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THE CANADA MEDICAL RECORD.

VOL. XVI.

MONTREAL, JUNE, 1888.

No. 9.

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Original Communications.

ASTHMA.

A CLINICAL LECTURE, DELIVERED AT THE MONTREAL GENERAL HOSPITAL,

By F. WAYLAND CAMPBELL, M.D., L.R.C.P. London,
Dean of and Professor of the Theory and Practice of
Medicine in the Faculty of Medicine of the
University of Bishop's College.

GENTLEMEN,—The patient now before you is suffering from spasmodic asthma. When the attack is not present, auscultation does not reveal anything abnormal. During an attack you will hear on using the stethoscope, whistling and wheezing sounds. Bronchitis and emphysema are often found co-existing with this disease, and when present you will have these characteristic signs. To any student who desires to study fully this disease, I would recommend Hyde Salter's work on Asthma. He says that every case of Asthma has a climate which will cure it. The trouble is we cannot tell just what climate will suit each case,—but it is somewhat singular that the majority of cases seem to do best in the dirty, smoky air of large cities. Hereditary spasmodic asthma is difficult, if not impossible, of cure, though very much can be done to relieve and diminish the frequency of attack. This disease has strange vagaries. Persons may often be all but permanently relieved by changing the house in which they live, but any return to the original place of attack is certain to bring about a recurrence. The chief characteristic is the suddenness of the onset. Occasionally, however, there is some warning, such, for instance, as

an unusually large discharge of pale, limpid urine. Then the patient has an extreme sense of suffocation, with tightness and oppression across the chest. He is forced to loose every particle of clothing, and at times so great is the dyspnoea that he rushes to the window, and places his head in a draught of fresh air. If this is not done, he sits upright, resting his arms or elbows on some support. Every muscle of respiration is called into action. We soon have signs of overloading of the venous system—the face cyanosed, lips blue, extremities cold, and pulse small and quick. The great majority of cases occur during the night, very often at the same hour every night. A hearty meal before retiring is often known to induce an attack, which may end suddenly after lasting a few hours, or it may last a day or more, though the last is seldom. Occasionally a cough sets in towards the close of an attack, but the expectoration is slight, as a rule. The prognosis is favorable, death being a rare occurrence during a fit, as it is termed, of the disease.

The treatment of asthma is divided into treating the paroxysm, and treatment to prevent a recurrence. In treating asthma it is best always to use single remedies. It would take more time than we have at our disposal to mention even all the drugs which have been found beneficial. To relieve an asthmatic paroxysm, tobacco is one of the best. It is of course very likely that a patient using tobacco for this purpose may acquire a fondness for the weed, but if it is going to be useful in future attacks, he must not use it as a social comfort, or it will loose its effect. At times a few whiffs of a cigar will stop

the paroxysm, but as a rule the smoking must be continued till constitutional effects are manifested by a depressed circulation, cold perspiration and nausea. If the heart is weak this remedy must not be employed; smoking *Datura Tatula* is often very useful. *Stramonium*,—smoking the leaves is also a common remedy. They may be smoked alone in a pipe or in cigarettes, or the leaves may be mixed with tobacco, and made into cigars. In the same way the leaves of *Hyosciamus* and *Belladonna* have been found valuable. The most common remedy is saltpetre paper. A saturated solution of nitrate of potassium is prepared, and in this is soaked blotting paper, which is then dried and cut into strips; when lighted, those strips burn slowly, and the patient inhales the smoke. Some advise a very small proportion of arsenic to be added to the saltpetre solution. Cocoa leaves are also advised to be smoked, mixed with ordinary tobacco. The latest remedy is pyridene. This is used in quantities of a drachm, and vaporized on a hot plate in a closed room. It is said to be very useful. Emetics are sometimes found useful, and perhaps the best is Tartar Emetic. Nitrate of Anyl is often very serviceable in relieving a paroxysm. Nitro-glycerine gtt. 1 of a 1 per ct Sol. is recommended also. Sudden fright has been known to instantly cure a paroxysm. Chloral Hydrate, where the heart is not diseased or weak, in doses of 15 to 20 grs. is very good; $\frac{1}{4}$ gr. of morphia combined with $\frac{1}{200}$ of a gr. of sulphate of atropia will as a rule cut short an attack. If frequently used there is the danger of the Morphia habit, which is much worse than an attack of Asthma, bad as it may be; stimulants are bad, and never should be used. To prevent the return of the disease, there are several useful remedies, and first on the list stands arsenic, which must be continued for several months. Ammonium Bromide is well spoken of. The Bromides are eliminated by the bronchial mucous membrane, and are believed to exert a local anæsthetic effect. Potas. Bromid. is also used. *Cimicifuga*, a plant indigenous to this country, is a remedy not so much used, as I think it deserves to be. Quinine may be used both during a paroxysm and afterwards. If an attack is expected, say about one in the morning, a full dose of Quinine at 9 o'clock the preceding evening will sometimes prevent its coming on, or it may only modify the severity of the attack. It sometimes

fails to have any effect. Another remedy introduced during the last few years is *Grindelia Robusta*. It is highly spoken of, and may be given in doses of $\frac{1}{2}$ a drachm of the Fld. Ext. several times a day. In some patients who are sufferers from Hay, Asthma or Hay fever, there has been recently found hypertrophy of certain portions of the Schneiderian membrane. These hypertrophied points, are believed to be potent parts of irritation, and their destruction, by means of the galvano-cautery, have been followed by excellent results. This is a very recent advance on the pathology of this disease. Still more recently it has been suggested that possibly, in ordinary asthma, these points of hypertrophy may also exist in the trachial and bronchial mucous membrane. These points cannot of course be reached by the cautery, but it is suggested that this condition can be remedied by the persistent inhalation for months of the vapor of Iodine and Carbolic Acid. It is theoretically a good practice. I have seen hypertrophied tonsils greatly improved by this inhalation. Attention to diet is important. Indigestible articles must be avoided, and asthmatics must absolutely avoid eating before going to bed.

Society Proceedings.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

Stated Meeting, March 2nd, 1888.

JAS. PERRIGO, M.D., PRESIDENT, IN THE CHAIR.

Muscular Atrophy.—Dr. Stewart exhibited two cases of muscular wasting.

Extirpation of the Uterus.—Dr. Wm. Gardner exhibited two uteri removed by the vaginal method. In the first case, the patient, aged over 50, was sent to him by Dr. A. A. Browne of this city. There was a history of menopause for several years, then hemorrhage and other discharges for eight or ten months, and severe pelvic pain for three or four months. Decided failure of strength and general health. On examination, a friable, ulcerated, easily bleeding condition of the cervix. No enlargement of the uterus or palpable involvement of vagina and broad ligaments. The diagnosis was cancer,

and extirpation of the uterus advised. The patient consented, and the operation was done on the 18th of February. On opening the uterus, the diseased action was found to have extended some distance within the cavity of the body, thus accounting for the severe pain. The patient made an easy recovery, and left Dr. Gardner's private hospital, feeling better than for months previously.

The second specimen was from a patient of Dr. C. O. Browne of Knowlton. She was aged 29, married twelve years; five pregnancies, all to full term, the last labor two years and four months previously. She had suffered from uterine symptoms and intense nervousness for six years. All the symptoms had been much worse for twelve months, during which time pelvic pain, hemorrhage and dirty-colored vaginal discharges were constant and pronounced. On examination, the uterus was retroverted and prolapsed, the cervix lacerated, of stony hardness, and the posterior lip occupied by an ulcer which Dr. Browne asserts to have existed for four months. The diagnosis was probable malignant disease, and extirpation recommended. Three weeks later she entered Dr. Gardner's private hospital, and the operation was done on 1st March. The method adopted in this case was that practised by Martin of Berlin, the posterior cul-de-sac being opened as the first step. The patient made a tedious recovery. The pulse ranged for several days from 150 to 180, being, in fact, at times scarcely to be counted. Other symptoms were without any alarming feature. The pulse before operation was between 120 and 130. The specimen was pronounced by Dr. Johnston to be not malignant, but in view of the clinical character of the case, and the fact that the microscope was not always a certain means of diagnosis of cancer, Dr. Gardner felt justified in extirpating the uterus and ovaries in this case. The operation had been done in Germany several times, for conditions well known not to be malignant, but not amenable to other methods of treatment. When the mortality has been reduced, as in Leopold's hands, to six per cent., as a result of improved technique and otherwise, then he (Dr. Gardner) considered it perfectly justifiable for certain cases other than malignant, and in future he intended to advise it for a limited number of such. This was the fifth case

in which he had extirpated the uterus without a death and without alarming symptoms.

Dr. Roddick asked if Dr. Gardner would recommend extirpation of the uterus for chronic endometritis.

Dr. Gardner replied that the question was an important one that often presented itself to the gynaecologist. The operation is now done with comparative safety, and in selected cases would certainly operate in this way.

Dr. J. C. Cameron referred to the necessity of microscopic examination of the tissues removed by scraping, before a diagnosis of malignant disease is made. The microscope is not used as much in America as it should be in such cases. The German gynaecologists are setting us an example in this respect.

Sutured Patella.—Dr. Bell showed a patella which had been sutured five months previously. The patient, a young Norwegian sailor, fell from the rigging of his ship and fractured his patella, nine weeks prior to the arrival of his ship in port. He had had no treatment of any kind. He was admitted to hospital on the arrival of his ship in port, when the patella was found to be fractured transversely through its centre. There was no sign of any union, and on flexing the leg the parts separated widely, so that the articular surface of the end of the femur could be distinctly felt through the skin. The patella was treated by paring off the rounded cartilaginous faces of the fracture, and suturing with three strong sterilized silk sutures. The first dressing was not removed for six weeks, when the wounds were all perfectly and soundly healed, and the patella apparently firmly united. A splint was applied for three weeks longer and then removed, and the patient allowed up, and advised to practice passive movement of the joint. After three weeks of this passive motion the union of the patella fragments seemed to be not so firm, and the patient was put to bed and a plaster-of-Paris splint applied. In six weeks more this was removed, and the house surgeon applied a light posterior splint of Gooch's ribbed splinting, and with this he walked about in perfect health and comfort until the 22nd of January, four months after operation, when he complained of a little fever and some pain in the leg and knee. On examination, the knee was found tender and slightly swollen, and a sore which had been produced on the skin by the

corner of the splint and dressed with a little dry gauze was found to contain fully an ounce of pent up pus, which was removed and the wound treated. He also had a suppurating ingrown great toe nail on the foot of the same side. Pyæmia developed, and the patient died in four weeks, just five months and a half after operation. The pyæmia was undoubtedly due either to the sore on the skin or the ingrown toe-nail, and could not have been in any way directly due to the operation, as the knee had been perfectly healed and free from pain or other symptom for over three months before the pyæmic symptoms appeared. At the autopsy, ulcerative endocarditis was found, as well as several purulent foci in internal organs. The patella was found to be perfectly united, the union being quite firm and evidently bony. The silk sutures were found just as they had been left at the operation, the silk being apparently unchanged.

