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Original Communications.

PROF. KOCH'S METHOD OF TREATING TUBERCULOSIS AS OBSERVED IN BERLIN AND LONDON.*

By Dr. J. B. McCONNELL, Professor of Pathology, University of Bishop's College, Montreal.

I arrived in Berlin on December 20th, 1890, the beginning of the holiday season, and at a time when the excitement in regard to the new treatment for tuberculosis had somewhat subsided, and most of the foreign physicians had left. But few students were in attendance at the hospitals, and the quiet which thus prevailed was an advantage to one wishing only to observe the effects of the treatment by Prof. Koch's lymph, and the best time to gain information in regard to the cases was found to be during the rounds* of the assistant physician in the early morning as he enquired into and recorded the progress of the treatment. My observations were made chiefly at the clinics of Drs. Cornet, Krause and Bergmann at the Charité and Moabit Hospitals and at the City of London Hospital for diseases of the chest, Victoria Park, and one cannot express too much gratitude for the pains taken at one and all

of these institutions to give visiting investigators the fullest information.

Most of the cases had then been under treatment from three to six weeks, and some of the temperature charts conspicuous at the head of each bed at the Charité had by being attached to one another grown to be a couple of yards and over in length, and so arranged that the progress of the temperature, pulse and respiration tracings—in different colors running along together—could be seen at a glance. I was a little surprised to note at some of the clinics in Berlin how completely the minute directions given by Prof. Koch for the use of the lymph were ignored. I saw the lymph dropped immediately into the diluting solution without any other measurement, and the same syringe used with one patient after another without re-cleansing or the application of any antiseptic to the seat of inoculation, all apparently without any penalty resulting from the nonconformity to specified rules.

One can but inadequately convey in a single paper the great amount of information which one can note down in the course of 15 days' study among several hundred cases. The details of typical results of the application of the lymph must now be so familiar to all that I will confine myself to a few notes of special features and some general

*Read before the Medico-Chirurgical Society, Montreal.

observations, and particularly in regard to tuberculosis of the respiratory organs. As the effect of the remedy is to produce a necrotic action on the living tuberculous tissue, which has to be thrown off by the system, the best results are to be seen in the tuberculous affections of the outer surfaces, or where the focus of disease has free drainage.

The marvellous results in lupus are the most striking features of the lymph treatment. At Bergmann's clinic cases were to be seen in all stages of treatment, from the first intense local reaction to the freshly formed cicatricial tissue. Two cases of lupus of the face where reaction had ceased with full doses (.1 c.c.) were considered cures. One of those, which had healed after 10 injections and had resisted a week previous to my visit, December 24th, had been again injected the day before and presented several nodules of local reaction, showing apparently that the affection had relapsed. One case, after 15 injections, and another after 14, the last being .06 c.c., were also apparently about well. Dr. DeRuyter stated that 4 or 5 cases of joint tuberculosis had showed rapid improvement under the treatment, but I did not make any special enquiry into these cases. In one case of enlarged glands at angle of jaw, sub-acute inflammation had occurred, followed by a decrease in size, but they did not regard it as proof of a cure. As complications they had observed exfoliations of the epidermis, exanthematous and pustular eruptions, even after small doses, and children had diarrhoea and bloody stools.

At Cornet's and Krause's clinic on Ziegelstrasse demonstrations were given by Dr. Friedlander. Three cases lupus, 4 joint affections and some 20 cases phthisis were being treated. One case of lupus, affecting half of cheek, lip and nose, was considered cured, and was having evaporating lead lotions applied to the face to remove the redness still remaining. She had had 17 injections, the first of .01 c.c., on November 13th, and last,

.3c.c. on December 25. No reaction occurred after 13th injection, December 10th, when .1 c.c. was given. On the 25th the dose had been increased to .3c.c. and he intended continuing at intervals of 3 or 4 days, increasing dose by .1c.c. until .6c.c. was reached. The general reaction was usually very pronounced in lupus. He began with .001c.c. and often had very strong reaction with .005c.c. The injections were given every 3rd or 4th day. No antipyretics or medicinal treatment employed. In another case treated first on the 18th December, the reaction and swelling of the face had been intense from .005c. c., given on 23rd; at this date (29th) crusts had formed and been thrown off and a second series covered the affected spots on the face. She suffered from great weakness, severe pains in limbs and back and was considered too ill to be reinjected. Although at the end of the treatment in these cases there is but little elevation of temperature, he advised against suddenly stopping the injections. One patient who had left the hospital for a week came back much reduced. He compared the action of the lymph in this respect to that of morphine or arsenic. From his remarks on this occasion I gathered the following points:—Localized tuberculosis in joints required much larger doses. He begins with .1c.c. Case No. 4 gave no reaction with a first dose of .05c.c.; required .1c.c.; injections were given over hip or deltoid. Reaction usually occurs five to six hours after; in phthisis they found that the reaction was later, may be within 12 but sometimes as late as 24 hours. It was necessary to find this out in each case, so that reaction can be secured during the day. Their experience had been that hæmoptisis was produced in many of the cases; in one where it had occurred three years previously this result followed. Of frequent occurrence also were pleuritic pains in the side affected. He advised always beginning with .001c.c. and not repeat for two days even if no reaction occurred, and then give the same dose. It is a fact somewhat generally experienced that reaction often does not

occur until after the second or third injection with the same quantity of the remedy. Patients were subjected to close observation for several days before injection. In some cases the fever which was present on admission subsided after a few days rest, in others it continued, when the treatment must be applied with great caution. When a dose of 1c.c. was reached and failed after a few times to increase reaction the treatment ceased. In some cases where this point had been reached and bacilli could not be found in the sputum they have reappeared in a week or two after, and then a dose of 15c.c. was followed by reaction. He observed that the bacilli did not stain so readily after the treatment as before.

On December 29th an interesting case of laryngeal tuberculosis was shown. The patient had been under Krause's care for several months. The tumescence in the left vocal cord was diagnosed by Virchow as being tuberculous. A cure apparently resulted with the lactic acid treatment. Five months ago he reappeared with ulceration at the same site, which again healed with lactic acid applications. Milligramme doses of lymph caused no reaction. The treatment was stopped for two weeks, when 01c. c. (on the 28th) produced reaction, thus confirming the previous diagnosis. One case of phthisis only was regarded as having been successful. Infiltrations existed in one apex only. The bacilli had disappeared after five weeks treatment, and the abnormal physical signs were gradually disappearing. The larger number of cases showed but little gain, but the treatment would be persevered with.

(December 28th). In the Charité the number of cases of every form of tuberculosis was somewhat bewildering to one having limited time at his disposal, and only points of special merit could be noted. I studied the cases chiefly in Prof. Leyden's wards, and am much indebted to Dr. Klemperer, his first assistant, who spoke good English, for the great interest he took in giving me the most important features of

each case. Microscopes, &c., were kept at hand on side tables. The method employed is known as *Gabbet's*.

Fuchsin,	1 gm.	} Stain in this (heated) two minutes.
Alcohol,	10 "	
Acid Carbolic,	5 "	
Aq. distillat,	100	

Methylene blue,	2 gm.
Acid sulphuric,	25 "
Aq. distillat,	100

(filter) Four minutes in this solution.

Tall glass jars graduated were used to collect sputa, which was when about to be examined spread out on a soup plate, the bottom of which was blackened.

(December 28th.) A case of pharyngeal and laryngeal tuberculosis, which was first treated on the 10th November—no fever on entering—had not made much progress. She had had twenty injections during the seven weeks, 1st '02, this day '09, reaction had occurred each time and does so still. Suppuration had occurred in one tonsil, the whole pharynx presented a red, swollen, spongy appearance, was expectorating over a pint a day of reddish muco purulent flaky secretion. She was steadily losing in weight.

In another case of laryngeal tuberculosis in a healthy female, where two months' ordinary treatment had failed to effect a cure, the ulcer on the inter-arytenoid fold had completely healed after 11 injections, last one '08 cc. During the treatment pharyngeal tuberculosis was brought to light evidenced by the severe inflammation which resulted, a clear line of demarcation could be seen between the healthy and affected tissues. As the reaction is not great, she was to get 1c.c. the next day, and when this dose failed to react she would be considered cured. In neither case did any stenosis result.

A case of chronic phthisis in both apices, four years duration, had been treated four weeks; first injection '002c.c. caused no reaction; same dose next day caused reaction; three days after '003 caused no reaction; in two days same dose reacted. No reac-

tion of late with 01c.c. doses. Increasing in weight. A cure was expected in this case.

A case of pharyngeal abscess, followed by disease of the atlas, reacted; had been four weeks under treatment without any improvement, but they would continue the injections for months.

A case of cervical spondylitis with hemiplyia had reacted to eight doses during four weeks.

An anæmic woman, whose parents had both died of phthisis, was injected, reaction occurred, and a patch of inflammation appeared on left cheek, having the appearance of a reacting lupus patch. The face had apparently been healthy previous to the injection. A similar case had been observed among Dr. Heron's cases in the Victoria Park Hospital, London, and Dr. Malcolm Morris mentioned to me a similar occurrence in one of his cases.

Two cases of what were classified as bronchitis, gave reaction, but no bacilli were found.

One case of leucocytosis and one of chlorosis, gave reaction and no other signs of tuberculosis.

A case of leucorrhœa having been injected, reaction followed, and after third injection cough was developed and bacilli were found in the sputum.

Frau Scholles on entering had no cough, the small amount of sputum that could be hawked up was devoid of bacilli. After the third injection the sputum increased and bacilli were found.

Rimkus, aged 31, whose mother died of consumption, had deposits in both apices. Bacilli in sputum, is a good example of delayed and prolonged reaction: 002c.c. given on December 22nd, produced reaction in 38 hours; 25th, 004c.c., reaction 36 hours after; 28th, 005c.c., reaction 15 hours after and lasted 18 hours, highest temperature 39.4; December 1st, 005c.c. reaction 23 hours after; December 4th 005, reaction 8 hours after; on 22nd 006, still produced reaction, temperature 39.2°;

on 25th 04c.c., produced reaction, temperature 41.8°; 29th 006c.c., temperature 37.2°.

Among the 50 or 60 cases of phthisis which I looked into one-half were advanced cases, having reaction but reaping but little benefit. Some felt worse and were becoming opposed to a continuation of the treatment. Fully one-half seemed to be benefited and hopes were entertained that after longer treatment good results would be obtained.

In the Moabit suburb hospital, (visited December 31st) which consists of a series of one story buildings looking in the distance like a row of tents, four of the buildings were devoted to cases receiving the Koch treatment. Better results had been obtained here generally than in the Charité probably owing to the unexcelled sanitary conditions, and superior character of the interior arrangements. Prof. Koch gave personal attention to the cases here. Interested myself here chiefly in the cases where the effect of the lymph was aided by surgical operations in the wards of Dr. Sonnenberg and obtained the following information which appeared a day or two later in the *Deutsche Medicinische Wochenschrift*.

