is more likely, *exhaustion*, caused, in the first place, by long continued labor pains, and added to by the many and varied attempts at delivery by instruments through the vagina, which finally reached the climax when Cæsarean section was performed, and by loss of blood incident thereto.

I will conclude this imperfect report of a most interesting case by saying that, taking it all together, it was a remarkable one, as this is the first case that has ever come under my notice where a woman had borne a child naturally and then had to be delivered subsequently by Cæsarean section. And when you consider the many disadvantages we labored under—performing the operation in the country, at midnight, by the light of two small coal-oil lamps, with only the assistance of the medical men, and the thermometer at zero, the wonder is that we

succeeded so well. Had I the same case to attend again, I should never perform craniotomy, as I believe it takes away the only chance of the mother, and of necessity destroys the child, which, in this instance, might perhaps have been saved. I will say nothing in reference to the other operations which might have been made, or the different ways of performing this operation, leaving these points for you to discuss.

## REPORT ON PHARMACOLOGY AND THERAPEUTICS.

By JAMES STEWART, M.D.,

Professor of Materia Medica and Therapeutics, McGill University; Physician to the Montreal Dispensary, and Director of the University Dispensary for Diseases of the Nervous System.

### ANTIPYRETICS.

It is proposed in the following article to give an account of two drugs recently introduced into practice belonging to this class, and to point out in a general way their worth as compared with agents of the same class that are, and have been for some time, in more or less every-day use. As these two agents are purely antipyretics, and have no influence directly, as far as is known, over the duration of any of the pyrexial diseases, it will be appropriate to indicate what are the necessary qualities of a good antipyretic. First, a desirable antipyretic should be able to act with promptitude; second, it should be certain in its action; third, its effects should last several hours; fourth, the subsequent ascent of the temperature should take place gradually; fifth, it should be devoid of untoward effects, especially those of a dangerous nature.

After considering the actions of these agents, we will be able to see in how far they fall short of those qualities.

### ANTIPYRIN.

This is an alkaloid, which, like kairin, is obtained synthetically from the chinoline series. It acts as pure antipyretic, reducing an elevated temperature from whatever cause produced.

Judging from the cases reported up to the present, it appears to have a more powerful influence on the pyrexia of typhoid and

tuberculosis than that of any other disease. Prof. Pribram of Prague reports nine cases of typhoid fever treated with it. In three of these cases, one of which was very severe, the disease ran a practically non-febrile course from the administration of a dose of antipyrin every time the temperature reached 100°F. In the first, which ran a course of 14 days, the above result was obtained by the administration of an ounce of the drug for the whole period. In the second, which lasted 24 days, 4 ozs. were administered; while the third case, which had a duration of 13 days, only required a little more than half an ounce for the whole period to keep the temperature below 100°. In the remaining six cases, Prof. Pribram ordered only a sufficient quantity of the antipyrin to keep the temperature reduced to 100°, and this result was obtained by doses not exceeding 20 grains in the 24 hours. With the exception of one who died from double pneumonia, all the patients recovered.

The results of the antipyrin treatment of Prof. Pribram's cases may be thus summarized: By the use of large doses in three cases, the course was non-febrile; the use of small doses in six cases prevented a rise above 100°.

Antipyrin is eliminated with the urine. This elimination commences about three hours after a single dose is given, and continues for a period of twelve hours. Its presence is detected in the urine by the chloride of iron, which, when added, changes the color of the urine to a brownish-red. The depth of the reaction with the iron test corresponds closely with the sinking of the temperature. The more influence exerted on the temperature, the more pronounced is the color on the addition of the test.

Demuth has recently reported a large number of febrile cases treated with antipyrin, including three cases of scarlet fever, four of diphtheritic angina, six of pulmonary tuberculosis, three of facial erysipelas, three of acute rheumatism, two of intermittent fever, one of typhoid, and four of pneumonia. To adults he administered half a drachm, repeated this in three hours, and then gave 15 grains every two or three hours until the wished-for reduction of temperature was brought about. In all, usually

not more than one and a half drachms was necessary, and the time occupied in attaining this was about twelve hours. The temperature fell promptly, often to the normal, and in a few of the cases to below the normal. Following the reduction of the temperature, there was a fall in the pulse-rate.

The antipyretic effects of the antipyrin was most constant in typhoid, next in the tuberculous cases. It was less marked in the diphtheritic cases, but in every case there was a distinct antifebrile action. Demuth did not have any untoward effects in his cases. In no case was there any cinchonism. The drug was taken readily, and did not cause any irritation of the stomach. Collapse symptoms were never present. In a few cases where the temperature was brought below the normal, the pulse was small, but it soon regained in power, even before the temperature had risen to the normal. In not one case could he observe that it had any directly favorable influence over the course of the disease for which it was given. As soon as its effects had passed off, the temperature regained its previous height. Its action did not usually last any longer than twelve hours.

Argutinski and others report various forms of rashes due to antipyrin. This observer has more than once noticed such from even as small a dose as seven grains.

Profuse sweating has been observed after the use of antipyrin, but this is of rare occurrence compared with the frequency with which it attends the use of salicylic acid, kairin, hydrochinon, &c.

Pavay, after a considerable trial of antipyrin, comes to the following conclusions:—

1. Antipyrin always reduces a high temperature in doses of from 2.0 to 4.0 (3ss to ʒi), the minimum depression amounting to 2.5°F., the greatest to 7.2°F.

2. The reduction of the temperature sets in from one to two hours after the dose is given, and continues from 12 to 16 hours.

3. It does not exercise any marked influence on the pulse or respirations. The tension in the arterial system being increased after the fall of the temperature.

4. Sweating is generally observed, but never to such a degree as is observed when salicylic acid is given in antipyretic doses.

5. Nausea, vomiting, pain in the stomach, vertigo and noises in the ears only very seldom observed. Collapse never.

6. It possesses marked advantages over resorcin, hydrochinon and kairin, on account of its freedom from dangerous effects.

7. It acts with great certainty as an antipyretic in pulmonary tuberculosis, pneumonia and typhoid fever.

8. In acute rheumatism, it has an influence on the fever; none on the pain.

9. When injected under the skin or into the rectum, its antipyretic action is just as marked and as certain as when taken internally.

10. Its easy solubility and pleasant taste makes it a desirable antipyretic for children.

11. Its action does not diminish, even when given for a lengthened period.

12. It should be given with caution when there is cardiac weakness.

13. In pulmonary tuberculosis, it acts quicker and more certain than any other antipyretic. This is its great advantage.

#### THALLIN.

Thallin is also a synthetic alkaloid obtained from the chinoline series. It forms salts, the lactates, sulphates and the hydrochlorates, especially, being adopted on account of their stability and easy solubility for internal administration.

Jaksch, first assistant in Nothnagel's klinik, reports 86 cases of different febrile disorders treated by these different thallin salts. The majority were cases of typhoid, acute rheumatism, erysipelas, puerperal sepsis, pneumonia and tuberculosis. In all the antipyretic action was marked, especially in the tuberculous cases. The temperature minimum occurred usually from two to four hours after the administration of the salt, while the duration of the fall was not longer than five hours. The ascent was generally attended with a rigor. In no case was any direct influence over the course of the disease evident.

Mingazzini has found no difference in the action of the sulphate and lactate of thallin. Either salt, in doses of 0.12 (2 grains),

reduces the temperature about  $1^{\circ}\text{F}$ ., the duration of the fall varying from four to six hours. After doses of .25 (about 4 grains), there is a fall of  $2\frac{1}{2}^{\circ}\text{F}$ . Doses of .50 (8 grains) reduces the temperature quicker and lower than when the same quantity is given in two divided doses at intervals of three hours.

Thallin can be administered hypodermically without causing either abscesses or subcutaneous infiltrations. The fall of temperature, when given this way, is not only quicker, but greater. During the fall of the temperature, sweating, which is often profuse, is generally present.

Mingazzini did not observe vomiting, cyanosis, or symptoms of collapse in any of his cases, profuse sweating and rigors being the only unpleasant untoward effects observable. The more marked and durable the antipyretic effect, the more severe and prolonged were the rigors. In a few cases the rigors lasted two hours. Another undesirable effect that this observer noticed was that the temperature very frequently attained a higher level after the elimination of the drug than it previously had.

Thallin is eliminated with the urine, which it colors dark green. On the addition of chloride of iron, the color changes to a red.

#### ANTIPYRIN AND THALLIN COMPARED.

*First, with respect to the certainty of action.*—Both agents have a very certain action, for, when given in appropriate doses in cases attended with considerable pyrexia, they reduce the fever. They both act more powerfully as antipyretics in the pyrexia of pulmonary tuberculosis and typhoid fever than that of any other disease. When antipyrin is administered, the temperature commences to fall in from one to two hours after, and continues falling for a period of from four to six hours, when the maximum fall is reached. Thallin is somewhat longer in causing a fall of temperature, taking usually three hours before any marked effects are noticeable; but once the effects are manifest, the maximum depression is quickly reached, usually within two hours after.

As regards the duration of the antipyretic effects, the fall in the cases of antipyrin lasts usually twelve and even sometimes sixteen hours, but with thallin seldom longer than six hours.

The subsequent ascent after antipyrin is somewhat slower than it is with thallin.

*With respect to untoward effects*, neither agent can be said to be perfectly free from them, but they are less marked after antipyrin than after thallin. Both cause more or less sweating, but with neither is this a contra-indication of any moment. Rigors frequently attend the subsequent ascent of the temperature after thallin, while they are extremely seldom seen after antipyrin. Both cause exanthems, which quickly disappear after the effects pass off.

In estimating the positive qualities of an antipyretic agent for evil, by far the most important point to take into consideration is the influence that it exercises on the heart. An antipyretic which has a cardiac depressant action is a two-edged tool. This is the reason that kairin has been practically discarded from practice. In full antipyretic doses it is apt to cause symptoms of collapse. It is the possession of these qualities that makes large doses (20 grains and upwards) of quinine such a dangerous remedy. Salicylic acid is not free from this action either. With regard to antipyrin, no indisputable case has been brought forward where any symptoms of collapse have been apparently directly due to it. As much, however, cannot be said of thallin.

From the knowledge we at present possess of these agents, we may conclude that they are equally effective, but that antipyrin is the safest. Whether it is absolutely safe when given in proper doses remains to be seen.

#### THE ANTIPYRETIC ACTION OF ANTIPYRIN, QUININE AND THE SALICYLATES COMPARED.

There can be no question whatever about the far greater efficiency of antipyrin. Its action is certain. The antipyretic action of quinine and the salicylates, on the other hand, is far from being so, if we exclude the action of the former in malarial fever and of the latter in acute rheumatism. He who relies on the anti-febrile properties of either of these drugs in pulmonary tuberculosis or typhoid fever will meet with frequent and great

disappointments. Further, they both constantly give rise, in full antipyretic doses, to the unpleasant group of symptoms known as "cinchonism," and not uncommonly we find their cardiac depressant action present in a greater or less degree.

There has been a good deal of speculation over the supposed mode of action of antipyrin and thallin in reducing temperature. It is highly probable that both of these agents have a direct action in lessening the production of heat. The reduction they effect is certainly not wholly due to a vaso-motor paresis, for the fall generally commences before the patient begins to sweat, and it is as pronounced in those cases unattended with sweating as in those which are. Further, they effect reduction of the temperature when agaracin (a powerful anhidrotic) is simultaneously administered with them. Whether they have a direct antiparasitical action or not has not been shown or rendered even probable. Neither, as yet, have been shown to have any power directly of influencing the duration of any of the febrile diseases.

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## Hospital Reports.

MEDICAL AND SURGICAL CASES OCCURRING IN THE PRACTICE OF THE  
MONTREAL GENERAL HOSPITAL.

UNDER THE CARE OF DR. RODDICK.

### *Case of Cancer of Right Kidney—Secondary Affection of the Liver—Autopsy.*

E. C., æt. 17, unmarried, was admitted 25th November, 1884, suffering from weakness and enlargement of the abdomen. Has always enjoyed good health up to four years ago, since which time she has been troubled more or less continuously with pain in the right side, under the lower ribs. About thirteen months ago first noticed a lump in the abdomen to the right of the umbilicus. Says it appeared to her flat and about the size of a small saucer. It was tender on pressure. Previous to this she could go about, driving and walking a great deal: since then, however, has been obliged to remain quiet, as movement always aggravated the pain, and at times caused nausea and vomiting. Four months ago was seized with sudden and severe pain in the same

locality, with vomiting, which kept her in bed for three or four weeks. Her general health has perceptibly failed for the past four years, being weak and anæmic. During a year or more, appetite has been lost, emaciation very marked, and anæmia decided. For the past three months has been confined to bed almost constantly. Bowels have been generally quite constipated. Tympanites has, at times, been troublesome. Menses have ceased for four months. Urine has been voided naturally, and she has noticed nothing unusual in its appearance.