Discussion.—Dr. ARMSTRONG said he thought the specimen showed bony union, and asked Dr. Bell why he thought the union was not good when the dressing was taken off.

Dr. BELL replied that there was movement at that time between the parts, though subsequently complete union occurred.

Dr. RODDICK congratulated Dr. Bell on the excellent result of this operation, and was inclined to accept his explanation of the cause of the pyæmia, as, if the knee had been the starting point, there would not have been such union, and the joint would have been seriously affected. He referred to a case of a young girl recently confined, who came to hospital with a painful knee. The bursa patellæ was found enlarged, and on the inner side of the leg, two inches above the inner malleolus, was a small ulcer the size of a shilling, unhealthy and sloughing; proceeding up from this was swelling and suppurative cellulitis to the bursa patella, which also was in a state of suppuration. The bursa was opened, cleaned and drained, and the cellulitis and ulcer treated, with the result that the girl was well in two weeks.

Dr. SHEPHERD saw the case with Dr. Bell in hospital. He found undoubted mobility after the dressing was removed, and did not think now that the union was a complete bony one, but the parts were no longer movable. He thought there was a line of fibrous union bet-

ween the fragments. The pyæmia was not due to the operation, but to sores on the leg and foot.

—
Stated Meeting, March 25th, 1888.

JAS. PERRIGO, M.D., PRESIDENT, IN THE CHAIR.

Subdiaphragmatic Abscess.—Dr. SHEPHERD exhibited the patient, whose case he had related at a previous meeting of the Society, and who had suffered from subdiaphragmatic abscess. When the case was reported to the Society, a sinus remained below the costal cartilages on the right side. This had now completely closed, and the patient felt as well as ever he did. Liver dulness was normal, and breath sounds in right lung clear in every part.

The Bacillus Scarlatinae.—Dr. MCCONNELL read the following paper on this subject:—

The nature of the contagium of scarlatina is a question which has during the past year occupied a prominent place in English medical societies and periodicals. In December, 1885, an outbreak of scarlatina occurred in London, and it was supposed that the infection was conveyed by milk from a dairy in Hendon. The subject was investigated by Dr. Klein. Several of the cows were found to be suffering from an infectious disease characterized by vesicles and ulcers on the udders. From this Dr. Klein isolated a streptococcus. He also discovered a similar organism in the blood of scarlatina patients after the fourth day. Inoculation experiments were performed, and Dr. Klein concluded that the Hendon cow disease was identical with scarlatina. In a critical review of this subject by Dr. Geo. Thin, at the Dublin meeting of the British Medical Association, doubts were cast upon these conclusions; and later, Prof. Crookshank was deputed by the Agricultural Department of the Home Office to make further investigations. Abstracts of the voluminous reports of the investigation were, in December last and January of this year, placed before the Pathological Society of London. The conclusions arrived at were that the *streptococcus scarlatinae* of Dr. Klein was identical with *streptococcus pyogenes*, a micro-organism found in acute abscess, etc., and frequently found associated with a number of other affections, and that the Hendon disease was cow-pox.

Researches regarding the nature of the contagium of scarlatina were made in the early part

of 1887, at the Bacteriological Laboratory of Edinburgh University, by Dr. Alex. Edington. Eight different organisms were isolated. A streptococcus, provisionally specied as *rubiginosus*, was found in 20 per cent. of the original tubes inoculated with scales from scarlatina patients during the stage of desquamation, or from the blood, and is apparently identical with Dr. Klein's streptococcus scarlatinae. A bacillus was found to be present in the scales in every instance when examined after the third week, and in every case the same bacillus was found in the blood during the first three days of the fever. Rabbits and calves were successfully inoculated, producing a disturbance and appearance resembling scarlatina in man. The conclusions formed were that this bacillus (called *B. scarlatinae*) was the specific cause of scarlatina, and that the other organisms were "merely concomitants, and pass into the blood only after the vitality of the system and tissues has been lowered by the entrance of this specific organism."

In September last I inoculated test tubes of potash peptone gelatine from several cases of scarlatinae, using sterilized capillary tubes, to which about an inch of the original glass tubing remained, this part being plugged with cotton wool; the finger from which the blood was taken being previously covered with lint saturated with a 20 per cent. solution of carbolic acid. In the first case the blood was examined about the beginning of the fourth day of the disease. The tubes, on being incubated, were all found to be sterile. The blood of another child in this family was examined on the second day of the disease, when almost a pure culture of Edington's bacillus was obtained.

On Oct. 13th, 1887, similar cultivations were made from a child, five years of age, suffering from scarlatina, on second day of fever; and also from her sister a few days later. The same bacillus was procured. The lower limb of the first child was in accordance with Edington's method of securing the desquamation, wrapped in sterilized cotton wool, after being cleansed and disinfected. The scales procured on the twenty-second day gave an abundant culture of the same bacillus, associated with micrococci. The character of this organism, as you can ascertain from an examination of these stained specimens and cultures, are distinctive. Dr.

Edington's description appeared in the *British Medical Journal* of August 6th, 1887. The bacillus, which is motile, is from 2 m. to 5 m. in length and 4 m. to 5 m. in breadth; it is markedly aerobic, grown on jelly in the incubator at from 18° C. to 23° C., it will form a pellicle at the surface in from 24 to 36 hours. The time in which the pellicle will form, and the rapidity with which it will liquify the gelatine, is less, where the material used is the last of a number of successive inoculations from tube to tube which increases its activity. The pellicle forms more readily on bouillon, is semi-transparent, looking like parchment, very firm, and formed by the interlacing of the bacilli into a felt-like membrane, it now becomes wrinkled, and the margin may be pushed up the side of the tube ovoid; spores then form, and in three or four weeks the pellicle will disappear. It grows rapidly on milk and on potato, forming a citron-white pellicle, which becomes darker in color; grows less readily on agar-agar, and poorly on blood-serum. On plates the growth is characteristic. The colonies grow for a day or two before the gelatine begins to liquify; this occurring first in the centre, and proceeding outwards, the bacilli then become motile, and later assumes the form of Leptothrix filaments. The colony then has the appearance of three zones—Leptothrix in the centre, actively multiplying bacilli at the margin, and motile bacilli at the edge of the liquified portion.

The point of chief interest is the fact that the bacillus is found in the blood only up to the third day of the fever, and not in the desquamation until the twenty-second day. The rapid growth of the bacilli is in harmony with the short period of incubation of scarlatina, and the finding of the bacilli in the scales is in accord with their well known infectiousness; and the prolonged duration of their infective powers is explained by the tendency to spore formation, even in the blood, which characterizes the bacilli. The practical utility of this addition to our knowledge concerning scarlatina was demonstrated by Dr. Jamieson,—at whose suggestion the experiments were carried out,—even before the discovery of the real nature of the contagium, from the fact that by applying antiseptic remedies to the throat in the earliest stage, bathing the surface, and applying carbolized ointments as soon as desquamation began, he was enabled,

on the arm of a friend, without whose assistance without any special isolation of the patients, to prevent the spread of the disease to any other member of the family in which it occurred, even in instances where a number of young children were allowed to associate as usual with the affected member. During the last three years this happy result had invariably been attained. Although not yet fully trusting to these baths and anointing alone—that is, without isolation—one case where this was impossible illustrates the utility of these measures. In this family there were three children; the oldest had scarlatina on Dec. 15th last; the anointing was fully carried out, and although the children mingled together constantly, the others escaped the disease.

Further investigations will be required before this organism can be fully established as being the true specific cause of scarlatina, as evidenced by the first report of the committee of the Edinburgh Medico-Chirurgical Society appointed to investigate the subject, in which they stated their inability to infect calves by either blood or scales of scarlatina patients. Their susceptibility to scarlatina is a point claimed by both Drs. Klein and Edington in their experiments; but that we have in the antiseptic treatment of the skin and throat a means of preventing the spread of the disease seems well established, and should the claims of Dr. Illingworth for biniodide of mercury as an abortive in this disease be sustained, great advance has been made in the management of this prevalent affection, and the night of empiricism, which has hitherto prevailed in regard to the treatment of this class of disease, we may anticipate will soon give place to the light of scientific methods.

A Case of Lightning Shock.—Dr. MILLS read a paper on this subject, and Dr. BULLER gave the intra-ocular changes produced.

Stated Meeting, April 6th, 1888.

JAMES PERRIGO, M.D., PRESIDENT, IN THE CHAIR.

Alopecia Areata.—Dr. ARMSTRONG exhibited the case, and gave the following history: The patient is a young woman of 25; married last November. About a month after marriage noticed a large bald patch a little behind and to the right of the situation of the post-fontanelle.

From that time to the present new patches have continued to appear at short intervals on different parts of the head, until now there are twelve or fourteen patches, varying in size from a 20 cent piece to that of a half dollar, and situated back and front and at both sides. It is for this reason principally that I show the case. There is still a difference of opinion as to the etiology of this form of alopecia. Thus Duhring and Stelwagon, in Pepper's System of Medicine, Vol. IV, state that the disease is "not parasitic, nor is it contagious." Balmano Squire, in the third volume of Reynolds' System of Medicine, defines the disease as contagious, and produced by a vegetable parasite, the *microsporion andonini*, and he inserts an illustration of the spores of the fungus. The appearance of these patches, situated on all sides of the scalp, suggests very strongly to me the idea that the disease is parasitic. If due to nerve disturbance, one must admit that some cause is acting which involves the terminal twigs of many different nerves and of several branches of the same nerve. I am not familiar with any variety of nerve disturbance at all analogous to the condition which obtains in this case of alopecia. The large patch, with several smaller ones appearing secondarily and subsequently, suggests the idea of contagion, the same as occurs in ringworm of the scalp. I know of an instance where father and son suffer from alopecia areata, the one having it some time before the other.

Discussion.—Dr. BELL said the ordinary clinical history of the disease was against the theory of a parasitic origin. The pathology is very doubtful. He never made a practice of separating patients from the rest of the family, and in most cases there is recovery in a few months, but the hair is apt to come in differently pigmented, if not white. Treatment was usually expectant, used a shampoo to keep the skin healthy, and gave tonics.

Dr. TRENHOLME had seen coal oil, well rubbed in, restore the color of hair when the color was spoiled.

