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THE PREVENTION OF PUERPERAL SEPTICÆMIA.*

BY DR. A. H. WRIGHT,

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We have heard much in recent years about the best methods of preventing puerperal septicæmia, and some may think that the subject has been pretty well "threshed out." My observation and experience, however, prevent me from coinciding with any such opinion. On the contrary I think we should continue to discuss the matter until sepsis in the lying-in room becomes practically unknown. When this happy condition of things comes into existence—and I fear it will not come for some time—we will still do well to use our best endeavors to prevent a recurrence. A few years ago most of us thought that puerperal fever could scarcely be avoided in our ordinary lying-in hospitals. To-day we know that puerperal septicæmia is more common as a rule in private practice than in well-conducted hospitals, even though they be crowded. This fact is anything but creditable to the general profession, and I now ask the members of this Association to see to it that such a reproach or stigma shall not long be attached to obstetric practice in the Province of Ontario.

Within three months of last year I happened

* Read at the Meeting of the Ontario Medical Association, June, 1889.

to see six cases of puerperal septicæmia—two in the general wards of the hospital, and four in consultation outside. Of these six, four died. There was no report of any general epidemic at the time, and my surprise was only exceeded by my regrets at such disastrous possibilities. A physician of Toronto—one of the most careful and intelligent I know—told me recently that he had nine cases of puerperal septicæmia last year. Another, who had been out of college about a year, with, I fancy, a very limited mid-wifery practice, told me he had had five cases of puerperal fever with one death. To commence one's obstetric career with such a record as this is sufficiently bad, but the saddest feature connected with his recital was his apparently thorough want of appreciation of his own responsibility in the matter. I refer to these facts to show that puerperal septic infection is far too common, and yet how much of it exists I have but a vague idea. We are not to judge of its effects simply from its death-rate. Those suffering from the milder forms of septicæmia generally recover in a sort of way after a more or less protracted illness, but the proportion of such who are not to some extent crippled for life is, I fear, comparatively small.

Can we prevent this septicæmia which is followed by results so disastrous, so appalling? Yes, I think we can. Certainly we should try. In fact we should make it the chief aim of our life, as far as our obstetric work is concerned, to prevent it. How shall we do so? My answer is simple enough, and will probably be generally

accepted, by modern antiseptic, or, more correctly, aseptic methods. And yet I must confess that mountains of rubbish have been heaped up in the endless discussions that have taken place in connection with this subject during the last few years. Many an enthusiast, who has pinned his faith on some special antiseptic, fully assured that his favorite remedy will purify dirty hands or dirty instruments, has not, to my mind, grasped the first principles of aseptic surgery or midwifery. He who thinks that he may be indifferent about minor details and trust entirely to certain solutions to purify his instruments and cleanse his hands, knows practically nothing about asepticism. What we actually require for ourselves is thorough and perfect cleanliness, and the essentials for such are hot water, soap, a nail brush, and a penknife. We want for our patients proper cleansing of bleeding surfaces, and dressings which will keep them clean, and, along with these, good ventilation, thorough drainage, and perfect plumbing. The majority will probably agree with me when I say that modern antiseptic remedies furnish us invaluable assistance in our efforts towards asepticism.

My intention is to describe certain features of our ordinary methods in the Burnside Lying-in Hospital with a view to the prevention of puerperal septicaemia, and to refer to a few points therewith, interesting both to hospital and private accoucheurs. The patient on admission receives a warm bath, and is kept thereafter as clean as possible. She is dressed entirely in clothing belonging to the hospital. She is allowed to do light work, and her surroundings are as cheerful as possible. When the labor pains commence she is clothed in a clean night-dress and drawers, and placed on the delivery bed in charge of the resident assistant and one of the nurses. The presentation is made out as far as possible by abdominal palpation. Vaginal examinations in the first stage are made occasionally, but as seldom as possible. A basin of warm water, soap, and a nailbrush are placed on the wash-stand, and near them a second basin containing a solution of bi-chloride, 1-1000. Each one who touches the patient is expected to first wash the hands thoroughly, using the soap, nailbrush and a penknife. The hands are then rinsed carefully in the bi-chloride solution immediately before

examining the patient. If internal examinations be repeated, this rinsing of the hands is to be done before each. During the latter portion of the first stage, while the presenting part is pressing on perineum, the vulva is protected by a towel which has been soaked in the bi-chloride solution. After the delivery of the child no vaginal examinations are made, unless they are absolutely necessary on account of some abnormal condition. The placenta is expressed by the modified Crede plan, or perhaps more correctly by the Dublin method. The assistant watches carefully the condition of the uterus and endeavors to keep it contracted by pressure with the hand or gentle rubbing with the fingertips. The nurse takes away the soiled clothes and washes the vulva with a bi-chloride solution. No vaginal or intra-uterine douche is used either before or after labor, excepting in rare instances where in the opinion of the visiting accoucheur it is advisable. The antiseptic pad is then applied. This pad which I now show is made from a piece of butter-cloth twenty-one inches square. This is doubled and a cut made extending inward six inches, which will leave seven inches of cloth at one end, and fourteen inches at the other. Before folding, a layer of absorbent cotton fourteen inches long and seven inches wide is placed in the centre, and over this the butter cloth is folded from either side. The next step is to double the part containing the absorbent cotton, then double again, and over this fold one-half of the piece at the top, which will be three and a half inches in width and completely envelopes the pad, leaving a stub at each end which can be slipped under the binder and pinned to keep in position. A piece of butter cloth ten inches square with a layer of absorbent cotton in the centre, folded so as to be four inches wide is also prepared. This is wrung out of a solution of bi-chloride, 1-1000, and placed over the vulva. The dry pad is applied as before described. I am indebted to Miss Snively, the matron of the General Hospital, for this description of the pad, and I may add that to her is due the credit of bringing it to its present state of perfection. The pads are changed every six hours or oftener if required. Wash cloths are used which consist of antiseptic jute folded in a piece of butter cloth. These, together with the

pads, are burned after being used once. I have to show you a sample of an antiseptic pad used by Dr. Price in the Maternity Hospital of Philadelphia, where the most careful antiseptic precautions are observed with remarkable success. Dr. Price described this pad in a recent report of the work done in his hospital, and kindly sent this pad with a written description in reply to a letter received from Miss Snively. A comparison of the two pads will show, I think, that our Burnside pad is simpler, requiring no sewing. It also has greater absorbent powers, is less clumsy and less expensive. The average cost for each patient is seventy cents.

Our methods in this Maternity Hospital are sufficiently simple and are very easy to carry out. They are in no sense "meddlesome," they involve watchful care on the part of the physicians and nurses, they are thoroughly effective. Septicæmia in the Burnside has been exceedingly rare during the last few years. The temperature rarely reaches 100°. The patients generally go out in two weeks after labor in good condition.

I will refer briefly to a few points in connection with the methods I have described.

1. *Vaginal and intra-uterine douches.* I object to the use of such douches because they are unpleasant for the patients; because they interfere with that physiological rest which the torn and bruised parts should have; because septic matter or air may be introduced and brought in contact with rents in the cervix, vagina, or vulva; and finally, because they are unnecessary. I think that our results without them in this hospital prove that they are not required. Some practitioners agree that they are unnecessary as a matter of routine in all cases, but advise their use when the hand has been introduced into the vagina or uterus. I do not use them even under these circumstances, but endeavor to have my hands clean, and find that such precautions are quite sufficient. I have here a chart of a case of hæmorrhage continuing three hours after labor, in which I introduced my hand into the uterus and with much difficulty removed some placental detritus. I then sutured a deep cervical rent, and a lacerated perineum. I simply wiped out the vagina with sublimated absorbent cotton, without any douching, and the patient has made up to the

present time a good recovery without any rise of temperature. Dr. Price, of Philadelphia, in the report to which I have referred, tells us that the patients in his hospital receive a vaginal douche of bi-chloride solution immediately before and after labor. His results are so marvelously good that I can say nothing against his methods, but I still feel that our own records show that equally good results may be obtained without douching. I am always open to conviction, and if at any time our methods appear faulty, I may try this limited douching. I am exceedingly anxious, however, to adhere to methods which can easily be carried out in private practice, where douching by incompetent nurses is absolutely injurious. I may simply add, without further discussion, that the dangers of bi-chloride poisoning after delivery have been found very serious.