Patient looks very pale and thin, with a waxy, transparent skin and blue veins. Examination of the abdomen shows a rounded tumor projecting from the surface a little to the right of and below the umbilicus. It feels about the size of two fists, and is distinctly fluctuating. It is quite continuous above with what feels as the firm edge of an enlarged liver, extending obliquely across the abdomen to the left hypochondrium. The hepatic region is prominent, as are also the epigastric and left hypochondriac, the whole feeling solid and resisting. The area of dulness is very extensive—on the right side, from the 4th rib to the crest of the ilium; on the left, from the same level above to the edge of the costal cartilages. Heart and lungs found normal.

A few days after admission, a very small quantity of clear blood was noticed in the urine, with a corresponding trace of albumen. This was present for three or four days, when it disappeared. After this, no abnormality was observed in the urine.

On 2nd December, the fluctuating tumor was aspirated with a large needle, and about 8 ozs. of fluid removed. This had the appearance of broken-down blood, and was of a chocolate color. The operation was followed by some relief to the symptoms for a short time.

The patient, however, soon again began to suffer much abdominal pain as before, necessitating the free use of morphia hypodermically. The mass evidently increased in size, extending beyond the dimensions above given. She fell into a condition of extreme marasmus, with great prostration, and died exhausted March 4th, 1885.

The autopsy showed that the original growth was a softened sarcoma of the right kidney, the organ weighing about two pounds, made up of sarcomatous growth containing several chambers, which held a grumous fluid similar to that removed. The liver was enormously enlarged, and studded with soft secondary growths of various sizes.

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### Reviews and Notices of Books.

**On some Common Injuries to Limbs, their treatment and after-treatment, including Bone-setting.**—By EDWARD COTTERELL, M.R.C.S., Eng., and L.R.C.P., Lond. London: H. K. Lewis.

This small book describes those affections of the extremities following injuries which have been often so successfully treated by bone-setters. Mr. Cotterell thinks that if surgeons paid more attention to the after-treatment of joint injuries the occupation of the bone-setter would be gone and the public much benefited thereby. Dr. Wharton Hood, many years ago, drew attention to the subject, and showed that the cases successfully treated by the bonesetter were those in which, after an injury, adhesions formed external to the joint. These adhesions are broken down by the rapid manipulations of the bonesetter, and the patient gets well as if by a miracle. In stiff joints following injuries, it is now the common practice (thanks to Dr. Hood) to place the patient under ether and forcibly break down the adhesions; the result of this treatment is quite as successful as that of any bonesetter, though not surrounded with as much mystery. Dr. Cotterell also fully describes the treatment of the various fractures—lawn tennis arm, rider's sprain, lawn tennis leg, sprained knee and ankle, &c. In sprained ankle, he immediately straps the foot and leg, and allows the patient to walk about; and in Potts' fracture, he advocates the immediate application of plaster-of-paris. The book is well worthy of careful perusal, and the reader will get many tips in the treatment of those rather obscure affections following injuries which are passed over with but a word or two in the ordinary text-books. The work is nicely

got up in large type, and is written very tersely and concisely, which is a recommendation in these days of tiresome prolixity of book-makers.

### Clinical Lectures—

**On Scrofulous Neck.**—By T. CLIFFORD ALLBUTT, M.A., M.D., Cantab, F.R.S., F.R.C.P. And

**On the Surgery of Scrofulous Glands.**—By T. PRIDGIN TEALE, M.A., M.B., Oxon, F.R.C.S.

These two lectures draw attention to a subject which is of as much interest to the surgeon as the physician. Scrofulous neck is an affection which every practitioner of medicine sees and would be glad to know how to treat, now that the “royal touch” and priestly conjurations have, owing to the faithlessness of the present generation, ceased to be of any avail. Dr. Allbutt describes in a clear and entertaining manner the rise and progress of scrofulous glands. He strongly advocates the early extirpation of every caseous gland, and hopes, “if such a practice becomes universal, scrofulous necks and all the hectic, asthenia, emaciation and phthisical risks which belong to it, will become matters of history.”

Mr. Teale tells us how to extirpate glands, and shows how successful their removal is and what a beneficial influence the operation has on the health of the patient. He strongly advocates the scraping out of glands which have broken down and are discharging, and which cannot be dissected out. The question of the removal of glands which have not supplicated or become caseous he considers to be yet an open one.

**Diagnosis and Surgical Treatment of Abdominal Tumors.**—By SIR SPENCER WELLS, Bart. London: J. & A. Churchill.

This is a cheap edition, printed in double columns, of Sir Spencer Wells' well known work. The subject matter is somewhat condensed, and much new material added. It is got up in the style of Sir Henry Thompson's cheap edition of his work on the bladder. The book is published at three shillings and

sixpence, a price which brings it within the reach of all. Little need be said in praise of the work of a surgeon whose reputation is world-wide. It is a most valuable book, and the record of the author's own work, which in great part forms the history of ovariectomy. The chapter on the rise and progress of this operation is most interesting and instructive. Included in the work is a short account of the operative treatment of various kinds of abdominal tumors other than uterine and ovarian, such as splenic, renal, hepatic, &c. One thing strikes a reader acquainted with the literature of abdominal surgery, and it is this: that the name of Mr. Lawson Tait is not mentioned even in connection with oöphorectomy and cholecystectomy. It seems to us that a book on abdominal surgery which takes no notice of the very valuable and original work of Mr. Tait is incomplete, and we wonder greatly that a man of Sir Spencer Wells' reputation and standing should be weak enough to allow private feelings to have such influence with him, when writing for the general profession, as to make him ignore the work of a colleague and fellow-searcher after truth.

We advise all those who perform, or even contemplate performing, operations on the abdomen, to carefully peruse this book. Its handy and cheap form will now doubtless give it a popularity it never had before.

**The regimen to be adopted in cases of Gout.—**

By DR. WILHELM EBSTEIN, Professor of Clinical Medicine in Göttingen. Translated by JOHN SCOTT, M.A., M.B., Honorary Physician, Manchester Southern Hospital for Diseases of Women and Children. London: J. & A. Churchill.

This little treatise first discusses in a brief manner the pathogenesis of gout as bearing upon the question of diet and mode of life; then sketches an outline of the regimen which, the author thinks, is most to be relied upon. Amongst other special forms of treatment, the German fruit-cures are alluded to. "Such fruits," it is said, "as cherries and strawberries, which contain an organic acid, can be taken with good results, and are less injurious to digestion than the alkaline carbonates." "When

the cure is confined exclusively to the use of fruits, as, for example, in the grape-cure, we must be very cautious. Dyspeptic troubles are easily induced by such means, and the mischief thus wrought counterbalances any good that may be derived from the fruit." The writer has made enquiries extensively amongst the physicians treating workmen in the lead-mines of the mountains, and the result has been to throw considerable doubt upon the existence of a causative relationship between chronic lead-poisoning with gout and contracted kidneys. The dietary, clothing, exercise, climate, &c., are all considered in the light of their bearing upon the disease.

**Lectures on Diseases of the Nervous System, especially in Women.**—By S. WEIR MITCHELL, M.D., Member of the National Academy of Sciences, Physician to the Orthopædic Hospital and Infirmary for Diseases of the Nervous System. Second edition, revised and enlarged; with five plates. Philadelphia: Lea Brothers & Co.

The impetus given by Dr. Mitchell to the study of certain special and intractable forms of nervous disorder is everywhere recognized, and he has many followers in his successful methods of treatment. His lectures, which are admirably written, are full of interest and instruction, eminently practical, and contain a large number of illustrative cases. The present edition, besides a certain number of alterations in some of the early lectures, has been increased by the addition of lectures upon the difficulties of diagnosis in hysterical diseases of joints, on the relations of hysteria to organic disease of the spine, and on hysterical disorders of the rectum.

**On Bedside Urine-testing: A clinical guide to the observation of urine in the course of work.**—By GEO. OLIVER, M.D., Lond., M.R.C.P.L. Third edition. London: H. K. Lewis.

This is a very handy little volume, very carefully prepared, and containing excellent practical directions as to the readiest methods of making clinical examination of the urine for all im-

portant substances. Several of the procedures differ from those commonly adopted. For instance, for taking specific gravities, instead of the urinometer the author prefers a glass bead accurately representing 1008. By means of this and a graduated tube, accurate estimates of the specific weight can be made of even very small specimens of urine. For albumen, Dr. Oliver strongly recommends the test-papers of potassio-mercuric-iodide and of potassium ferrocyanide as being most convenient, most delicate, and open to fewer objections than any others. We can highly recommend this manual to the attention of all careful practitioners and clinical students, who will find therein many suggestions and aids in their prosecution of this important part of medical work.

**The Physician Himself and what he should add to to his scientific acquirements in order to secure success.**—By D. W. CATHELL, M.D., late Professor of Pathology in the College of Physicians and Surgeons of Baltimore. Fourth edition. Baltimore: Cushings & Bailey.

We have already taken occasion to introduce this work to the favorable notice of our brethren, and gladly notice the appearance of the new edition. The present is said to be enlarged by the addition of nearly three hundred new suggestions. We make no doubt that it will meet with a constant demand, as every old physician and recent graduate will want to see what this observant writer and canny counsellor has to say.

**A Treatise on Practical Chemistry and Qualitative Inorganic Analysis, adapted for use in the laboratories of colleges and schools.**—By F. CLOWES, D.Sc., Lond., Fellow of the Chemical Societies of London and Berlin, Professor of Chemistry at the University College, Nottingham. With illustrations. From the fourth English edition. Philadelphia: Lea Brothers & Co.

We have here a complete guide and text-book for the student through his course of practical chemistry. It covers the whole ground thoroughly, and gives innumerable hints and explanations

to make the work more easy and intelligible. It is divided into seven sections. In the first, some simple directions are given for preparing for use the apparatus which it will be necessary to employ. In the second, the preparation of certain gases is described, and experiments illustrative of their properties are detailed. The third section prepares the worker for chemical analysis by a description of the most important methods and processes employed in qualitative analysis. The reactions which are employed as tests and methods of separation are contained in the fourth section. The fifth is occupied with the detection of the constituents of simple salts; the sixth, with the analysis of any liquid or solid inorganic substance. The seventh consists of information concerning the fitting and furnishing of the chemical laboratory.

Teachers and students of chemistry cannot do better than make a constant companion of this useful text-book.

**A Treatise on the Science and Practice of Midwifery.**—By W. S. PLAYFAIR, M.D., F.R.C.P. Fourth American from the fifth English edition. With notes and additions by ROBERT P. HARRIS, M.D. Philadelphia: Lea Brothers & Co.

The first edition of Dr. Playfair's work appeared in England in 1876, and now we have a fifth English and a fourth American edition. After these facts little need be said of its popularity and adaptation to the needs of students and practitioners of midwifery. It has been well said that the necessities in the writing of books are mainly two—those of the reader and those of the writer. Whatever may have been the necessity of the writer of the work in question, Dr. Playfair, by his work, met a much felt want of the profession. While the author does not claim many changes in this edition, following as it does so closely on the previous one, the whole has been carefully revised, and the chapter on "Conception and Generation has been in great part rewritten and made to incorporate the most recent advances in embryology."

One or two points only can be noted in the space at our dis-

posal. The author, in speaking of the treatment of the umbilical cord, alludes to the treatment by laceration, and states that he has used it in many cases, but prefers the ligature. His friend Dr. Stephen has used it in several hundred cases. In discussing transfusion, Schäfer's method of immediate transfusion is described and endorsed. Dr. Playfair still adheres to the theory that in some cases of puerperal septicæmia the disease is autogenetic. This theory, we believe, will be rejected with advancing knowledge of the subject. It is not sound logic to assert that because we cannot see a source of infection from outside it must therefore be generated within the body of the puerpera. A little reflection will suggest enough possible avenues for the entrance and development of germs, without resorting to the autogenetic theory.

This work remains one of the very best text-books on Obstetrics in our language. That able obstetrical statistician has done his editorial work most satisfactorily. This edition is dedicated to Dr. Emmet.

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### Books and Pamphlets Received.

A TEXT-BOOK OF MEDICAL PHYSICS, FOR THE USE OF STUDENTS AND PRACTITIONERS OF MEDICINE. By John C. Draper, M.D., LL.D. Philadelphia: Lea Brothers & Co.

THE CLIMATE OF CANADA AND ITS RELATIONS TO LIFE AND HEALTH. By W. H. Hingston, M.D., D.C.L. Montreal: Dawson Brothers.

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### Society Proceedings.

#### MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

*Stated Meeting, April 17th, 1885.*

E. H. TRENHOLME, M.D., 2ND VICE-PRESIDENT, IN THE CHAIR.

*Tubercular Lung with Pleura from a case of Hydropneumothorax.*—RR. R. J. B. HOWARD exhibited the specimen, and said that on opening the thorax the right lung was emphysematous and contained many grey granulations about the anterior part of middle lobe. Left pleural cavity contained a blood-clot measuring 17 oz.; on removing this, the pleural sac was everywhere lined by firm buff-colored membrane nearly a  $\frac{1}{4}$ -inch thick. The pulmonary portion was equally thick, and bound the lung

firmly down to the vertebral column. A small opening communicated with a cavity in the lung, this opening being situated high up behind. So firmly attached was the lung that it had to be cut out; in doing this the cavity was opened. It occupied the whole upper lobe, and would have held a hen's egg. Its walls were lined in the upper part by a smooth, grey membrane, but the larger part of the walls were ragged and crossed in all directions by strands of tissue, in many cases consisting only of one or two vessels of considerable size. The cavity contained a good-sized clot. No open vessel was found. The lower lobe contained many caseous nodules. Evidently the cause of death was hemorrhage from the pulmonary cavity into the pleural space—in fact, internal hemorrhage, a very unusual termination. The patient had had pneumothorax for months, and his chest was opened and drained about two weeks before. There was more fear that the operation might have caused, or at least accelerated death, but he could find nothing to lend color to this view—in fact, the obliteration of the pleural cavity from the bottom was commencing.