Fibroid of the Uterus.—Dr. LAPHORN SMITH exhibited a patient to illustrate the effects of electrical treatment, and read the following history:—

The patient came to me on the 19th March, very wretched in appearance, and leaning heavily

she was hardly able to walk. She measured 32 inches around the waist, although her normal waist measurement she said was 21 inches three years ago. I was unable to pass the sound any further than $3\frac{1}{2}$ centimetres, but with it at this distance I gave her 50 milliamperes with the negative pole during seven minutes. She came again on the 20th March, telling me that she had had less pain since and could walk better, and that her friends told her she was looking better. I gave her 150 negative for five minutes, which she bore well. On the 23rd she was menstruating, so I did not give her any electricity, but her belly was not at all tender to pressure, and the menstrual flow was more profuse than usual. On the 27th she came again, having ceased menstruating; instead of lasting fifteen days, as it did before treatment, it only lasted five days, but she lost more in the five days this time than she did in fifteen before—not more, however, than a woman should lose at a period. She measured 4 inches less around the waist. I gave her 150 positive for five minutes, the sound entering five centimetres. On the 29th March she measures only 27 inches around the waist, and she feels so much better that she thinks she will soon be able to return to work. I gave her 140 positive for five minutes.

March 31st.—She says she has a hollow at the pit of her stomach now, instead of a lump. I gave her 125 negative during five minutes, which she bore well, the sound entering five centimetres.

April 3rd.—Waist measurement steadily decreasing, and she is hardly at all sensitive over the abdomen. Gave her 100 negative for five minutes. *5th*—Gave her 100 negative during six minutes, which she bore easily.

This is as far as I have got with the case, and of course I am only in the middle of the treatment; but the result has been so striking, and her previous condition having been so well authenticated, and she seemed so willing to come here to show herself, where it is not always easy to bring them, I thought it would be interesting to the members to see one of the many cases of the kind I have at present under treatment.

Perforating Ulcer of the Stomach.—Dr. ARMSTRONG also showed a specimen of round ulcer of the stomach, remarkable for its large size, as well as the obscure previous history. The patient

was a well-nourished, but anæmic, unmarried woman, aged 28, a nurse in the Western Hospital. For a year past she had complained of being out of sorts, at one time having well-marked left intercostal neuralgia affecting the seventh and eighth nerves of that side. She had also complained of burning pain at lower end of back, which was found to be due to a retroverted uterus, and which was relieved by the use of a suitable pessary. Her appetite had been poor, but she always denied suffering pain after eating, and had never vomited her food except once. For about a month or six weeks before the symptoms of perforation developed, she had nearly every day complained of severe abdominal pain, referred principally to the region of the umbilicus, and sometimes of pain in left iliac fossa. This was unaccompanied by corresponding pain on pressure. Her bowels moved every day, and the stools were of good color and formed, but not hard or dry. On Friday afternoon she suddenly took a severe chill, with severe pain referred at first to left iliac fossa. In a few hours symptoms of general peritonitis developed with vomiting of everything taken into the stomach. Death ensued forty-eight hours after the symptoms of perforation. At the autopsy there were the usual evidences of general suppurative peritonitis. The left fallopian tube was dilated to one inch in diameter, and contained pus. So far as could be made out, no rupture of tube had taken place. On the posterior wall of the lesser curvature of the stomach, a large round perforation was found, having a diameter of $1\frac{1}{4}$ inches. The edges were rounded and smooth. This is certainly a very unusually large opening.

Dr. PERRIGO said that the patient was under his care in the Western Hospital for some time; she then had paroxysmal intercostal neuralgia, coming on every afternoon. Small repeated doses of quinine had no effect, but large doses gave relief. There was no history of vomiting or indigestion.

Dr. BELL referred to a case recently shown by Dr. GEORGE ROSS. The stomach of a girl aged 19 had several ulcers; two were completely healed and some partially, one had perforated and caused death. During life there were no symptoms referable to gastric trouble. No history of vomiting or indigestion.

Renal Tuberculosis.—DR. LAFLEUR exhibited the kidneys and bladder from a case of renal tuberculosis. The right kidney was much enlarged, nodular, and could be distinctly mapped out externally. Its capsule was thickened and adherent to the liver, ascending colon and duodenum. On section, was found to consist of a collection of small cavities filled with creamy pus and caseous detritus, all communicating with pelvis of kidney. Ureter was dilated and infiltrated with tubercular nodules. In left kidney there was a small caseating nodule at the apex of one of the pyramids, and the rest of the organ showed marked amyloid reaction. Ureter normal. Bladder was filled with pus, and its mucous membrane was ulcerated in several places and deeply pigmented. Vesiculæ seminales were normal. Epididymis of right testicle was tubercular. The lungs and liver contained miliary tubercles. The oldest tubercular deposit was found in some of the bronchial glands, which contained a gritty, mortar-like material.

Foreign Body in the Nose.—The patient was shown by Dr. LAPHORN SMITH, who stated that he had exhibited a somewhat similar case seven or eight years ago, that of a child about two years old, which had been suffering for several months previous to his seeing it from a foetid discharge from the nostril, which had been treated for catarrh. In that case the cause of the discharge was found to be a piece of wood much larger than could be forced into the child's nose, but which the child introduced in a dry and much smaller state. The present case was that of a girl 14 years old, who had been troubled with ozæna ever since she was 3 years of age, and the odor from which had become latterly so very unpleasant, that her parents were forced to keep her in a separate room from those occupied by the rest of the family. She had been treated for catarrh at several public institutions, but, probably owing to the fearful smell, none of the attendants had ever examined her nose carefully. Dr. Smith had himself hurriedly prescribed for her general health at the Montreal Dispensary some years ago, without examining her, as she was supposed to be suffering from the sequelæ of smallpox. But a few days ago she was brought to his office, when, on examining her nose with a speculum and probe, a hard, grey and glistening object was seen and felt. It was readily removed with a suitable pair of forceps, when it turned out to be a shoe button, which she must have introduced ten or twelve years ago,

and which he showed to the Society. The button was incrustated with phosphates. There was a little bleeding from the surface of the cavity which it had hollowed out for itself in the nostril. Dr. Smith said that his object in showing this case was to emphasize the importance of making a local examination in every case of this kind, as, if this had been done in the first instance, years of discomfort would have been saved the patient. Although only a short time has elapsed since the button was removed, the ozæna has completely disappeared, and the ulcerated surface was almost entirely healed.

Seven Consecutive Successful Ovariectomies.—DR. TRENHOLME exhibited cystic ovaries and enlarged tubes, removed last week from Miss G.G., a young woman aged 22, which makes the seventh operation performed since he was last at a meeting of the Society. The patient was of slight build, and suffered from a persistent menorrhagia since the menses began. There were at such times severe pelvic pains, and she was unable to perform her daily work, by which she had to obtain her living. On examination, finding both ovaries and tubes enlarged while the uterus was normal, any possible treatment except the removal of the appendages was excluded. The specimens now shown are much shrunken. The ovaries were as large as small hen's egg, and so densely adherent that they ruptured during their removal. The tubes were as large as a small finger, filled with blood, and so densely adherent that their removal was difficult. The opening into the abdominal cavity was about $2\frac{1}{2}$ inches long, and closed with three silk worm-gut sutures; horse hair was used for superficial sutures. A few layers of antiseptic gauze held in place by two straps of adhesive plaster completed the abdominal toilet.

Case 2.—Miss S., aged 28; always suffered during menstrual period. Of late has had to use morphia to relieve the increasing distress. All her family having become insane, and fearing for her own sanity, she consulted me. On examination, found enlargement of both ovaries and a small fibroid, size of a plum, in the posterior wall, at the fundus of the uterus. Removed appendages in my usual way. Result, perfect recovery.

Case 3.—Mrs. W., aged 30, always suffered since menses began, but of late the sufferings are intolerable without opiates. Has been under various treatment, but without relief. Found both

ovaries cystic and right tube enlarged about one inch in diameter by $2\frac{1}{2}$ long. Recovery from operation and her former sufferings good, but ulcers of rectum have retarded perfect restoration to health.

Case 4.—Mrs. R., aged 32, as a girl, was a terrible sufferer during the flow of the menses; has borne three children. After the first, a thrombus formed in right side of pelvis, which was opened after several months suffering; subsequently bore two children, although the sac refilled and escaped several times. During past summer she caught cold, which caused intense suffering. On examination, found a tumor size of foetal head on right side of uterus and above the former cyst, though close to it. While operating, the walls of the cyst were so friable, that it was with difficulty that the thick tarry contents were prevented from entering the cavity of the abdomen. The operation was followed by a tedious convalescence, owing to the refilling of the old abscess, which had to be tapped several times. Eventually she made an excellent recovery, although the walls of the abscess are still tender, and form a small tumor.

Case 5.—Mrs. D., 22 years, mother of two children. History very like that of case 4. Sufferings are so severe during menstruation that she prefers death to life. On examination, found both ovaries enlarged, also left tube. Result of operation, perfect recovery and the acquirement of sexual pleasure, a thing never before enjoyed.

Case 6.—Mrs. S.; ovarian cyst, 18 lbs.; recovery perfect.

Case 7.—Mrs. C.; enlargement of both ovaries, left one behind the uterus. Diagnosis of suppurating cysts of ovaries. Operation was difficult on account of adhesions, which were very dense and universal. Both ovaries were about the size of hen's eggs and filled with putrid pus, which escaped into the peritoneal cavity. The rotten state of the cyst walls caused rupture with the slightest touch. A curious horn-shaped cyst sprang from the fimbria of the left ovary, back of the fundus uteri, and curling upward and forward over the uterus was attached by the point to the walls of the abdomen. It was about $1\frac{1}{2}$ inches at base and 6 inches long, filled with clear fluid.

Electricity in Gynæcology.—Dr. LAPHORN SMITH read the following paper on this subject:—

As all diseases of women may be attributed to disorders of the nerves of sensation, of motion, or

of nutrition, three forms of electricity may be employed as remedial agents; and although the subject of electricity in gynæcology is too big a one to bring within the scope of a small paper, still I think I might briefly outline the various kinds of electricity used in gynæcology and the various diseases in which they are rationally indicated.

Disorders of sensation are the most numerous and, perhaps, the most important, because it is pain which most often brings a woman to consult us. In what exactly pain consists nobody knows, but this we do know, that when it depends on disordered innervation alone, we possess a certain remedy for it in the faradic current of tension, or from the long, fine wire. I have many times proved its efficacy in cases of ovarian neuralgia, and in some of them I believe that the necessity of oophorectomy has been done away with. On this point, Apostoli says: "The current of tension alone is very well borne by nearly all uteri, and in particular by those of hysterical patients; alone the current of tension, with a very great tolerability, and a much greater power of radiation than that of quantity, enjoys the remarkable quality of rapidly calming peri-uterine pain, and that, too, all the better, and in a manner all the more permanent, when it is employed in cases of neuralgia of an hysterical nature."