Four cases had been operated on by Dr. Sonnenberg during the month preceding my visit, December 31st, and on that day all were free from fever, and except one case were progressing favorably. The operation was done in the space bounded above by the lower edge of the clavicle; in yards by the edge of manubrium; outside by the pectoralis minor; below by the second rib, the pectoralis major drawn down. Chloroform was the anæsthetic used. The incision is made from without inwards about 12 c. m. long and 1½ to 2 c. m. below and parallel with the lower edge of the clavicle. The pectoralis major is cut through and the opening cleared with a blunt instrument to the periosteum and intercostal muscle. All hemorrhage is checked and the parts held apart by retractors. An incision is then made through the periosteum, along lower

edge of first rib, and the periosteum separated by a levator from the front of the rib. The intercostal muscle is then divided and the periosteum separated from the back of the rib with Langenbeck's *geiss fuss*. An arched piece is then removed from the first rib and cartilage with a grooved chisel or pliers and the opening cleared to the pleura. The intercostal artery is not injured and the upper part of the rib is left. If the surfaces of the pleura are adherent an exploratory puncture is made with a hypodermic needle to find the cavity. If blood appears in the syringe try in another direction, when the cavity is entered muco-pus will be aspirated. The cavity is opened by passing the pointed thermo cautere—heated to dull red—along the course of the needle, keeping in mind the position of the large blood vessels. But little matter flows out. The cavity is then explored with probes or the finger for communications from other vomicae and these are enlarged by the thermo cautere, making one cavity. It is then packed with sterilized gauze and one suture put in the centre of the wound, antiseptic gauze protective and bandage applied. The dressing is changed daily. If no adhesions are found, as happened in one case, a pneumo thorax results. In this case it was circumscribed and the dyspnoea soon disappeared, and the pleritis set up glued the surfaces together, after which the cavities were opened. In a few days after the reaction resulting from the operation subsides, the injections of Koch lymph were begun. In the three cases where adhesions had occurred the operation was well borne, no local or general complications. For a day or two there was considerable coughing and irritation, but it was easily allayed and no pain was complained of. The lung can be touched and burned without pain—unlike the pleura. When the eschar was thrown off the wound was larger and the effect of the tuberculin observed, which were well marked. Dr. Sonnenberg considered the lung tissue more susceptible to the action of the remedy than any other.

The first patient was a coachman (W. Meister) aged 36 years, with no hereditary predisposition, had suffered more or less since 1880 with all the usual symptoms of phthisis, including haemoptesis, had at the time of operation (15th Dec.) a cavity in right apex and infiltration in left. An injection of '005 c.c. tuberculin produced a slight reaction. On the the third day after the operation the temperature was normal, when '005 c.c. produced no reaction. Slight reaction on two following days from 1 and 2 c.m.m. The doses were gradually increased, reaction always slight.

The second patient (G. Adams) aged 43, had no hereditary taint. His lung affection dated from an attack of pneumonia in 1886. Had lost 35 pounds during last three years. There was a cavity in the right apex and infiltration in left. He was operated on, on the 15th Dec., and on the 18th temperature had returned to normal, when the injections were commenced.

The third patient (W. Kippenhahn) aged 44, suffered since the spring of 1889 and had a cavity in left apex with consolidation in right. In all three the pleural surfaces were adherent over the cavity.

The fourth case (C. Feidler) aged 37, had been an invalid for over a year. Had constant fever during preceding summer and had lost in weight. A cavity existed at a point opposite the fourth intercostal space right side; dulness in left apex. Had continued fever up to the time of operation. The chest was opened in the fourth interspace. The pleural surfaces were not adherent and a pneumo thorax was produced and an adhesive pleritis occurred. After the symptoms of this subsided the cavity was opened.

In the *Deutsche Medicinische Wochenschrift* of February 5th, Dr. Sonnenberg reports that he had operated on another case since, and that the three cases first operated on were cured, and the last one as good as cured. Fiedler had succumbed. The lymph injections had no effect upon him, the tem-

perature being the same as before the injections.

In between three and four weeks after the operation in the three successful cases, the dose of tuberculin had reached 0.1 c.c. and when no reaction occurs with the dose it is repeated again after eight days. If reaction again occurred .1 c.c. was given every day until reaction ceased and wait again 8 days.

The cavities rapidly enlarged after the injections began, to two or three times their original size through destruction of the tubercle tissue and the breaking down of the walls between the main cavity and adjoining smaller ones. A profuse flow of pus and greasy caseous detritus come away leaving a healthy granulating surface. That this melting away of the affected tissue was owing to the action of Koch's remedy was proved in the last case operated on: no injections were given for 14 days after, when the changes above mentioned did not occur. They followed as soon as the injections were begun. No complications occurred. As the cavity gradually closed the secretion diminished and became less purulent and the bacilli were fewer in number. The patient's general condition has much improved, one gaining four pounds in the last week. No eruptions of miliary tubercle was observed near the cavities or wound. He doubts whether the small tubercles, sometimes seen near cavities or ulcers on larynx or tongue are real tuberculosis tubercles, as he has seen them disappear in 2 or 3 days after their appearance, and one which was removed three days after its appearance and examined showed softening but no bacilli.

He thinks it premature to formulate any rules of guidance in regard to the class of cases that are likely to benefit by the operation. There should be a fair general condition of body vigor, and a limited localization of the disease. It is useless where there is general infiltration.

When, from the effect of the lymph or otherwise, the cavity cannot be emptied

through the insufficiency of the bronchial outlet, and there is retention with continued fever, it will be indicated. Whether to use the lymph treatment for some time before the operation or not, or whether the chest should be opened before a cavity forms are points still to be determined. The cavities, at the time of the second report, were reduced to a *cul de sac* not larger than a pea, the original space being occupied by a connective tissue growth. A few bubbles would still escape on deep breathing, but the sinus was quickly closing, and the cases proved beyond doubt the perfect success of this new method of treating lung cavities in suitable cases.

On January 7th I visited the Victoria Park Hospital (City of London Hospital for diseases of the chest). Dr. Herron, who has charge of the cases treated here, is a firm believer in the efficacy of the remedy in suitable cases. He and the pathologist to the institution, Dr. Wetherhead, took great pleasure in describing the progress of their cases (25 in number), all of whom, without exception, showed more or less gain from the treatment. None of the cases were in an advanced stage of phthisis. The wards were remarkably cheerful, bright and airy, lacking no modern convenience, and well attended to. No case admitted unless bacilli were found in the sputum.

I can only briefly refer to some of the cases. H. B., aged 28, the first case, had tubercular infiltration in both apices with coarse rales and the usual physical signs: Bacilli in sputum. Father and mother and two uncles died of consumption. Was first treated on the 24th November. Owing to the small amount of deposit .01 was given as the second dose, giving reaction, 1 or 2 now taking .1c.c. doses daily with but slight reaction. No bacilli could be found after 27th December. His general condition had improved, but the dullness at the affected points had not changed, and this might be said of most of the cases. Neither had they observed any increase of dullness to occur. The respirations in one case

during the decline of the reaction, suddenly rose to 72, with a pulse of 90, the temperature a few hours later becoming sub-normal.

Case 7 was considered a very good result of the treatment. He entered hospital four weeks before, suffering from severe cough, hæmoptisis, night sweats, had lost 14 lbs. during the preceding three months. Had gained 10 lbs since admission, five during last 10 days. No hæmoptisis after the second injection. No night sweats during last week. No bacilli discovered the day previous and at the two previous examinations they were lessening.

S. M. in hospital 5 weeks, had infiltration in both apices with an obstinate distressing cough. This ceased in three weeks after the treatment was begun. .002c.c. were given at first. No reaction until .006c.c. was given. This was increased until .1c.c. was given, which was not followed by any reaction, but a smaller dose next day, produced temperature of 104.8. Since then 10 doses, each .1c.c. had not given any reaction. The abnormal physical signs on right side had completely cleared up, and in the left side crepitation was less. The bronchial breathing had given away to harshness, and his breathing was slower and more free. Had gained six pounds.

It was observed, as a result of an injection in lung consolidation, that crepitant rales occurred in the adjoining portion of the lung, coming on in about six hours after and disappearing in 24 to 48 hours. The quantity of sputum was also greater.

Even in cases where no reaction occurred the sputum gave evidence of increased disintegration of tissue by the greater quantity of elastic fibres and even complete alveolar arrangements which were found.

Dr. Heron gave it as his opinion that every patient with tuberculosis should be given the benefit of the treatment or the physician would neglect his duty.

From what I witnessed of the effects of Prof. Koch's remedy for tuberculosis in Berlin and London, I cannot but conclude

that all that its discoverer has claimed for it has been justified by the results obtained. So far we have abundant proof of at least a temporary cure in lupus, laryngeal and pharyngeal tuberculosis, and in phthisis pulmonalis when the disease is in an early stage, and of all tuberculous deposits where easy exit can be obtained for the disintegrated tissue and they contained bacilli. That surgical assistance in advanced lung tuberculosis, as suggested by Prof. Koch, may in many cases secure a ready discharge for the dissolving structures where it would not otherwise occur, thus avoiding the probability of a reinfection of the system from freed bacilli. It is now more important than ever before that physicians should recognize this insidious disease in its earliest stages. In all cases of cough where resolution does not soon occur under the ordinary medication, the sputum should be examined for bacilli, or the diagnostic feature of the lymph utilized. In this way we may hope that an advanced and incurable case of phthisis will become a rarity and a reflection on the patient for neglect of his case or on the physician who may have had him under observation when his case was curable.

Although the remedy has been tested in all parts of the world, and the reports indicate results all the way from those which are exceedingly unfavorable to those where undoubted and striking benefit has been obtained, nothing has been noted which renders necessary a change in the statement regarding it first made public by Prof. Koch and reiterated in his second communication of January 15th, 1891, when he states: "All I have lately seen is in harmony with my former observations and I have nothing to retract of what I have before stated." Tuberculin has a specific effect on lung tuberculous tissue, leading to its rapid disintegration, and when the necrotic products can be readily thrown off good results are obtained as in external tuberculosis or in the larynx or pharynx, and when a limited portion of lung tissue is effected, with

unobstructed drainage into bronchial tubes. Where the favorable conditions are absent, benefit is not so certain, and, as has been pointed out by Prof. Virchow and other pathologists, the artificially necrosed tissues loosened in parts where the products cannot readily be thrown off, may set free bacilli, which, passing into the lymphatic vessels, stud the tissues in the vicinity of the diseased focus with an abundant crop of fresh nodules, or getting into the blood current, directly or through the lymphatics, may cause a more or less general eruption of fresh miliary tubercles or tubercular infiltration. The fact that such can develop during the course of treatment with tuberculin has been adduced to disprove the specific action of the remedy on new tuberculous tissue, but much has yet to be learned as to the exact manner in which the remedy affects the necrosis. The tendency in the lymphoid, epitheloid and giant cells, characteristics of tubercle tissue, is to a process of cheesy degeneration, and the surrounding of the abnormal tissue by the leucocytes with a barrier wall. Does the increased proportion of bacillary product in the blood, represented by a dose of tuberculin, simply accelerate this change already begun, leading to rapid softening of the tissue and the formation of a strong inflammatory zone around the foreign growth cutting off the blood supply, as occurs in cases where, without any specific treatment healing of the lung occurs—or is its action explained by the theory advanced by Prof. Watson Cheyne? He attributes the formation of tuberculous tissue to the irritative action of the products of the bacilli and supposes that tuberculin has a special affinity for these chemical poisons and that by a chemical combination, a new and highly irritating body was produced which led to rapid necrosis. The latter explanation can scarcely apply in view of the evidence of the post mortems described by Prof. Virchow, where tubercles developed during the course of the treatment. Kromayer's conclusions in a recent number of the *Deutsche*

Med. Wochenschrift, throws some additional light on this important point. He states that tuberculin acts only on tubercles which are peripherally vascularized—a condition not found in very young or very old tubercles. This limited action of tuberculin would indicate also that in tubercular infiltration, where no tubercles are produced, only scattered masses of epitheloid cells in gratulation or young fibrous tissues—the remedy could not be so effective.