DR. GEO. ROSS said he had first seen this patient about 18 months ago, but that he had been in the hospital previously for months with phthisis and softening of the left apex. The day before seeing him he had been seized with severe pain in the left side, accompanied with shortness of breath and distress. This continued for 24 hours. On examining, pneumothorax was found, but there was no fluid. The left chest was distended with air, the heart pushed over, pulse rapid, and he was cyanotic. After a time fluid gradually replaced the air till the left side was full. Was then tapped and serous fluid removed, giving great relief and feeling much better. Went home, where he improved and gained weight. He came to the hospital once a month to be examined. After some months the chest again refilled and he became feverish. He was again tapped, a sero-purulent fluid coming away. The fluid rapidly re-collected, accompanied with fever and emaciation. An incision between the ribs was made by Dr. Shepherd and a drainage tube put in. The fever lessened, though some remained. The pulse was still rapid. He was improving, till

onè day he suddenly became pale and exhausted, and blood leaked out by the tube. But for this accidental ulceration of the vessel in the lung he thought this patient might have recovered. A similar case had been treated by Dr. Wilkins and himself ten years ago, who recovered, and is now alive.

DR. KENNEDY said that this case recalled one he had seen years ago, that of a man who died from fracture of the skull. At the post-mortem the right lung was found collapsed and in a fibroid condition, the side of chest sunken in, and the viscera had adapted themselves to the altered shape of the chest. The organs appeared healthy, and the man would have lived years but for this accident. He had been operated on for pyothorax two years previously.

DR. GODFREY said he had seen a similar case where a woman died seven years after from tuberculosis of the opposite lung.

*Pieces of Necrosed Bone from an Abscess at site of Potts' Curvature.*—DR. SHEPHERD exhibited eight small bits of bone removed by him from an abscess at the side of the spine. A second abscess was on the side—both following inflammation produced by a kick over the part.

*Antiseptic Midwifery.*—DR. ARMSTRONG read the following paper on this subject :

That Sir Joseph Lister has done a great deal for surgery—by enlarging the field of justifiable operations and by rendering the results of all operations more satisfactory—none will deny. But to what extent the details of his method of operating are essential there is still a wide difference of opinion ; and even the soundness of the theory upon which his practice is based may be safely questioned. Indeed there is a suspicion among not a few that, after all, we may find in the future the lesson to be learned from the practice of Lister is that absolute cleanliness of the part operated, upon the part of the operator, and of instruments used in the operation, *is the great essential of success*, and the thanks of the profession to Joseph Lister should be none the less profound, because his labors have been none the less effective if the suspicion should prove to be correct. The germ theory is the fashionable way of accounting for many of the acci-

dents of surgery, as well as for the presence among us of many diseases. Lest we again lay ourselves open to the charge, sometimes laid against us by the lay press, of allowing ourselves to be led to one extreme by some prominent professor with an unpronounceable name, and then in a short time following some other leader as blindly to the other extreme, let us pause and examine some of the facts of familiar occurrence in every-day life, and ascertain whether or not they are in harmony with the theory advanced.

Antiseptic surgery is based on the theory that the atmosphere which we breathe and by which we are surrounded contains germs which, when allowed to come in contact with wounds, are capable of lighting up unhealthy action in them; and this theory has been more and more widely applied, until now, by some, it is taught that the physiological action of child-birth should always be conducted on what are known as strictly antiseptic principles, and it is this somewhat new application of the germ theory that I purpose briefly to discuss this evening.

Do our parturient patients whom we attend in confinement in the ordinary way, without the use of any antiseptic dressings or douches, and without any special previous cleansing or disinfection of their apartments, present, as a rule, symptoms of septic inoculation? So far as my experience goes, the answer is decidedly in the negative. If I am not much mistaken, it is the exception for men who do a large midwifery practice among the middle and lower classes to have cases of septic poisoning occurring among their parturient women. We younger men are often called to attend women in their confinement whom we see for the first time when they are in labor,—women who live in unhealthy, low, badly-drained localities, and in houses not overclean and ill-ventilated—women whose surroundings are eminently adapted to favor the growth and spread of atmospheric germs, and yet even among these I believe it is comparatively rare to have trouble of a septic character. Now if a man confines 100 women, and 98 of them make perfect recoveries and two of them present symptoms of septic poisoning, should he blame any one of the many surroundings common to them all

as air, or should he look for some extraordinary agent to account for the evil. The experiences of ages and all medical literature teaches the latter. We constantly hear and read of septic cases due to a portion of decomposing placenta or membrane or blood-clot remaining in the uterus or vagina, or cases that can easily be traced to contagion carried by the accoucheur. Now, is it possible for the strictest antiseptic precautions to prevent the occurrence of septic infection of women during and after their confinement? Let us suppose, for instance, that we have had apartments to be occupied by our patient newly whitewashed and papered and disinfected, and the bed, bedding and napkins and all the clothes to be used by the patient thoroughly carbolized or sublimated, is our patient then safe? I fear not, unless the accoucheur and nurse themselves see to it that they neither touch nor enter the presence of any unclean thing. If the doctor comes from examining a child with diphtheria, or a patient with erysipelas, and enters that chamber and touches the patient or the napkins, he unavoidably communicates the poisons to the patient or to the napkins and the napkins to the patient. I think I cannot better illustrate not only the *possibility*, but the *probability* of such a sequence of events than by quoting an account of similar occurrences from the latest edition of Emmet's "Principles and Practice of Gynæcology." On pages 717 and 718 of this work Emmet relates the two following cases. In the first one Dr. Emmet was about to remove a small ovarian cyst from a young girl in apparently perfect health. Dr. Emmet says: "The sponges, instruments and ligatures had been prepared with unusual care, and I never performed an operation where there seemed so little liability for any complication to occur." Just before the operation several physicians from the Polyclinic or Post-Graduate Medical School sent in cards of introduction from some of the staff, requesting that they might witness the operation, and they were admitted. Just as the doctor was commencing the operation one of these gentlemen picked up a pair of forceps or scissors from the tray to show a friend alongside. Emmet caught his hand, requested that he would not touch the instruments, and then went on with the operation,

neglecting to disinfect the hand that had touched the gentleman's coat. In less than twenty-four hours, the report says, the girl was doomed, and died on the sixth or seventh day. It was found at the autopsy that an abscess had formed, extending from the wound and around the pedicle, and that the girl died of septic peritonitis. Emmet adds that the man who picked up the instrument was responsible for the girl's death.

The other case is that of a woman suffering from prociencia, sent to Dr. Emmet for treatment by Dr. A. Jacobs. At the operation, after Dr. Emmet had denuded a large surface, Dr. Jacobs, who was present, placed his finger upon the prolapsed surface to satisfy himself that it was unusually hard. Two days after the operation, the patient's temperature was found to be  $105^{\circ}$ . Upon removal of the sutures, the whole surface which had been freshened was found covered with a diphtheritic deposit as thick as a piece of chamois leather. It was ascertained that Dr. Jacobs had examined the throat of a child suffering from diphtheria early that morning. The operator had not seen a case for years; Dr. Bache Emmet, the assistant, had not in six months. The nurses were out of the way of meeting the disease, and the patient had not been out of the house for several weeks.

Now the two points I would make here are :

1st, How remarkably easily septic matter is conveyed. From what we know of the properties of septic matter, it does seem that, if the air is full of them, all wounds exposed to the atmosphere pressing these germs against exposed surfaces with a pressure of 15 lbs. to the square inch should become infected; yet we know from experience that this is not the case, and the fact that this is not the case is good evidence that the atmosphere ordinarily does not contain them. That wounds heal kindly and by first intention, and that women are confined every day without any septic trouble supervening, and without the so-called antiseptic precautions being taken, certainly proves this much, that the so-called antiseptic precautions are not essential to perfect healing of the parts after an operation or to perfect recoveries after confinement.

2nd, That, in spite of all possible antiseptic precautions, one

touch from a known and well-defined source of contagion renders all our antiseptic preparations useless.

May not the question be fairly asked : If all the known and well-defined sources of contagion are strictly guarded against would we need all this paraphernalia to protect our patients against an imaginary foe ? When going through a hospital and seeing wounds filled with pus that have been made under the spray and dressed according to Lister's method, it is really amusing to listen to the many explanations given to account for the presence of the pus and the unhealthy action. Some little detail, we are gravely told, was accidentally omitted, and this is the result. Explanations which can only be compared to the reasons given by those estimable people possessed of more goodness of heart than of wisdom when trying to account for the non-restoration to health of some one who had something the matter with him, and had been prayed over by the brethren possibly for months together. Herbert Spencer, in his essay on the coming slavery, says that when railways were first opened in Spain peasants standing on the track were not unfrequently run over, and that the blame fell on the engine-drivers for not stopping, rural experiences having yielded no conception of the momentum of a large mass moving at a high velocity ; and he goes on to speak of a political momentum which, instead of diminishing or remaining constant, increases. I think we might recognize a momentum in antiseptic theories—a momentum that seems to be carrying us into irrational and absurd practices, that after a time we shall be compelled to give up, but not without the loss of prestige and influence with the public. According to the present rate of progression we shall soon, when called upon to attend a case of midwifery, be compelled to retire to our bath-rooms, wash and scrub in disinfectant solutions, don a fresh suit of disinfected clothes, and, like the Romish priests, when called to administer the communion at a person's residence, we shall go forth, preceded by couriers to clear the way and open doors, etc., not daring to touch a door-bell knob, lest, possibly, an unclean mendicant has first handled and defiled it.

Would it not be better if our line of action were directed

against more tangible sources of septic poison than the atmosphere we breathe. Instead of becoming machines, let us more carefully and intelligently avoid known sources of danger. We, as general physicians, must attend diphtheria, scarlatina, peritonitis, etc., but if we do, before going from these cases to attend confinements, let us take those measures to ensure against conveying them to our patients which every-day experience proves to be sufficient, rather than inflict upon our patients a long detail of preventive treatment, which is repugnant, troublesome and costly, both as to time and money. More than this, these very precautions which some would induce us to take to insure the safety of our patients may be made indirectly to increase this danger by rendering us less careful in avoiding known sources of contagion. When in Philadelphia a year ago, in conversation with Prof. Levis, he expressed himself as a thorough believer in Listerism. He told me that when going through Sir Joseph Lister's wards Lister remarked to him that his wards were æsthetically dirty but surgically clean. That simply proved that it was possible by great care and by the use of every precaution to keep a surgical wound clean in an æsthetically dirty ward; but it shows the tendency to trust to these more showy and formal means of prevention, and to neglect the ordinary rules of cleanliness, which have been rightly said to rank next to godliness. Let us first pluck the beam from under our finger nails, and then, perhaps, we shall see more clearly to pluck out the mote from the atmosphere.

DR. KENNEDY said he did not believe in treating a natural process as if it were pathological. He spoke against the use of the spray, etc., in labor, and thought that antiseptic injections were very seldom needed. The giving of these injections by the physician was lowering him to the position of nurse. He had read of poisoning following the use of injections of solution of bichloride of mercury.

DR. CAMPBELL endorsed Dr. Kennedy's views. During his 23 years of practice he had attended 1,700 cases of midwifery, and only had six cases of septic trouble, using only ordinary precautions. Most of the cases of septic poisoning were among the better classes.

DR. A. A. BROWNE said he had never seen antiseptic midwifery carried out. He thought the main things to attend to were cleanliness and having fresh air. In the Vienna hospitals the fresh air was heated before going through the wards.

DR. SHEPHERD said that of late years the term antiseptic treatment had a wider meaning than Listerism. Lister himself says that the spray is the smallest part of the treatment. Fifty per cent. of deaths used to follow amputation of the leg; now the death rate is five or six per cent. The case is not, Did a number do well *without* antiseptics? but, Do all? He has notes of 20 major operations dressed antiseptically without a death, and all but one healed by first intention.

DR. TRENHOLME, in over a thousand cases of midwifery he attended, never had a case of septic poisoning, and only had two deaths—one from shock after delivery by forceps in a woman with a deformed pelvis; the second, a woman who got up and walked in the snow a few hours after delivery. He attributed his success to following, as far as he could, Dr. Goodell's teaching, which was to have his patients walk from the room they are confined in into the room they intend remaining in during convalescence; also, getting the woman to sit up every day for a few minutes. This was done to favor expulsion of clots, etc. He was also very particular to see that the uterus, after delivery, was completely emptied of all membranes.

DR. CAMPBELL said he always orders his patients to use an ordinary chamber instead of the bed-pan, thereby necessitating her sitting up.