"In all neuralgias of the pelvis," he says, "whatever may be their origin, nature or severity, the element of pain can and always should be treated, most often successfully, by the faradic current, and always by the current of tension alone. It is harmless and efficacious only on condition that we conform ourselves to the following rules:—

1. Never to make the patient suffer, and never to apply a stronger intensity than she can bear.
2. Make the operations last long, and continue them until the appearance of a manifest sedation.
3. Make by means of the bipolar excitor an intra-uterine application whenever possible, or a vaginal one in other cases."

By these simple means, therefore, we can successfully treat a numerous class of cases, in many of whom the ovaries would have hitherto been removed, and that, too, without curing the pain, which was the very object of removing the healthy ovaries.

In the faradic current of quantity—that is, from the short, thick wire—we possess a rational treat-

ment for all diseases of the uterus, owing their origin, directly or indirectly, to relaxation or loss of tone of muscular fibre. This category includes all forms of flexions and versions, and prolapsus, as well as subinvolution and the pathological conditions resulting from it; for all displacements of the uterus (as may be seen by referring to this rough chart) are due to the organ being too heavy for its supports, or the supports being too weak to hold up the normal weight, or to a combination of the two causes in some cases. As far as flexions are concerned, it requires no argument to show that the uterus is a hollow muscular column, held upright on itself by its own tonicity, and that whenever the walls of that column become weak or relaxed, or whenever the superincumbent weight becomes increased, the column will bend, either forwards or backwards, according to certain principles. Also, it will be admitted by every one that relaxation of the muscular walls of the bloodvessels in the uterus will allow an increased quantity of blood to remain in it, and thereby increase its weight.

But it is when we come to talk about the muscle in the uterine supports that people look at us blankly as though they had never heard of such a thing. This unfortunate ignorance of such important structures is probably due to the habit we have fallen into of calling these supports ligaments, which conveys the idea to our mind of fibrous tissue. Others, again, have been brought up with the idea that the uterus was held in its place in the pelvis by means of the fold, of peritoneum, which in reality only cover the ligaments, and which are quite incapable of performing the functions which we know the ligaments of the uterus do perform. To those who do not see any muscular tissue on the uterine supports, it is folly to say that those supports can be strengthened by means of the faradic current, which has no beneficial action whatever on peritoneum or ligamentous tissue. I have not time now to argue this matter out, and I must assume for the moment that there is muscular tissue in these so-called uterine ligaments. Now, I have only to remind you that every time a muscle contracts, it develops, in consequence of its improved nutrition; the products of tissue waste being removed by the veins and lymphatics, and room being left for a fresh supply of arterial blood. With the interrupted current we can produce artificially many thousands of contractions at each seance, and in the course

of a few weeks, treatment we may even bring about hypertrophy of the muscular tissue, in the perineum, vagina, and ligaments. You know that the strength of the blacksmith's right arm is proverbial simply because he makes its muscles contract the most; and medical men engaged in administering faradism through their own bodies, *en route* to their patients, attest the fact that their arms become enormously increased in size thereby.

It is also generally admitted that faradism is an excellent remedy for chronic constipation, because it causes the muscular fibres in the intestine to contract and thereby develop. In fact, the faradic current of quantity does directly and at the very spot just what ergot, quinine and strychnine do indirectly, after being absorbed by the stomach and carried by the circulation to the affected parts.

While writing this I have just received a letter from a leading practitioner of Toronto, asking me if I could tell him what was meant by the quality current, a term employed in the writings of Engelmann of St. Louis. The answer is that it is used to designate the current of tension, as opposed to the current of quantity; but I think it would be better to give the two latter more explicit terms, as both the current of tension and the current of quantity are currents of different qualities. This reminds me of another question which I am asked every day, viz.: Why won't the ordinary McIntosh faradic battery do for gynaecological work? Simply because it only contains one kind of induction coil; and if that coil is long and fine, it is not suitable for diseases characterized by relaxation of muscle. If, on the other hand, it is coarse, it is not only of no use, but positively hurtful in diseases characterized by pain. It is only on condition that the proper kind of current be given in the proper cases that we can hope to have satisfactory results.

You will naturally ask me what have been the results of the two faradic currents in my hands? In suitable cases eminently satisfactory; in unsuitable ones, disappointing. For instance, in cases of proclivencia, due to increased weight of the uterus, the increased weight being due to areolar hyperplasia, the use of the faradic current alone will be disappointing, because it has not the power to cause absorption of fibrous tissue. It will, it is true, increase the strength of the supporting muscles, but in such cases something more is required, and that is to reduce the weight of the

hypertrophied organ. Fortunately we possess in the continuous current, especially the negative, the means of causing the reabsorption into the circulation of the plastic exudation. It is a question for investigation whether the pelvic muscles ever become so completely atrophied as to utterly fail to respond to the faradic stimulus. In that case, of course, it would be useless to employ it.

A brief outline of the following case might be of interest:—Mrs. R., aged about 70, came to my office in a pitiable condition. Her uterus was hanging outside of her body, and the cervix was lacerated and covered with star-shaped fissures and ulcerations. The organ was enlarged in every diameter, the sound entering nearly five inches, and it had a hard feeling to the touch. Her thighs were excoriated, and her clothing was stained with blood coming from the raw surface of the uterus, which stuck to them whenever she sat down. At times she was quite unable to go about. From the 1st to the 18th of September I gave her six applications of the coarse faradic wire in the vagina, with the only result that she felt and was observed to be much stronger, and she was able to go about more. From the 18th September to the 16th October I gave her an intra-uterine application of the coarse wire faradism, with the result that the sound enters at most $4\frac{1}{2}$ inches. As the uterus still came out of the body, though not so much as before, I decided to try the continuous current, in order to improve the nutrition of the organ to such an extent as to make it return to a size and weight more nearly approaching the normal. In this hope I was not disappointed, for after giving her bi-weekly applications of the negative current of 100 milliamperes for five minutes each time, from the 16th October till the 27th November, I was enabled to make the following entries in my note-book:—

Nov. 6th.—Uterus rarely comes out now, and when it does, it goes back of its own accord when she sits down. *9th.*—Excoriation on thighs all gone.

13th.—Uterus only been down once since. *16th.*—Fissures on os completely healed. *20th.*—Uterus remarkably soft to the touch. *23rd.*—Sound enters only three and a half inches.

Dec. 1st.—Discharged, for the present, as the uterus has not been down since last time of coming.

I did not see her again till April, 1888, when I was called to attend her for paralysis. I took advantage of my visits to ascertain the condition

of the womb. I found it still soft, small, and well up in the pelvic, and she stated that it had never given her any trouble since.

This is only one of many similar cases. My general experience has been that we can surely relieve those cases of partial prolapsus, in which the patient complains of a dragging feeling in the back, and which I believe to be due to relaxation of the muscular tissues of the pelvis. Faradism alone is insufficient in those cases in which there is, in addition to relaxation of the supports, an increased weight of the organ to be supported, in which case the trophic action of the continuous current, preferably negative, will be necessary.

The continuous current will form the subject of another paper, but in the meantime I may say that the field for its use is daily enlarging, and, among many others, its employment in strictures is eminently satisfactory.

Stated Meeting, April 20th, 1888.

DR. TRENHOLME IN THE CHAIR.

Drs. J. A. Hutchinson, Brodeur and D. McG. Decow were elected members of the Society.

Multilocular Cyst.—Dr. TRENHOLME exhibited a large multilocular ovarian cyst, which he had removed from a woman aged 40. The operation was not one of unusual difficulty, and the patient was doing well. It had first been noticed eighteen months ago, and had grown very rapidly.

Pyelo-Nephritis; Infiltration of Urine with Sloughing of Urethra.—Dr. LAFLEUR exhibited specimens for Dr. Shepherd from a case of surgical kidney, caused by enlarged prostate. Patient, aged 67, complained of retention of urine, which was relieved by catheterization, and followed by infiltration of urine in perineum and scrotum, with formation of abscess between neck of bladder and rectum. Scrotum was œdematous and gangrenous. Through incision in perineum finger could be passed into a cavity about the size of a large walnut, between neck of the bladder and rectum, which contained some necrosed tissue. Catheter passed through urethra could be felt at posterior part of this cavity for about an inch, the urethra having completely sloughed away in this situation. The pelvis and ureter of the right kidney were dilated, and contained ammoniacal urine, but the organ appeared otherwise normal. The left kidney was enlarged, and its capsule was loosened in places. The pelvis and ureter were

moderately dilated, thickened and deeply pigmented indicating chronic inflammation, and contained very foul, thick, greenish-grey muco-pus. The apices of the pyramids projecting into calices of pelvis were necrosed, while the rest of the parenchyma was intensely inflamed, the pyramids being dark red with small yellowish areas, indicating formation of abscesses; in the cortex the same change was taking place, but not to such a marked degree. The walls of the bladder were much thickened, the mucous membrane deeply pigmented and roughened, while the cavity, which was contracted, contained a mixture of ammoniacal urine and dark green muco-pus. The prostate was enlarged, and friable on section. The immediate cause of death was croupous pneumonia affecting lower and middle lobes of right lung.

Concretio Pericardii.—Dr. LAFLEUR also exhibited for Dr. Wilkins a heart, showing complete adhesion of parietal and visceral layers of the pericardium, from a patient who had suffered from severe attacks of acute rheumatism.

Suppurative Appendicitis with Pyæmic Abscesses of the Liver.—Dr. LAFLEUR exhibited specimens from the case; and reported that at the autopsy sinuses were found over the lower part of the abdomen, which converged more or less towards right iliac fossa. Pelvic cavity contained five ounces of thin, putrid fluid, with a few flakes of lymph, but the peritoneum was everywhere smooth and glistening. Appendix deeply pigmented and glued to tissues in iliac fossa by firm, inflammatory, fibrous tissue. At its midile was a perforation a quarter of an inch in diameter. From this point sinuses diverged in three different directions. One sinus, which appeared to be the oldest, on account of the thickness of its walls and their intense slaty pigmentation, lay beneath the sheath of the psoas muscle, passing upwards and backwards as far as the ligamentum arcuatum internum, where it formed a cul-de-sac. A second sinus was traced inwards and downwards over the brim of the pelvis, into the loose cellular tissue around the bladder and rectum, opening externally in the perineum half way between the scrotum and the anus. The third sinus passed in a curved direction outwards to the abdominal wall, where it divided into several branches, running in the main parallel to Poupart's ligament, upwards towards the iliac crest and downwards into the scrotum. There was no abscess cavity in connection with appendix or

cæcum. The liver was enlarged, and on the under surface of the right lobe was a fluctuating swelling the size of a large orange, which contained thick foetid pus, and was traversed by bands of necrosed tissue. Another abscess cavity existed under the coronary ligament, and a third one, an inch and a half in diameter, was found on the upper surface of the right lobe, which was adherent to abdominal wall in that situation. The liver tissue around these cavities was studded with minute foci of suppuration, showing origin of the large abscess cavities from fusion of multiple lobular abscesses. There were no thrombi in the portal vein or in the vena cava and its main branches. The infection was probably conveyed to the liver from a small branch of the portal vein involved in inflammatory change about appendix or cæcum. The kidneys were anæmic, and showed slight fatty changes in tubules. Pericardium contained five ounces of slightly turbid, yellow serum, with a small amount of adherent lymph. There were no endocardial changes. The spleen was enlarged and soft. Brain and lungs were normal. The immediate cause of death was perforation of the appendix.