2. *The expression of the placenta.* It has been found that the placenta can be easily expelled in the great majority of cases by pressure over the uterus, and I think it very important that the fingers should not be introduced into the vagina after the delivery of the child. An examination after even slight rents have occurred in cervix, vagina, or vulva, is infinitely more dangerous than before; because there are a number of torn blood vessels and lymphatics ready to absorb the slightest degree of septic matter that may be brought in contact with them. You may say that if our hands are clean such dangers are avoided. That may be true to a certain extent, but I feel that there is always a danger of introducing air. I take broader grounds, however, and insist that we should take no risks that we can possibly avoid; and if our fingers are not required in the vagina after the delivery of the child, why in the world should we stick them there? The obstetrician should do as little manipulation work as possible in a normal labor; he should allow nature to do the whole work if she can; he should endeavor to keep his patient cheerful and hopeful, while he himself is ever attentive and watchful; he should take every possible precaution even in the minutest detail; his only thoughts should be bestowed on his patient's welfare, and not on any glory for himself. He who acts on these principles does his duty to his patient, to his profession, and to his Creator.

3. *The antiseptic pad.* I have an idea, the correctness of which I hope I may never have the opportunity to prove, that puerperal septicæmia is more frequently caused by absorption of septic matter by the torn fourchette or perineum than from any other source. This is the surface that is most exposed to the ill effects of septic midwifery, and should, therefore, receive our most careful attention. The ordinary discharges, which are generally innocuous during their passage outwards, may become septic very soon after they have been exposed to the air, when they are likely to be absorbed by the vessels of this superficial rent, and thereby cause general poisoning of the system. We endeavor to avoid this by the use of the antiseptic pads, and cleansing the vulva with the bi-chloride solution when the pads are changed. In private practice I do not use the pads, but after cleansing with a similar solution, have the fourchette or perineum dusted with iodoform, and have a layer of absorbent cotton, which has been dipped in the bi-chloride solution, placed over the vulva. This is covered with the ordinary napkin, which should of course always be perfectly clean. In three or four days the rent has probably become a granulating surface, which, as you know, is comparatively non absorbing, and our chief dangers from septicism are absent.

These details which I have described, and the brief explanations which I have given, have, it appears to me, the merit of simplicity. I feel certain that our success in surgery and midwifery depends largely on our scrupulous attentions to such minutæ. By experience I have discovered that these apparently small matters are difficult to learn and difficult to teach. After a careful study of the best means of preventing one of the greatest of obstetric misfortunes, septicæmia, I am thoroughly convinced that if you and I, and with us the general profession of this country, arrive at a proper appreciation of the dangers which exist, and the best means of preventing them, which I have so imperfectly described, that incalculable good will be the result. It will be a grand and glorious day for all civilized countries in the universe when every variety of puerperal septicæmia has been extinguished. Let us as general practitioners never rest satisfied until, in this fair Province of ours, that desirable end has been accomplished.

A COMMON AND EASILY PREVENTABLE CAUSE OF RETRO-DISPLACEMENTS.

BY A. LAPHORN SMITH, B.A., M.D.

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During the last few years the views of the profession on the subject of displacements of the uterus have changed very much. Whereas formerly a long list of symptoms were attributed to anterior displacements, and many pages of works on diseases of women were devoted to their description and treatment, now it is pretty generally admitted that the uterus, if otherwise healthy, may be anteverted at a very acute angle with the vagina and still the patient may be in a condition of perfect freedom from pain. Nay, more; one operator has gone so far as to sew the uterus to the anterior vaginal wall, thus causing an exaggerated anteversion as a remedy for retroversion. Far different is it, however, with retro-displacements, which are admitted by all gynecologists to be very troublesome conditions both for the patient and her attendant. Believing as I do, that they are very often caused by a prolonged dorsal decubitus after confinement or after miscarriage, when the uterus is especially disposed to obey the unailing laws of gravity, I am convinced that a more general realization of this fact would lead to the prevention of a disease which is sometimes very difficult to cure. Judging from my office practice I can say that the history of nearly every case of retro-displacement that has come to my knowledge has dated either from a labor or a miscarriage. Of course the size and weight of the uterus after the latter occurrence will vary with the period of pregnancy at which it occurs. But with regard to the former, we know that immediately after labor the uterus weighs nearly two pounds and measures seven to eight inches in length. One week later it should have come down to one pound and measure five or six inches in length. A weight of two pounds is quite sufficient to make the organ gravitate to the lowest part, so that if the woman lies on her back the fundus of the uterus will fall on to the promontory of the sacrum, while the os is held more or less fixed, or is carried forwards and upwards. As the uterus becomes smaller it will slide down the hollow of the sacrum. The

round ligaments which are now generally supposed to act as ropes to hold the fundus forwards, are unable to do so owing to their great relaxation or elongation during pregnancy, and as they become shortened again through the same process of involution as that by which the uterus becomes smaller, if involution of the latter is arrested so will it be with these ligaments.

If the uterus then gravitates into the hollow of the sacrum before involution has taken place, several things will happen. First, the round ligaments remain elongated and cease to act as stays for holding the uterus forwards. Second, the uterus is left in the position of a bottle with the mouth up, so that the abundant secretions are retained in the organ, or worse still, leak through the fallopian tubes into the peritoneal cavity. Third, the heavy fundus presses on the iliac veins and thus shuts off the outflow of blood from the uterus.

After a miscarriage the same thing may happen if the patient be ordered to remain on her back.

Now there is hardly any part of the body where drainage is more important than from the uterus, for if the secretions which leak through into the peritoneal cavity happen to be infected with poisonous microbes, as they too often are, then we shall have in addition to the subinvolution and retro-displacement, an active local peritonitis with effusion of plastic lymph (nature's method of limiting the extent of the damage), which binds down the tubes and ovaries in the new and faulty position in which it finds them, closes up the pavillions and even seals the uterus firmly to the sacrum, from which later on the gynecologist may have the greatest difficulty in detaching it. Moreover it is one of the qualities of organized plastic lymph to contract, and unfortunately in this locality the result of its contracting is to constrict the tubes so that they are not only no longer able to move freely to embrace the ripening egg on the ovary, but the circulation of the tube is so interfered with that it becomes congested and sensitive. Sometimes even the strangulation is so great that its watery or purulent contents are unable to escape, and then we have hydro- or pyo-salpinx, for which the only cure may be removal.

If the parturient woman were ordered to

remain on her face or on her sides as much as on her back, the uterus would occupy a position of ante flexion, which of itself is natural, the round ligaments would have the traction taken off them long enough to allow them to become shortened or involuted, the uterus would drain itself, and probably salpingitis and ovaritis, due to dirty confinements, would cease to occur.

The erroneous idea that a woman should remain motionless on her back for ten days after delivery probably had its origin in the endeavor to counteract the opposite error of getting up and working a day or two after, which civilized women cannot safely do. In a state of nature it is far different; the Indian woman fastening her child to her back and running after the tribe on the march, and in doing so bending forward so as to place the uterus in anteversion and thus secure perfect drainage.

Some years ago I called attention to the importance of allowing the newly delivered woman to sit up in bed while evacuating the bladder and bowels, because by so doing the clots in the vagina and the discharges in the uterus could gravitate outside, at least several times a day. Modern women I believe it is necessary to keep in the recumbent position for at least a week after delivery, but I think that it is still more important that they should not lie on their backs all that time, as by so doing they are exceedingly apt to contract retro displacements.

Selections.

IMMEDIATE SIGNS OF DEATH.

TRANSLATION OF A PAPER BY M. BROARDELL
IN THE GAZETTE DES HOSPITAUX.

A pathognomonic sign of death does not exist. It has also been claimed that a declaration of real death is an uncertain one. There is, indeed, a work in which it has been proved conclusively that Napoleon never existed! However a sum total of facts, uncertain when taken separately, may give in their totality an absolute proof. In typhoid fever, neither the headache, nor the epistaxis, nor the gurgling, nor the diarrhoea, constitute separately absolute symptoms; nevertheless it is from the simultaneous appearance of these signs that we unhesitatingly make the diagnosis of typhoid fever.

It is in the early stage that the diagnosis of death should be established, so that one may know whether one may desist in efforts to recall the patient to life, and whether he may be buried. Now, at this time, functions only are abolished, and there are only negative signs. Cerebral apoplexy will not be confounded with death; for in apoplexy the circulation and respiration still continue.

The immobility of the features which results from the abolition of movement is almost characteristic. The skin is retracted, the nose is pinched, the beard and nails seem to be elongated. A powdered appearance of the nostrils is not a sign of death. People die with the eyes open, and that is why one likes to close the eyes of one's friends. The value of this sign has been much insisted on; and, indeed, it is a very good one. Sometimes there is a little external strabismus, and the pupil looks upwards. Often, at the supreme moment, the pupil is enormously dilated. Since we are speaking of the eye, I may relate the experience of a medical man who claimed that he found the silhouette of the assassin and of a dog in a photograph which he had made of the retina of the victim. It was absolutely impossible for me to discover there what this physician believed he had seen.