Prof. Koch considers the action of tuberculin to be that of a protoplasm destroyer by producing coagulative necrosis. This condition of the cell inhibiting the further growth of the bacilli and tends to their destruction. Artificially introduced into the circulation, this process is accentuated at the point infected, and extended further from the bacilli lessening their chances of being nourished; an inflammatory limiting zone thrown around such a focus should complete the arrest of the tuberculous growth. That some normal element is irritated by the remedy is shown by the reaction that can be produced in a healthy person by a large dose. The cases of Leukæmia, which I have mentioned, where doses similar to those which produce a reaction in the presence of tuberculous tissue, gave rise to reaction, would seem to support the views of Prof. Koch, that the white blood corpuscles or their modifications are the susceptible elements.

It would seem from the fact that sub-miliary tubercles and old ones or masses encapsuled are not affected, that the remedy acted chiefly on the inflammatory tissue which is normally thrown around tubercular foci formed of the migrated leucocytes and that the specific action of the remedy obtains in these corpuscles thus modified by the tubercle virus, accentuating the inflammatory and degenerative changes. We must, however, await further observations, clinical and post mortem, for a true solution of the question how the necrosis is brought about. The potency of tuberculin in this respect necessitates

great caution in using it, and entails considerable responsibility, judging from the untoward results which have been reported. Not only must careful observations be made as to the exact physical condition of the patient, but the fact that the remedy brings to light unsuspected foci must not be lost sight of. Some of the unfavorable consequences are haemorrhage, perforation of the intestine, the production of necrotic tissue which cannot be got rid of quickly enough, the retained substance undergoing further degenerative, change causing hyperpyrexia and symptoms of septicæmia, excessive inflammatory changes in the lungs, pleura, etc. If with an exact knowledge of the patient's condition one proceeds cautiously with small doses, accidents are not likely to occur, but, as they have occurred under these circumstances, patients submitting themselves to the treatment should be fully warned of these possibilities which, fortunately, are very exceptional.

The fact that, by improved hygienic surroundings, open air exercise, and the application of all those means which are known to favor the production of a more vigorous condition of the general health, we can only in a certain proportion of cases bring about a resolution of incipient phthisis, and that this has been the only means of hope we have been able to hold out to those afflicted with pulmonary tuberculosis, led to an exaggerated expectation on the part of the mass of the profession, and especially the public, as to this supposed absolute specific. The pendulum has just now swung out in the other direction and we hear chiefly of the failures, but already it is moving backwards and from the most reliable sources, among the vast number of experimenters throughout the world more favorable results are being obtained, and as our knowledge will increase in regard to the best methods of applying the remedy and the conditions suitable for its application, we will realize *Tuberculinum Kochii* to be one of the most valuable additions to our list of remedies which this cen-

tury has witnessed, and second only to the remedy we hopefully await for, viz.: one capable of destroying the living germs as they exist in the living tissues, without injury to the host.

Society Proceedings.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

Stated Meeting, January 23rd, 1891.

F. J. SHEPHERD, M. D., PRESIDENT, IN THE CHAIR.

Continued from page 130.

Case 2.—In this patient very much the same conditions were present. He was an older (28) and stronger man. Consolidation at right apex. There had been slight hæmoptysis. Bacilli and elastic tissue in sputum. The temperature, taken every two hours day and night for six days before treatment began, never went as high as 99°. The best reaction was obtained from the second injection (of 0.002 c.c.), when the temperature reached 101°.

Case 3.—This was a case of tubercular laryngitis with left apex dullness. History of hæmoptysis. No bacilli. The temperature after the first injection went to 103°, but no such reaction has since been noted.

Dr. Jas. Bell reported as follows:—

(1) G. M., aged 6 years, a waif left on the wharf in the autumn of 1889, with advanced hip-joint disease and scrofulous sores about the face, neck and body. In May, 1890, the hip-joint was excised, the whole neck and head of the femur and the upper two-thirds of the great trochanter being removed. Patient recovered with a good, useful limb and good mobility. During the summer he developed tubercular disease of both testicles. The left which was completely disorganized, was removed in November, and the right, which was simply felt as a hard nodular mass of epididymus, was left alone, as it seemed to be in a quiet, non-progressive condition. Good recovery followed operation. Patient was injected on December 23rd, the dose given being .0002 gm.; no reaction followed. On the 29th he was injected again, the dose being .0003 gm. Only slight general and no local reaction followed, the temperature only reaching 99°, injections then discontinued.

(2) C. H., aged 25. Suppurating disorganized testicle. Diagnosis doubtful. No family history of tuberculosis. History of posterior gonorrhœa for about six months, when acute orchitis super-

vened, ending in suppuration in August last (1890). Hardness of epididymus and pus discharging sinuses remained. Injected on December 25th dose .002; no reaction. Dec. 27th, injected again dose .004 grm.; slight heaviness and temperature rose to 99°F.; no local reaction. Injections were then abandoned and the testicle removed a few days later. The testicle (shown at the meeting) was literally filled with tubercles, which were pronounced by Dr. Johnston to be not of very recent origin, and not attributable to the injections.

(3) N. B., aged 26. Diagnosis doubtful. Thought to be tubercular disease of the bladder and kidneys in an early stage. Symptoms: frequent and painful micturition; blood in small quantities at end of micturition; urine containing pus in considerable quantities; intense albuminuria; emaciation. Symptoms lasting 2½ years, and coming on as a sequel of posterior gonorrhœa; temperature ranging from 99° to 100°F. before injection. Injected on the 21st of December dose .002; no reaction, general or local. Again on the 22nd, dose .004; no reaction, general or local. Injections discontinued and patient discharged at his own request.

(4) A. M., male, aged 25. Had suffered for five years from bladder irritation, with pus and blood in urine. Never had gonorrhœa. Left testicle had all the characters of tubercular disease of that organ. A nodule had existed in the lower end of the epididymus for more than a year, and a little local suppuration had occurred twice, leaving a sinus which discharged for some time. Sinus was now closed. In September a perineal section had been performed, but had failed to give him relief. On the 1st of November Dr. Bell had opened the bladder above the pubes, and with the aid of the electric light scraped and cauterized several tubercular ulcerations around the neck of the bladder. The bladder wall was found to be studded with tubercles which had not yet broken down. Prompt and satisfactory relief had followed the operation, and the patient's general health had improved greatly. Patient was injected on account of the tubercular testicle and the tubercles known to exist in or beneath the mucous membrane of the bladder. He was injected as follows: Dec. 20th, .001 grm.; slight and general reaction. Dec. 21st, .004 grms.; marked febrile reaction, pain and tenderness in testicle, and increase in pus and albumen in urine. This patient was injected again as follows: Dec. 24th, .006 grms.; Dec. 30th, .008; Jan. 19th ('91), .006. The same symptoms of local and general reaction followed each injection, and after the last injection some blood was found in the urine for the first time since the supra pubic operation, performed on the 1st of November. This patient is enthusiastically hopeful, and has gained three pounds since the treatment began. As his general health has

been steadily improving since the operation on the 1st of November, and no observations as to his weight had been made prior to the use of the parataloid, this slight increase of weight must not be given too much prominence as an evidence of the curative effects of the remedy.

(5) A. D., a little French-Canadian child aged 5 years, suffering from a tubercular knee-joint of eighteen months, standing, but in early and quiescent condition, so that the child could walk almost without a limp, and could extend the leg fully. This little girl had been under observation for eight days before any injections were given her. During this time she was carefully examined and her temperature, which was taken every four hours, was uniformly normal. She was given the first injection 24th of December; dose, .0002 grms.; distinct local and general reaction followed. The knee became red, hot and painful, and increased a quarter of an inch in circumference, while the temperature rose to 101°F., and the child was very drowsy and sick at her stomach. The reaction began about eight hours after the injection, and the temperature had reached the normal again within 24 hours. The knee, however, remained a little tender, and lay in a position of increased flexion. She was injected again as follows: Dec. 28th, .0003; Dec. 31st, .0004; Jan. 8th (1891), .0005; Jan. 14th, .0005; Jan. 19th, .0005 grms.—six injections in all. The same symptoms and local signs followed each of these injections—the knee on one occasion increasing three-eighths of an inch within a few hours, and the highest temperature reached being 103°F. The local manifestations on each occasion subsided a little later, and less decidedly than the constitutional symptoms. At the present time (Jan. 23rd) the knee is half an inch larger than when the first injection was given. The knee is semiflexed, and is painful and tender, so that the child cannot be induced to put the foot to the floor, nor can she allow the leg to be extended. In short, the knee had grown very rapidly worse under the treatment.

In recapitulation, Dr. Bell said that while the first case was beyond all doubt a markedly tubercular child, no reaction had followed the injection. This might be explained, however, by the fact that all the tubercular lesions, with the exception of the right testicle, had been removed. The second case had not reacted, although the testicle, when removed, was filled with tubercles which must have developed within six months. The third case was doubtful, and, although no reaction followed the injections, was probably tubercular. The fourth case showed clearly that a change of some kind had taken place in the diseased organs. The fifth case, however, gave the most undoubted evidence of the power of the parataloid, but this power was shown, so far, not in a curative effect, but the reverse, as the joint disease had been

apparently greatly aggravated by it. On the whole no cures had been effected, nor even distinct improvement, nor had it proved serviceable as a diagnostic agent, but, with possibly one exception (the last case), no ill effects had been observed from its use.

Dr. Johnston said that he had examined the sputum daily for tubercle bacilli in Dr. MacDonnell's three cases; Dr. Smith, house physician to the General Hospital, having assisted him in preparing the specimens. The sputum had been examined daily for a week before commencing the treatment. Up to the time of speaking no change had been noticed in the sputum. The number of bacilli had remained stationary. In the case of tubercular laryngitis no bacilli had been detected. The testicle extirpated by Dr. Bell had the ordinary appearances of a tuberculous testicle. Microscopically it showed no unusual amount of necrosis.

In one of the cases of lupus, that of the old woman, tubercle bacilli had been found in the sections, but were very scanty. The lupoid tissue was free from any unusual appearance. In the other lupus case, that of the young girl, there was marked proliferation of the endothelial cells in the small vessels, showing an intense, acute inflammation. These observations confirmed the statement which had been made that the action of the lymph upon human tuberculous tissue was quite different from what had been observed in the case of guinea pigs. In the human subject the condition seemed to be one of irritation, not degeneration, about the young tuberculous tissue. The effect of the treatment upon the sputum would only be secondary, as the living tuberculous tissue did not come away with the sputum.

Discussion.—Dr. McConnell remarked that he had seen some good results from the treatment. To get a good effect from the remedy he considered it necessary to build up the system. In Dr. Bell's case of tuberculosis of the testicle, he thought that from such a small amount of tuberculous material we could not expect much reaction. He would present his report on the subject at some future meeting of the society.

Dr. Mills referred to a case of hemorrhage which had occurred after the injection of Koch's lymph.

Dr. Hingston said that he had just begun the injection of the lymph. He thought that it was still in its probational period. Dwelling upon lupus, he remarked that one thing seemed to have been forgotten, and that was, that some cases of lupus without any treatment whatever will get well. Dr. H. could recall several cases during his practice of cure. He agreed with Dr. MacDonnell that patients with tuberculosis of the lungs should be selected with great care, and should be examined for days and days before the Koch treatment was adopted.

Dr. Shepherd, referring to the case of lupus in the old woman, remarked that she had pre-

viously been under his care for seven or eight years. The diseased area had been cauterized and scraped several times. She had improved temporarily. Since the injection of the lymph had been begun he considered her condition worse. In the second case of lupus, that of the young girl, after the injections had been discontinued for two weeks, there was a great reaction, which probably shows an accumulative action in the lymph. He had not yet seen any report of absolute cure of lupus from this treatment. The Vienna results had not been very promising. There had only been one case of apparent cure. As to its diagnostic power, reaction had been noticed in cancer cases in New York. It was also known to light up latent tubercular foci.