Dr. BELL gave the following history of the case: The patient, a very stout man, was admitted into the General Hospital in July, 1887, suffering from symptoms of perityphlitis. He was discharged apparently cured in a few weeks, but returned in December with various sinuses over the lower part of the abdomen and scrotum; all these sinuses led into the right iliac fossa, which contained much dense inflammatory tissue. These sinuses discharged a large amount of foetid pus. Dr. Bell, under whose charge the patient was, opened up and scraped the sinuses and evacuated many pockets of pus, but could not find the course of the pus in the iliac fossa. The wounds were packed with iodoform gauze, and a dressing of washed gauze applied. The temperature, which had ranged from 100° to 103° F., became normal, and the patient gradually gained strength. Three weeks after he suddenly became maniacal. After this no dressings could be kept on, and the patient's condition gradually grew worse; the temperature became high and irregular, and two weeks later he died suddenly, apparently from collapse. He never recovered his sanity. There was no family history of insanity.

Dr. SHEPHERD thought that the direct cause

of death was abscess of the liver and pyæmia. The mode of origin of the sinuses from perforation of the appendix was the most interesting feature of the case. Even if a diagnosis could have been made early, the autopsy showed that treatment by abdominal section would not have been more effective. At the operation, owing to the fat in the abdominal walls, the sinuses could not be traced. He regarded the iodoform poisoning as one of the incidents of the case, but not as the cause of death.

In answer to Dr. RODDICK, Dr. BELL said that the temperature was decidedly septic at first, but after evacuation of the sinuses it fell to normal, and remained so for weeks. At the time of the operation, he was convinced that all the pus had not been evacuated.

Some Rare Forms of Extravasation of Urine.—Dr. BELL read a paper on this subject, which appeared in the May number of the *Canada Medical and Surgical Journal*.

Discussion.—Dr. FENWICK was with Dr. Bell at the operation for ovariectomy mentioned in the paper, and was greatly surprised to find the bladder so high up. Sometimes this accidental wounding of the bladder was unavoidable. He had himself once wounded a prolapsed bladder in a operation for hernia, but the patient ultimately made a good recovery. He had seen several cases of mania produced from the use of iodoform; the most recent case was that of a stout old gentleman, on whom he had operated for lateral lithotomy. Iodoform dressings were used, and the patient several days after became affected with mania, which lasted two weeks; he, however, recovered perfectly.

Dr. SHEPHERD said that the case of urinary infiltration, following wound of the bladder during the performance of an ovariectomy, was a very interesting one, owing to the probability of death having resulted from iodoform poisoning. He had several cases of mania following operations, in all of which iodoform had been used, though only in small quantities, and he was in doubt whether to attribute the mania to iodoform, the anæsthetic, or to traumatism. In all cases there was an hereditary taint. Only one died,—a case of sequestromy of the femur in a man aged 25. Acute mania came on in five days after the operation; only about one drachm of iodoform had been used. In another case, a pericæcal abscess in a man aged 40, acute mania

came on the second day and lasted one month. The patient ultimately recovered. A small amount of iodoform was used, and only at the operation. Several of the patient's immediate relatives had died insane, and the patient himself was subject to fits of ungovernable temper. The third was a case of amputation of the breast in a woman aged 60. A mild form of insanity followed from the anæsthetic, and the woman never completely recovered up to the time of her death, a couple of years after, from cerebral hemorrhage.

Dr. RODDICK was very much interested in the cases of iodoform poisoning. He believed it is frequently due to idiosyncrasy. He had seen one case follow excision of the breast where iodoform had been used. There was a history of insanity in the family. The mania lasted ten days. He thought iodoform should be used with more care. Large quantities are unnecessary; he had found it to produce severe eczematous irritation of the skin. He now uses carbonate of bismuth in preference to iodoform, as it is less irritating. He also sometimes uses boric acid and naphthalin. Lately he had been using hydronaphthol with benefit. It is odorless and non-irritating. Referring to the case of infiltration of urine, he thought the explanation of the case by supposing perforation of the prostate and posterior layer of the triangular ligament was not necessary, as it is well known that when the membranous portion of the urethra is perforated the urine escapes behind the anterior layer of the triangular ligament—the tendency of the fluid is to infiltrate backwards towards the rectum and not to come forward. If the posterior ligament be perforated, then the urine extends behind the pelvic fascia into the pelvis, and is generally fatal.

Dr. STEWART had seen Dr. Bell's first case, and regarded it as a case of iodoform poisoning. It is well known that in cases of mania from any cause, the mania remains long after the removal of the cause. Cases in which there is much adipose tissue are more liable to poisoning, because the fat decomposes the iodoform in contact with it.

Dr. ARMSTRONG asked if it was necessary to use iodoform at all. Recent experiments have demonstrated that it is devoid of germicidal properties. He thought its use was unnecessary in the treatment of sinuses.

Dr. TRENHOLME, referring to the case mentioned by Dr. Bell when the bladder was wounded, said he thought the bladder should never be emptied before an operation, as it is much more easily avoided when containing fluid. If it be accidentally wounded, then sutures of shoemaker's thread or silk should be used, not catgut, which is very unreliable.

Progress of Science.

IPECACUANHA SPRAY IN CHRONIC BRONCHITIS.

WILLIAM MURREL, M. D.

The ipecacuanha spray was originally introduced as a remedy for chronic bronchitis and other diseases of the throat and respiratory organs, in consequence of the reputed success attending the use of a nostrum, both in London and Paris, by an irregular practitioner. It was difficult to obtain any clue to the composition of the secret remedy, as apparently the proprietor varied the constituents from time to time, in order to puzzle the analysts and escape detection. A number of preliminary trials were made, which speedily demonstrated that even if the specific were not ipecacuanha wine, that very useful drug entered largely into its composition, and that locally applied in the form of a spray it was capable of affording relief to congested and irritated bronchial mucous membranes. Sometimes the ipecacuanha wine, pure, or diluted with an equal quantity of water, used with a small steam vaporizer, but more commonly the ordinary hand-ball spray apparatus, such as is employed for the production of local anæsthesia, was preferred. A solution in spirit made of the same strength as the wine was found equally efficacious. After a few visits the patient was usually taught how to use the apparatus himself. The following may be regarded as typical of a number of cases which have been under treatment at the Westminster Hospital during the last six months. David J., æt. 53, a cigar maker by trade, has had a cough in the winter for 12 years or more. There is not much dust in his work, and he is not exposed to wet or cold, but he has travelled a good deal, and has known what it is to rough it. The cough is troublesome, but it is not paroxysmal. There are no bad attacks of cough, but there is a good deal of hacking, and this keeps him awake at night. There is very little expectoration, certainly not enough to give him any trouble. He has had no hæmoptysis, and has not lost flesh. On examining the chest, the percussion note is found to be normal. Small râles are detected at the left apex in front, and at the right base posteriorly. The

patient was given 15 cc. of ipecacuanha wine, with an equal quantity of water, by a steam spray apparatus, and this was repeated on three successive days, the dose being gradually increased to 30 cc. On the fourth day the hand-ball spray was used, and at the expiration of the week the patient reported that his cough had entirely left him, and that he was practically well. On examining the chest it was found that the rhonchus had disappeared. [Five other cases are given in detail, and the writer concludes]: Most successful results are obtained from the employment of the ipecacuanha spray in cases of chronic bronchitis and bronchial catarrh. In fibroid phthisis there is often a marked improvement, even when no constitutional treatment is adopted. A single inhalation will sometimes restore the voice in case of hoarseness due to congestion of the vocal cords. The spray must be warm, and the patient should not go out for some minutes after inhaling. Care should be taken to see that the spray really enters the chest, and is not stopped by the arching of the tongue against the wall of the mouth. The best results are obtained by using the spray for about ten minutes three or four times a day. In the majority of cases of winter cough relief will be obtained in ten days.—*Med. Press, Lond.*, April 25.

TREATMENT OF CHRONIC BRONCHITIS IN CHILDREN.

By THOMAS J. MAYS, M.D., Professor of Diseases of the Chest in the Philadelphia Polyclinic.

Med. News:—Quite an extended experience in the treatment of these cases teaches us that persistent counter-irritation is of the first consideration. If there is much impediment to the ingress and egress of air, or, in other words, if there is much dyspnoea, the child is at once placed in bed, the chest is enveloped with a hot flax-seed meal poultice (covered well with oiled muslin), which must be changed every three hours. In most cases, however, it is not necessary to order the child to bed, and counter-irritation is produced by a mild croton oil liniment. Croton oil and sweet oil, well mixed in proportion of one to two parts of the former to six of the latter, is well rubbed into the skin of the child's chest—in front, under the arms, and between the shoulder blades not with a flannel or cloth, but with the mother's or nurse's fingers, twice a day, and then the chest is well covered with a layer of cotton wool. It is important that as much as ten or fifteen minutes be spent in rubbing the liniment well into the skin, after which the hands must be thoroughly washed. In the course of four or five hours a red blush of the skin will appear, ending in fine, yellow-pointed pustules. Simultaneous with this eruption the cough becomes easier, the expectoration more free, the dyspnoea less—in fact, the most remarkable change will be brought about in the little patient.

Our attention was first called to the usefulness of this application by Dr. Park, in a short contribution to the London *Practitioner* for March, 1882 (p. 170), and although he principally recommends it in acute bronchitis, we can say that we have found it as useful in the form of bronchitis here described as he did in the acute form of the disease. Indeed, we may add that we have also given it a fair trial in acute catarrhal affections of the chest in children, and never had any reason to feel disappointed with its action.

The interval treatment must be directed toward a stimulation of the bronchial mucous membrane, and toward a recovery of the appetite. The former will be attained in a great measure by the following combination :

℞. Ammonia muriat..... 3 j
 Ex. euphorbia pil. fld.....
 Tinc. digitalis, aa.....f ʒ ij
 Atropiæ sulph.....gr. $\frac{1}{10}$
 Chloroformi..... .gtt. xij
 Syr. tolu,
 Syr. picis liquid., aaq.s.f ʒ j
 Aquæ, ad.....q.s. f ʒ ʒ iv M.

Sig.—One teaspoonful every three hours.