Continuing the study of the modifications of mobility, we find falling of the lower jaw; to avoid the unpleasant spectacle of this gaping mouth, the chin is usually drawn up with a handkerchief. This is a sign which, taken by itself, is of no great value. There are, in fact, some who die with the jaws contracted, particularly as the result of tetanus, or certain poisons, such as strychnine. Sometimes strychnine produces relaxation, when the patient has taken a dose insufficient to kill him quickly; so that in this form of poisoning one may have, according to the class, either firm contraction or absolute relaxation.

For a long time it has been noticed that after certain wounds death is accompanied by intense muscular rigidity, so that a person may become suddenly immobile at the instant he receives a wound, and remain fixed in the position which he had before death. At the battle of Inkermann a colonel had his head carried off by a ball, but he remained on his horse and led a fine charge at the head of his men. Some time

before, at the battle of Alma, a French surgeon was greatly astonished to find Turks in the attitude of prayer immovable in death. I recall the case of a soldier who remained seated on the bank of a stream ready to carry his goblet to his mouth at the moment when he had his head carried off by a shell. At Bazeille, similarly a French soldier was killed while taking aim at a German, and he preserved this offensive attitude after death. Generally cases in which this phenomenon has been observed, and which are of great interest from a medico-legal point of view, have wounds involving the spinal cord or the medulla oblongata. Sallust records that the countenance of Catiline preserved after death that fierce appearance which he had when marching on Rome, and Fodéré claims that suicides or those who have been assassinated preserve in their physiognomy the expression of the sentiments which were likely to animate them during the last moments of their lives. While I was engaged in legal medicine, I very often came in contact with courts of justice, and I found this characteristic well marked only once. It was in the case of Marie Regnaud; she was lying across her bed, her hand directed towards the bell cord, and her contracted countenance expressed, without doubt, terror. What is certain is, that you should always note the aspect of the physiognomy, taking no note of the emotion which might make you see more than there is.

A few moments after death the sphincters are relaxed, gas and sometimes fecal matters escape. Flexion of the thumb towards the palm is produced in most cases; Devergie has observed it seven times in ten.

In order to be certain that death was real, some physicians asked the Senate of the empire (French) to order experiments to be made on all dead bodies with a Ruhmkorff coil. They would have borne the deceased on an open bier to the door of the church, and there the priest himself was to make a certain number of trials. This proposition was abandoned because of the numerous essential difficulties of carrying it out.

Some have spoken of scarification; it is not a convincing proof, since hysterical persons may be pricked without blood appearing.

In a communication made to The Academy, Dr. Josat presented a pair of forceps of his

invention provided with interlocking teeth, and starting with the affirmation that the most sensitive part of the body is the nipple, he claimed that there was no apparent or pretended death that could resist a bruising of that part by his forceps.

The sensitiveness of the mucous membrane of the nose has been made to do duty, and on this point I recommend to you a proceeding which consists in injecting a drop of ether into the nasal fossa; a very lively stimulation follows.

Budin has shown that when the palpebral reflex has been abolished anæsthesia has been pushed a little too far; but this sign relates rather to surgery than to thanatology. Dr. Collonges has instituted a sign which he regards as certain. All that is necessary is to introduce the finger of the subject into one's ear; if he is alive one hears a sound peculiar to the muscles; if he is dead one hears nothing. Dr. Collonges has even invented an instrument which permits him to perceive the least sound.

I pass to the consideration of stoppage of respiration. There is no sign which is more uncertain, since in cases of apparent death there is precisely cessation of respiration. Winslow proposed to place a glass full of water on the eighth rib, so that the least respiratory movement would cause it to overflow. But movement of gas in the dead body would produce the same result.

The most certain signs are drawn from the circulation. Bouchat has said: "It is not to the pulse that we must direct attention, but to the heart; and if, after having auscultated for three minutes, not a single heart-beat is heard, one may affirm that life is extinct." And then he extended this test to five minutes, then to twenty minutes. Here it is that we find ourselves in the presence of numerous causes of error, which depend on him who is auscultating, and on him who is being auscultated; on the one hand, delicacy of hearing may cause a defect in the observer, and on the other the heart may continue to beat in a slow and noiseless fashion. By the name of *akidopeirastic* is to be understood a proceeding which consists in plunging into the heart a long needle, the outer end of which indicates the condition of movement or non-movement of the heart. This is an experimental method which is not very prac-

tical when there is any doubt as to the reality of death.

It has also been proposed to open the temporal artery; but there are diseases, such as cholera and syncope, where the circulation is arrested. The same objection applies to opening a vein. It is better to have recourse to the more simple method of tying a ligature firmly round a limb and noticing whether or not congestion is produced.

I come now to a much more important sign of death, this is the *sugillation* or cadaveric lividity, which shows itself in the form of violet discolorations appearing as if made with a brush in those parts where the body does not rest on a resisting surface. Some imagine that these may be confounded with ecchymosis; but at first the position of sugillations can be changed by altering the position of the body, and then if an incision is made a coloring matter is found in the veins, and at the end of a certain number of hours this coloring matter transudes into the tissues. M. Mollant, mortality inspector, has never seen them wanting in 15,146 bodies which he has had to examine, even in cases of puerperal hæmorrhage. It is therefore an excellent sign. Here, however, is a source of error; there are diseases where sugillation appears four or five hours before death; but these are certain extreme cases of cholera, anæmia, and asphyxia. Cadaveric lividity develops when, the capillaries being paralyzed, the blood accumulates in the dependent parts, and the coloring matter of the corpuscles is carried in the serum. It may be observed immediately after death, or five hours after, according to the kind of death.

Coagulation of the blood is also one of the conditions on which medical jurists have often differed. It has been said that living blood coagulates, while dead blood does not. It is true that blood drawn from an individual in full health promptly coagulates, but blood drawn from a dead body also coagulates after a longer or shorter time; there are also cases where the blood coagulates in the vessels while the individuals are still alive. I do not see how one can gain any assistance in making a diagnosis of death from these different phenomena, so very difficult to appreciate.

A sign of death which may be considered as

almost certain is derived from the temperature of the body. But not only does the corpse not become suddenly cold at the moment of death, but in certain cases there is even an elevation of temperature post-mortem, due doubtless to the intensity of chemical action which then supervenes. This phenomenon usually takes place in zymotic diseases, and in cholera in particular, which is characterized by its subnormal temperature. One is often very much astonished at seeing the temperature suddenly rise to $107.5^{\circ} F.$, or $109.5^{\circ} F.$ It is of greater interest to know how long this temperature takes to fall. The cooling goes on at unequal rates; at first there is a pretty sudden lowering, then a period of rest, and then a much slower loss. One of my students has been able to prove that the cooling takes place from the periphery towards the centre, but that correspondence with the surrounding temperature is reached only at the end of forty or fifty hours, although the experiments were made on the marble slabs of the amphitheatre in a medium favorable for cooling. It is to be remarked that this cooling varies greatly according to the medium in which the body is kept.

Formerly the question was often debated whether those who were drowned cooled more quickly than others. Well, as water absorbs heat ten times better than air, a body plunged in water will cool ten times quicker than a body exposed to the air.

Finally, the size of the body should also be taken into account, especially when we have to do with very much emaciated or very fat persons. Fat is a bad conductor of heat, and consequently retards cooling.

What degree on the thermometer can we mark as a certain sign of death? Here are too very instructive facts. While M. Bourneville was an intern at the Pitié, an individual was brought to him who had been found completely nude lying on the couch in his bedroom, and who had a temperature of $80.7^{\circ} F.$ in the rectum. This individual died, and at the moment of death the thermometer rose from $82.4^{\circ} F.$ to $96.8^{\circ} F.$ The second case is one of M. Laborde's. He was attending a person dead-drunk who had a rectal temperature of something over $78.8^{\circ} F.$; they succeeded in heating him up and bringing him back to life. A tem-

perature, then, of $79^{\circ} F.$ is not incompatible with life. But I am convinced that if one observes a temperature of $68^{\circ} F.$ one may certainly consider the patient dead. It is upon this view that a certain number of authors have constructed *thanatometers*, which are only varieties of the thermometer, and consequently useless instruments, since the latter is sufficient.

The other signs of death which have been insisted on, are the following: The physician who is observing the death should energetically rub the body so as to raise the epidermis; six, seven, or eight hours afterwards there will be at the same place a parchment-like spot (*plaque parchminée*) indicating death of the tissues. But besides this operation, which would compel the physician to uncover the body, not being agreeable to the friends, I recall the case of a young girl who, being suddenly taken very ill in a house where she should not have been, had been so energetically rubbed by the person who had taken charge of her, that she had not more than half a square inch of epidermis left on her body; eighteen hours after her death there was no parchment-like spot.