*Cases in Practice.*—DR. CAMPBELL related a case of a gentleman who had gonorrhœa over two years ago, and who, about a week after marrying a perfectly healthy lady, had a recurrence of a discharge similar to his old gonorrhœa. Dr. Campbell asked, Would this be called a gonorrhœal discharge and be infective?

Several gave it as their opinion that it was a case of non-specific urethritis, such cases not being rare in newly-married men.

*A child without nipples.*—DR. KENNEDY described this condition lately seen by him in a boy; no rudimentary glands could be made out.

DR. SHEPHERD said that more of such cases were recorded where deficiency was only on one side.

Stated Meeting, May 1st, 1885.

T. J. ALLOWAY, M.D., 1ST VICE-PRESIDENT, IN THE CHAIR.

*Case of Suppurative Tubercular Peritonitis simulating Ovarian Tumor.*—DR. GARDNER read a paper on this case, which appeared in the June number of this JOURNAL.

*Case of Partial Epilepsy.*—DR. MIGNAULT read the following paper :

The occurrence of cases of transient or partial epilepsy are by no means rare, and, though less striking and, so to speak, impressive than the convulsive forms, are still worthy of study, and from the mildness of the morbid process seems much easier to arrest, and perhaps cure, than the former variety. The multiplicity of manifestations of this disease may often mask its presence, and, as in the case here cited, may almost be overlooked by the patient himself.

On the 12th of last February I was summoned to see M. H., aged 40. He occupied a private ward in the Hotel Dieu, and came to be treated for what is called biliousness. I gave him the usual treatment, a purge, and subsequent doses of nitromuriatic acid, and the patient left the hospital, apparently feeling much relieved, and returned to his home in Boston.

About the 25th of the same month patient returned, and complained of renewed attacks of biliousness. The patient, a few days afterwards, mentioned incidentally that he suffered from occasional attacks of vertigo and fatigue. It was only some days later that he described, after several questions, the nature of these vertiginous attacks. The seizures occurred as follows:—On a sudden, without preliminary warning, he would lose consciousness, and, being possessed of a fixed idea, would set to work to execute it mechanically. He generally fancied that it was necessary for him to go to bed; accordingly he would seek some room where he knew a bed was situated, and would undress and get into it. As often happened, being a teacher in an orphan

asylum, he would manage to crowd himself into a child's cot, and would, to his intense disgust, suddenly resume consciousness and find himself cramped and stiff from the exertion. On another occasion, while waiting for a train at a railway station, he started off to walk along the track. As he crossed a bridge, stepping from sleeper to sleeper, he was loudly shouted at by several persons, but he was still unconscious, and pursued his way for about four miles, when he was both astonished and amazed to find that he had wandered so far away from his destination. This feat was all the more remarkable from the fact that my patient was very lame from hip disease in childhood, and wore a boot with a cork sole which replaced the shortening of the diseased leg. He states that the duration of these fits is from a few minutes to an hour, and that they generally occur in the daytime and very irregularly. He only has had them since the last two years, and they occur simultaneously with disordered digestion and torpid liver. No premonitory symptoms ever occurred. From the statements of eye-witnesses, the patient at these times becomes very pale, the eyes are wide open and have a fixed expression. He answers quietly and reasonably any question which may be addressed to him, and will often even apologize for the trouble he is giving. The patient, who is an intelligent and serious man, avers that he has not the slightest consciousness of what occurs.

Upon questioning patient as to his history, he states that at 18, while a student at college, he suffered from epileptic seizures of the convulsive form, and that they disappeared after two years of treatment. They did not interfere with his general health; and he attributed them to fatigue after severe study. Patient belongs to a healthy family, and there is no trace of any neurotic disposition.

The pathology of epilepsy came to my aid in the diagnosis of this case. Assuming, with modern authority, that epilepsy is the result of sudden and acute anæmia of the cortex, with congestion of the medulla, we may presume that in this case there is simply acute anæmia of the cortex, without notable congestion of the bulb. As it is probable that the conscious centres are

located in the cortex, and, moreover, that all the mandates of the mind are communicated to these convolutions, it is easy to explain the absence of conscious control and the occurrence of mechanical actions. The cortex—the bond of union between mind and matter, so to say—paralyzed, and the great ganglia in perfect condition, the movements are simply like the reflex spinal movements, and are called on in precisely the same manner. The diagnosis of this case seemed at first rather difficult, and I was inclined to believe it a case of catalepsy. The absence of rigidity, however, and the history of the patient, led me to class it among those cases termed “partial epilepsy,” and in a late number of the *New York Med. Abstract* several such cases are cited and thus named. The treatment employed ultimately was based upon my pathological ideas, and then alone was it successful. I tried at first the anti-epileptic mixture of Brown-Sequard for two weeks, and the attacks were of frequent occurrence. I then thought of treating the cerebral anæmia, and gave the patient  $\frac{1}{2}$  gr. nitro-glycerine thrice daily. I followed in this the idea of Hammond of New York. The results were excellent. The fits ceased, and patient passed three weeks without a single seizure. At the end of that time he noticed a copious deposit of lithates in the urine, with a diminution of that secretion, and the following day two seizures occurred; both were very brief in their duration. I prescribed a mixture of pot. bicarb., and all went on well as before.

The patient left shortly afterward for Boston. At last accounts he was still well, and whenever the urine became loaded he had recourse to the potash mixture, and so the fits were averted.

DR. HENRY HOWARD took exception to the name of the paper, and said that it should be called a mild form of epilepsy. Another form was the marked epilepsy. He knew of a gentleman who has had attacks of this nature for ten years, but is not aware of the fact. He has a momentary loss of consciousness, with slight quivering of the muscles of the face. Another, a lady, has attacks which are not more severe than the aura of an ordinary epilepsy. She suddenly feels a something run up from the foot to the heart, and in a few minutes is perfectly well again. The

Italians have been writing much on epilepsy. They show that cortical epilepsy, when the lesion is in the motor area, always is accompanied with convulsions, which begin in the side of the face opposite to the brain lesion. The arm is next affected, then the leg, and last the trunk. When the lesion is in the peripheral or lower centres, then there are no general convulsions. In a pure case of cortical epilepsy, there must be biting of the tongue and relaxation of the sphincters.

DR. CAMPBELL, who has on several occasions spoken of the great benefit of nitro-glycerine in epilepsy, again mentioned his continued success with it, and related one or two cases where a wonderful change for the better has followed its administration.

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*Stated Meeting, May 15th, 1885.*

T. J. ALLOWAY, M.D., 1ST VICE-PRESIDENT, IN THE CHAIR.

*Atmospheric Materies Morbi.*—DR. HENRY HOWARD read a somewhat lengthy paper on this subject, of which the following is a brief abstract :

We don't know, and perhaps we never will know, what were the characteristics of primordial matter, whether of atoms or molecules, or both together. Physical science teaches us that all the different degrees of matter have their own peculiar structure, consequently each has its own peculiar phenomenon, force or function, such as psychic, motor and sensorial. . . . Now what do we mean by the term "atmospheric materies morbi" ? The great physical scientist, Prof. Tyndall, demonstrated by the most conclusive experiments that the atmosphere was filled with floating matter, which, under favorable circumstances, produced a very low living animal organism, but he did not demonstrate whether it was mineral, vegetable, or animal matter, or all three combined. . . . The question naturally suggests itself, how so many persons fall victims to these germinal diseases—typhoid fever, cholera, etc. Dr. Howard dwelt at some length upon the action of the toxic germ of cholera causing paralysis of the vaso-motor nerves, and concluded by saying that he thought the treatment must tend towards restoring those nerves to their normal state.

## Correspondence.

To the Editor of the CANADA MEDICAL & SURGICAL JOURNAL.

DEAR SIR,—When I undertook to write you a letter from Berlin for the JOURNAL, I did not count on the difficulty which exists of seeing objects of general interest to the medical world through the windows of a chemical laboratory.

The "busy practitioner," as a rule, rather prides himself on having forgotten all his chemistry, while chemical formulæ have long ceased to recall anything but the headache and feeling of despair they once produced while being rapidly stored up for a primary examination.

As this is the greatest European centre for research in organic chemistry, there is, as one would expect, an enormous amount of work being done of interest to the medical public, but in the vast majority of the researches the chemical interest so far overshadows the medical that it is no easy task to find suitable material for such a letter.

The investigations regarding the relations and constitution of the poisonous alkaloids found during the decomposition and putrefaction of albuminoid bodies form, to the medical world, the most interesting and important subject now engaging the attention of European chemists. The brilliant experimental researches of Pasteur and Koch, while of the highest importance in themselves, have, unfortunately, created a frantic desire among pathologists to shine in the same field of research. The result is that every proud owner of a sterilized test-tube, a plug of cotton wool and a tame rabbit now poses before the public as a bacteriologist, and when he has transferred half the contents of his test-tube to Bunny's stomach and introduced the remaining half in various other parts of his victim's economy, Herr Dr. Bacteriologist proceeds forthwith to cover with the martyr's obituary eighteen or more pages of the *Berliner Naturwissenschaft Centralblatt*.

Fully as scientific and practical, though far less theatrical, have been the recent attempts to elucidate the phenomena of disease through chemical research about the nature of ptomaines.

It has long been established that the tissues of men and animals undergoing decomposition contain certain putrid principles or poisons. Attempts have been made at different times to isolate their toxic principles, but their unstable nature and the extremely small yield obtained from large quantities of putrid material,—owing to the defective processes employed—have until quite recently deterred chemists from undertaking research in this direction. Highly poisonous basic extracts were obtained, however, and their physiological actions partially studied. These syrupy extracts were found to possess toxic properties very similar to many well known vegetable alkaloids, especially atropine and curare; while others resembled in physiological action morphine, strychnine, conin and digitalin, or combined the action of two or more of these alkaloids. These cadaver alkaloidal bodies received from Selmi the name of Ptomaine. They attracted attention at first owing to their possible confusion with vegetable alkaloids, many cases having arisen, especially in Italy, in which it could not be proven that alkaloidal poison found after death in cases of supposed homicide was not of putrefactive origin.

Commissioners appointed by the Italian and German governments to investigate these bodies, issued lengthy reports containing a series of color tests by Stass Otto and Dragendoff, which have, with a more complete knowledge of the nature and constitution of ptomaines, proved unreliable. Indeed all this early work on the ptomaines is quite unreliable, for two reasons: first, the substance used for the experiments was in no case a well characterized body, possessing a definite chemical individuality, but usually a syrupy extract; secondly, the methods used for extraction were highly unscientific, chemically, as strong, hot acids, and even glycerine, were resorted to in isolating these products. Nencki was the first chemist who isolated a basic product of decomposition and established its chemical individuality.—*Jour. f. Praktische Chemie.*, Bd. 26, '82.

In decomposing gelatin, he found a base which he obtained in crystals, and ascertained its formula to be  $C_8H_{11}N$ . This collidin body is the first ptomaine obtained in a pure state.

Lately, in decomposing fish, a Ptomaine has been found by the French chemists Gautier and Etard identical with Nencki's base.

Since Nencki's important research much attention has been directed to the careful study of chemically pure Ptomaines. Owing to their occurrence elsewhere in dead bodies, the original signification of the word Ptomaines (Gr. *Ptoma*, a cadaver) has been extended to include all toxic alkaloidal bodies formed during putrefactive action.

Prof. Breger, of I. Berlin Med. Clinic, has during the past two years been engaged in isolating and studying these interesting bodies. To give more than a brief outline of his very successful researches would be out of place in a letter of this kind. First of all, from peptone, artificial and natural, he obtained a body similar, chemically, to a ptomaine, but in a purer state, possessing very feeble toxic properties—Ptomopeptone. From putrid horseflesh, beef and human muscle tissue he has recently isolated an alkaloid of the highest interest, whether regarded from a chemical or pathological standpoint. To this body he has given the name of "Neuridin"; its formula is  $C_5 H_{14} N_2$ . As most of the recently isolated ptomaines resemble this substance very closely, whether obtained from putrid flesh, fish, gelatin or vegetable albumen, we may regard its physiological action as typical of this class of bodies.

Prof. Breger experimented with neuridin on frogs, rabbits, cats, guinea-pigs and mice, and has just published a detailed account of his observations.—(Berichte XVII., XVIII., and "Ueber Ptomaine," 1885. Hirschwald, Publisher, Berlin.) Among mammals, cats were found to be most susceptible to this poison, and guinea-pigs least; but owing to the great difficulty with which large amounts of the chemically pure substance was obtained, accurate series of experiments were only performed on the frog and rabbit. Large frogs were found to react slowly to a dose of .001 gm. (about 1-65 gr.), while .002 gm. was invariably fatal.

Two to five milligrammes of the hydrochloride of neuridin was injected into the dorsal lymph sac of the frog. In 2-5 minutes

a spastic paralytic condition of the animal follows. To chemical, mechanical and electrical stimulants the animal at first responds, but later only certain sets of muscles react. The reposed heart at this stage is found still beating, even if the breathing has ceased. Systole short and weak; diastole lengthened, finally stopping in full diastole. At first the heart's action is quickened by the poison, and after it has ceased to beat it may for a time be renewed by stimulants and often by atropine. Atropinized frogs withstand, though not always, the action of neuridin. The action of this alkaloid on rabbits is very interesting.