For the purpose of aiding digestion, and as a general tonic, the following will be found useful :

℞. Acid. phosphorici dil.,
 Acid. nitro-muriatic. dil.,
 Acid. sulphuric. aromat.,
 Tinct. ferri chloridi, aa f ʒ ss M.

Sig.—Thirty drops in sweetened water after each meal, three times a day.

The diet should be exceedingly liberal, although no food must be allowed which is likely to disagree. Our main reliance must be placed on rich milk, soup, oatmeal, beef, mutton and other kinds of nutritious food. At no time during the treatment is it necessary to confine the child within doors during pleasant weather. Indeed, out-door exercises should be encouraged as much as possible. —*Epitome of Practical Medicine and Surgery.*

CHLORIDE OF SODIUM IN THE SICKNESS OF PREGNANCY.

Dr. Greene states that he has recently had two very severe cases of sickness during pregnancy. The first patient had been under several physicians, who had tried all kinds of remedies, but nothing stopped the sickness. When seen by the author she was in the seventh month of pregnancy, and very much reduced. Before resorting to the induction of premature labor, it was decided to try the effect of small doses of chloride of sodium (common salt) in chloroform-water. It was given in 5-grain doses in one ounce of chloroform-water. After the first dose the sickness was lessened, and by the time six doses had been taken it had entirely ceased. It was found

necessary to continue the medicine three times a day up to the time of delivery. The patient had a good labor, and made a good recovery. In another case a similar treatment was followed by the same result. The action of this drug seems to be accounted for by its strong antacid; yet soda, potash, and ammonia gave no beneficial results. The author suggests to call the remedy in prescribing by its chemical name, as some patients might despise it when called common salt.—*Medical Press.*

MECHANICAL TREATMENT OF WHOOPING-COUGH.

Goldsmith gives a practical method by which he has had unexpected success. He treats this disease mechanically. Believing that the nose and the naso-pharynx constitute the seat of the contagion, he injects a solution of salicylic acid (1 to 1000), or corrosive sublimate (1 to 10,000), into the nose, making the injection every two hours, and effected in this way a complete disinfection of the nose and naso-pharynx. He only uses the injection in the day time (six times), the next day only four times, and in most cases the whooping-cough disappears by this treatment. Should another attack appear in a few days, it would only be necessary to make a few more injections. Goldsmith declares that whooping-cough in the first stage will certainly disappear in the short time state under the above-mentioned treatment.—*New-York Medical Times*, April, 1888.

TO DISGUISE THE ODOR OF IODOFORM.

Dr. Andrew Fraydon communicates the following item to the *Medical News* of recent date :—

After a large experience in the use of iodoform in Jefferson College Hospital and elsewhere, I have found the following formula to be very satisfactory and to mask the odor thoroughly :—

℞ Balsam. canadensis,
 Iodoform, aa ʒ j
 Vaseline, ʒ vj.
 M.—Solvo.

SUCCESSFUL EXCISION OF A TUMOR OF THE SPINAL CORD.

Surgery is a science, or perhaps we should say a fine art, which will tolerate no limits to its domain. It has of late taken up the invasion of the brain in earnest; it has just made its first successful dash at a tumor in the spinal cord. Last Tuesday evening, before the meeting of the Medical and Chirurgical Society, a private patient of Dr. Gowers and Mr. Victor Horsley very generously allowed the Fellows and visitors of that Society the opportunity of seeing all that had been

done for the improvement of his condition. He had spent about three years in severe pain, which was most intense just below and inside the angle of the left scapula, and was accompanied by absolute loss of motion and sensation of the body and limbs below that level. The upper border of the anæsthesia was distinctly in the region of the fifth intercostal nerve on the left side, on the right it was less accurately defined, but did not extend higher. All the symptoms agreed with those of tumors of the spinal cord, and the intense pain afforded ample justification for making an attempt to excise the tumor. Mr. Victor Horsley accordingly removed the spines and parts of the laminae of the fifth and fourth dorsal vertebrae; but not until the third vertebra had been similarly treated did the tumor come into sight. It was a small oval myxoma compressing and making a deep impression on the left side of the spinal cord below the third vertebra. It was easily shelled out, and under careful antiseptic treatment the temperature did not rise more than 1° F. The wound healed rapidly, except at the uppermost point, where a drain had been left in by which a little cerebrospinal fluid flowed away very slowly. For three or four weeks the former acute pain did not lessen, and even at times seemed more agonizing; but after that it gradually and intermittently decreased, and now, after seven months, is entirely gone; the sensation and motion of the body and legs are almost completely restored. This is, we believe, the first times that such an operation had been attempted, and we must most heartily congratulate both the patient and his advisers on the triumphant character of its success. However far and however quickly surgery may advance, it will long be a memorable day when it gained its first victory on so new a field and over so formidable an enemy.—*British Medical Journal*, Jan. 28, 1888.

PERMANGANATE OF POTASH IN DIPH- THERIA.

In a communication in the *Brooklyn Medical Journal*, May, 1888, Dr. L. D. Mason says that a solution of permanganate of potash, used in the form of a spray through the atomiser, has given him more satisfaction and better results than any other drug so used. A stock solution is prepared of potassium permanganate, 3 ij to distilled water $f\frac{3}{4}$ ij, or grs. v to $f\frac{3}{4}$ j; one fluid drachm of the solution is added to about $f\frac{3}{4}$ jss or $f\frac{3}{4}$ ij of water, the average capacity of the atomizer bottle. It is then ready for use as a spray, in the manner already indicated. The first notable effect is the almost immediate arrest of the fetor exhaled by the patient; and when once this is corrected and the disinfection properly kept up, it will not recur during the treatment. By this means, he says, we rapidly simplify and reduce to an innocuous product the diphtheritic exudate; the self-poisoning that has been in progress is

arrested or modified. The danger of the patient to himself, if we can so express it, and to others also, is averted, a downward tendency is arrested, and the chances of recovery greatly enhanced.

An occasional mouth-wash or gargle can, he says, be used between the spraying, if not contra-indicated. If used, it should be prepared with hot water, a weaker solution of potassium permanganate will answer. Fluid nourishment, taken hot if possible, will have a good local effect. All cloths, etc., on which secretions are caught, should be frequently burned, their places being supplied by fresh clean pieces. Old and small pieces of linen are preferable to larger cloths or handkerchiefs. The hands and face of the patient should be kept clean, using bay rum or alcohol and water. In a word, he advises that a perfect antiseptic condition of the patient and his surroundings should be secured and maintained. His experience with potassium permanganate was, he says, first a surgical one, as a deodorizer and mild stimulant in the cleansing of foul ulcers and sloughing tissues; secondly, in puerperal septicaemia, as an intra-uterine douche; in scarlatina anginosa, with putrid sore throat, and the so-called "snotty nose" complication and secondary glandular infiltration; and, finally, in diphtheria; and in none of these conditions has it disappointed him as to its antiseptic, and antiseptic properties. Used in the form of a spray he regards it as perfectly safe: "We can use it freely. We will not poison our patient. We cannot so confidently speak of the possible effects of other drugs used for purposes of disinfection; indeed poisonous, if not fatal, effects have been traced to some that have been so used." He advises that the use of the spray should be continued until the last vestige of the diphtheritic exudate has disappeared. The frequency of its use will depend on the amount of exudation present, and the stage of the disease. As a rule, the absolute control of the fetor is the best guide.

THE EFFICACY OF LARGE DOSES OF ARSENIC IN CHOREA.

The curative property of arsenic in certain forms of chorea is well attested by numerous unimpeachable observations. It is equally certain, however, that arsenic does not always cure. Dr. James Sawyer in an article, published in *The Birmingham Medical Review*, maintains that when arsenic fails to manifest its ordinary therapeutic efficacy, it is because the drug is not administered in the right way. Properly exhibited, he regards its action as little less than specific. According to him, in order to get the best effects of arsenic in chorea, the remedy must be employed in large and increasing doses. The medicine may be safely "pushed," until irritative vomiting is excited. As with other drugs, some manifestation of physiological action coincides with the direct therapeutic effect of the remedy. It may be remarked

in this connection, however, that irritative vomiting belongs rather so the pathological than to the physiological effects of arsenic, a fact which Dr. Sawyer's enthusiasm for this remedy may have caused him to overlook.

The author describes a typical illustrative case as follows: "A little girl, ten years old, weakly and neurotic, has subacute, general chorea. I give her five minims of Fowler's solution of arsenious acid, in an ounce of water, thrice daily. In three days, the dose increased to ten minims; in three days more, to fifteen, in three days more, to twenty, and so on, until she is taking thirty-five minims of the solution, or a little more than a fourth of a grain of arsenious acid, thrice daily. From the commencement of the treatment, the choreic movements gradually subside in severity, in frequency and in extent of distribution, and when the large dose of more than half a drachm of Fowler's solution is attained, the movements entirely cease, and a little vomiting and stomach-ache warn us that we have reached the earlier physiological manifestations of our remedy. We then withdraw the drug altogether for two days. Afterward, for a few days, we give a reduced dose, ten or fifteen minims of the solution; then the remedy is finally discontinued. The child remains well. After a fortnight's further observation, she is dismissed from our care, cured."

Perhaps the author claims too much for his favorite remedy. But it may be well, in suitable cases, where moderate doses of arsenic have failed, to test the therapeutic efficacy of the drug in the larger doses employed by Sawyer.—*Medical Record*, April 14, 1888.

TREATMENT OF RECTAL PAIN WITH CONIUM.

Dr. W. Whitla, Physician to the Royal Hospital, and Consulting Physician to the Ulster Hospital, Belfast, in a communication to the *Practitioner*, April, 1888, says: The object of this brief paper is to bring under notice the value of hemlock as a local anæsthetic in painful affections of the rectum and anus. In pruritus ani, especially when associated with or caused by hæmorrhoids, or fissures about the anus or in the lower part of the rectum, the physician or surgeon often finds much difficulty in giving relief. The pain and annoyance caused by a minute fissure is very often uninfluenced by cocaine, even when used as a strong solution, and if relief should follow it is seldom complete, and is always of such very short duration that the patient will generally discontinue its use, preferring the misery of his ailment to the exacerbation of suffering caused by the application of the remedy. Morphine, carbolic acid, creasote, belladonna, and the usual array of local sedatives, have been found in the hands of most observers to give very uncertain results in painful conditions of this region of the body. It will be

perhaps the experience of most that they have more frequently aggravated than relieved. Their application I have noticed, when used to allay the pain of an inflamed pile, has sometimes added a more distressing symptom, namely, itching.