Dr. Roddick asked Dr. G. T. Ross if he had seen in Berlin any operation performed for surgical tuberculosis subsequent to the use of the lymph; also, if he had seen any autopsies on other cases than pulmonary tuberculosis; and, thirdly, whether the accumulative effect had been noticed.

Dr. G. T. Ross said that he had seen slight hæmorrhage follow the remedy, which had to be discontinued for a few days. Many of the cases which he had reported had been carefully examined by able men before the injection of the lymph was commenced. He admitted that good diet and good surroundings improved many cases of phthisis, yet he believed that the improvement in the cases that he had seen was to be attributed to the lymph. He had not seen any surgical operation after this treatment, nor post-mortems in any other case than that of phthisis. Referring to the results that had been obtained here, he believed that the dosage had been too small, particularly in cases of local tuberculosis.

Dr. Bell stated that the dose, though small, had produced very severe reaction.

Dr. Roddick remarked that in a case of lupus injected with 1-10 cm. slowly increased had produced great reaction. He had seen one case in Baltimore where the patient, after the injection of 2-10 cm., had become seriously ill.

Examination of Sputum for Tubercle Bacilli.

—Dr. Johnston demonstrated the method of examining sputum for tubercle bacilli which he employed in the Montreal General Hospital. The cover-glasses were smeared with sputum by means of a thick platinum wire, the end of which had been flattened out to form a small spatula. When dried, it was fixed in the usual way by passing through a flame. The staining was effected by placing a drop of carbol. fuchsin solution (magenta, 1 grm.; alcohol, 10 c. cm.; 5 percent. carbolic lotion—90) upon the smeared side of the cover-glass and holding it in a small flame till bubbles rise, allowing it to boil gently for half a minute or less. After spilling off the excess of staining fluid, the cover-glass was immersed in acid methylene blue (methylene blue 2 grammes, 25

per cent. by volume; sulphuric acid 100 cc.), and allowed to remain there for one minute. It was then examined directly in water, or could be dried and mounted in balsam if desired. In most cases this examination could be made in less than five minutes.

Stated Meeting, February 6th, 1891.

F. J. SHEPHERD, M.D., PRESIDENT, IN THE CHAIR.

Hæmatoma of the Ovary.—Dr. T. J. Alloway exhibited two interesting specimens of hæmatoma of the ovary. In one ovary, the larger of the two, a cavity existed in the oöphoron portion of the ovary which contained about three drachms of dark, tarry blood. This cyst ruptured on the ovary being brought to the surface for ligature. In the second specimen the cavity of the ovary contained a hard, dried, coffee-colored blood-clot about the size of a marble. Dr Alloway said that the ladies from whom these ovaries had been removed were young women between the ages of 25 and 30, one married and the mother of one child. They were chronic invalids, and had been so for some years. The first case was operated on ten months ago; she was now in robust health and acting in the capacity of trained nurse. The other case had been but recently operated upon, and was improving. He said that he had now exhibited three cases of this rare pathological condition before the Society. He thought the condition more common than was generally supposed. The symptoms were the same as those seen in hyperæmia of the ovary and chronic ovaritis unless rupture takes place, when alarming shock and collapse will follow, according to the amount of blood lost. He had no doubt that follicular hemorrhage was a frequent cause of intra-peritoneal hæmatocele. It was due to excessive ovarian congestion and escape of blood from the larger deep-lying veins into one or more ruptured vesicles. The number and size of the hæmatocele sacs were in direct proportion to the extent of congestion.

Contortion of the Fallopian Tubes.—Dr. Alloway also exhibited this specimen. He explained that this is a twisting or bending of the tube upon itself irrespective of inflammatory adhesions. He said that Dr. Haultain of Edinburgh had recently drawn attention to this peculiar condition saying that it was in his experience, the most frequent morbid condition of the tube met with, and that it gave rise to very distressing symptoms. Sterility and dysmenorrhœa are the two principal associated conditions found in connection with *contortion* of the Fallopian tubes. In regard to the ætiology of this lesion, he said it was very difficult to offer an explanation, but it was thought that it had something to do with developmental irregularity. Before birth the Fallopian tube is in a state of contor-

tion similar to the specimen exhibited, and it is not till puberty that, by a gradual process of straightening, it has acquired its normal undulating form, so that this condition may really be a continuance of the foetal state. This, however, would not explain cases that occurred after pregnancy had taken place, but under such circumstances it is thought there was an inherent tendency on the part of the tube to return to its foetal state.

Aneurysm of the Aorta simulating Aneurysm of the Innominate.—Dr. R. L. MacDonnell related the history of the case, which was briefly as follows: W. H. (colored), aged 33, barber, was admitted to the hospital in October last with an apparent pulsating tumor over the innominate artery. The patient had formerly been a Pullman car conductor. There was no history of syphilis or intemperance. In August last he began to suffer with severe pain in the right side of the neck, and behind the right ear; subsequently pain was felt in the upper axillary region of the chest, and in the right shoulder, which he believed to be rheumatism. He then came under the notice of Dr. J. A. MacDonald, who advised him to enter the hospital. On admission there was slight bulging of the chest, and dulness on percussion over an area of two and a half inches in diameter, occupying the space between the clavicle and the sternum. The pulse was not perceptible in the right radial, brachial, carotid or temporal arteries. There was tracheal stridor and weak breathing at the left pulmonary base; no tracheal tugging; no laryngeal paralysis. The diagnosis was aneurysm of considerable size involving the innominate artery, and possibly the ascending arch. The absence of tracheal tugging and laryngeal paralysis, together with weak breathing at the base of the left lung, rendered an involvement of the transverse arch highly improbable. No symptoms pointed to the third part of the arch or the thoracic aorta. In Dr. MacDonnell's experience, the tracheal tugging was met with when the transverse arch was enlarged and rested on the left bronchus against the angle which that tube forms with the trachea. When the aneurysm occupied a point on the transverse arch beyond the crossing of the left bronchus, the tracheal tug was not perceptible; since the tumor dragging down the loop formed by the vagus and the left recurrent nerves (which bend around the aorta behind the root of the left lung) produced pressure upon the left bronchus from behind, this pressure was incapable of making a pulsatile impression on the left bronchus such as to be transmitted to the larynx. The patient was put to bed and 10 grains of the iodide of potassium ordered daily. He left the hospital Dec. 6th, feeling much better, almost free from pain, and no apparent increase in the size of the tumor. He was readmitted Jan. 23rd with great dyspnoea;

the tumor had increased considerably in size, bulging from the chest-wall as large as half a cricket ball; it was pulsatile, and its walls were thin. The pulse in the right wrist was now present, though small. Death took place in six days. The reappearance of the pulse was attributed to the rapid enlargement of the tumor in the direction of the front of the chest, which relieved in a slight degree, the pressure upon the innominate, and allowed the blood to flow again through the vessels.

Dr. Johnston exhibited the specimen. It was situated at the junction of the first and second part of the arcus aortæ. The innominate lay just within the sac; another sac lay in direct contact with the innominate artery all the way to its bifurcation, and was closely bound to it by inflammatory connective tissue. The sac was as large as two fists, and had eroded the first and second ribs in the right supra-clavicular region. The anterior wall of the sac was formed by the pectoralis major. The sac contained a large amount of fibrin, not very firm. The great arteries and veins were free. The sac lay in front of the trachea and pressed upon the right bronchus. The left bronchus was quite free of the tumor. The recurrent laryngeal nerves were normal. There was intense tracheitis, with an ulcer on the anterior wall of the trachea one and a half inches above its bifurcation. There was acute broncho-pneumonia of the right lung.

Dr. James Bell was interested in the case, inasmuch as the patient had originally been sent to his wards for surgical treatment. Ligature of the carotid and subclavian had suggested itself, but an examination revealed the fact that these arteries were already occluded. The absence of syphilis in the history, and of any atheromatous change in the vessels, together with the comparative youth of the patient, were very remarkable. He spoke of the cases recently reported by Macewen where the formation of white clot was artificially produced by pricking the sac through and irritating its inner surface with fine needles. Encouraging results had followed this treatment in the four cases reported by Macewen, in two of which the results were verified by subsequent post-mortem examination.

Dr. Geo. Ross regarded the case as being most interesting, but it was not in his experience a very unusual thing to find innominate aneurysm closely resembling in its symptoms and physical signs aneurysm of the arch, or *vice versa*, and he had already a case closely resembling that brought before the society by Dr. MacDonnell. A correct diagnosis was impossible under the circumstances of this case. The points brought forward by Dr. MacDonnell with regard to tracheal tugging were interesting, though he was not prepared entirely to agree with the opinions expressed. He was under the impression that tracheal tugging could be produced by an aneurysm pressing upon the

trachea from in front and exerting pressure downwards as well as backwards. He must, confess, however, that the result of the autopsy in the case before the Society strongly supported Dr. MacDonnell's view of the causation of this physical sign, and the aid it could afford towards the localization of the tumor. In the present state of our knowledge relating to the localization of thoracic aneurysms, surgical interference with innominate aneurysms will always be extremely hazardous. It is very desirable that all cases presenting themselves, in which it is difficult to determine whether a given aneurysm is innominate or aortic, should be most carefully examined and reported, so that some points might be determined by which to establish the diagnosis.

Round Ulcer of the Stomach causing Fatal Perforation.—Dr. R. L. MacDonnell stated that the patient, a woman, aged 59, had been under his care in the Montreal General Hospital up to about ten days before her death. Her case was interesting in the duration of the symptoms. The patient, who had been a needlewoman, began to suffer from pain and distress after food, with occasional vomiting, some twenty years ago. She was supposed to have dyspepsia up to 1877, when she was first seen by Dr. G. E. Fenwick, who noticed the "coffee-ground" appearance of the vomited matter. He elicited from the patient that she had been vomiting a darkish fluid for some years past. She was then suffering from severe pain in the epigastrium, vomiting after food, and hæmatemesis when she entered the hospital, and was under treatment for gastric ulcer for six weeks. She derived much benefit. With the exception of slight epigastric pain, she remained free from severe symptoms until 1888, when she was again admitted complaining of severe pain and vomiting after food. There was no hæmatemesis. She recovered, and continued apparently well till the beginning of this year, when she again applied to the hospital with symptoms of gastric ulcer. She was admitted under Dr. MacDonnell. The patient was now much emaciated; the abdomen was very flat, and its walls extremely thin. There was diffuse tenderness over the epigastrium; no tumor perceptible. The patient was kept in bed several days and her symptoms carefully watched. Milk diet was ordered. Gastric distress was noticed to increase until evening, when vomiting gave her relief. It was thought that the symptoms pointed to cicatrized ulceration, which was probably delaying the advance of food through the stomach. A soft tube was therefore introduced every day at 4 p.m. and a pint of water slowly passed through it. The discomfort was relieved, no vomiting occurred, and she was able to sleep without epigastric discomfort or pain. At the time of her leaving the hospital she was free from pain and able to take most of the common articles of diet without

discomfort. On her return home she ate freely of what was going, when she was taken suddenly ill, and in a few minutes was in a condition of collapse. She was seen by Dr. W. G. Stewart. There was very severe pain at the epigastrium, and copious vomiting of a "coffee-ground" fluid. He was aware previously that the patient was the subject of gastric ulcer. He was unable to afford her any relief. At the autopsy, when the abdomen was opened, the ulcer was plainly visible in the right half of the epigastric region, and it presented a decidedly punched out appearance. The ulcer was situated near the pylorus, close to the lesser curve; its edges were raised, and there existed much thickening of the surrounding gastric wall. The stomach was moderately dilated. The abdominal cavity contained about a pint of "coffee-ground" fluid similar to that which had been vomited. There were evidences of general peritonitis.