A dose of .005 grm. produces the characteristic symptoms, and .04 grm. is invariably toxic. It immediately produces profuse alkaline salivation, with flow of mucus from the nose and lachrymation—the last temporary, while the salivation and mucus discharge continues till death. The respiration, at first quick and labored, (accessory muscles called into action) soon becomes shallow, irregular and less frequent. Its action on the heart of the rabbit is similar to that on the frog. It was noticed, however, that if the right and left vagus be cut beforehand no characteristic heart symptoms were observed, so the heart muscles were probably not directly affected. The pupils were usually contracted. Violent peristaltic action of the intestines, with local tetanic contractions, ensued with diarrhoea and profuse urination. Clonic spasms of the muscles, preceded by a singular weakness and trailing of the hind limbs, always followed on a lethal dose.

In cats, mydriasis is constant, and a very marked alkaline sweat always appeared on the paws. In every case a hypodermic of atropine put a stop to the symptoms.

Regarded chemically, neuridin is a very complex amine, and related to Cholin ( $C_5 H_{15} NO_2$ ), Neurin ( $C_5 H_{12} NO$ ), and Muscarin ( $C_5 H_{14} NO$ ).

Among the list of recently isolated ptomaines, I can only note a few. Breger has obtained a body from putrid fish,  $C_5 H_{14} N$ , acting like muscarin, and having atropine as an antidote. From putrid horse-flesh, a ptomaine  $C_5 H_{11} N$  has been isolated (Ber. XVI.) From excrementitious matter Prof. A. G. Pouchet ob-

tained  $C_5H_{12}N_2O_2$  (*Comptes Rendu*, 97). Breger, from decomposing glue, got a body  $C_5H_{14}NO$ . Bocklisch, last February, obtained neuridin and a substance identical with muscarin from putrid fish (Ber. 18). In April Pouchet (*Comptes Rendu*, 99-100) obtained from cholera stools a ptomaine whose vapors exert a violently poisonous action, many of the symptoms resembling those of cholera.

In 1881, during a threatened epidemic of ergotismus gangrenosus, the Russian Minister of the Interior instituted a commission to investigate this phenomenon of ergot. A. Poehl, a member of this commission, has observed that the mycelium of *Claviceps purpurea* has the power of peptonizing the albumen of the seed with formation of ptomopeptones and ptomaines. The same power is possessed by a form of mildew which occurs on the maize, especially in Lombardy, and here the inhabitants suffer from an epidemic caused by the maize similar to ergotismus. This author has frequently obtained ptomopeptone from the action of *penicillium glaucum* on albumen of meal.

With regard to the genesis of the ptomaines, we may note :

(1.) These alkaloids are always associated with fungoid growth. Whether the fungus belong to the schizomyces—*e.g.*, bacteria, etc.,—or higher in the scale of plant organisms, such as *penicillium glaucum*, *Claviceps purpurea*, and the maize mildew, in every case an alkaloidal body resembling muscarin is the product of their growth on nitrogenous bodies.

(2.) These alkaloidal bodies belong chemically to a well-marked series of organic compounds, containing cholin, neuridin and muscarin, the different members of which are easily changed one into the other by simple processes of oxydation, hydration, and reduction, as the recent researches of Prof. Berlinerblan (*Bericht* 17) on the synthesis of muscarin from cholin fully proves.

The members of this organic group, like all complex amines, are decomposed into simple amines, then into ammonia, carbon dioxide and water by excessive oxydation. Furthermore, it is to be remembered that putrefaction is a process of oxydation, and that proteids rapidly putrefying or in an advanced state of

decomposition yield no ptomaines, but only simple amines, ammonia, carbonic acid and water. This last fact goes to show that these toxic bodies are one of the earliest-formed products of decomposition, and strengthens the probability of their formation during life by bacterial action.

(3.) The isolation of definite chemically-pure poisons, which are the result of bacterial action, has at least given something tangible and definite to replace the hitherto rather vague speculations as to the nature of the poisons produced by bacteria.

Prof. Breger, in a short note recently published, states that experiments now being made by him go to show that the variety of alkaloid produced depends on the nature of the food substratum—*i.e.*, that the same bacteria will split up a highly toxic body from one nitrogenous substance, and a comparatively innoxious one from another. The converse proposition—that different bacteria produce different ptomaines from the same food substratum—has been practically reserved by Gautier and Étard, and we may expect something of interest on this in an early number of the *Comptes Rendu*.

The only observations that I can find relative to the production of ptomaines during life is the rather unsatisfactory work of Prof. Pouchet above noted. I have purposely, in this rather lengthy notice of ptomaines, omitted what really forms the bulk of all the recent papers, *viz.*, the theoretical interest of these bodies to chemistry and the improved methods of extraction now adopted. Abstracts of most of the papers (which appear in the *Berichte*), can be seen in the journals of the Chemical Society.

As that inquisitive individual, the "counsel for the defence," can make much capital out of the existence of these toxic alkaloids normally in the cadaver, it may be of interest to some readers of the JOURNAL to know that Prof. Marino-Gucco (*Gazzetta Italiana*, 13) has determined the toxicological question of the difference between ptomaines and vegetable alkaloids, as the hydrochloride of the cadaver-alkaloids is not decomposed by sodium bicarbonate. The ptomaine then remains in solution and the vegetable alkaloid is extracted in the usual way.

In conclusion, let me say that, whether we regard its possible influence on the theories of pathology and physiology, or its importance as a connecting link between abstract and physiological chemistry, the many-sided subject of the ptomaines is one promising an interesting and useful future.

Sincerely yours,

R. F. R.

BERLIN, June 24th.

### Extracts from British and Foreign Journals.

Unless otherwise stated the translations are made specially for this Journal.

#### **A New Discourse on a Stale Subject.**—

It may be that the truly epochal events in the world's history take place quietly, unnoticed by contemporaries, and only brought to their merited prominence by the discerning hand of later historians. We believe that there is before us an illustration of this. In the domestic history of man we see at one end two forked sticks supporting a pole; at the other the porcelain basin, traps, toilet paper, and all the other Sybaritic appliances of a modern closet. Standing half-way between is the heretofore unknown figure of Sir John Harington, who, in 1596, gave the world the earliest description of a water-closet, in a small pamphlet entitled "A New Discourse upon a Stale Subject." We are indebted to our ever-enterprising contemporary, *The Sanitary Engineer*, for a republication of the important document. Sir John wrote in a rude age, but the sensibilities of the people had not then been materialized and deadened by modern science, which now discusses with equal freedom the arrangements of a water-closet and the adulterations in candy. Sir John, therefore, introduces his subject in a periphrastic and half-apologetic manner. He remarks: "For when I have found, not only in my own poor confused cottage, but even in the goodliest and stateliest palaces of this realm, notwithstanding all our provisions of vaults, of sluices, of grates, of pains of poor folks in sweeping and scouring, yet still this same whoreson, saucy stink, though he were commanded on pain of death not to come within the gates, yet would spite of our noses, even when we would gladliest have spared his company, press to the fair ladies chambers;

I began to conceive such a malice against all the race of him, that I vowed to be at deadly feud with them, till I had brought some of the chiefest of them to utter confusion ; and conferring some principles of philosophy I had read, and some conveyances of architecture I had seen, with some devices of others I had heard, and some practices of mine own I had paid for, I found out at last this way that is after-described, and a marvellous easy and cheap way it is ; and I dare speak it upon my credit, not without good experience, that though it be neither far-fetched nor dear-bought, yet it is good for ladies.”

Having thus given a brief review of reasons and effects, Sir John describes in a vivid and realistic style the state of the closets of that period, and the methods which had so far been employed to avoid the malodorous results of defective sewage. It is interesting to note that our author is moved entirely by æsthetic feelings to gain the object which he seeks. There is no word regarding disease, but only of stenches and their unpleasantness. After many trials Sir John devised a water-closet, very much in principle like the modern ones. A tank of water above, a pan, a stop-cock, etc., are among the features of his invention, which is illustrated with some mediæval cuts. Whether his device became widely adopted historians do not say. These learned gentlemen tell us much of kings and battles, and but very little of the things that really occupied the thoughts and time of the people. But at any rate, we have Sir John Harrington's invention at the present perfected and adopted to an extent no doubt far beyond the dreams of the philosophical student of the “Stale Subject.” And certainly some credit should be given to a man who was the first apostle of sweetness, if not of light.—*N. Y. Record.*

### **Functions of the Membranes in Labor.**—

In a paper read before the Chicago Gynæcological Society, and published in the *Chicago Med. Journal and Examiner* for March 1885, Dr. H. T. Byford advocates a departure from the methods now taught, in the preservation of the membranes from rupture until they dilate, or aid in dilating, the vulva, as they are some-

times observed to do when they are unusually tough and the child is born with a "caul."

According to the present obstetric teaching and practice, as he understands them, the patient in labor is encouraged to go about the room until near the end of the first stage, thus, whether purposely or not, stimulating the uterus to contraction, and adding gravitation to the other forces that bear upon the membranes in the cervix. This practice, with subsequent pulling at the os with the finger, or pressure upon the abdomen whenever the pains lag a little, or both, often has for its effect the discharge of the amniotic fluid at, or near the end of, the first stage. If, however, pursuing an opposite course, the patient is put to bed upon her side as soon as, or soon after, the os commences to dilate; and if the pains are more severe than can be easily borne (as they are apt to be in highly civilized communities), an opiate, or other anodyne, is given to keep her comfortable, the presenting bag will be relieved of the weight of the abdominal contents, and saved from the more intense and frequent action of expulsive powers that accompanies an erect or semi-erect position.

After the os is widely dilated, and the membranes receive but little support from the cervix, they will be less liable to rupture if we put the patient upon her back during uterine action. The head will be better able to form a ball valve, and thus take part of the pressure from the presenting pouch, viz., as much as is required to overcome the elasticity of the ring of the cervix against which the descending head impinges. Now, after the os is widely dilated, when the resistance to the descent of the head is small, and the consequent strain upon the protruding membranes great, a change occurs which invalidates the reasoning by which some of the German authors would make their rupture, or the bringing of labor to a stand-still inevitable at or near the complete opening up of the uterine neck. The membranes, being loosened from the lower segment of the contracting uterus, are pushed down through the dilated cervix along with the head, instead of being merely stretched; they come in contact with the undilated vagina and are supported by it; and as the whole

parturient canal is converted into one cavity, the head follows the bag of waters down to the vulva, just as it followed it down to the external os, aiding in the dilatation, and sharing the pressure from behind. The second stage of labor becomes a kind of repetition of the first, the dilatation of the vagina and vulva being an analogue of that of the cervix and external os.

The membranes, with such management, are subjected to no more strain during the second stage of labor than they are under the prevalent mode of treatment during the first stage. In fact, the pressure upon the membranes under the ordinary start-on-the-run management is not usually sufficient to rupture them as early as is commonly supposed. In Dr. Byford's experience, they have either ruptured at or near the beginning of labor or else persisted after the os has been dilated. Students are taught to rupture at the end of first stage; and nearly all the physicians that he has consulted usually find it necessary to do the same. Indeed, recent graduates are apt to betray a thrill of pride at the recital of the number of times they have successfully performed this hair-pin obstetric operation.

When the membranes, he goes on to say, are ruptured at the end of the first stage, there results, after a temporary rest, a rapid and very great change in the character of the labor, but when they are preserved from rupture it is impossible to tell, without the finger in the vagina, when the first stage ends and the second begins. The torment that belongs to the stretching of the cervix subsides, and the labor gradually assumes a straining character, but only at the last moment, after the vulva is dilated to half or two-thirds of the size necessary for the exit of the head, is that severe suffering felt, of which primiparæ are otherwise wont to complain as soon as the head commences to bulge the perineum, or even after. The vagina is filled with a tumor so smooth and soft that its presence cannot be felt by the patient at any one point, so elastic that a light finger touch indents it, and yet the whole power of almost every uterine muscular fibre bears efficiently upon it. It is strange, he thinks, that obstetric science can teach the deliberate breaking up of this simple process of nature and the substituting of an unnatural

and artificial one, by which nearly all of the fibres of the lower half of the uterus operate only to contuse its own structure against the bare parts of the foetus without materially aiding in its descent, while the fibres of the fundus jam the hard, rough, inelastic and comparatively unyielding head down through the vagina against the perineal centre, bulging and stretching the perineum, according to Lusk, from "four to five inches in its antro-posterior direction," and all of this without any provision for a gradual dilation of the vulva, or of making its axis, before delivery of the head, correspond with the axis of the pelvis.

After speaking of the mechanism of dilatation of the perineum and vulva, by means of the membranes, he gives the following other reasons for keeping the membranes intact: Malposition of the head in the pelvis can more often be determined before rupture, and be corrected with greater facility. The body of the child cannot easily be grasped by irregular or tonic contraction of the uterus, as it occasionally is after rupture, when the parts of the child impinge upon the interior of the uterus—a condition of affairs which, when present in only a slight form, sometimes renders impossible the rotation of the occiput forward without disastrous twisting of the child's neck. The cord is much less liable to prolapse, and, if prolapsed, can be more easily made to slip back into the uterus.