There is also the so-called test of burns. During life when one is burnt with a flame or some blistering instrument, there appears a flab which contains an albuminous fluid. In legal medicine you will find yourselves face to face with burns on the cadaver, and you will be asked whether they were made during life or after death. In the first case you will observe all round the burn a zone of congestion formed by a series of small veins in which there is blood. It is not always just so, however. In persons still alive but very ill, there comes a time when the epidermis reacts no longer, and the nurses tell you, "Sir, the blisters do not rise any more." On the other hand, on a leg which you have just amputated, you can produce bulbs filled with albumin. Again, some years ago a mechanic, whose shop had been blown up and who died in a super-heated temperature, was found covered with bulbs, but without a sign of the redness of which I have just spoken.

There is another sign which seems to be a better one, namely, the *explosive blister*. The finger of the patient is brought within half an inch of the flame of a taper; a blister slowly

forms and suddenly bursts from the explosion of its gaseous contents. It may be asked whether the same effects would not be produced on the living subject; I once tried it on an amputated leg and the phenomenon was observed.

G. A.

LACTOSE, A NEW DIURETIC IN THE TREATMENT OF HEART DISEASES.

BY PROF. G. SEE.

Milk is the most certain diuretic we possess; because of this, and also because it is a perfect food, it plays a most important part in the therapy of diseases of the stomach and heart.

Prof. G. See has carried out a series of experiments to find the diuretic element or elements in milk, with the fortunate results of discovering what he considers the most certain, the most efficacious, and the most harmless of all known diuretics, viz., sugar of milk.

To the action of this substance on the secreting structures of the kidneys is alone to be attributed the remarkable diuretic power of milk, and its efficacy in reducing dropsies occurring in cardiac affections. As regards the other constituents of milk, chloride of sodium has no diuretic effect taken in quantities contained in milk, the potash salts have very little action, and caseine and fat appreciably lessen the diuretic power even of sugar of milk itself. The exhibition of three ounces of sugar of milk dissolved in four pints of water, and withholding from the patient all other fluids, milk, bouillon, tea, soup, wine, mineral waters, etc., produces a copious diuresis, which rapidly reduces dropsies occurring in all forms of heart disease, no matter what the lesion may be, degeneration of cardiac muscle, disease of the aortic valves, etc. The diuretic action is less constant in patients suffering at the same time from arterio-sclerosis.

Generally the drug is well borne—if the solution is badly tolerated mint water or brandy may be added. All other drinks ought to be either diminished or entirely prohibited. Lactose has the immense advantage of allowing at the same time the administration of all kinds of food—it allows giving a meat diet, which is so often indispensable to sustain the failing strength of patients suffering from cardiac disease.

In dropsies of cardiac origin lactose is unfailing, but in dropsies of renal origin its action is either doubtful or nil. In cardiac affections it only fails where complicated by Bright's disease, and when the albumen amounts to from eight to ten grains to each quart of urine. The less the amount of albumen the more favorable is the diuretic action of lactose, and this is so marked that the degree of implication of the kidney may be measured by the amount of diuresis produced. Some diuretics act by the high blood pressure produced, as digitalis, convallaria, or strophanthus; others, as for example the alkalies, by promoting osmosis; a third group, caffeine, theobromine, act directly on the secreting structures of the kidneys, and it is among the members of this last group that we must place lactose.—*Translated by Dr. D. W. Montgomery for the Pacific Medical Journal.*

NAPHTHALIN IN FŒTID DIARRHŒEA.—Holsti has tried naphthalin in intestinal catarrh with fœtid excreta. The dose for adults was $7\frac{1}{2}$ grains four or five times a day; and it was never necessary to prolong the treatment beyond 10 to 14 days. For children of one to two years of age the dose was $1\frac{1}{2}$ to 2 grains four times a day. In all cases, children as well as adults, an improvement was noticed from the beginning, though sometimes a relapse took place. This author recommends naphthalin especially in cases of obstinate chronic enteritis, where other remedies have failed. He has not experienced any ill effects from it in adults, but a child a year and a half old, who was taking $1\frac{1}{2}$ grains four times a day, became profoundly anæmic, although the intestinal catarrh was considerably lessened. That is why Holsti recommends circumspection in the exhibition of this remedy to small children, especially if prescribed for a lengthened period.—*Journal de Médecine de Paris.*

SALOL IN CHILDREN'S DISEASES.—Demme has used salol in four cases of articular rheumatism, two cases of acute endocarditis, and in two cases of vesical catarrh; besides, he has prescribed it for external use in two cases of burn. Two patients, aged respectively eight and fourteen, suffering from acute rheumatic polyarthritis, took in 24 hours as much as 36 grains of

salol. The treatment was continued for five days in one case, and for seven days in the other, with the reduction of the temperature the daily dose was diminished to 21 grains. The salol did not act rapidly (the disease lasted about 15 days), but on the other hand, there was no return. A girl seven years old affected also with rheumatism took, at intervals, 50 grains of salol; in 48 hours the temperature fell from 103.6° F. to 99° F., and at the same time the pain and swelling of the foot, right knee and left elbow were considerably lessened. In the case of another girl of nine, salol had not a beneficial effect; it brought on vomiting and an eruption of urticaria after 8 or 10 hours, with no change in the condition of the joints or of the fever. Sodium salicylate was then prescribed with relief after eight hours, soon followed by a relapse. Fifty grains of antipyrin was then administered, with complete recovery after four days treatment. In endocarditis salol gave good results in cases where the pulse was modified by digitalis. It acted well in a case of cystitis caused by cantharides; 12 to 20 grains daily diminished the pain, increased the urinary secretion, and caused the alkaline reaction and mucopus to disappear from the urine. Towards the end of the treatment the urine was of a brownish-green color similar to that produced by carbolic acid.—*Journal de Médecine de Paris.*

TOTAL EXTIRPATION OF THE PREGNANT CANCEROUS UTERUS.—In October, 1888, Dr. Zweifel, of Leipzig, removed a cancerous uterus in the sixth month of pregnancy. The operation was performed half through the abdomen and half through the vagina. First the patient was placed in the lithotomy position. The cervix was separated from the vagina, and Douglas' pouch opened by means of a Paquelin's cautery. The vagina was then packed with iodoform gauze. Then the patient was placed in the usual position for abdominal section, the uterus exposed and opened and the child extracted. An elastic ligature was applied to the lowest part of the uterus, and the broad ligaments were tied above it. Then the uterus was cut away, and the vesico-uterine fold opened. The abdominal wound being closed, the patient was once more placed in the lithotomy position, and the cervix freed entirely from its connec-

tions. Dr. Zweifel objected to leaving the wound open, as he had often seen intestine prolapse and adhere to dressings. He therefore closed the corners of the wound, and inserted a T-shaped gutta-percha tube. The patient recovered, convalescence being retarded by the formation of a large bed sore after an attack of gastric catarrh, with emaciation. The child was not saved. An abstract of the case appeared in the *Centralblatt für Gynakologie*, No. 12, 1889. Total extirpation of the cancerous uterus, at term, has been performed twice by Schroder, with fatal results, and once by Bischoff, where the left ureter was tied, and the patient died. Sir Spencer Wells' case, performed at the sixth month, the mother recovering, occurred in 1881, and is well known to British surgeons.—*Brit. Med. Jour.*

LARYNGEAL ULCERS IN TYPHOID FEVER.—Dr. Antonoff publishes in the *Ejenedëluyay Klinischekaya Gazeta* the result of a series of histological examinations of laryngeal ulcer occurring in typhoid fever. The earliest change, he says, is a hyaline degeneration of the membrana propria of the capillaries and smaller arteries, and in places of the connective tissue of the mucous membrane. The epithelium dies from coagulative necrosis. The reticulum formed becomes the seat of micrococci. There is no inflammatory infiltration in the broken-down tissue, but the process takes place on the border between healthy and morbid tissue. If the ulceration goes deeper perichondritis with formation of pus, phlegmonous inflammation of the soft parts, and loosening of the fibres of the cartilage take place.—*Lancet.*

PATHOLOGY OF EXTENSIVE BURNS.—Oscar Silbermann, of Breslau, finds that in extensive burns the red corpuscles alter their form, and are able to exert less than their normal resistance to heat, drying, compression and staining. In consequence of these changes thrombosis and stasis in different organs are very frequent, especially in the lungs, kidneys, stomach, bowels, spleen, liver, skin, and brain, and most of all in the smaller branches of the pulmonary artery. The stasis in the lungs produces a very considerable impediment to the emptying of the right ventricle, with enormous venous congestion and

dangerous arterial anæmia. This again leads to apoplexies and parenchymatous alterations in the above-mentioned organs, also to dyspncea, cyanosis, coma, a small pulse, angina pectoris, eclampsia, anuria, and to a diminution of the surface temperature.—*Lancet*.