Obstruction of the Cystic Duct; Cancer (?) of the Gall-Bladder.—Dr. Johnston exhibited this specimen for Dr. Molson. It showed a large calculus the size of a pigeon's egg in the cystic duct, two inches above the junction with the common duct. A small calculus the size of a bean lay just at the orifice of the ductus communis choledochus. In the region of the gall-bladder was a ragged, fibrous mass as large as an apple. Examination of this tissue under the microscope showed a dense fibrous stroma, in which a large number of lymphoid cells were found. The microscopic appearance of the growth was not that of cancer.

Dr. Molson remarked that the patient was 64 years of age; fairly well nourished. There was a history of frequent vomiting, which always yielded to careful dieting. Two weeks previous to her death there was incessant vomiting, which proved uncontrollable, although every remedy that could possibly relieve her had been tried. There was no pain, no sign of jaundice, and nothing could be made out by examination. The patient gradually died of asthenia.

Dr. Campbell asked if there had ever been any history of biliary colic.

Dr. Stewart wished to know how Dr. Molson explained the vomiting.

Dr. Shepherd remarked that, according to Tait, jaundice was of rare occurrence with only one or two calculi in the gall-bladder. He believed the condition might have been benefited by an operation.

Dr. Molson replied that there had been no history of colic, and that the vomiting was probably purely reflex.

Diabetic Coma.—The subject of acetonuria having formed the subject of an interesting paper recently read before the Society prompted Dr. J. A. Hutchison to report a case of diabetic coma which had lately been under his care:

J. D., aged 50, was brought home from work in the morning of Nov. 13th in an exhausted

condition. When seen by Dr. H. he complained of loss of appetite and constipation. On the following day the patient was very drowsy, and could only be aroused with difficulty. The case now appeared to be one of uræmic intoxication. The patient's previous health had always been good. He had been a soldier, led a fast life, and drank a great deal but for the past twenty years he had been steady and regularly at work. There was no history of syphilis. For twelve years he had been passing an abnormally large amount of urine, but no attention was paid to it. Lately the amount of urine increased; there was marked loss of appetite, great thirst, and obstinate constipation. The patient was now considerably emaciated; the skin dry and sallow. Four to five quarts of urine were passed a day. It was of a pale straw-color; spec. gr. 1032. Fehling's test gave a large deposit of oxide of copper. On Nov. 19th, the third day under observation, the patient felt better and was able to move about the house. On the morning of the 20th he became very dropsical; breathing was slightly stertorous, and the pupil of one eye dilated (the other eye had been destroyed some years ago). The pulse could be faintly felt at the radial. During the day coma increased until death ensued at seven o'clock that evening, one hundred and twelve hours from the time he had left his work. The urine had been chemically examined by Dr. Ruttan. No acetone was found.

Dr. Hutchison remarked that the case was interesting to him from the fact that such advanced disease should have given rise to so few symptoms, that a physician was never consulted until a few days before death. An abstract of the autopsy performed by Dr. Johnston was as follows: "Body of a spare, emaciated man; skin sallow, rough and dry. Heart and lungs showed nothing special. There was slight cloudy swelling of the kidneys, with several large clear cysts in the centre of each organ. Intestines and stomach were normal. The supra-renal capsules and semilunar ganglia showed no gross pathological changes. Brain: pia, thick and opaque over the convolutions, was readily detached; sub-arachnoid fluid was abundant, and the posterior cornuæ of the lateral ventricles were dilated. Throughout the cortex, as well as the white matter, ganglia at the base and medulla, the brain cut with resistance. This was probably due to an atrophic change, with a relative increase of the connective tissue."

Cystic Degeneration of the Placenta.—Dr. C. O'Connor exhibited this specimen, which showed extensive mucoid change and enlargement of the villi of the chorion. The patient, aged 32, had been delivered of two full-grown children. There was no history of syphilis. On examination the os was found partially dilated, placenta presenting, and considerable

bleeding. The vagina was tamponed and Dr. Telfer called in, who anaesthetized the patient. The os was dilated with the fingers, and an enormous quantity of cysts removed, sufficient to fill an ordinary wash-basin. The uterus then contracted firmly and the hemorrhage ceased. Creolin douche was given and a hypodermic of ergotin. The loss of blood had been considerable; the patient was blanched, almost pulseless, and the extremities cold. Frequent hypodermics of brandy were given. At eleven o'clock next morning the pulse was 126 and temperature 99°. She steadily improved and made a good recovery.

Dr. Telfer confirmed Dr. O'Connor's report.

Dr. Reddy, in referring to these cases of cystic degeneration or hydatidiform mole, believed that there was a loss of vitality in the ovum, which disappeared early, and the placenta went on to cystic degeneration.

Progress of Science.

SYPHILITIC ALOPECIA.

Syphilitic alopecia was noticed by medical writers in the sixteenth century, and Shakespeare makes a distinct reference to syphilitic alopecia in *Timon of Athens*, Act iv, Scene 3, where Timon urges Phrynia and Timadra to assist him in his general curse of mankind. "Make curl'd-pate ruffians bald," says that misanthrope. Professor Fournier, in a course of lectures recently delivered at the Hôpital St. Louis, stated that only one in twenty of his private syphilitic patients lose their hair to any appreciable degree. Alopecia is by far most frequent in the asthenic form of syphilis, where great debility and general disturbance occur, with relatively trifling specific symptoms, in patients not necessarily feeble. Yet this alopecia is not a result of pure debility or of a family tendency to baldness, as it is occasionally seen in its severest and most rapid form in the mildest cases of syphilis. Professor Fournier states that specific baldness comes on between the third and the sixth month. In carelessly treated cases this symptom may be delayed till the course of the second year, but never later. The baldness of middle-aged men has, as a rule, nothing to do with syphilis. Syphilitic alopecia may be purely symptomatic, being caused by pustular and other syphilides of the scalp, or essential. The latter form is the more frequent; the hair falls out without any cutaneous irritation, redness of the scalp, or headache. lesions of the bulbs have been described. There is a general tendency either to free thinning of the hair or to patchy baldness, but these different types are often mixed, and when soli-

tary are irregularly diffused over the scalp. The patches are never so free from hair as in tinea decalvans. Syphilitic alopecia is never permanent, according to Professor Fournier. At the end of five or six months the hair begins to grow again, even when the case is not treated. The beard and moustache are often attacked. The eyebrows often suffer and undergo a change, particularly prominent in young men. In youth the hair of the eyebrows are thick and regular, and lie smoothly. When attacked by alopecia the hair becomes thin, and those which remain stick out in all directions. Sometimes there are bald patches as well. These changes constitute what is known in Paris hospitals as the *signe d'omnibus*, as a patient is thus rendered diagnosable, even in a public vehicle. In tinea decalvans of the eyebrows all the hairs fall; in pilary keratosis, which is congenital, the skin of the brow is reddened.—*Brit. Med. Jour.*

DIET IN CHRONIC BRIGHT'S DISEASE.

Dr. Nikolas S. Zasiadko, of St. Petersburg (*Vratch*, No. 39, 1890, p. 889) has carried out a series of comparative clinical experiments on ten patients suffering from chronic nephritis, his object being to elucidate the influence of a vegetable, animal, and mixed dietary on the course of the disease. In each instance the experiment lasted thirty days, during the first ten of which the patient was kept on a vegetable diet, during the second ten on an animal one (with the addition of some bread), and during the third period on a mixed diet.

It was found that:

1. Under the influence of vegetable food, the daily amount of albumen in the urine markedly decreased; the arterial tension sank, dropsy considerably increased; the pulse became slower, weaker, and more easily compressible; the appetite was gradually lost; the general state grew worse, the patient becoming weaker, apathetic, etc.
2. Under the influence of animal food, the daily quantity of albumen in the urine markedly increased; the arterial tension rose; cedematous swellings were diminished; the pulse became more frequent and fuller; the body weight decreased *pari passu* with the disappearance of dropsy; the daily amount of the urine, the proportion of its solid constituents, and specific gravity increased; the general state improved, the patient growing stronger, more cheerful, etc.
3. A mixed diet stood midway in its effects, but came nearer to the animal one in regard to its influence on albuminuria.
4. The proportion of albumen in the urine *per se* affords no criterion for determining the gravity of the renal lesion. The patient's dietary should also be always taken into considera-

tion, as the ingestion of an abundant proteid food raises the said proportion by causing a "dietetic albuminuria," which quickly disappears on decreasing the quantity of food proteids.

5. In view of the fact that chronic Bright's disease (a) consists in a general affection of the vascular system and not of the kidney alone and (b) is accompanied by a profound alteration of the blood, characterized by an increased proportion of water and a decreased proportion of proteids, hæmoglobin, and morphological elements, rational treatment should consist in raising the patient's general nutrition by means of a liberal diet abounding in proteids. Such diet does not give rise either to any renal irritation (hæmaturia, hæmoglobinuria, exacerbation of the renal process), or to uræmia.

6. The best dietary for chronic Bright's disease is a mixed one. In interstitial nephritis accompanied by general weakness, animal should predominate over vegetable food; in parenchymatous nephritis with profuse albuminuria, vegetable food with milk should be in relative excess.

7. Roasted or cooked Italian chest-nuts markedly diminish the proportion of albumen in the urine, owing to their containing tannic acid.—*Supp. Brit. Med. Journal.*

CREOLIN: ANTISEPTIC OR TOXIC?

Some important evidence as to the action of creolin on the human subject may be gathered from a thesis on that compound published at Breslau during the course of this year. Dr. Bitter, the author, notes that creolin has already been used in more than 2,000 midwifery cases at Breslau. As appears to be the case with nearly every new compound of the kind, the results, according to Drs. Born and Bitter, are most encouraging. In four of the midwifery cases, however, symptoms of poisoning occurred during the administration of a course of creolin injections. Three of the patients were suddenly seized with feelings of restlessness, anxiety, nausea, darkness before the eyes, and a tendency to syncope. The most peculiar feature in these cases, was a strong flavor of tea or smoke in the mouth, of which all the patients complained. This symptom lasted for a long time, while the nausea, etc., disappeared immediately upon the discontinuance of the vaginal injections of creolin. The fourth case was more severe; the patient suffered from great restlessness and prostration for several days after the injections were left off. About thirty-six hours after the beginning of the attack the urine, drawn off with the catheter, was very dark and strongly albuminous. Within a few days these symptoms of acute nephritis disappeared. Dr. Bitter advocates creolin as superior to other disinfectants on account of its "relatively" (*sic*) non-

poisonous qualities, its excellence as a deodorizer, and its blandness when applied to skin, mucous membranes, and wounds. It neither dries the vaginal mucosa nor causes any contraction of the canal. Creolin has no special hæmostatic action. Dr. Bitter finds that there are disadvantages in creolin, as the emulsions employed for injections are opaque, and the preparation of creolin usually on sale appears to be unstable.—*British Medical Journal. Pract. and News.*

ARISTOL.

I have drawn the following conclusions after observing its action during the past five months:

1. The drug is free from all objectionable odors.

2. When used over large surfaces you obtain all of its medicinal effects without any toxic effect. It is not absorbed.

3. It possesses stimulating, alterative, and anesthetic properties; the latter effect less marked than that obtained from iodoform.

4. It does not produce any discoloration of the skin.

5. On account of its dark color you can readily observe how far the powder has been used on a diseased surface.

6. It is not irritating, and its use is not contra-indicated in the treatment of facial eruptions, as chrysarobin and pyrogallie acid.