He then concludes as follows: After having ruptured them too soon in a number of instances, I now wait until the head threatens to come through with the membranes intact, and, in order to keep them so until then, I advise my strong patients not to bear down much, or else give a little chloroform with each pain. We can usually, by thus diminishing the pressure, delay rupture long enough for the head to be delivered with or between the succeeding pain or two. The uterus not having been long in direct contact with the foetus, the least possible injury will occur to each; the vagina will have suffered neither from dragging down nor friction, nor will the hemorrhoidal circulation be long interfered with. But above all, the perineum will have been taken care of, and Goodell's riddle of the sphinx be solved. Whenever the membranes rupture before their office of dilating the vagina or

vulva is completed, a strong or covered rubber-bag may be introduced and then inflated with water or air, until it fills the lower unoccupied part of the vagina, so as to be made to dilate the vulva, during pains, somewhat after the manner of the membranes themselves. When a rubber-bag is not at hand, the vulva can be partly dilated by two or three fingers placed in the vagina and pressed backwards gently, but firmly, with each pain, and the capping of the head by a membranous perineum, wherein lies the chief danger to its integrity, be prevented.—*Gaillard's*.

**Treatment of Cholera during the Algid Period.**—Doctor Georges Rigoletti attributes the principal symptoms of the algid period of cholera, such as lowering of the temperature of the exterior of the body, cyanosis, change of countenance, inextinguishable thirst, difficulty of respiration, epigastric constriction, hiccough, vomiting, muscular cramp, prostration, general collapse, and paralysis of the heart, to a lack of the normal proportion of water in the blood. Two indications correspond with the symptomatology:—

1. To restore to the tissues their normal water, and to the blood its normal serum, in order that it may perform its functions.

2. To excite the nervous force and to stimulate the heart. To fulfil these regulations Dr. Rigoletti proposes the hot bath, containing ammonia and wood ashes.

The bath is prepared with water of a temperature ranging from 100.4° F. to 104° F.; about one quart of aqua ammonia and a sufficient quantity of wood ashes. The duration of the bath is from fifteen to twenty-five minutes, and it may be renewed in the same day, and for many days in succession, according to the case. To avoid the ammoniacal vapors, the patient is so covered as to prevent their reaching the head. The patient, on being removed from the bath, is covered with warm blankets, which favor and maintain reaction. Frictions with camphorated alcohol are also to be practised, and aromatic infusion of chamomile and spirits are to be administered. If the reaction comes on too violently, it is to be moderated by

ordinary measures. The efficacy of the bath is more prompt when the algid state is least advanced. The method was used in 1884 with much success in the epidemic at Naples, and the official report as to its value is as follows :

1. The hot alkaline bath administered at the beginning of the algid period stimulates the peripheral circulation and increases the power of reaction.

2. The nervous forces are strengthened ; the patient is so much relieved that many times during the day he requests the bath ; the constriction of the epigastrium diminishes and disappears.

3. The pulse, often imperceptible, is gradually strengthened ; the features become more natural, and the face even sometimes becomes flushed. Anuria almost always ceases in the bath.

4. Diarrhoea continues, but the vomiting and hiccough disappear with the administration of the bath.

5. The ammoniacal vapors excite cough and interfere with respiration, and for this reason it is necessary to protect the patient from them. However, the effect of the vapors is beneficial in that they increase the power of the voice, and render it less rough and more intelligible. In conclusion, the hot alkaline bath is a powerful therapeutic agent in the algid period of cholera, and its effects are most constant.

Dr. Rigoletti concludes his paper by stating that reaction, under treatment with the bath, is always *prompt*, occurring within twenty-five minutes ; *complete*, as shown by the disappearance of all algid symptoms, and *constant*, having never failed in twenty-three cases in which the algid condition was treated by its use. He considers it the remedy, *par excellence*, for the period of the disease, and much superior to the intravenous injections of salt water proposed by Dr. Hayem and to the subcutaneous alkaline injections of hot water suggested by Prof. Cantani.—*Journal de Médecine de Paris*, May 10, 1885.

**Tuberculosis.**—A very striking example of the possibility of the transmissibility of tuberculosis from man to animals lately occurred at a farm at Charenton, which is situated just

outside Paris. One of the farm servants who had charge of the poultry-yard was phthisical, and in coughing used to expectorate a quantity of sputa, which the fowls were observed to swallow. In a few weeks, the owner of the farm having remarked that the fowls died in rapid succession, took one of the latter to the veterinary school at Alfort to ascertain the cause of this extraordinary mortality among his poultry. M. Nocard, one of the professors of the veterinary school, examined the fowl and found that the lungs and liver were infested with tubercles about the size of a pea, and of a yellowish gray color. Numbers of bacilli were also found in the microscopic preparations. The fowls were killed and the poultry-yard disinfected, which a less scrupulous farmer would not have done.

—In the fourth supplement to the “Transactions” of the Sei-I-Kwai, Mr. K. Takaki, F.R.C.S., Director-General of the Imperial Japanese Navy, contributes a paper on the cause and prevention of *Kak'ke*, or beri-beri. In the year 1883 a very large number of cases occurred amongst the men in the ships of the imperial navy, about a fourth of all the men employed having been attacked, and on board one ship, in a single voyage, out of 278 men 161 were attacked and 25 died. A searching enquiry into the possible causes of the disease led to the belief that it was mainly due to a deficiency in nitrogenous articles of diet and excess of the carbo-hydrates; the daily average of the sailors being in the proportion of one part of nitrogen to twenty-eight of carbon, instead of one to about fifteen. In order to test the correctness of this view a second ship was fitted out and sent exactly the same trip as had been taken by the former vessel when the outbreak took place, but the diet was so regulated that the proportion of nitrogen to carbon taken by each sailor was one to seventeen. On this voyage four cadets and ten men were attacked by the disease, none of the cases, however, proving fatal. It appeared that the four cadets had been unable to take their weekly allowance of one pound of condensed milk, whilst eight out of the ten men had not been able to take their allowance of meat in the same

way as their companions, so that the occurrence of these cases served to confirm the view that the disease was due to a defective diet. In the year 1884 these views were carried into effect, as far as possible, with the result that the percentage of cases fell from 25 to 13.—*London Medical Times*.

**Something New under the Sun—Interna Spina-Bifida.**—Dr. Thomas was consulted by a married lady, aged 28, two years married, but sterile. She complained of nothing but pain in sacral region, and sense of weight. On examination he found a sac filled with fluid, occupying the cavity of the sacrum, and pushing the rectum aside slightly, but in no way occasioning serious inconvenience. He believed the failure to conceive was due, not to the pressure of this tumor but to a congenital sharp anteflexion, and advised non-interference. The case stumped the doctor—he didn't know what to make of it—though he examined the case repeatedly, at intervals, for two years, when he lost sight of it. Some time afterwards he was consulted by a beautiful girl, 19 years of age, who appeared to be perfectly healthy, but who suffered from dysmenorrhœa. She was engaged to be married and she and her mother were anxious to have any impediment removed that might be in the way, and hence the consultation. Dr. Thomas found a sac filled with fluid, situated in the curvature of the sacrum, and impinging on the vaginal canal to such an extent as to almost completely occlude it, and this, the doctor thought, was the cause of her dysmenorrhœa. He strongly advised non-interference, stating that in view of the obscurity of the case radical measures were not justified. Mother and daughter insisted, and finally the doctor consented to a compromise—he would aspirate the sac. He did so with the smallest-sized Dieulafoy's needle, drawing off eight ounces of perfectly limpid non-albuminous fluid, which was submitted to Dr. Garrigues for examination. Dr. Garrigues declined to give an opinion of the nature or source of the fluid. The effect of this operation was alarming; the girl was thrown into violent fever with headache, which lasted several days. This was attributed

to the "thief in the community," malaria, and treated with quinine and morphia hypodermically. Some six months afterwards, the patient and her mother called again: the sac had refilled, and they renewed their importunities for an operation. Dr. Thomas was strongly impressed with the impropriety of any operation, especially in view of what has just been related, and was possessed, he says, of a strange feeling of dread and fear. However, he yielded. He would open the sac, and establish drainage. With proper assistance, patient in lithotomy position and anæsthetized, Dr. Thomas made an incision into the sac and stitched the edges to the vaginal opening. There was discharged about half a pint of the same clear fluid, resembling hysterical urine. In five hours, at 5 p.m., she was seen by Dr. DuBois, one of the assistants; severe headache and marked tendency to hysteria. In the morning, headache more severe, pulse 110, temperature 102. In the evening, symptoms same, with a peculiarly wild and maniacal expression. Still the doctor did not suspect the real nature of the case. Next morning all symptoms were favorable, but in the afternoon the physician was summoned in haste to see her. Found her in a condition bordering on hysterical mania, with a pulse of 120 and temperature 104, with strong tendency to opisthotonos, and showing marked signs of incipient tetanus. "Now," says the doctor, "there suddenly flashed across my mind the full recognition of the case; an exactly similar one, which had occurred to Dr. Emmet in the Woman's Hospital, came back to my memory, from which, until now, it had been entirely effaced; and, as if a curtain had been lifted, I saw clearly what had, until this moment, been so obscure. I had opened a sac formed by the meninges of the cord, which had projected through an imperfection in the sacrum, into the pelvic cavity. The membranes of brain and cord were deprived of the rachidian fluid, and the consequences were before me! I at once collected my assistants and anæsthetized the patient with chloroform, and sewed up the opening in the sac. \* \* \* \* Whether from chloroform narcosis or not I cannot say, but for some hours after this the patient markedly improved, and I had great hopes that I

had retraced my unfortunate steps in time ; but about twelve hours after the closure of the sac the heart suddenly failed, opisthotonos occurred, the patient shrieked from severity of her cephalalgia—and died !”

In the conclusion of this most interesting record, Dr. Thomas says :

“ Where a cyst is found in the pelvis, behind the rectum, filling the hollow of the sacrum, apparently attached to that bone, let the diagnostician carefully exclude the possibility of its being spina-bifida before interfering with it.

2. “ If it be decided to interfere with such a tumor, let a small portion of the fluid be first drawn by a hypodermic needle, and if this be found to be a limpid, non-albuminous fluid, let the probabilities of the sac being connected with the meninges of the cord receive due consideration, and guard against further interference.”—*American Medical Digest.*

**Episiotomy in the Iparæ.**—We are in receipt of a pamphlet, a reprint from the *Amer. Jour. of Obstetrics*, Vol. XVII, No. 3, 1885, by W. P. Manton, M.D. (Harvard), Detroit. It is entitled, “ A Plea for Episiotomy.” It seeks to show that episiotomy should be more frequently resorted to than it is, and adduces numerous statistics to support the proposition. He says it is particularly valuable in iparæ, and intimates that if iparæ were more generally accorded the benefits of episiotomy, the occasions for perineorrhaphy would be materially diminished. Episiotomy is, therefore, something which should become immensely popular with iparæ. Don't know what episiotomy on the ipara is ? Dr. Manton tells you in his pamphlet that it consists in making an incision with a probe-pointed bistoury, or scissors (he prefers the knife), on one or both sides of the frenulum, about three cm. above its middle. Iparæ is, we suppose, gynæcological for primiparæ. The ingenuity of the gynæcologist in the direction of word-making is really something wonderful. He has knocked the ophthalmologist completely out, and the ophthalmologist is not to be sneezed at by any means.—*Ed. Medical Age.*

**The Use and Abuse of the Tampon in Abortion.**—The tampon as a means of arresting hæmorrhage from the cavities of the body or from wounds has been known to the profession for many years. It seems a very natural thing, when blood is escaping with dangerous rapidity, to apply a plug of some sort to stop the leak. There are some things to be guarded against, however. That the bleeding is actually arrested, and not merely diverted into another channel, is of primary importance. Again, there are conditions in which the plug may do mischief. As applied to uterine hæmorrhages, these two elementary principles are so well known that no one will question the correctness of either. A woman with the vagina firmly plugged may bleed to death into the cavity of the uterus. A tampon allowed to remain too long may do harm in various ways. A tampon injudiciously applied may precipitate the catastrophe it was intended to avert. Of this injudicious application of the tampon in cases of threatened abortion it is the purpose of this paper to treat.

Dr. Keene then quotes the views of Leishman, Playfair, Tyler Smith, Cazeaux, Shröder, Lusk and others and says: Now, out of this mass of authority, sometimes conflicting, but generally unanimous, what deductions are to be drawn? That the tampon is to be used as a last resort, and only where the hæmorrhage is dangerous or the abortion clearly inevitable. We have, moreover, the observation of so experienced an obstetrician as Shröder, that the hæmorrhage of abortion is seldom dangerous and scarcely ever fatal—a view which Lusk seems to share. Of course, in their hospital experience, a physician is always at hand to meet any emergency, while in private practice, and especially in the country, another condition of things prevails. Yet it seems that enough has been said to indicate plainly that the routine practice of plugging, in threatened abortion with but slight hæmorrhage, merely as a precautionary proceeding, has no countenance from the authorities.