It is a long time since conium has been recommended and used as a local anæsthetic; I had tried it when other remedies had failed, and with only such success as did not tempt me to persevere, in some cases the patients asserting that their symptoms were aggravated. About a year ago I noticed somewhere in our current medical literature very satisfactory reports of this drug from an American source, but I regret that I cannot recall the name of the physician or the journal. Having studied the action of conium some years ago on the endings of the sensory nerves, by applying a strong ointment made with the extract to ulcerated surfaces, and painful excoriations and superficial neuralgias, I was led to believe that it had little or no influence upon the sensory terminals. Discovering, however, that the extract of the *British Pharmacopœia* is a most unreliable, and generally almost inert preparation, I determined to try the effects of the *Succus*. Accordingly I have had an ointment prepared in the following manner:—Two ounces of the pharmacopœial juice are placed in a small evaporating dish, and permitted to evaporate slowly at a heat under 150° F., till the bulk is reduced to about one and a half or two drams. This can be done by placing the dish on the top of an ordinary domestic hot-water cistern for twenty-four or forty-eight hours. The syrupy liquid is then carefully triturated with as much lanolin as will make the weight up to one ounce; the result is a perfectly smooth adhesive ointment of a light brown or dark fawn color, and stable.

Happening to have several rectal cases in which severe pain and torturing pruritus were prominent features, the ointment was carefully applied. One was a case of multiple small fissures accompanied with intolerable itching; another was associated with severe tenesmus and excoriations from the pus flowing from an iliac abscess bursting through the levator ani muscle and penetrating the rectal walls; another was complicated by a bleeding villous growth. These with two cases of hæmorrhoids, one of which had an ulcerated surface, were so markedly and speedily relieved by the conium ointment after nearly every known remedy had failed, that I was surprised at the result.

In a considerable number of cases during the last year the same highly gratifying success was achieved by this remedy, whilst I cannot recollect a single instance where the ointment caused inconvenience. It should be freely smeared *inside* the sphincter, and owing to its adhesive quality can be carried a considerable distance up the rectum by the introduction of the fore-finger of the patient. I have never noticed after its use the serious drawback which follows the prolonged application of every other greasy application to this region, namely, a tender, sodden, or raw state of the skin

about the margin of the anus. The ointment appears to me to paralyze the endings of the *motor* nerves distributed to the fine muscular layer under the surface of the mucous membrane; the reflex twitchings of the layer keep up the perpetual pain uneasiness in diseases of the rectum and anus associated with abrasions, ulcerations, or fissures. At the same time it undoubtedly paralyzes the sensory filaments. I have obtained relief from its use in vaginismus and some painful conditions of the male urethra, and find it a good lubricant for the sound or catheter.

To the ointment prepared according to the above formula there may be added 10 or 12 grains of the persulphate of iron as recommended by Mr. Cripps in fissure. From carefully watching the results of this combination of conium with iron, I am seen a fissure heal completely under its use. In acute inflammation of hæmorrhoidal growths associated with swelling and painful thobbing, some relief may be obtained by the free application of the conium ointment without iron, but it is in those exquisitely painful fissures or conditions in which there is a loss of substance in the mucous surface, that this remedy will be found to give more relief than any other drug.

NEW METHOD OF APPLYING TAXIS.

Mr. G. Jameson, Resident Surgeon of the Medical College Hospital, Calcutta, in a letter to the *British Med. Journal*, April 28, 1888, says: A few days ago a native presented himself at the dispensary of this hospital with a large right scrotal hernia, which had been down for some months. The man was placed on his back, and the tumor manipulated. The coverings were fairly tense. Before attempting reduction, I casually asked the patient if the tumor ever got smaller. He replied "Yes," and proceeded to give me a demonstration in taxis which I had not previously heard of. Lifting up the tumor with his left hand, he placed his right thigh on his abdomen, then crossed it over to the left side, catching the tumor between the pubes and thigh, then applying pressure. The hernia disappeared with a gurgle and a snap before I had time to call the attention of the students to this novel procedure. The reduction was complete.

ANTIPYRIN IN THE TREATMENT OF SEMINAL EMISSIONS.

The older remedies for this affection, camphor and lupulin, have very properly been abandoned. Kurschmann says that the sedative action of lupulin on the genital organs is far from demonstrated, and the employment of camphor is not more reliable, although Zeissi, Purjesz and others consider it the best remedy in this affection. Nux vomica, arsenic and atropine have also been recommended, while Diday prefers the bromides of potassium and sodium to all other remedies. He recommends from thirty to eighty grains of the bromide

of potassium to be taken on retiring. But these large doses of bromide will produce acne, and are also liable to induce mental enfeeblement. In order to avoid the dangers of bromides, Thor, of Bucharest, has been experimenting with antipyrin in the treatment of these affections. He advises the patient to take from seven to fifteen grains of the drug on retiring. In seventeen cases, he has completely cured the complaint, without any unpleasant consequences. According to Beart, antipyrin is useful in neurasthénia of the sexual organs, but in these cases from 1 to two grains a day should be given.—*Revista de Cincias Medicas*.

AN INHALATION FOR PHTHISIS.

In the *Rev. du Therapeutique* for December 1, 1887, Filleau and Petit give the following formula for inhalation in phthisis:

℞	Carbolic Acid.....	gr. 30
	Essent. Terebinth.....	3 12½
	Essent. Picis.....	3 5
	Eucalyptol.....	3 7½
	Chloroform.....	gtt. 5

M. S.—To be inhaled four to six times daily, for five minutes at each sitting.

MARSON'S TEST FOR SUGAR IN THE URINE.

Dissolve two grains of ferrous sulphate in about 150 minims of the urine, add five grains of caustic potassa, and boil. A dark green precipitate forms if sugar is present, and the supernatant liquid is reddish brown or black, according to the amount of sugar. When sugar is absent, the precipitate is greenish brown in color, and the liquid is colorless.—*London Medical Recorder*, Feb. 20th.

It may not be generally known among physicians that the bromide of lithium is almost a specific for muscular rheumatism.—*Bartholow*.

A FUMIGATION FOR ASTHMA.

Sawyer (*Birmingham Med. Rev.*," "*Lyon Méd.*") recommends the following as having afforded the best results that he has observed among those of a great number of inhalants:

Potassium nitrate,	} each,	2 parts
Powdered aniseed,		
Powdered stramonium leaves,	4 "	

A thimbleful of the mixture, fashioned into a little cone, is placed on a plate and lighted at the top.—*N. Y. Medical Journal*.

CREASOTE IN PHTHISIS.

Dr. Peter Kaatzer, of Rehburg, strongly recommends in the *Berliner Clinische Wochenschrift*, March 12, 1888, the administration of creasote in the treatment of phthisis. After trying various formulæ he settles upon the following as the best:

R Creasoti purissimi.....2 parts
 Alcoholis.....30
 Tr. gentianæ,
 Ext. coffeæ.....aa.10 "
 Aquæ destillatæ.....100 "

M. Sig.—Shake well and take a tablespoonful in half a glass of milk twice daily.—*Epitome of Pract. Med. and Surgery.*

TO REMOVE FRECKLES.

R Hydr. præcip. albi, 5 parts ;
 Bismuthi subnitrici, 5 parts ;
 Ungt. glycerini, 20 parts.

M. Apply to freckles every second or third day, but not more frequently.—*Memorabilien.*

SALICYLIC ACID IN SKIN DISEASES.

Dr. Besnier, in a clinic reported in the *Journal de Méd. et de Chir. Prat.*, April, 1888, recommends salicylic acid in the following skin diseases :

In pityriasis versicolor, the affected parts should be bathed every evening with hot water and soap. The following ointment should then be applied :

Acidi salicylici.....gr. xlv
 Sulph. præcip.....gr. ccxxv
 Vaselini..... $\frac{5}{3}$ ij

The bathing and the application of the ointment should be renewed every evening ; recovery usually occurs in about fifteen days.

Salicylic acid will also, he says, act well in senile pruritus, that is to say in the violent itching occurring in old people, unaccompanied with senile retrograde changes in the skin. In these cases, besides starch baths, the author advises that every evening the whole body should be bathed with a sponge dipped in very hot water (at about 104°), or with water containing a teaspoonful of the following liquid :

Aromatic vinegar.....f $\frac{3}{4}$ viij
 Carbolic acid.....gr. lxxv

The body should then be covered with the following powder, applied with slight friction with the hand :

Starch..... $\frac{5}{3}$ iij
 Salicylate of bismuth.....gr. cl

The salicylate of bismuth may be replaced by salicylic acid. Finally, it may be employed with advantage in acne with comedones. The following ointment may be used every evening for eight days :

R Salicylic acid.....gr. xxx
 Precipitated sulphur
 Potash soap.....aa $\frac{5}{3}$ jss

At the end of eight days some emollient application is made, and a great number of comedones will be found to have been expelled.—*Revue Médicale*, April, 1888.

PRELIMINARY TREATMENT OF PSORIASIS.

To remove the scales which occur in psoriasis, and thus increase the efficiency of remedial agents to be subsequently applied, Dr. Alf. Stocquart recommends (*Archives de Médecine et de Chirurgie Pratiques*) the following :

R Ammon. Carbonat.....2 parts:
 Lanolini puriss.....5 parts.
 Cerat. Simplicis.....10 parts.

M.

This is to be applied twice daily, and is neither irritating nor painful. It leaves a clean, smooth surface, and its chief value lies in the fact that it is cheap.

LACTIC ACID IN DIARRHŒA.

M. Hayem at the *Soc. des Hôp.* stated that in diarrhœa, especially the green diarrhœa of children, he had found a teaspoonful of a two per cent., solution of lactic acid, every hour, efficient. In adults when the flux was chronic and accompanied with dyspepsia, a rapid cure was effected by three tablespoonfuls of the same solution. Where the diarrhœa was bilious and acid, he ordered large doses of bicarbonate of soda.

THE CANADA MEDICAL RECORD

A Monthly Journal of Medicine and Surgery.

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 LONDON.

SUBSCRIPTION TWO DOLLARS PER ANNUM.

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

MONTREAL, JUNE, 1888 .

We owe an apology to our readers for being a number behind in getting the Journal into their hands. Owing to an unusual rush of work about the spring of the year, our publishers were unable to overtake it, and once behind, it is a more difficult task than one would imagine to catch up again. This we have now, however, every prospect of doing, having added some young blood to our editorial staff; the next few num-

bers will succeed each other every two or three weeks.

We are especially anxious to encourage our readers in all parts of the world to communicate to us anything of interest which may come under their medical observation; we shall also be happy to make room in our columns for letters of inquiry on any topic in which the Profession is interested, and we will be glad to publish the answers which others of our readers may send in. Our object is to save from oblivion the immense amount of knowledge, born of experience, which must be lying in the possession of our thousand readers, and which might otherwise die with them.

To begin with, we would like those of them who have kept records of their midwifery practice to give us an honest account of the percentage of deaths, and the cause of death in fatal cases, and whether the death rate has been less during the last few years?