7. It appears to possess the necessary properties to make it an efficient substitute for iodoform.—*McLaughlin, Va. Med. Monthly.*

McConnell gave the following as the latest and best internal treatment for gonorrhœa:

Salol,	3j;
Oleores. cubebæ,	3j;
Copaibæ,	3j;
Aluminis,	3iv;
Pepsinæ sacch.	3ss;
Ol. gaultheriæ,	gtt. x.

M. Ft. capsul No. xx.

Sig: Two every three hours.

This treatment prevents the occurrence of gonorrhœal rheumatism. The salol is slightly decomposed by the gastric juice, but is actively decomposed by the intestinal juices into salicylic and carbolic acids, thus acting as an antiseptic in the urinary tract through which it is eliminated.—*Times and Register.*

SALOLIZED COLLODION.

In both acute and chronic rheumatism the following will serve as an excellent application to the joints:

Salol,	} ̄̄̄	parts 4;
Ether,		
Collodion		parts 30. M.

LEAD POISONING.

Dr. G. L. Walton (Boston Medical and Surgical Journal, October 30, 1890), records a fatal case of lead poisoning in which ataxia was the prominent symptom. The patient was a man, aged fifty-four, whose first manifestation was numbness in the hands. This passed off; then numbness showed itself in the left foot, and persisted gradually spreading up the leg until it reached the back. This numbness and an increasingly staggering gait were the chief things he complained of. There was an uncomfortable sensation in the head, hardly amounting to headache. He had no eye troubles, no pains, no wrist-drop, no loss of power in the limbs, no vertigo, no gastric crises. He could not stand with his feet together and his eyes closed; there was some loss of sensation in the left leg, knee-jerks natural, no ankle clonus, pupils natural, urine natural. The opinion was formed that he was suffering from neuritis of obscure causation. Two months later, the suggestion having been made that the case might be one of arsenical or lead poisoning, examination was directed to these points, and after the administration of iodide of potassium, lead was discovered in his urine, but he still had no blue line and no wrist-drop, and no other manifestation of lead poisoning. The patient was treated with iodide of potassium and continued to excrete the iodide of lead, but he steadily grew worse, and died four months after the lead was first recognized. The only source of lead poisoning that could be found was an old kettle. It was tin-lined, and some water boiled in it for some time was subsequently found to yield traces of lead. Three cases of pseudo-tabes from lead poisoning have been reported by Dr. J. J. Putnam.—*British Medical Journal*.

THE FIRST THERAPEUTIC MEASURE
IN APOPLEXY.

The following is an extract from a clinical lecture delivered by Dr. Heidenhain (*Berlin Clin. Wochenschr.*). The treatment of apoplexy is apparently so self-evident, and has for decades remained unchanged, that at first it seems preposterous to make any changes or alterations whatever.

Doubtless the experience of H. has often occurred to many physicians in their regular practice. The doctor is called to see a case of extensive apoplexy, and elicits this history. The patient has suffered a slight attack of paralysis; he complains of vertigo and a sensation of weight and immobility in both the upper and lower extremities; there is distortion of the facial muscles, and speech is impaired. The patient has been undressed and placed upon a bed; scarcely has this been done, when a second, more profound attack occurs.

This and similar scenes constantly recur in practice; invariably the profound attack occurs shortly after the patient has been placed upon the bed in the horizontal position. This is done again and again, despite the fact that this position conduces to the cerebral hemorrhage, and defeats the very object which it is desired to accomplish, *i. e.*, prevention of recurrent profuse hemorrhage.

After these experiences, it is absolutely necessary that after the first, the mild attack of cerebral hemorrhage, the patient shall be maintained in the sitting-erect position for a long time; so long, in fact, as the patient's condition will permit. Meanwhile, ice to the head, hot mustard foot-baths, rapidly-acting hydragogue cathartics, and in selected cases leeches, will be the prophylactic measures which in conjunction with position as above described will often prevent a second attack.

Just as such grave error is often committed in the treatment of apoplexy, so are errors of equal seriousness committed, even by physicians, in the treatment of syncope due to cerebral anæmia, the reverse condition of the foregoing.

A short time ago H. was called to see a woman who, in consequence of great loss of blood, was in the state of profound syncope. Two doctors were endeavoring to restore her to consciousness, but their efforts were unavailing; and why? The woman lay, or more correctly stating, sat in a semi-recumbent position on a sofa, the head supported on a mass of pillows. H. having ascertained the nature of the trouble, at once removed the pillows, placed the woman's head on the seat of the sofa with her feet elevated on some pillows, when in a few seconds she recovered consciousness. Just as important as it is for the syncopical to lie with the head lower than the feet, so important is it for the apoplectic to occupy the sitting position.

In conclusion, H. suggests that as the application of Esmarch's elastic bandage is so effective in the treatment of profound syncope, so the ligation of the extremities might be successful in the treatment of cerebral hemorrhage, the reverse condition.—*Pittsb. Med. Review*.

POINTS IN THE DIAGNOSIS OF GASTRIC
DISORDERS.

Professor Ewald, says the *British Medical Journal*, in examining the condition of the œsophagus, attaches great importance to the sounds heard with the stethoscope placed on the pit of the stomach. The sounds which accompany and follow the act of swallowing are normally two, *viz.*, the first, *spritz-gerausch* (syringe gurgle); and the second, or *luft-gerausch* (air gurgle). The first has no diagnostic value, and is often absent in cases of hysteria, etc. The second is of great significance, and when present denotes normal contraction of the walls of the œsophagus.

The absence of the sound signifies a stricture or obstruction of the middle or lower third of the esophagus. The best tests for free hydrochloric acid are tropeolin and Günzberg's reagent phloroglucin vanillin. The routine examination of the contents of the stomach to determine the amount of acid present is carried out as follows: 10 cubic centimeters of stomach contents are taken, and two drops of phenolphthaleïn added thereto in a saucer. To this a standard one-per-cent salt solution is added drop by drop from a graduated tube till the color changes to red. The percentage of acid present is determined by the amount of salt solution added, the normal acidity being between forty and sixty cubic centimeters of this graduated cube. The absorptive power of the stomach is determined by giving iodide potassium internally. This should be found in the saliva in from fifteen to twenty minutes. To ascertain the motor power of the viscus, a capsule of salol (one gram) is given, and the urine tested with perchloride of iron for salicylates. Another less convenient method is to give a definite quantity of oil by the mouth, and after a given interval remove the contents of the stomach and ascertain the quantity of oil still present.—*American Practitioner.*

TRANSMISSIBILITY OF SYPHILIS.

As published in his magnificent *Atlas of Venereal and Skin Diseases*, Prof Morrow's conclusions in reference to the hereditary transmissions of syphilis are:

1. A syphilitic man may beget a syphilitic child, the mother remaining exempt from all visible signs of the disease; the transmissive power of the father is, however, comparatively restricted.

2. A syphilitic woman may bring forth a syphilitic child, the father being perfectly healthy; the transmissive power of the mother is much more potent and pronounced, and of longer duration, than that of the father. When both parents are syphilitic, or the mother alone, and the disease recently acquired, the infection of the fetus is almost inevitable; the more recent the syphilis, the greater the probability of infection, and the graver the manifestation in the offspring.

3. While hereditary transmission is more certain when the parental syphilis is in full activity of manifestation, it may also be effected during period of latency when no active symptoms are present.

4. Both parents may be healthy at the time of procreation, and the mother may contract syphilis during her pregnancy, and infect her child in utero. Contamination of the fetus during pregnancy is not probable if the maternal infection takes place after the seventh month of pregnancy.

A REMEDY FOR PALPITATION.

Dr Gingeot (*Revue générale de clinique et de thérapeutique*), suggests as a valuable remedy for palpitation—one that has proved serviceable to him—the application of cold to the precordial region. Attention must be paid to the method of applying cold. The simplest plan of all is to apply a wet sponge over the region of the heart in the morning before dressing. At night, when in bed, the patient or an assistant may put a cold compress over the heart, well covered with dry bandages, to retain moisture and prevent any wetting of the clothing. When this compress is warm, the patient may remove it, and will probably fall asleep. There are objections to the ice-bag, one being the condensation of insensible perspiration upon the surface of the skin. The ether-spray is a simple and convenient method of refrigeration. With proper instruction as to necessary precautions in the use of ether, the patient can apply cold in this way at any hour of the day or night. Palpitation of purely nervous origin seldom fails to be greatly benefited by the application of cold; and a certain success often follows its use in cases of palpitation due to organic disease. Equalizing the heart's action will often prevent an increase in its size. It is also useful in aneurism and passive dilatation.—*N. Y. Med. Journal.*

EHRlich's TEST FOR TYPHOID FEVER,

Make two solutions, one consisting of 72 minims hydrochloric acid and 10 grains sulphanic acid in 3 ounces distilled water; the other, a freshly-prepared $\frac{1}{2}$ -per-cent solution of sodic nitrite in distilled water. To 26 parts of urine from a typhoid-fever patient, and 25 parts solution 1, and one part of solution 2, and the mixture is rendered alkaline by addition of ammonia. A bright orange-red color appears.—*Pract. and News.*

For gonorrhoea Shoemaker advises cleaning the parts with a hot solution of common salt, and the use as an injection of three grains of corrosive sublimate to six ounces of water. Internally he advises the use of terebene in ten-drop doses three times a day, in capsule or on sugar. In a gleet condition the combined use of terebene and belladonna, he thinks, is probably the best treatment. He instanced a case of gleet which had been treated by all the best venereal specialists in this country, which was finally cured by Ricord, of Paris, by the use of belladonna in one-drop doses four times a day, increased to three drops three times a day. Terebene, he says, has not only a most decided action on the gonococcus, but has also a soothing and sedative influence on the mucus membrane of the urethral tract.—*Times and Register.*

THE RELATION OF LUPUS TO TUBERCULOSIS.

Few diseases of the skin have excited so much interest and attention as lupus vulgaris and the affections cognate to it either in name or nature. At the present moment this interest has been intensified, because the influence of Koch's fluid upon tissues affected with tubercle bacilli was in this disease exhibited most remarkably, and the phenomena could be most easily observed. The effect of Koch's fluid upon it has been regarded as a conclusive proof, from the clinical side, of the bacillary origin of lupus vulgaris, which Koch himself had already demonstrated on the microscopical side, though the bacilli were so few and far between as to leave many observers of large experience still unconvinced. It is not, therefore, to be wondered that Mr. Hutchinson should have taken this subject for a series of post graduate lectures, and should tread again the path which his footsteps have so often traversed, each time trying to do something to smooth the way for other travellers; and it is not without interest for us to learn what effect the new light on the subject has upon the mind of so able and experienced an observer.

The lecture before us shows that Mr. Hutchinson still considers common lupus "as a variety of inflammation induced by any one of many local causes of irritation and inflammation;" the peculiarity of the inflammation being due to the special proclivities of the individual, the parasite being at most a secondary phenomenon; but it is not easy to gather to what extent he ascribes a modifying influence to the presence of the bacilli. That this influence is not a very strong one in his view may be inferred from this observation: "If, indeed, it were asked whether the clinical evidence more favored the belief of the alliance of lupus with tuberculosis or with cancer, I am inclined to think that the reply would have to express hesitation." A little further on he says that parts affected by lupus not infrequently take on cancerous growths, and he quotes Dr. Bayha, of Tübingen, who had met with four cases of such a combination in his own practice, and then says: "I doubt much if many observers could collect from their own observations as many as four cases of lupus in which the patients had subsequently succumbed to any form of internal tuberculosis." These are strong statements to make, and coming from so careful an observer can not fail to attract much attention. It is to be hoped, therefore, that in one of the lectures which are to follow he will give us his own experience as to the number of cases in which he has observed cancer associated with lupus. The number of cases on record is certainly not very great, and there is a remarkable paucity of cases in English literature, most of them having been reported from France or Germany.