Besides the natural bias of the physician's mental makeup—his individual personal equation—his views will vary as his

experience has been large or small. To a beginner, the loss of a slight amount of blood from the uterus of a pregnant woman is fraught with direful forebodings. As his experience widens, hæmorrhage will become dangerous less frequently, abortion will take its place under the inevitable class with much less facility, and the tampon will be employed only to fulfill its two legitimate indications.

The young practitioner is not the only offender in the over-free use of the tampon. His older brother may well look to the well-worn grooves in which his practice moves more or less smoothly to discover whether he, too, is not a devotee of the tenet that the foetus has no rights which the physician is bound to respect. The tampon is legitimately employed only when for good and sufficient reasons it is necessary to terminate gestation.—*Dr. J. W. Keene in New York Med. Journal.*

**Gross on Gonorrhœa.**—In the early treatment of gonorrhœa, Prof. Gross condemns the use of injections. His plan is as follows:—If possible, put the patient to bed; give him at the outset a purge, by administering Epsom and Rochelle salts, each  $\bar{3}$  ij, in lemon syrup. Allow no meat or any stimulating articles of diet, etc. Malt liquors do more harm than alcohol, so interdict both. No tea or coffee, but give him milk, eggs and some oysters, etc. Three times daily he is to hold the penis in a cup of hot water—quite hot. Keep the organ there for five minutes at a time, then wipe it gently each time.

The internal treatment will be by the “antimonial and saline mixture.” **R.** Antimonii et potassii tartrat., gr. 1-10; magnesiæ sulphatis,  $\bar{3}$  ij.; morphiæ sulphatis, gr. 1-16; tinct. aconiti radicis, gtt. j.; liquor potass. citrat., f  $\bar{3}$  ss.; olei limonis, gtt. ss.; elixir. simplicis, f.  $\bar{3}$  ss. **M.** **Sig.**—Ter die.

By this treatment the urine will be rendered bland and unirritating. Should the urine persist in “scalding,” then add to the above prescription gtt. x tinct. cannabis. indicæ. To prevent or cure chordee, order at night a suppository of: **R.** Extract. opii; camphoræ,  $\bar{aa}$  gr. iij.

In the course of four or five days the discharge from the

urethra will look more like laudable pus ; then order an injection :  $\mathcal{R}$ . Hydrargyri chloridi corrosivi, gr. ij. ; aquæ destillat.,  $\mathcal{O}$  j. Sig.—With a syringe that holds an ounce, inject into the urethra—having first “ flushed ” the canal several times by voiding urine—and retain the fluid for five minutes..

Internally, a useful combination is that used at the out-door department at the hospital, and consisting of :  $\mathcal{R}$ . Cubebæ,  $\bar{5}$  ij. ; alum pulv.,  $\bar{5}$  j. M. Sig.—Of this take a heaping teaspoonful in a tumbler of water ter die ; the dose to be increased.

Should the discharge per urethram still persist, use an injection of :  $\mathcal{R}$ . Liquor. plumbi subacetatis, f.  $\bar{5}$  j. ; aquæ, f.  $\bar{5}$  x. M. Or :  $\mathcal{R}$ . Plumbi acetatis, gr. ij. ; zinci sulphat., gr. iij. ; aquæ, f.  $\bar{5}$  j. M. Or :  $\mathcal{R}$ . Acidi tannici, gr. ij. ; aquæ, f.  $\bar{5}$  j. M.—*Coll. and Clin. Record.*

### **Syphilitic Phthisis. Does it exist?—**Dr.

FREDERICK S. SHATTUCK, of Boston, in his report on Progress in Medicine, published in the *Boston Med. and Surg. Jour.*, March 5, 1885, quotes from Hiller and says:—It has long been known that syphilis may attack the lungs ; but a vast deal more has been heard of pulmonary syphilis since the question was broached whether the direct cause of the characteristic lesion of phthisis—caseation and cavity formation—may not sometimes be the venereal virus : that is to say, whether there is not also a syphilitic phthisis.

After a careful critical study of all the literature of the subject and also of three cases under his own observation, Hiller concludes that there is, as yet, no clear scientific proof of the existence of such an affection. In the reported cases of syphilitic phthisis sufficient evidence is lacking either of the destructive and ulcerating nature of the pulmonary process or of the syphilitic origin of the same. Those cases in which the diagnosis was apparently confirmed by the autopsy were really simply combinations of syphilitic with either phthisical or bronchiectatic lesions.

The anatomical changes in the lung chargeable to syphilis are cicatrices, connective-tissue growth, gummata, and chronic

induration of the pulmonary tissue in the form of peri-bronchial growths, nodular formations, and diffuse lobular condensation, which generally start from the bronchus of the part (diffuse syphilitic infiltration).

The diagnosis of these changes during life may be made with a certain degree of probability at times, but can never be made with certainty. The shortness of breath, cough, scanty and sometimes bloody expectoration, and other signs, rational as well as physical, are so wanting in characteristic peculiarities that the syphilitic nature of the affection cannot be made out from them. The diagnosis is to be based rather on the history of the case, the presence of well-known symptoms of general syphilitic infection, and laryngoscopic examination, which will reveal in nearly all cases of pulmonary syphilis old lesions of the upper air-passages.

### **Irrigation of the Stomach in Ileus.—**

Kussmaul has introduced a new method in the treatment of intestinal obstruction and reports four cases in which success followed the above-indicated simple practice after all other measures, such as the opium-treatment and the application of rectal injections, had proven of no avail. The favorable action of the washing out of the stomach is due to the removal of the fluid, when it is withdrawn, of large quantities of fecal matter. Thus the intestine is unloaded, the peristaltic action is quieted, nausea and vomiting arrested and the cleansed stomach rendered capable to retain nourishment. A large, soft stomach-tube is inserted and copious quantities of water so introduced. In one of Kussmaul's cases the obstruction was relieved by a single irrigation, that brought away five quarts of intestinal contents. In another case complete relief was secured after irrigation twice a day for 23 consecutive days.

The observation of the foregoing cases demonstrates that the irrigations may be palliative in all cases, and curative in those that present no insurmountable occlusion. The palliative effects consist in the relief of the singultus and the feculent vomiting. To this end the method is a rational one and deserves preference

to the usual mode of giving opiates, ice, etc. The irrigation not only cleans the stomach but also the upper intestine. It appears that in such conditions of obstruction the pylorus relaxes and the water introduced passes readily into the duodenum. The directly curative effects Kussmaul explains as follows: (1) The removal of the stagnating intestinal contents relieves the distension of the upper sections of the intestine; the pressure within the abdominal cavity is thus materially reduced, and more room is afforded. (2) Thus the peristaltic action above the obstruction, that was violent and irregular, becomes normal and quiet. (3) The restoration of a normal peristaltic movement may accomplish relief in cases of twist or intussusception, *i.e.*, cases in which the occlusion is not absolute.

Senator adds that when the stomach and the upper small intestine is much distended by irritating fluid and gaseous contents, the peristaltic action becomes paralyzed and the intestine relaxed. The removal of the fluid and gaseous contents, however, restores the normal conditions and normal peristaltic motion in the relieved intestine follows.—*Weekly Med. Review.*

**A Method of Averting Syncope.**—It is well that we should always be prepared to avert what may or may not prove to be a serious, or even fatal, syncope. In persons whose hearts are weak, fainting or syncope is not at all uncommon, and may be produced by very slight causes. Hence we reproduce the concluding paragraph from an article on the subject by Dr. Wm. J. Notely, in the *Lancet*, March 14, 1885.

“Now, in all cases where the syncope is not complete, and where the heart continues to act, though feebly, measures are taken to restore the patient by adopting such means as are calculated to strengthen the action of the heart and facilitate the flow of blood to the brain. In many cases a person accustomed to faint from slight causes will be able to avert the syncope by adopting such means, and it is for this purpose that I wish to draw attention to the efficacy of heat applied to the head. In a person with a weak heart, syncope may be produced by simply sitting with the feet in hot water, and, in like manner, it may

be averted by application of heat to the head. Any-one may convince himself of this by first producing faintness in himself artificially. This may easily be done by getting into a bath of 110° F. In a few minutes he will begin to feel faint. Let him then plunge the whole of his head except the nose and mouth beneath the surface of the water, and in less time than it has taken to bring on the faintness all the disagreeable sensations will cease, and he will now be able to continue in the bath, perhaps for half an hour longer, without any inconvenience. From this it would appear that the application of heat to the head is a measure of some value in averting a threatened attack of syncope.—*Med. and Surg. Rep.*, April 11, 1885.

**Carbolic Acid in Indigestion.**—Dr. Edward Berdoe writes as follows to the *Brit. Med. Journal*:—“ I have lately treated several cases of indigestion with carbolic acid, and the results in each instance have been so fortunate that I am anxious to add the results of my experience. I have found it most useful in that form of dyspepsia known as fermentative, accompanied by constant sour rising and eructations of gas, with pain after meals, and discomfort, even after drinking milk or cocoa. My attention was first directed to it by Dr. Fenwick, who gave the glycerine of carbolic acid (1 part of crystallized carbolic acid to 4 parts of glycerine). The dose is from five to ten minims in mint-water, or other convenient vehicle. As it mixes well, I think it a more safe and elegant form than a solution of the acid in water only. When there is much pain of the stomach after food, I have found it useful to add five or six minims of the liquor opii sedativus to each dose; and when there is want of tone in the seat of digestion, and bad appetite, five or ten minims of the tincture of nux vomica will often be found serviceable, I have found these remedies also very valuable in the above combination in cases of pyrosis, where, I think, the sedative influence of the carbolic acid on the mucous membrane is far more useful than the bismuth one usually given in such cases. It is an interesting subject of inquiry whether the carbolic acid acts by arresting fermentative changes in the stomach, or by its well known anæsthetic influence on mucous

membranes. I have long given one-grain pills of this remedy in cases of vomiting from various causes, and have rarely found it fail to arrest it. In some of these cases there was no fermentative condition of the contents of the stomach; some of them were cases of reflex vomiting; yet all were, with few exceptions, greatly benefited. It would be desirable that the subject should be still further discussed by those who have had experience of the drug."

### **Vinegar in Diarrhoea and Dysentery.**—

Premising that Dr. John H. Brinton used to recommend, fifteen years ago, injections of cider vinegar in gleet, we note the following practical contribution from Dr. Amos Sawyer to the *St. Louis Medical and Surgical Journal*, January, 1885: "About a quarter of a century ago, when giving me some good advice for a young practitioner to follow, the late Dr. B. F. Edwards, of St. Louis, Mo., whose accuracy in the measurement of the action of remedies, truth in statement, and justice toward the members of the profession, made him a shining light in the early history of our State, among other things, says:— 'Never make fun of an old woman's remedy, for not only will you give offense and thereby injure your practice to the extent of her influence, but you may throw away what would have proved upon trial to be a valuable adjunct in your practice.' He then cited this case to illustrate the importance of his injunction: 'In 1839, while practicing in Madison county, Ill., I was induced by the representations of *an old woman* to make the trial, in dysentery and diarrhoea, of tablespoonful-doses of *pure cider vinegar*, with the addition of sufficient salt to be noticeable, and it acted so charmingly that I have never used anything else.' He was prescribing it in 1870, making it a period of forty years."—*Medical and Surgical Reporter*.

**Chloral Hydrate for Chordee.**—In the *Med. Age*, Dr. Morris C. L. Kitchen says that for two years he has been using chloral hydrate, gr. x., potas. bromid., gr. v-x to aq. dist. ʒ j. as an injection for chordee. and has *never* known it to fail of affording perfect relief. He usually adds morph. sulph., gr. ij. to the ʒ j.

CANADA

# Medical and Surgical Journal.

MONTREAL, JULY, 1885.

## THE SMALLPOX.

In the month of April last we made a few remarks upon the outbreak of smallpox in this city. The disease was then confined to a very few localities, and the Health authorities were doing all in their power to prevent its extension. We were at that time justified in expressing the hope that their efforts would be successful. Unfortunately, this has not been the case. It has rapidly spread until up to the present time at least 100 cases are known to have occurred, and 61 deaths. The history of the outbreak is of a most lamentable kind. It will be remembered that two imported cases found their way to Montreal from Chicago. One went to the Hotel-Dieu, the other was taken to his own home. In the latter case, although the disease was communicated to others in the same house they were all well looked after, and as far as that case was concerned it was stamped out. The actual epidemic, therefore, is entirely traceable to the hospital case. Where a single case has to be dealt with, there ought to be no sort of difficulty in taking such instant, careful, precautionary measures as would ensure the safety of a community. The strictest isolation in the sense in which that is understood by every educated medical man, and the destruction of all fomites, will, in careful hands, assuredly give the desired result. There is good reason to believe that these measures were not adopted in the Hotel-Dieu, but that access to the patient was freely allowed to a large number of persons. Some of these took the smallpox and several deaths occurred. Patients even in distant wards sickened, and were conveyed to

the Civic Hospital Finally, it was decided to close the hospital, and all who could be, were discharged. This was a most unwise proceeding. Several of them developed smallpox, and have aided in establishing foci of the disease in various quarters of the city—the result, as stated above, being that we are now suffering all the discredit of a city afflicted with the dreaded scourge. Compare this with other cities. In Boston, *e. g.*, in the four years from 1870 to 1873 there were 1100 deaths from smallpox; in the eleven years since 1874 only 26. A correspondent, writing recently from Boston, says:—"We have had this spring about half-a-dozen cases of this disease, apparently developed from three or four different sources." *There*, however, each case as it occurred was promptly removed to the special hospital, and it *never got a foothold*.