RESECTION OF THE LIVER.—Boggi (*Wiener Med. Presse*, No. 21, 1889) has been successful in resecting a portion of the liver. The history of the case is as follows: A woman entered the hospital with a tumor in the right hypochondriac region. Loops of intestine overlaid the tumor. A double echinococcus cyst was diagnosed. On operation, two enormous echinococcus sacs were found, the one placed superficially in front, the other lying deep and behind. The tumors, which weighed three pounds, were enucleated. Since approximation of the edges of the huge wound was not possible, a portion of the liver parenchyma three inches long was resected. The bleeding was stopped by catgut sutures. The edges of the cavity in the liver were secured in the belly wound. On account of the escape of gall from the liver the dressings required frequent changing at first. This secretion gradually disappeared and healing was quickly accomplished. A microscopic examination of the resected portion of liver showed that the lumina of the bile canals in the region of the cysts were patulous. This demonstrates the risk of leaving the fresh liver surfaces, after excision of the cyst, free in the peritoneal cavity. As was done in this case, the edges of the liver wound should be secured in the opening of the abdominal parietes.

Ceccherelli observes that, according to experiments upon animals, only a certain amount of liver substance can be removed. If more than one-third is resected, life can no longer be preserved.

Postemski has found that the peritoneal cavity of a dog withstands a certain amount of gall, but if the flow is continued a fatal non-septic peritonitis is set up.

In regard to the question of hemorrhage from the liver, Babacci strongly insists upon careful approximation of the bleeding surfaces. Experiments have shown that while the thermo-cautery is efficient when the livers of small animals are wounded, it is by no means to be

relied upon in the case of larger animals. The approximation of fresh liver surfaces after excision of a portion of the organ is best accomplished by the elastic suture which has been soaked in five per cent. carbolic solution. This suture supports the parts very satisfactorily, completely fills the needle punctures, and is especially valuable in this location because the liver is constantly subject to changes in volume. *Am. Jour. of the Medical Sciences*.

ERYTHEMA MULTIFORME AND ERYTHEMA NODOSA IN THEIR RELATION TO RHEUMATISM.—Garrod (*St. Bartholomew Hospital Reports, Boston Med. Jour.*) says:

1. Both erythema multiforme and erythema nodosum occasionally appear in direct association with rheumatism.

2. They are usually attended by some degree of arthritis.

3. The arthritis which accompanies these erythemata may have any degree of intensity, from the severe joint lesions of acute rheumatism to the slightest joint pains.

4. Collateral evidence, such as the presence of chorea or old heart lesions, is sometimes obtained pointing to the rheumatic nature of the slighter joint lesions.

5. Active cardiac lesions may accompany erythema with the slightest arthritis, and probably occur sometimes in the absence of joint symptoms.

6. Erythemata without joint symptoms is not uncommonly met with in patients who have previously suffered from rheumatism, but in some cases there is no indication of any association with rheumatism. In a word, it appears probable that erythema multiforme and erythema nodosum are often, or even usually, manifestations of the rheumatic process, and their appearance should always lead us to suspect such causation. We are not, however, justified in concluding that such eruptions have always this origin, nor in concluding from their presence alone that the patient is the subject of rheumatism.—*American Lancet*.

THE ETIOLOGY OF PARAMETRITIS.—Dr. Bumm has by close investigation discovered the staphylo-cocci and strepto-cocci in all cases of parametritis, and concludes that these inflam-

mations are infectious. The cases where the inflammation produced an effusion which was not discharged, but in time became absorbed, he finds to be also infectious from his experiments. To prove this he has had a long canula needle constructed, by which he draws off a small quantity of the exudation, and finds the staphylo-cocci and the strepto-cocci which are the source of infection. He has endeavored to produce traumatic parametritis in dogs by pressure and injury of other kinds, but cannot succeed where the micro-organism is absent. He therefore concludes that all parametritis are infectious sources of the disease. Bumm does not agree with Kaltenbach's opinion that this micro-organism is not pathognomonic of parametritis. Kaltenbach said that the presence of the micro-organism was of no value as a diagnostic sign, as the strepto-coccus could be found in the normal secretions of the cervix and vagina. Bumm denies this and affirms that the strepto-coccus is never found in these secretions unless in morbid and infecting conditions.—*Vienna Cor. Med. Press and Circular.*

DEATH FROM CHLOROFORM.—We have received the following particulars relative to a case of death under chloroform narcosis which recently occurred at University College Hospital: A powerfully built man, aged 56, was admitted on June 15th on account of extensive epitheliomatous ulceration affecting the tongue and floor of the mouth. As he had been an habitual drunkard, he was kept in the hospital and prepared for the operation, which took place on June 27th. Although he was stated to have had an attack of acute Bright's disease, with extensive oedema, he was, at the time of the operation, free from albuminuria. While in hospital he had an epileptic fit; there was a history of previous fits. The operation undertaken was removal of the anterior half of the tongue and incisor portion of the jaw. Chloroform was administered by a house physician, who employed Junker's inhaler. The patient was a somewhat longer time than usual in going off, but otherwise took the anæsthetic well, until at the close of the operation he became restless, and in order to place the lip stitches it was necessary to push the anæsthetic. During the operation very little blood was lost and the

pulse was good. As soon as the chloroform was again resumed the patient's face became cyanotic and respiration stopped. The stump of the tongue was dragged forward—it had been kept well forward with a string all along—and one deep inspiration followed. An attempt was made to catheterize the larynx, when another deep gasp occurred. Subsequently to this no respirations took place, although artificial respiration was maintained for some time, having been commenced as soon as breathing appeared hampered. Laryngotomy was performed, but without effect. Indeed there did not appear to be any mechanical hindrance to respiration. All the usual means of resuscitation were adopted, but without avail. A *post mortem* examination revealed a practically healthy heart-muscle, but extensively adherent pleuræ. It may be added that the heart-sounds were noted at the time of the operation, and were of normal character. It seems almost impossible that any further precautions could have been taken in this case, or that anything could have prevented its occurrence; no appreciable shock was evidenced and no contra-indication for the anæsthetic present.—*Brit. Med. Jour.*

CREASOTE IN TUBERCULOSIS.—Professor Sommerbrodt, of Breslau, in two communications to the *Therapeutische Monatshefte*, declares that an experience of over 5,000 cases has proved to his own satisfaction that creasote is not merely a useful drug for the symptomatic treatment of tuberculosis as has been conceded by others, but that it exerts a specific influence on the disease by the resistance it offers to the cultivation of tubercle bacilli. Dr. P. Guttman had by his experiments shown that tubercle bacilli could scarcely be cultivated in sterilized serum containing 1-4000th of its volume of creasote, and the culture entirely failed when the solution was a little more concentrated. He concludes that if it were only possible to administer sufficient creasote for the blood to contain that drug for some time in the proportion of 1-4000th of its own quantity, tubercle bacilli would probably cease to develop. This, he contends, is impossible, not only because the required quantity of creasote in the blood would be more than twenty grains, but because it would be impossible to determine what quantity

of creasote would have to be administered to make twenty grains of it circulate in the blood. Sommerbrodt believes that it is possible to give the necessary quantity of creasote. He has been prescribing for some time to many hundreds of tuberculous patients capsules of creasote, each containing one grain of the drug. These capsules were taken, three the first day, and every succeeding day one more until the eighteenth day, after which the same quantity—from twenty to twenty-five grains per day—was continued for many months. The author says it is impossible to presume that the twenty grains of creasote have already entirely passed out of the blood by the time the second or third dose of the drug is given, so that probably such an accumulation of creasote takes place in the tissues as to fulfil Dr. Guttman's postulate. He has at any rate had the most gratifying success with this medication, and his experience was that the more creasote a patient could bear in a day the greater was this success. The *modus operandi* of the creasote, Dr. Sommerbrodt says, has not yet been sufficiently cleared up. The drug is certainly a stomachic tonic and diminishes the secretions, but these can hardly be its chief effects. He rather believes, although the experiments on animals have so far led to negative results only, that a sufficient quantity of creasote must make the soil unsuitable for the cultivation of tubercle bacilli. He suggests therefore that serum from a man who has for some time taken more than twenty grains of creasote be used to cultivate tubercle bacilli, so as to find if this acts differently from the serum of another person used for the same purpose.

SOME APHORISMS ON THE TREATMENT OF URETHRAL STRICTURE.—I. That gradual dilatation is unquestionably the safest method of treating urethral stricture. Aside from hæmorrhages, abscesses, urinary infiltration, curvature of penis during erection, sloughing of tissue, etc., not unusual concomitants of internal urethrotomy, rigors and urethral fever, are also exceptional phenomena in gradual dilatation. Most strictures yield to this method promptly and satisfactorily.