With regard to the association of lupus and phthisis, Besnier observed it eight times in thirty-eight cases of lupus, that is, over twenty per cent. No doubt further observations are desirable on this point, but we must look for them among physicians who see much of phthisis, rather than from dermatologists, as when phthisis has set in the lupus becomes a matter of secondary importance. Even as regards the family history, Mr. Hutchinson tells us that statistical proofs fall far short of our general impressions as to the frequency of the connection, but that it is otherwise as regards lupus erythematosus; but on this head he promises us further information. Statistics which are to upset so completely the general opinion held on this subject, will be awaited with interest. It is clear, therefore, that Mr. Hutchinson's views are not yet materially altered by any facts furnished by the effect of Koch's injection, though he admits that further knowledge of it may compel such an alteration. He concludes his lecture by saying that, seeing that a considerable group of maladies are inseparably "associated together in the lupus family, it is probable that one and all should be regarded as forms of chronic infective inflammation deriving their peculiarities from the proclivities of the individual attacked and not from specific elements of contagion."

Whether we agree with Mr. Hutchinson or not, it is instructive to note that there are still two sides to the question, and although the influence of Koch's fluid lends a strong support to the bacillary theory, our experience of it is at present far too limited to found any pathologically strong argument upon it. Already we hear of other diseases, such as leprosy, showing decided reactions after injections, and Koch himself is of opinion that it is not so much a bacillus destroyer as a destroyer of a certain ill-formed tissues in which the bacillus resides, and if other similar tissues, due to the action of other bacilli, break down after injections of the fluid, its diagnostic value is *pro tanto* diminished, and we shall still have to discuss the origin and nature of lupus on the other and older grounds. Many of the mooted points might be cleared up by collective investigation. If, for example, each of the members of the Dermatological Society would carefully inquire into the family history and note the complications of every case of lupus vulgaris and erythematosus which came before them, and contribute them to either the secretaries or any one appointed by the Society, a sufficient number of cases to afford really reliable data would soon be collected. Common as lupus is supposed to be, its frequency is overrated on account of the chronicity of the disease and the way in which patients wander from one hospital to another. Some means, therefore, to prevent the record of a case several times over would have to be adopted. Again, the registrars of consumption hospitals might be applied to to

furnish the cases of phthisis and lupus which have occurred during, say, ten years; and, conversely, they might well inquire whether in any of the relatives of phthisical patients cases of lupus or other form of local disease of supposed tubercular origin existed. Investigations on these and similar lines would settle this much-vexed question in a way that would be found impossible by any individual observer.—*London Lancet. American Practitioner.*

TREATMENT OF "COLDS" BY SODIUM SALICYLATE.

In a recent number of the *Memphis Medical Journal* the claim is made that salicylate of sodium is as equally efficacious in the treatment of bad colds as it is in tonsillitis. A prescription of half an ounce of salicylate of sodium with half an ounce of syrup of orange peel, and enough mint-water to make four ounces, is recommended in the dose of a dessertspoonful every three or four hours, until the specific action of the salicylate—that is, ringing in the ears—is produced. It is claimed that aching in the brow, the eyes, the nose, together with the sneezing and the nasal discharge, will then cease, and will entirely disappear in a few days, not leaving, as is usually the case, cough from the extension of the inflammation to the bronchial tubes.

PHENACETIN AS A HYPNOTIC.

It is almost insoluble in water, soluble in alcohol, almost tasteless, may be given like sulfonal, in wafers and compressed tablets, as a powder or with brandy. As an antipyretic and neuralgic it is not as potent as antipyrin and antifebrin, but it is much less a cardiac depressant. In the insomnia of overwork, of nervous irritation, in febrile states, or from headache, it is a hypnotic of great value, in doses of five or ten grains, repeated if necessary. In sleeplessness of intense neuralgia, less than a gramme, repeated two or three times, as needed, is not likely to be effectual, the fact having been first ascertained that there is no intolerance of the drug.—*Boston Medical and Surgical Journal.*

EARLY LAPAROTOMY FOR CATARRHAL AND ULCERATIVE APPENDICITIS.

Professor Senn concludes as follows:

1. All cases of catarrhal and ulcerative appendicitis should be treated by laparotomy and excision of the appendix, as soon as the lesion can be recognized.

2. Excision of the appendix, in cases of simple uncomplicated appendicitis, is one of the easiest and safest of all intra-abdominal operations.

3. Excision of the appendix in cases of appendicitis, before perforation has occurred, is both a curative and prophylactic measure.

4. The most constant and reliable symptoms indicating the existence of appendicitis, are recurring pains and circumscribed tenderness in the region of the appendix.

5. All operations on the appendix should be done through a straight incision parallel to and directly over the cæcum.

6. The stump after excision of the appendix should be carefully disinfected, iodoformized, and covered with peritoneum by suturing the serous surface of the cæcum on each side over it with a number of Lembert stitches.

7. The abdominal incision should be closed by two rows of sutures, the first embracing the peritoneum, and the second the remaining structures of the margins of the wound.

8. Drainage in such cases is unnecessary, and should be dispensed with.—*Jour. Am. Med. Assn.*

ANTIPYRIN IN CHOREA.

In a paper recently read before the Société Médicales des Hôpitaux de Paris (*Bull et Mém.* December 25, 1890), Dr. Charles Legroux states the results of the treatment of chorea by antipyrin in sixty cases observed throughout their course. He found that antipyrin had a beneficial effect in two-thirds of the cases, rapidly diminishing the intensity of the disease, and shortening its duration; recurrence, however, took place in three-fifths of the cases. In the cases in which the drug failed this was found to be due in some instances to intolerance (vomiting, diarrhoea, etc.), or to cutaneous eruptions; in a few cases the drug appeared to have no effect on the disease. He found it necessary to give large doses, and to reach the maximum dose in a short time. Between the age of six and fifteen doses as high as three to six grammes (about $\text{ʒ} \text{ iiss}$ to $\text{ʒ} \text{ iij}$) a day were well tolerated for several weeks. Serious symptoms of poisoning were never observed, and in some cases in which an eruption or vomiting was at first noticed, when the use of the drug was resumed after a short interval these symptoms did not recur. None of the cases treated had any rheumatic symptoms, but none were of a serious character.—*Supp. British Med. Journal.*

ointment for comedones.—The *Canadian Pharmaceutical Journal* quotes the following prescription, said to be used by Unna in the treatment of comedones:

R.—Solution of hydrogen	} of each 2 ounces.	
peroxide		
Vaseline	}	
Lanolin		1 ounce,
Acetic acid		1 drachm,
Mix and perfume.		

TREATMENT OF CERTAIN SPRAINS.

In an article in the *University Medical Magazine*, Dr. D. Hayes Agnew calls attention to certain cases of persistent lameness which have been ascribed to sprains of the ankle, and treated as such with but temporary benefit. The lameness returns on the patient's resuming exercise.

In these cases the trouble is not in the ankle joint, but in the sheath of the tendon of the peroneus longus muscle. This will be easily evidenced by pressure along the course of the tendon, between the external malleolus and the base of the metatarsal bone of the little toe. There is little, if any swelling; pain will also be experienced on forcibly abducting the foot. The differentiation from ankle sprain is comparatively easy, for here there is diffuse swelling about the joint, especially in front, and unusually severe pain on flexing and extending the foot. When the tendon and its synovial membrane are involved, a Dupuytren splint should be applied on the outer side, fixing the ankle and holding the foot in an abducted position. The tendon is thus relaxed and pressure is taken from its canal. With rest and anodyne applications the inflammatory trouble will subside in a week or ten days. The patient must not now be allowed to walk around in an ordinary shoe. A number of plies of leather are to be applied on the outer side of the sole of the shoe, gradually thinning off toward the inner side of the foot, and relieving the tendon from pressure. Such a shoe should be worn for some time, and only restored to its original form by gradually removing one layer of leather at a time from the sole.—*International Journal of Surgery*.

CHRONIC PHARYNGITIS.

The following is said to be a good application:

R Ergotini.....gr. xv.

Tinct. iodini.....ʒ i.

Glycerini.....ʒ i-

M. S.: Apply thrice daily with a camel's hair pencil.—*St. Louis Med. & Surg. & Journal*.

SALOL IN ACUTE TONSILITIS.

In a recent article on this subject, Dr. Jonathan Wright quotes Gouguenheim's conclusions on this subject as the most satisfactory summary. They are as follows: 1°. Salol acts beneficially in acute anginas of whatever cause. 2°. It quiets the pain and dysphagia with the greatest rapidity. 3°. In quieting the pain it may shorten the duration of quinsy. 4°. It lowers the temperature. 5°. In nearly all cases it diminishes the duration of the angina. 6°. In order to attain those results, the dose should not be less than four grammes (sixty grains) daily.—*St. Louis Med. and Surg. & Journal*.

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MONTREAL, APRIL, 1891.

CONVOCATION OF BISHOP'S COLLEGE.

The 20th annual convocation for the conferring of degrees in medicine was held on Tuesday 31st ult, in the Synod Hall, and was one of the most largely attended in the history of the College, most of the leading ladies of the city being present. The Chancellor Mr. Henneker, read an excellent address which was listened to with marked interest.

The valedictorian for the faculty was Dr. McConnell, who touched upon the most important scientific discoveries of the day, and concluded by giving the graduates some excellent advice, among other things telling them that they would do well to spend the next two or three years in either going to Europe, or else in perfecting themselves in the use of the microscope. He also pointed out the value of a knowledge of French and German. Dr. Woods on behalf of the graduates read a bright and cheering address in which he thanked the professors for all the trouble they had taken during their four years study. He also referred in feeling terms to the many acts of kindness shown them by the Faculty, and especially by the Dean who was beloved by all. When Miss Ritchie went up for her diploma there was

an outburst of enthusiasm from the whole audience, in which her fellow students and graduates joined most heartily. A striking feature was the reception by Mr. Edwards, a colored student from Jamaica, of the Wood gold medal for general excellence, and the Nelson gold medal for surgery. This is the second time a colored student has carried off these honors. The high standing of Miss Ritchie and Mr. Edwards in the examinations prove that intellect and industry are quite independent of either sex or color.

MATERNITY HOSPITALS.

A recent outbreak of diphtheria of the genital tract among four recently delivered women in the maternity department of one of our hospitals, which has completely put a stop to all operations there for the present, shows the urgent necessity for removing the midwifery department to another building no matter what immediate sacrifices may have to be made. Experience has proved over and over again that a maternity should never be carried on in a general hospital; but besides the sanitary reasons there is also the ethical one, that unmarried women have a reasonable objection to be operated on in a hospital which has the name of being a lying-in-one. What we would suggest is that the corporation of this hospital erect a one, or at most two storied brick pavilion on the end of their lot, of such a character as to be good for only ten or fifteen years, at the end of which time it might be pulled down to make room for a more imposing structure. The ideal maternity should not have a sewer pipe nor a drain pipe of any kind within its walls; all closets and soil pipes should be in a separate tower connected with the main building by a passage way.

APOLLINARIS WATER.