What was the reason for this absence of all sanitary precautions in the original case? It has been stated, and we see no other possible explanation of it, that it was looked upon as chicken-pox and that its real nature was only admitted upon the occurrence of undoubted smallpox of severe type amongst those who had been in contact with the patient. We can only say, however, that seeing that the physician who first saw the man pronounced it varioloid, it would certainly have been wiser on the part of the hospital authorities to have acted accordingly, even supposing the former to have been mistaken.

In connection with this matter it is very pertinent to enquire what regulations are in force at the office of the Board of Health. The day after the affected man arrived in Montreal, the physician who had procured his admission into hospital made a formal report to the Sanitary Inspector that a case of smallpox was known to be in the city (stating where he was). Of so little consequence, however, did this statement appear to be that, *weeks afterwards*, neither the Chairman nor the medical Health officer were aware of its occurrence, nor were any enquiries instituted or suggestions made with reference to preventing its spread in the vicinity. Surely such things should not be. It is devoutly to be hoped that, under the new *regime* at the Health Office, a repetition of such laxity will be impossible.

As many persons have a strong prejudice against allowing members of their families to be taken to the Civic Hospital, we may quote the following remarks from the Boston letter of the Philadelphia *Medical Times* :—

“The hospital at West Roxbury, far from being a pest-house in appearance, more nearly resembles an artistic suburban school-house. Here the policy of the city physician has been to give the patients, one and all, the most luxurious treatment at his command. The patients are given anything (in reason) that they ask for, and doubtless many of the poorer classes receive more dainties of food and drink than they ever saw before in their lives. But the desired effect has been produced. The quality of the accommodations and the treatment are pretty generally known among the lower classes of the city, and there is now no reluctance shown by any one who is taken with the disease to go there for treatment. Ignorance, prejudice, and fear, which formerly led to the concealment of the disease and thus imperilled a whole community, are now disarmed, and prompt information, removal, and isolation have borne good fruit in the stamping out of an epidemic which might have attained formidable proportions.”

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### THE INTERNATIONAL MEDICAL CONGRESS.

The new Congress Committee of the American Medical Association met in Chicago on the 24th ult. Acting on legal advice, the original committee of seven decided to go to Chicago and act with the newly-appointed members. Several of the ablest lawyers in the country gave opinions to the effect that the American Medical Association possessed full control and power in the matter. The upshot of the meeting is a lively row. The chief change made in the sections was the removal of all new-coders from office, thereby displacing, among others, the chairmen of sections on Diseases of Children and on Laryngology—Drs. Jacobi and Lefferts of New York. Dr. H. I. Bowditch of Boston, on account of alleged new code sympathies, was also removed from the office of Vice-President of the Congress. The

membership of the Congress was limited to delegates from the American Medical Association and societies in affiliation with it. A complete change was made in the Executive Committee. Dr. Billings resigned the office of Secretary-General, and Dr. Packard of Philadelphia was nominated for the office. No sooner were the proceedings of the Chicago meeting made known than the members of the profession in the eastern cities interested in the organization met and expressed their emphatic disapproval of the action by unanimously refusing to have anything to do with the Congress under the present *regime*. We happened to be in Philadelphia on the occasion of the meeting in that city, and found that the leaders of the profession were of one mind in their determination to withdraw. Similar resolutions have been passed in Boston and Baltimore, and we may say that the majority of the men eminent in scientific medicine and surgery in the United States have decided to hold aloof from the Congress. When we ask why they take this serious step, we learn that they have, in the first place, a deep distrust of the American Medical Association as an organization which could satisfactorily carry out such an undertaking, and they have a still deeper distrust of the success of any congress where the best known scientific medical men of the country have been replaced by nominees such as Drs. Cole, Shoemaker, and others. The exclusion of the new-code men is felt to be a serious mistake, as carrying the quarrel of the American Medical Association into the International Medical Congress and refusing the fellowship of men with whom old-coders in New York are glad enough to consult. All, too, resent the insult offered to such a veteran as Henry I. Bowditch of Boston, who has devoted half a century to the advancement of the best interests of the profession in the United States.

What the result will be it is difficult to predict, but it is hard to see how a Congress can be held without such men as those who have signified their intention of resigning. It would be like a Congress in London without Paget, Lister, Jenner, Gull, Hutchinson, &c.; and we fear that when the profession in Europe hears of these dissensions, and the withdrawal of the very men

they would be most anxious to meet, many who otherwise would have come will elect to stay away.

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## REMARKABLE CASE OF PERIODICAL PARALYSIS OF THE FOUR EXTREMITIES.

On the 8th of June last, Prof. Westphal gave an account before the Berlin Society for Psychiatrics and Diseases of the Nervous System of a case of recurring paralysis of the four extremities in a boy twelve years of age. The patient was admitted into the Charité Hospital on the 15th of last March with one of these attacks, which came on suddenly the day before his admission. He first felt weakness in his right foot, and a quarter of an hour afterwards he was unable to walk or even stand. A few hours afterwards both arms were powerless. He complained of a pricking sensation in his legs. His arms were free from any disordered sensations. He was thirsty, and troubled with frequent desire to micturate. On the morning after his admission, there was complete paralysis of all four extremities without contractures. The cremaster and the skin reflexes, with the exception of the plantar, were present. The patellar reflexes were also present. There was complete loss of faradic contractions when the main nerve trunks were irritated. On the following day there was distinct reaction to both galvanism and faradism in the upper extremities, but not to faradism in the lower. The reaction to galvanism was not of the slow character, which constitutes the well-known reaction of degeneration. On the 17th of March, after his temperature suddenly went up to 39°C. (102.2°F.), he had profuse perspiration, with great thirst. This was followed by a complete disappearance of the paralytic symptoms. He remained well up to the 9th of April, when he again had complete paralysis of the four extremities, with loss of faradic reaction, which disappeared after twelve hours. Since the age of five years he has been subject to attacks of the above character, recurring every four to six weeks, and lasting from twelve to forty-eight hours. With the exception of scarlet fever, which was followed by nephritis, he was in

good health up to the time of his first paralytic seizure. Westphal acknowledged that he was unable to give a valid reason for the attacks.

In the discussion which followed, Bernhardt stated that paralytic symptoms resembling those described by Westphal at times followed intermittent fever. He also suggested the possibility of their being due to self-generated ptomaine-like substances, which acted not unlike curare, in paralyzing the motor nerve endings.

In proof of the non-malarial origin of the paralysis, Westphal mentioned the facts that the boy never suffered from intermittent fever and that his spleen and liver were normal in size, and that there had not been anæmia at any time.

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THE CANADA MEDICAL ASSOCIATION.—The annual meeting of the Canada Medical Association for 1885 was last year fixed for Winnipeg in the month of August. Some weeks ago, however, the Secretary, Dr. Stewart, was notified that, at a meeting of the profession in that city, it had been decided to request the Association to postpone its proposed visit until some future occasion. This action was reluctantly forced upon them by the present unsettled state of the country, owing to the Riel Rebellion and the absence of a number of their medical men with the military forces. The decision has been a great disappointment to many of our *confrères* in these eastern provinces, who had looked forward to availing themselves of attendance at that meeting whilst securing a pleasant summer holiday. We have also been informed that quite a number of medical men from the eastern cities of the United States had expressed their intention to be present, the growing interest in our north-western territories being one of the chief attractions. Much, however, as we may regret the decision arrived at, we have no doubt that it has not been reached without the careful consideration of all those concerned.

It may be remembered that last year, at Montreal, the gentlemen representing the town of Chatham, Ont., stated the desire of that enterprising place to receive the Association, but

were prepared to give way in favor of Winnipeg. In view of the inability of the latter to make the necessary arrangements, Chatham has again very generously come forward and renewed its invitation. This has been accepted, and we have now to announce that the annual meeting will be held at *Chatham, Ont., on the 2nd and 3rd September next.* We learn from the Secretary that several papers have already been promised, and everything bespeaks a large and successful gathering. We hope that all who can will be present and assist in making it so.

There is a matter which has been already discussed, and to which we would again draw the attention of the executive officers. It has been the custom, hitherto, for the local fraternity to entertain the entire Association. In the larger cities, where our numbers are greater, the burden of this may not be felt, but in smaller towns, with correspondingly smaller number of local members, the expense must be more than we could fairly expect them to bear. When the British Medical Association holds its meeting, there is also an annual dinner, but then every member who attends the latter pays a guinea for his ticket. We know that there is a strong feeling here that a similar rule should be adopted at our annual symposium, and would be glad to see it passed and acted upon at the Chatham and all subsequent meetings.

The following are the officers of the Association:—

*President*—Dr. Wm. Osler, Philadelphia.

*General Secretary*—Dr. James Stewart, Montreal.

*Treasurer*—Dr. Sheard, Toronto.

*Vice-Presidents*—For Ontario—Dr. Bray, Chatham; Quebec—Dr. Geo. Ross, Montreal; New Brunswick—Dr. Allison, St. John; Nova Scotia—Dr. Fraser, Windsor; Manitoba—Dr. Whiteford, Winnipeg.

*Local Secretaries*—For Ontario—Dr. Burt, Paris; Quebec—Dr. Jas. Bell, Montreal; New Brunswick—Dr. Walker, St. John; Nova Scotia—Dr. Almon, Jr., Halifax; Manitoba—Dr. Mewburn, Winnipeg.

## Medical Items.

**MONTREAL DISPENSARY.**—At a recent meeting of the Governors of the Montreal Dispensary, Dr. T. Johnson Alloway was elected gynæcologist to that institution, and Drs. R. J. B. Howard and J. A. Macdonald attending physicians.

**MEDICAL HEALTH OFFICER.**—Dr. Laberge has been appointed Medical Health officer for the city of Montreal. A growing epidemic of smallpox will tax all the doctor's energies, whilst in a hundred other directions he has ample scope to show what can be accomplished by well-directed assiduity and energy. We shall be happy to chronicle much improvement in our sanitary department under the new head. There is room for it!

**ELECTRICAL APPARATUS.**—In a series of notices of exhibits at the recent New Orleans Exposition, the *Chicago Tribune* says: "The McIntosh Galvanic and Faradic Battery Company of this city deserve especial mention for their fine display of goods and the wonderful improvement they have made in electrical goods generally, and especially for their combined solar microscope and stereopticon. It is an instrument that every school and college in the country should have. They received first medal for fine displays of electrical goods, and first medal for their combined solar microscope and stereopticon. Dr. L. D. McIntosh, the inventor, deserves great credit for arranging and making this display, because he met in competition the electrical inventions of Europe and America, and took the first medal."

**THE BEES AND APOLLO**—Once upon a time the Busy Bees were gathering honey from a flowery field on famed Hymettus. Suddenly, one Bee was heard to buzz much more loudly than the rest of his companions, who, upon listening, heard that he had found a new process for extracting a superior Honey of remarkable medical properties. He had also at the same time invented a very ingenious way by which he could with Comparative Ease make his Buzz sound four times as loud as that of the ordinary Bee. By means of these inventions he soon disposed

of large quantities of Honey at a High Price. But one day Apollo, who was experienced in the matter of Honey and its medical properties, came that way seeking some good sample for the use of his friend Diana who was a little ill. He looked at the new preparation, which was put up in chocolate tablets and called Honeyidea: He also listened to the new Buzz. "I think," he said, finally, "that the Buzz is much more wonderful and effective than the Honey; I will take it to Diana, who is found of buzzing."

Some days later, Æsop, on hearing this story, remarked that the Moral which he would add was that the Art of Advertising a new medicinal preparation is of more importance than the Art of making It.—*Boston Med. and Surg. Jour.*

—W. R. Warner & Co. have received the first premium at the World's Exposition, New Orleans, for great uniformity and solubility for their sugar-coated pills. This is the ninth World's Fair prize which attests to their excellence.

—Some time ago, at the suggestion of Dr. James H. Burns of Toronto, *Morse's Glycerole of Celery Compound* was placed before the profession to be used instead of the more powerful drugs in the treatment of teething infants and adults suffering from nervousness, etc., etc. The after effects of opium are well known and deplored. Upon young children, in any case, the continued use of opium is very objectionable. A remedy having the necessary soothing and quieting effects of opium, followed by a tonic and nutritive action to the patient, should be invaluable to the practitioner. Such a remedy we have in *Celery Compound*, which needs only a thorough trial to demonstrate its value. The proprietor guarantees the formula to contain *no opium in any form*, and only the ingredients therein mentioned, flavored with anise. It can be given in large doses, as a tonic, to the most delicate infant, with perfect safety.