2. The objection usually made to gradual dilatation is that often the patient comes from a distance and seeks speedy relief. To this comes

the obvious reply that we can not assume risks to the life of our patient in order to save time. But if time is an item, we know what continuous dilatation can do if he will confine himself to the house for a few days.

3. A urethra that is accustomed to instrumental manipulation will tolerate incision better than one that is not so accustomed. Should internal urethrotomy be decided upon, our patient is all the better prepared for having submitted to the obtunding effect which the passage of the instruments occasions.

4. In the pendulous portion of the urethra strictures are often so unyielding and resilient that dilating instruments have little or no effect upon them, and it may be said that the nearer such coarctations are to the meatus, the more do they partake of this character.

Such strictures are only amenable to dilating urethrotomy. But it must be said that while it is exceptional to have rigors with an elevation of temperature follow incisions near the meatus—

5. Other things being equal, the danger of internal urethrotomy increases with the depth of the stricture, that is, the distance the coarctation is from the meatus. The bulbous portion of the urethra is, from its anatomical nature, the most dilatable, and experience teaches that the nearer the stricture is to the bulb (not traumatic), the more it is amenable to dilatation. At least, not until this has been fairly tried and has failed should incision of this portion of the canal be thought of, and then—

6. External division is to be preferred to the internal in all strictures requiring incision that are accessible from the perinæum (notably if of traumatic origin).

7. Slight encroachments upon the urethral calibre when submitted to internal urethrotomy are not, as a rule, attended with the same inconveniences that follow the operation upon narrow strictures, but strictures of large calibre rarely require cutting unless indeed a superficial contracting band occasions sufficient reflex disturbances to require prompt relief.

8. What has been said of internal urethrotomy applies with redoubled force to divulsion, with this addition: First, that it is unnecessary in the bulbous portion, and, secondly, that wherever employed it is dangerous, rude, inexact, and a

purely mechanical means that does not exact and is exempt from surgical skill.

9. The term urethral fever has been objected to and urinary fever substituted on the assumption that the absorption of urinary constituents is the chief factor in the genesis of the complaint, but I do not think the choice of the substitute a happy one.

10. As to the ultimate results, thorough dilatation compares most favorably with urethrotomy.

It seems improbable that the absorption of urine can obtain in sufficient quantity from an epithelial abrasion produced by the passage of a sound that is capable of producing in rapid sequence rigors, fevers, suppression of urine, uræmic coma, and death.—*Dr. Alex. W. Stern in Journal of Cutaneous and Genito-urinary Diseases.*

INSANITY PROCEEDING FROM THE COLON.—The term "reflex" as applied to certain pathological conditions has been so often misused, and such erroneous conceptions have been formed under this all-embracing title, that we confess to a dislike of the term and only consent to use it in its most restricted sense. One has only to refer to the vast number of surgical procedures relegated to oblivion, to emphasize the erroneous conceptions formed regarding the reflex nature of some nervous disorders; clitoridectomy, circumcision, even castration, and lastly oophorectomy, which we believe to be still somewhat in fashion. Scarcely a portion of the body, or organ has escaped, and the recent literature from the pens of those who devote special attention to the diseases of a single organ, is filled with cases illustrating the potency and power of the particular organ, which they treat, to cause reflex nervous disorders. The ophthalmologist, not content with his reflex headache, neuralgia, etc., has recently added epilepsy to the list; the rhinologist has appended asthma to the pharyngeal tonsil; and a homœopathic surgeon has recently begun to dilate the anal sphincter and scrape out the rectum for almost every disease from hæmorrhoids to alopecia. The colon has thus far largely escaped; not, we think, through want of importance, but solely because no one seems to have devoted especial consideration to the diseases of this organ. The "colonologist" belongs to the future. So far as

my knowledge extends the earliest writer to call attention to the colon as a reflex cause of insanity, was Schroeder von der Kolk. It formed no mean division of his order of sympathetic insanities, only yielding in importance to the uterus and sexual parts. He regarded the trouble as a true reflex, an irritation beginning in the peripheral endings of the sympathetic nerves, propagated to the vaso-motor supply of the central nervous system, and there working disorder principally in the circulation. In these days of germs and ptomaines, a more acceptable theory to many will be that we have, in these cases, a true auto-infection: an addition to the blood of noxious elements which, circulating through the nervous system, produce toxic effects. It is probable that both theories have an element of truth. In some cases there may be a direct poisoning of the blood, while in others the disorders may be purely reflex in character. Von der Kolk was himself affected with this disorder. While suffering from constipation and fatigue from overwork, hallucinations and phantasms appeared to him and continued for three days. A large clyster was administered, which was followed by a copious evacuation of foul-smelling fecal matter; immediately the hallucinations disappeared and his mind became tranquil. There are no distinguishing symptoms of this condition, but an intellectual disturbance which has its origin in this source, is said by Schroeder to be characterized by a peculiar depression of spirits, by anguish of mind, and by the patient's self-accusations of wretchedness and baseness. The disease has a very slow course, and generally the mental anguish has existed for some time before the physician is consulted. . . . Regarding the treatment of this condition we incline to the view expressed by von der Kolk, who says: "All remedies which act as violent irritants of the colon, the so called drastics, only increase the tendency to stricture, they add to the sensibility of the colon, and the accumulation of blood in it, and cause watery stools, while the hard masses in the upper portion of the large intestine still remain. The disquietude, the excitement, and the uneasy feeling of the patient are thereby increased, but the strength is diminished, if these medicines are continued for any length of time; the circulation becomes

more and more irregular, the radial pulse becomes small and the limbs cool." In ordinary constipation where there is simple atony of the bowels, laxatives may be indicated; but where we have a true overfilling with distension of the pouches of the colon, cathartics are of little use, and may be positively injurious.—*Dr. Harold N. Moyer in Jour. Am. Med. Association.*

OFFENSIVE BREATH.—Offensive odor of the breath, due to bad teeth or other causes, may be overcome, or at least greatly abated, by the habitual use of Listerine. Add a teaspoonful to a tumblerful of water for a mouth wash and gargle, and if a little is swallowed, so much the better. Indeed, a bad breath is not unfrequently caused by the gaseous eructations of indigestion, and for this also Listerine is an excellent remedy, in doses of twenty to thirty drops in a little water.—*Sanitarian.*

Therapeutic Notes.

CHRONIC INFANTILE DIARRHŒA—*Gabler* (modified):

R—Zinci oxidi, ʒj
 Sodæ Bicarb, gr. xx
 Tinct. Krameria, ʒss
 Syr. Acaciæ ad., ʒj. M.

Sig.—ʒij every half hour till the vomiting and diarrhœa ceases.—*Union Médicale du Nord-Est.*

CHAPPED HANDS.—*The Revue de Thér. Méd. Chir.* gives the following salve, which, it says, is a most valuable toilet article. It keeps the hands white and smooth, and quickly remedies all redness and roughness of the skin:

Lanolin, ʒiijss
 Liquid paraffin, ʒijss
 Vaniline, grs. ij
 Attar of roses, gt. j. M.

The salve should be applied morning and evening.

MIXTURE FOR PYROSIS:

R—Bismuth carb, ʒij
 Magnesii carb. levis., ʒj
 Pulv. tragac. ver., gr. xx
 Aq. flor. aurantii, aa ʒij
 Syr. flor. aurantii, ad. ʒvj.
 M.—F. Mist.

Sig.—Three or four teaspoonfuls three times daily, after meals. (Squire.)

HABITUAL CONSTIPATION:

R—Aloina,
 Ext. nucis vom.,
 Ferri sulph.,
 Pulv. ipecac,
 Pulv. myrrha,
 Saponis, aa gr. ½.
 M.—F. Pil.

Sig.—One pill to be taken half an hour before last meal of the day. (Sir A. Clark.)—*The Medical Summary.*

THE
Canadian Practitioner

A SEMI-MONTHLY REVIEW OF THE PROGRESS
 OF THE MEDICAL SCIENCES.

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TORONTO, SEPTEMBER 2, 1889.

**MEETING OF THE CANADIAN
 MEDICAL ASSOCIATION.**

The meeting of the Canadian Medical Association, recently held at Banff, will long be remembered as one of the most interesting in its history. The geographical peculiarities of our Dominion, with its magnificent distances, are such that the numbers in attendance at the meetings of the Association cannot always be large, if such meetings be held in rotation in the various sections of the country. For years there has been a certain amount of opposition to the peripatetic system, as it has been called, but the majority have thought it better to preserve the national character of the Society by remembering all the provinces or territories in selecting the places of meeting. In the past we have met in the large cities, from Chatham in the west to Halifax in the east. Last year it

brought us to the west, but we were still westward-bound, and while we tarried we were entering the Rockies. After careful consideration the proposal was endorsed, and, as a consequence, many of us have had an opportunity of travelling several thousands of miles, over hills and dales, rivers and lakes, mountains and prairies, to our own Banff, which nestles so gracefully between mountain peaks and clouds in the far west.