The introduction of this water into Canada is comparatively of recent date, and its consumption is now very large. Most people who can afford to use it, do so. Teto-

tallers drink it plain, and find themselves better for it. Others employ it with wine or spirit and believe it makes an excellent diluent. To encourage its use as a plain, simple beverage, medical men are fond of recommending it. To convalescents it is a grateful drink—relieving thirst and leaving behind it a pleasant taste. Its cost, though much reduced within the past few years, still keeps it within the range of luxuries. It is, however, possible to reduce its price still lower by remitting the duty upon it—as well as upon all *natural* mineral waters—and such an effort is now being made. We hope it will be successful. We have not any Canadian water, so far as we know, that can compete with it, so then nothing can be urged, so far as protection is concerned, for the continuance of a comparatively high duty. In the United States we believe it is admitted duty free, this concession being made as the result of a memorial to the House of Representatives and Senate of the United States. This memorial was signed by hundreds of the leading medical men, among them being such men as Drs. Fordyce Barker, W. Gaillard Thomas and A. McLean Hamilton, of New York; Dr. Wier Mitchell, and others of equal eminence in Philadelphia. A somewhat similar memorial is being prepared for presentation to the Canadian Government, which we hope will be successful.

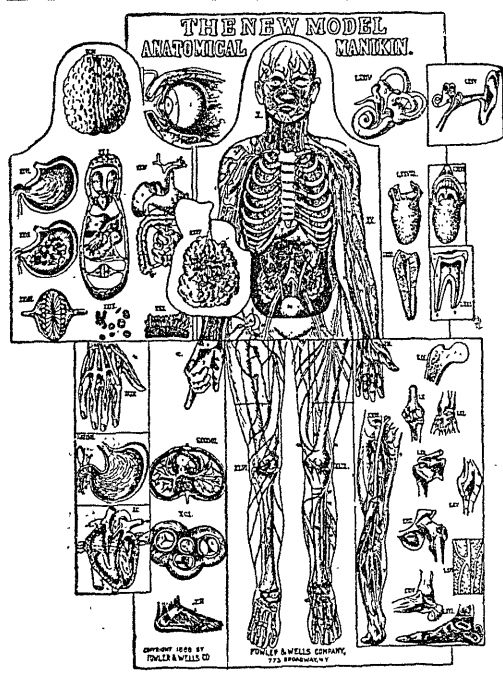
IODIDE OF POTASSIUM IN THE TREATMENT OF URTICARIA.

Stern has successfully treated five cases of chronic urticaria by the administration of iodide of potassium, four of the cases having been rebellious to all the measures usually employed in this disease. The fifth case was one of acute urticaria of a few day's duration. None of the patients were syphilitic and all were rapidly cured. In one case which had lasted for four months the intolerable itching disappeared on the second day of treatment, and a complete cure was obtained after two and a half drachms of the iodide had been administered. In two other cases, one of two years' and the other of six years' duration, the effect of the iodide was equally good, cure following the administration of six and eight drachms respectively.—*London Medical Recorder*, November 20, 1890.

BOOK NOTICES.

THE NEW ANATOMICAL MANIKIN. Fowler and Wells Co., 775 Broadway, New York.

The accompanying engraving gives only a very inadequate idea of this valuable work. When folded up the manikin appears to be an ordinary atlas, measuring about eighteen inches square, but when open it measures thirty-six inches in height, and is arranged so as to be hung on the wall. In this comparatively small space the publishers have managed with great skill to include no less than one hundred and two beautifully colored lithographic drawings, many of them life-sized, of every portion of the human body. This is accomplished by constructing the manikin in successive layers which open on hinges showing just what the dissector would see on removing successive layers of tissue by dissection. Thus at first we have a half life size view of the body with only the skin removed; there are the blue colored veins, the red colored arteries and the nerves tinted yellow. On one side a layer of muscles has been removed so as



to show the next layer and also the distribution of the arteries, while the bones and joints are outlined underneath. Every bone and muscle, nerve and artery and vein has a number on it, which by referring to a small index at once tells the name. By opening up the first sheet we then come to a posterior view of the body, every muscle being clearly exposed, in some cases there being three engravings of the same region so as to show the successive layers of muscle removed. Then we come to sections of the bones and joints, there being a beautiful engraving of each, showing the ligaments, the drawings of the ankle joints and sections of the other joints in the foot being especially good. There is also a microscopic section of bone. Nothing is omitted, even the lymphatic glands being faithfully delineated. Then comes the anterior view of the blood-vessels of the face and neck, and the thorax, showing lungs and

heart between the ribs; while lower down on the same plane is seen the stomach and intestines, the omentum having been removed. Engraving XXIV gives a very fine view of the stomach, small and large intestines, and the liver. XXIX shows a drop of blood, magnified, and XXX represents a section of villi of small intestine. Three drawings exhibit the appearance of the interior of the normal stomach and the changes which take place in it from alcohol drinking. Another part of drawings shows the normal and the brain congested by liquor. XLII is a beautiful drawing of the brain, spinal nerves and sympathetic system. LI shows in more detail the sympathetic and pneumogastric. All around the main charts are smaller ones about five inches square showing the special organs: anterior view of eye; anterior view of ducts and glands of eye; anterior view of eyeball, lids being removed; eye ball with nerves and muscles as seen from above; transverse vertical section of eye showing lenses, coatings and muscles; external ear; bony labyrinth; internal ear; tongue and throat; cancer of tongue; section of teeth; section of skin; larynx, vocal cords, and the internal and external muscles. No. LXI shows the cæcum and lower portion of ascending colon, laid open, showing the termination of Æum, appendix vermiformis, ileo cæcal valve and the opening of the appendix vermiformis. XCIII, XCIV. and XCV. are beautiful, full-sized pictures of the kidneys, normal and in a state of degeneration. Space does not permit us to go into the many other drawings in detail, but what we have said will enable our readers to judge of the great value of such an atlas to hang on the wall of their consulting rooms, where they can only be looking at it themselves but where they can constantly turn to it in order to explain to patients the nature and location of their disease. This is no longer an age of medical mystery: patients will not be satisfied with platitudes, they must know exactly what is the matter and where the trouble is. In some respects this is to be deplored, for it makes the lot of the practitioners a much harder one than it used to be, when no explanations were required. This atlas seems have been prepared for the express purpose of making this task a lighter one, for the practitioner only has to point to the atlas to make even the most stupid patient understand where his trouble is, and thus make him far more satisfactory in carrying out our directions. We venture to say that this atlas would pay for itself in a very few months by the increased number of visits which an interested patient will make to the consulting room.

PATHOLOGY AND THERAPEUTICS OF THE DISEASES OF WOMEN. From lectures given to physicians during the vacation courses by Dr. August Martin, Instructor in Gynecology in the University of Berlin. With 210 woodcuts. Translated from the second revised and enlarged edition, with the approval of the author, with notes and appendix, by Dr. Ernest W. Cushing. Second American edition. Published by E. W. Cushing, M. D., 168 Newbury street, Boston, Mass.

To Dr. Ernest W. Cushing, the talented editor of the *Annals of Gynecology* of Boston, and a Gynecologist of the highest order, those members of the profession who are interested in operative gynecology are under a heavy debt of gratitude for his laborious task of translating August Martin's book. That his labor has been appreciated is evident

from its having within two years of its appearance run through two editions. Gratifying as this must be to him, we think that several editions more would soon be called for were the existence of the translation more widely known. Any one who has seen August Martin operate will agree with us that as an operator he stands unique, while it is equally evident that he has contributed largely to form the character of modern operative gynecology in America, through his pupils. The translator aptly puts it in his preface when he says: "In determining to translate the work of Dr. Martin into English, I was influenced not only by a desire to show my appreciation of the many favors and courtesies which I received at his hands during a somewhat prolonged sojourn in 1885, but more particularly because the pathological theories advanced and the surgical treatment recommended, differed so materially from what I was familiar with in current theory and practice in this country."

On entering on a very active practice in a large hospital in 1886, Dr. Cushing was able to demonstrate the great safety and convenience of the treatment recommended in Dr. Martin's work. At that time these views were innovations, but since then most of them have been generally adopted. Such for instance is the regular use of the dorsal position; the constant employment of sublimated irrigation in operating; the free use of the sharp curette, followed by flushing of the uterine cavity in endometritis; the abolition of wire and shot in all operations; the accurate views as to endometritis, and the disposition to regard the conjection and heaviness of the uterus as secondary to the endometritis, instead of *vice versa* as was then commonly believed in the country. In addition to Dr. Martin's work proper, this translation contains an introductory chapter on the advances of gynecology in Germany, during the last two years so that it is in every respect up to date. Moreover Dr. Cushing's micro-photographs, which elicited the greatest admiration at the Congress in Washington, are inserted in the work opposite the appropriate subjects, as also are many other photo-engravings which appeared in the Annals of Gynecology. It is interesting to note that it has already been translated into French, Italian, Russian and Spanish as well as English. In conclusion we would urge all those who are preparing, or who are about to prepare to undertake gynecological operations to procure this work at once, the study, of which will amply repay them for the slight expenditure of time and money. To any who can we would say, "see Martin operate," but to all who cannot see him operate we would say, "read his book." The writer of this notice is under lifelong obligations to Dr. Martin for his kindness while a student of his in 1887, and has done what little he could to introduce his methods into this country; and he will be pleased indeed if by calling the attention of the readers, of THE RECORD to the merits of Dr. Martin's work, he may contribute a little more to give his master the merit he deserves. Of the translation it is hardly necessary to add that the original has lost nothing and gained not a little at the translator's hands.

PERSONAL.

Dr. O'Connor has taken the house formerly occupied by Dr. Laphorn Smith, while the houses formerly occupied by Drs. Blackader and Perry have been converted into shops.

Dr. Laphorn Smith, who removed his residence last spring to 248 Bishop street, retaining his office at 68 Beaver Hall, will in future have his office at his residence, 248 Bishop street, above St. Catherine street.

Dr. McConnell, who has been located for the past ten years in Bleury street, will remove on the first of May, to the corner of Union avenue and Berthalet street, just opposite to Dr. Major's. This is one of the best locations in the city, and as Dr. McConnell is now one of the "older" practitioners, we think the move will be a good one.

Dr. Geo. T. Ross will also leave Beaver Hall on the first of May, having rented the fine house being built by Dr. Dugdale, next to his own at the corner of Dorchester and Mountain streets. This latter locality is fast taking the place of Beaver Hall, there being at present grouped within a hundred yards of this corner no less than fourteen physicians, among whom are Drs. J. C. Cameron, J. Stewart, Stirling, Dugdale, G. T. Ross, Blackader, Allan, Drummond and Lockhurst.

We have much pleasure in welcoming to the ranks of the profession, Miss Grace Ritchie, (C. M., M. D. Bishop's College, 1891). By her assiduity in the classes and especially in her hospital and dispensary work, she has completely refuted the argument that women are unable to compete with men in intellectual work. We hope that ere long both Miss Ritchie and Miss Mitchell may be admitted to the meetings of the Medico-Chirurgical Society. As one of the leading members recently remarked, "the more we have of such workers in it the better." We understand that Miss Ritchie will proceed to London to take an English diploma before settling down to practice.

NEWS ITEMS.

W. R. Warner & Co. are evidently determined to keep in the van of therapeutic remedies. "Antalgic Saline" appeals to us to-day for recognition as a remedy for the relief of "headache," also for influenza and neuralgia, and as an antidote of "la grippe" they issue the "Pil. Chalybeate Compound."

Composition carb. protoxide of iron, grs., $\frac{2}{3}$.

Ext. nuc. vom., - - - - - gr., $\frac{1}{8}$.

Sig.: One pill every four hours and increase to 2 pills three times a day.

Antalgic Saline, one dessert spoonful every four or five hours till relieved for headache. The same mode of administration precedes that of the chalybeate pills for "la grippe."—*Weekly Medical Review*.

CONGRESS OF AMERICAN PHYSICIANS AND SURGEONS.—The meetings of the Congress of American Physicians and Surgeons will be held in Washington from 3 to 6 p.m., September 22nd, 23rd, 24th, and 25th, 1891. William Pepper, chairman of the Executive Committee.