To many it seemed that there was a fair prospect of a pleasant excursion, with a poor meeting from a scientific point of view. The result has been certainly a very delightful trip, and, we are glad to be able to add, a most excellent meeting in every respect. Leaving Montreal and Toronto, the chief starting points, the majority of the members reached Winnipeg on Friday, Aug. 9th. This vigorous and flourishing young city of the plains had a very pleasant surprise in store for us. Its medicos thought that we might possibly grow weary or hungry by the way in crossing the waters of Lake Superior, or travelling along its north shore, and generously prepared for us a banquet, which appeared to us, with our staid and old-fashioned ideas in the east, simply magnificent. So far as we know, the Association has never had any such experience in the past. We were not in the ordinary sense of the word visitors, but simply wayfarers, in a vast city extending on all sides many miles into vacant space over the prairies.

The banquet was given in the Queen's Hotel, on Friday evening, August 9th, and was a marked success in every way.

The party left Winnipeg by a special train on Saturday, and reached Banff on Sunday evening, August 11th. The regular sessions of the meeting commenced on the following morning, and ended on Tuesday night. The programme was certainly not a particularly long one, nor were the papers presented marked by any striking originality, but there was a general consensus of opinion that the proceedings taken as a whole were exceedingly interesting and instructive. The able, genial and popular President, Dr. H. P. Wright, made a rarely good chairman, and conducted affairs in a most happy and satisfactory manner. It should not be forgotten that a large amount of credit is due to Dr. George

Ross, of Montreal, the retiring President, who had much influence in deciding on the place of meeting, and worked faithfully and well to make it in all respects a success. The services of these worthy officers will long be remembered, and the assistance rendered by many of the members will ever be appreciated; but let it be recorded in letters that will never fade, that the name of the most indefatigable and patient laborer in the vineyard was Dr. James Bell, the worthy Secretary, of Montreal.

BANFF AS A HEALTH RESORT.

From a medical point of view, the profession were anxious to learn the virtues of this spot as a health resort. Banff Park is reserved by the Government as a national park, and is 26 miles long, by 10 miles wide. It occupies parts of the Bow, Spray, and Cascade Rivers, and several mountain ranges. Its beauties have been so often described that we will make no effort in that direction. It is situated 4,500 feet above the level of the sea, and the air is singularly clear and healthful, although, as is usual in high altitudes, it causes in new-comers for a time a certain amount of lassitude and disinclination for great exertions. It contains a number of hot sulphur springs, which possess undoubted virtues in the treatment of some diseases, especially rheumatism and syphilis. We have not as yet sufficient knowledge of the Park or its springs to enable us to speak more definitely on the subject. We can scarcely understand how we are to obtain the information we require until there is a proper medical supervision over it, as we hope there will be before long.

THE C. P. R. AND THE EXCURSION.

Among the many long excursion trips on this Railway, the recent medical excursion was probably the most important, and the profession have every reason to be well satisfied with its results. The officers and employees were uniformly kind, considerate, and courteous towards the travellers. It is no slight undertaking to move a large load of doctors, even though it contained, as this party did, less than the average proportion of cranks, over thousands of miles by land and water, and take care of them by the way, and so manage matters that all will be satisfied. So far as we can ascertain, they have practically accomplished this, and we have

much pleasure in cordially endorsing the vote of thanks tendered them by the Association.

TORONTO THE NEXT PLACE OF MEETING.

It was generally conceded by those in the party that Boston had now to take a second place, and that Toronto had become the "hub of the universe." The Torontonians present accepted the verdict with becoming and commendable modesty. The outcome was that Toronto was selected as the next place of meeting. Those present from the "Queen City" promised on its behalf a rousing meeting, and, with this object in view, a strong and active local committee of arrangements composed of physicians of Toronto was appointed. This committee will be considerably enlarged, and its members will be expected to work. We will have a President from Toronto, Dr. James Ross, who is enthusiastic, and will certainly work for the meeting with his usual energy and ability. The present President, Dr. Wright, of Ottawa, who retains office until the next meeting, will render all possible assistance. Many, both from the far west and the far east of our Dominion, who were at Banff, have promised to attend. All things considered, we think the prospects are bright, and we hope Toronto will see to it that the meeting of next September will be the largest and best that the Association has ever held.

REPRESENTATIVES FROM THE UNITED STATES.

Our brethren across the "imaginary line" are ever welcome at the meetings of our Societies. The United States certainly sent a very able contingent to Banff. Never has the Canadian Medical Association had more distinguished visitors. Among them were Drs. Currie and Whittaker, of Cincinnati; Drs. Gibney and Bulkley, of New York; Dr. Barker, of Philadelphia; Dr. Marcy, of Boston; Dr. Hannan, of Albany, and others. They took an active interest in the proceedings of the meeting and engaged freely in the discussions when called on. We were glad to meet them, sorry to part from them, and we hope they will visit us again next year in Toronto. In the meantime we have been asked to visit them. Let us do so.

The report of the Meeting of the Canadian Medical Association will appear in next issue.

CERTAIN SYMPTOMS OF ACUTE AND CHRONIC ARSENICAL POISONING.

An interesting paper was presented at a recent session of the Académie de Médecine by M. M. Bouardel and G. Pouchet on Acute and Chronic Arsenical Poisoning, which has received considerable notice, public attention having been of late much directed to arsenic as a toxic agent in connection with the sensational Maybrick case. In our own city, also, two inquests have been held by Drs. Duncan and Johnson within the past month, where medical evidence clearly established the cause of death as being due to this metallic irritant poison. The chronic forms of arsenical poisoning are still badly understood. The authors of the paper mentioned point out that between the acute and the really chronic form which causes death after several months, there is room for a sub-acute form, in which the same organs are affected and the same symptoms show themselves, but many variations are observed.

The scene usually opens with gastric troubles, which are constant but variable, sometimes a simple malaise, at other times the symptoms are more marked and may even make one think of typhoid fever. Constipation is more frequent than diarrhoea. During the second stage there are eruptions which consist of epidermic exfoliations and erythema of the eyelids and scrotum. Laryngo-bronchial catarrh may also be present, accompanied sometimes by lachrymation and conjunctival congestion. Headache, which extends over the entire cranium and lasts for a considerable period, is usually present in the third stage, associated with painful cramps, and in exaggerated cases pains of a lancinating character are felt, especially in the feet and ankles. The fourth stage is occasionally marked by the presence of paralysis of the lower extremities. The muscles of the foot proper are among the most affected. Convalescence from this form of intoxication fortunately is frequent, but protracted when paralysis is present. Death is due to a cardiac lesion. When the physician finds himself in the presence of symptoms above mentioned, and when the suspicion of arsenical poisoning has crossed his mind, he should make an analysis of the urine, being careful to collect it himself in order to avoid substitution. This

urinary analysis is not difficult and is an important element in diagnosis. In a case cited, arsenic was found in the urine sixty days after the suspension of a prolonged course of treatment, when the patient showed symptoms of intoxication induced by the excessive administration of Fowler's solution.

NOTES.

It is announced that "A Text Book of Animal Physiology," by T. Wesley Mills, M.A., M.D., will be ready this month.

TORONTO UNIVERSITY SENATE ELECTIONS.—The following gentlemen have been nominated to represent the medical graduates: Drs. Adam H. Wright, L. McFarlane, W. Oldright, W. H. B. Aikins, I. H. Cameron, and G. Acheson.

In a business letter one of our subscribers referred to THE PRACTITIONER in the following terms of appreciation: "Permit me to say that my enjoyment of the acute, accurate, substantial and suggestive literature of THE CANADIAN PRACTITIONER is very fine."

NEW YORK POLYCLINIC.—The annual announcement of the New York Polyclinic, a clinical school for graduates in medicine and surgery, shows an attendance for the session of 1888-9 of 383 physicians, making since the opening of the pioneer post-graduate school in 1882 a total of 1,883. These figures demonstrate beyond all doubt the popularity of the Polyclinic system of instruction. The most important feature of this year's catalogue is the Polyclinic Hospital. By the enlargement of their property the faculty have established an extensive hospital, which will afford at all times ample material for all clinical purposes. The Polyclinic and hospital buildings have been completely fitted out with all the modern appliances conducive to the healthfulness and comfort of the patients and physicians in attendance. The session of 1889-90 will open, Monday September 16th.

DOMINION MEDICAL ASSOCIATION.—Officers elected for following year:

President, Dr. James Ross, Toronto.

Vice-Presidents, for Ontario, Dr. Bruce Smith, Seaforth; for Quebec, Dr. Lachapelle, Montreal; for Nova Scotia, Dr. Johnston, Sydney Mines; for New Brunswick, Dr. Holden, St. Johns; for Prince Edward Island, Dr. McLeod, Charlottetown; for Manitoba, Dr. Spencer, Brandon; for North-West Territories, Dr. Brett, Banff; for British Columbia, Dr. Edwards, Nanaimo.

General Secretary, Dr. James Bell, Montreal. Treasurer, Dr. W. H. B. Aikins, Toronto.

Local Secretaries, for Ontario, Dr. Farley, Belleville; for Quebec, Dr. Elder, Huntingdon; for Nova Scotia, Dr. Muir, Truro; for New Brunswick, Dr. Raymond, Sussex; for Prince Edward Island, Dr. Warburton, Charlottetown; for North-West Territories, Dr. Higginson, Winnipeg; for British Columbia, Dr. Rutledge, Moosomin.

Book Notices.

Bournemouth as a Health Resort. By A. Kinsey-Morgan, M.R.C.S. Eng., Medical Health Officer for Bournemouth. London: Simpkin, Marshall & Co., 4 Stationers' Hall Court. 1889.

Bournemouth for many years has been a popular health resort, and this reliable guide will be found most useful to all desiring a knowledge of its climate, system of drainage, water supply, and its system of baths. The last chapter contains some excellent notes on sea bathing.

The Physiology of the Domestic Animals. A Text Book for Veterinary and Medical Students and Practitioners. By Robert Meade Smith, A.M., M.D., Professor of Comparative Physiology in the University of Pennsylvania, etc. Over 400 illustrations. Philadelphia and London: F. A. Davis, Publisher, 1889.

Unfortunately the space at our disposal forbids anything like a comprehensive review of this able and important work. It may be said that it supplies to the veterinary student the place in physiology that Chauveau's incomparable work—The Comparative Anatomy of the Domesticated Animals—occupies in Anatomy. Higher praise than this it is not possible to bestow. And since it is true that the same laws of physiology which are applicable to the

vital processes of the domestic animals are also applicable to man, a perusal of this carefully written book will well repay the medical student or practitioner. No doubt Dr. Smith's work will be hailed as a boon by the students of veterinary medicine in Canada, since English-speaking students—to their disadvantage as compared with their French and German fellows—have hitherto had absolutely no work to which they could turn to obtain specific information regarding the functions of the domestic animals. The illustrations are well executed and unusually well selected. It may be conjectured, however, that it is too prolix (containing upwards of 900 pages of rather too small print) to meet the approbation of the average veterinary student upon this continent. The fault here does not lie with the book, but with the veterinarian's curriculum, which requires, or rather *allows*, him to complete his course in two years. Rigid examinations upon such books as Dr. Smith's, however, will soon remedy this defection.

P.

Personal.

DR. F. B. HARKNESS has located at North Gower.

DR. J. J. BROAD has commenced practice in Cobocok.

DR. THOS. L. McRITCHIE has bought out Dr. Lawton's practice in Harwick.

DR. G. H. BOWLEY was admitted a member of the Royal College of Surgeons, August 1st.

A WELL-MERITED HONOR.—Professor A. R. Robinson, of New York, has been appointed by the Committee on Organization of the International Congress of Dermatology and Syphilography to be held in Paris, to open the discussion on the subject, Lichen.

DR. A. H. FERGUSON, of Winnipeg, has returned from his six months' European tour, having visited the principal hospitals of London, Glasgow, Edinburgh, Berlin, Paris and Hamburg, where he observed all the modern methods of surgical practice. He speaks very highly of Koch's course on Bacteriology and the great attractions of Hamburg as a surgical centre.

DR. L. L. PALMER expects to sail for Europe on the 15th of this month. He purposes attending some of the special clinics of Paris, Vienna and Berlin, and on his return about the first of January will resume practice in this city.

A SUCCESSFUL CANADIAN.—We are pleased to hear of the success of a Torontonian, Dr. J. D. Thorburn, son of Dr. Thorburn, of Toronto, who, since graduating in the University of Toronto in 1887, has spent two years in Great Britain and the Continent. Last month he was honored by receiving the appointment of Resident Medical Officer of the Hospital for Consumptives and Diseases of Throat, of Manchester and Bowden. The number of applicants was large, but the stranger "from a Colony" appeared to the Board of Management to possess the best qualifications. The Hospital is situated in Bowden, a town eleven miles from Manchester, while the Out-patient Department, with an average of eighty attendances a day, is in Manchester.

Miscellaneous.

CONVICTION FOR CAUSING SEVERE BODILY INJURY.—The following case bearing on the infliction of severe bodily injury came lately before the court at Steinamanger. A man was accused of the rape of a girl of 15, but on trial was acquitted. Coitus was admitted, but that it was forced could not be proved. During the trial, however, evidence was given to the effect that at the time of the intercourse the accused was suffering from gonnorrhæa, and that in consequence of this the maiden was infected. On this count the accused was convicted of doing grievous bodily harm and sentenced to one month's imprisonment. The Court above confirmed the conviction, but raised the period of imprisonment to six months. The highest Court of Appeal confirmed the conviction of the two Courts below, but again increased the term of imprisonment—this time to a year.—*Paris Cor. Med. Press and Circular.*

THERE is no other exhibit of the class in the United States section to rival that of Wm. R. Warner & Co. From the globe-advertising Philadelphia merchant comes an exhibit which

the native pharmaciens can look at with both admiration and wonderment. The display is enough to make any Frenchman curious, and their arrangement such as to be above deprecatory criticism; and those Frenchmen there could not be a people with better taste for the proper and harmonious exhibition of products. A glance through their own magnificent section of pharmacy will verify this. Readers would find superfluous a description in detail of the Messrs. Warner's essentially fine installation covering all their soluble sugar-coated pills, salts, etc. Suffice it to remark that at the Paris Universelle their exhibit is thoroughly representative, comprises all the makers' fabrications, and is decidedly an honor to the concern.—*Pharmaceutical Record.*

CONNECTION DURING PREGNANCY. — M. Witkowski, in his work on the History of Accouchements (*L'Histoire des Accouchements*), gives the following historical memoranda on this delicate subject: Mauriceau forbade his patients to permit the marital embrace during the two last months of their pregnancy, giving as a reason that alleged in Japan at the present day, viz., that agitation of the body and pressure upon the abdomen were injurious, or might become so, both to mother and fœtus. His contemporary and rival, Dionis, protested vigorously against this dictum, "Mauriceau," said he, "could not have based this advice on personal knowledge. During forty-six years of his married life he has never been able to get a child, while I have a wife who has been pregnant twenty times and borne me twenty living children, each one of which was happily born at full term. I am convinced, therefore, that the embraces of the spouse under the interdicted circumstances are not injurious." This, too, was the opinion of Bonaccioli, who practiced at Ferrara about 1530. "Women," says he, "who have continued to fulfil their marital duties during their entire pregnancy support the pangs of accouchement better than those who have been continent, and, besides, they never have that palor of visage which makes the latter so hideous." Sue remarks that this point has always been ignored by surgeon-accoucheurs, but that the prejudice against coition during preg-

nancy, and that continence renders parturition more facile, is very ancient, having been an accepted fact in the time of Hippocrates. It was founded, no doubt, upon the fact that the females of the lower animals instinctively shunned the approaches of the male during pregnancy. Rabelais says, "the beasts that go on their bellies will not endure the male, demonstrating his masculinity (*le mâle masculant*)."—*St Louis Med. and Surg. Jour.*

A DEFENCE OF SIR MORELL MACKENZIE. — At the annual dinner on behalf of the Golden Square Hospital for Diseases of the Throat, which took place at the Hotel Metropole on Saturday last, Lord Randolph Churchill, who occupied the chair, took advantage of the opportunity to defend Sir Morell Mackenzie from the criticism of which he, or rather his conduct, has been the subject for some time past. His Lordship claimed that he (Sir Morell) had been the means of prolonging a life very precious to the world by the exercise of great moral courage, and he expressed the hope that the time would come when national jealousy, political rancor, and professional rivalry would have so far subsided that he would receive an impartial judgment. This time will doubtless come, but we cannot help thinking that the friends of Sir Morell would have been better advised had they avoided this particular subject, for whatever the verdict of posterity may be, it is certain that public professional opinion is not at present disposed to modify the verdict arrived at when the subject was to the front. It must be very gratifying to Sir Morell to find himself able to rally so many influential friends around him on occasions like these, in spite of the fierce battle which has raged around his name in respect of matters of which, perhaps, the less said the better.—*Medical Press and Circular.*

Births, Marriages and Deaths.

MARRIAGE.

GALLOWAY—SANDERSON. — In Toronto, on Thursday, August 29th, Dr. Herbert P. H. Galloway, to Charlotte Elsie, youngest daughter of Dr. G. W. Sanderson, late of Orillia.