We take great pleasure in calling the attention of our readers to the Meeting of the Canada Medical Association to be held at Ottawa on the 12th, 13th, and 14th September. Apart from the fact that this year the Meeting is to be held in a remarkably central and accessible location, and, moreover, that it promises to be unusually interesting, there is another reason why every member of the Profession should be willing to make a temporary sacrifice to be present. That is the advantage it confers upon us to hear in two or three days the result of the life-long experience of our elder brethren. Our patients may grumble somewhat at our absence, but in their hearts they are far seeing enough to know that in the end they are the ones to benefit by the increased knowledge we there acquire.

Indeed, it is a well known fact that in the city here, where there are nearly two hundred competitors or more in the professional struggle, no one loses any of his practice by devoting a certain part of every year to study, either in the large American cities or abroad. In most cases we find shortly after our return that our practice has largely increased. Besides this, even the most humble among us has observed something in the course of his experience, which might be useful to the Profession, and which he is morally bound to communicate. There can be no better opportunity for doing this than at the reunion of

the whole Profession from every part of Canada. It might be objected that if every one attended these meetings and read a paper at them, there would not be sufficient time for them all. But this difficulty could be easily overcome by making the papers more concise than they sometimes are. We, therefore, reiterate our opinion that the time spent at the Medical Society and at the Association will not be lost, but will, like the golden wheat the farmer buries in the ground, before long bring a rich harvest in return; and we express the hope that there will be a large attendance of the rank and file of the Profession, at the Meeting this year in Ottawa. By applying early to Dr. Bell, General Secretary, Beaver Hall hill, Montreal, arrangements can be made for greatly reduced rates for medical men and their wives.

PROVINCIAL MEDICAL BOARD.

The Semi-Annual Meeting of the Provincial Medical Board of the Province of Quebec was held in the City of Montreal, on Wednesday, the 9th May, 1888, Dr. W. H. Hingston, President, in the Chair.

The report of the examiners for admission to the study of Medicine was read. Forty-six candidates had passed. Thirty-two were rejected upon certain subjects, and nine were totally rejected on all subjects.

It was moved by Dr. Lachapelle, seconded by Dr. Lemieux. That all candidates for license, who have passed the preliminary examination in any other province than that of Quebec, shall be obliged to sign a solemn declaration that such certificates were obtained in compliance with the requirements of such provinces, and not for the purpose of evading the law of the Province of Quebec.

An amendment was moved by Dr. T. Larue, seconded by Dr. Paré, That the Provincial Medical Board cannot, according to its by-laws, accept the certificate from any other province of the Dominion, for the preliminary examination of those who study Medicine in the Province of Quebec.

A sub-amendment was moved by Dr. Kennedy, seconded by Dr. Parke, That certificates for matriculation in Medicine, registered by the Ontario Council, be accepted for the present as heretofore, and that a committee be named to examine into the nature of the certificates, and

to report at the next meeting of the Board.

Both the amendments and the main motion were lost on division. Dr. Lachapelle then resigned from the Committee on Qualifications, and was replaced by Dr. Paré.

At the afternoon session, the reports from the assessors of the Universities of Laval, McGill, Victoria and Bishop's Colleges were adopted.

A duplicate license was granted to Dr. Alleyn, of New Orleans, formerly of Quebec, the original having been accidentally destroyed by fire.

Dr. Kennedy, for the Committee on Qualifications, reported that the following gentlemen were entitled to the license:

Victoria University.—Henri Ducharme, Jos. Beauime, Victor Bourgeault, E. A. Laferrière, Hyacinthe Bastien, L. A. Beaudry, J. C. Gadoury, J. A. Marcotte, J. E. Brault, E. E. Laurent, L. C. Bussière, Jos. Barolet, J. M. Picotte, J. A. Pomminville, C. T. Morel de Ladurantaye, J. T. Moreau, J. A. Paré, L. Leblanc, Jos. Thériault, Chas. F. Clerk.

Bishop's University.—V. J. Groulx.

Laval University, Montreal.—E. A. René de Cotret, Charles Marciel, Arthur J. Ricard.

McGill University.—E. H. P. Blackader, E. I. Quirk, F. G. Finley, W. G. Stewart, J. H. Bell, A. W. Haldimand, C. W. Hæntschell, W. W. Chalmers, R. Marr Kincaid.

The candidates were sworn and the licenses granted.

Dr. Kennedy then submitted the names of a number of candidates having the degree of M.D., who have passed their preliminary examination in Ontario, Manitoba, or New Brunswick.

Moved by Dr. Guay, seconded by Dr. Rousseau, That the question of admission to the study of Medicine be reconsidered.

The motion, on division, received a majority of votes, but the President ruled that a two-thirds vote was always required for reconsideration.

Moved by Dr. Grandbois, seconded by Dr. Howard, That in future the license shall be refused to those candidates who, belonging to this Province, have endeavored to evade the law of the Province by passing their preliminary examination in one of the other provinces, and that the candidates now before the Board, having such certificates from other provinces, be required to sign a solemn declaration that they have obtained such certificates in the regular course and not with any intention of evading the existing law.

Moved in amendment by Dr. Dagenais, seconded by Dr. Ladouceur, That, in future, the Board grant no license to candidates not possessing the certificate of preliminary examination from this Board, with the exception of the cases provided for by the law.

Amendment lost and main motion carried.

The following graduates signed the above declaration before Dr. Leprohon, J. P., were sworn, and received the license:

Victoria University.—Thos. Ennis, Félix Coran, Paul Royal and U. A. Dorais.

Bishop's University.—Frederick Taylor, Follin H. Pickel.

McGill University.—R. B. Struthers, J. A. Springler, W. D. T. Fergusson, F. D. Robertson, John Geo. McCarthy, F. G. Desmond, James Hewitt and C. P. Dewar.

Queen's College.—Jas. N. Anglin.

Dr. Alfred Smith, of the Toronto School of Medicine, also received the license.

It was resolved that the following members be a committee to take the steps necessary for the presentation of the Medical Bill before the Legislature: Drs. Lemieux, Belleau, Lachapelle and Parke.

Moved By Dr. Christie, seconded by Dr. Durocher, That the Bill be withheld for six months. Lost.

Meeting then adjourned.

WETTINC WITH FRESH AND SALT WATER.

The *Dublin Medical Press* says:—Whether a fact in science or not, there exists a very general impression amongst those who have been much at sea, that there is little or no danger to health from being wetted with sea-water. It is a proverb amongst sailors that there is no danger from getting wet from salt water. On the other hand, old tropical residents, far more even than those living in temperate latitudes, have a great fear of getting wet, either from rain or other sources. An attempted explanation of these different results was made so far back as in 1839, by Robert Mudie, who remarked that "the evaporation of sea-water from any surface has not nearly so cooling an effect as the evaporation of fresh water from the same, and thus a sailor may get wet and dry with the spray of the sea, and even with the sea fairly breaking over him, with far more impunity than a landsman

can get wet and dry by exposure to showers." The reason of this is easily explained, the evaporation of pure water is complete, and accompanied by nothing but an absorption of the action of heat, and a consequent reduction of temperature; but, in the case of sea-water, and the crystallisation of a certain portion of the salt, which has been previously distributed through the water, and the holding of which in a state of solution requires a certain action of heat; when the salt again crystallises this action is set free, and in so far counteracts the cooling effects of the evaporation, hence it is a fact that there is greater safety in being wetted with sea-water than with rain. Human experience has commonly shown great truths, ages before science has explained.

TREATMENT OF SICK HEADACHE.

Dr. W. Gill Wylie, of New York, has produced excellent results with the following method of treatment. So soon as the first pain is felt, the patient is to take a pill or capsule, containing one grain of inspissated ox-gall and one drop of oil of gaultheria every hour, until relief is felt, or until six have been taken. Dr. Wylie states that sick-headache as such is almost invariably cut short by this plan, although some pain of a neuralgic character remains in a few cases.

THE MONTREAL MEDICAL JOURNAL.

The *Canada Medical and Surgical Journal* will on the 1st of July change its name to "The Montreal Medical Journal," and increase its pages from 64 to 84 pages each number. We congratulate our contemporary on this evidence of its growth, and wish every possible prosperity.

BEAUTIFUL CHEMICAL PREPARATION.

A snow white mass of Caffeine, the active principle of coffee, (200 pounds, and of great value,) is now in exhibition in the window of William R. Warner & Co., 1228 Market street. This beautiful crystallization represents ten tons of coffee, and is used as an ingredient in the preparation of Brome Soda prescribed for the cure of headaches, migraine, nervousness, sea sickness, &c.—*Philadelphia Inquirer*.

DIET IN ALBUMINURIA.

The *Dublin Medical Press* says:—"The condition known as the 'large white kidney,'

a malady of tolerably common occurrence, is due in a large number of cases to the chronic irritation set up in the eliminatory organs by the excretion of incompletely oxidized nitrogenous matter, resulting either from excess of nitrogenous material ingested or from hepatic or other visceral disease. In either case it is important to bear in mind that the object to have in view is to reduce, or at any rate not to augment, the quantity of these partially oxidized products. For this reason albuminuric patients should avoid foods containing an abundance of these extractives. Beef tea, beef extracts, and the like are little less than poison to them, as they infallibly accentuate the irritation and aggravate its results. It has been found that the systematic subcutaneous injection of these substances in guinea-pigs gave rise to the characteristic renal lesions with the usual train of symptoms, the severity of which was in direct proportion with the quantities injected."

BRITISH COLUMBIA MEDICAL COUNCIL.

The regular Semi-Annual Meeting of the British Columbia Medical Council was held in Victoria on the 1st, 2nd, 3rd and 4th of May. Present: Dr. Davie (Victoria), Vice-President; Dr. Milne (Victoria), Registrar; Dr. Hanington (Victoria), Treasurer; Dr. McGuigan (Vancouver), Dr. Powell (Victoria), and Dr. DeWolf Smith (New Westminster).

The Treasurer's report showed that the Council had a satisfactory balance on hand, and it was resolved to devote a portion of this to the prosecution of unregistered practitioners throughout the Province.

Two candidates presented themselves for the license, but were referred for six months.

The election of officers for the ensuing year resulted as follows: President, Dr. J. C. Davie; Vice-President, D. W. J. McGuigan; Registrar, Dr. G. L. Milne; Treasurer, Dr. E. B. C. Hanington,—the two latter being re-elected.

The Committee on Fees, appointed at the last meeting, brought in a report recommending a scale of fees, which was adopted by the Council, and ordered to be printed.

The Council then adjourned. The next meeting will be held in Vancouver, on the first Tuesday in November, 1888.

CANADIAN MEDICAL ASSOCIATION.

The twenty-first Annual Meeting of the Canadian Medical Association will be held in the city of Ottawa on the 12th, 13th and 14th of September next. The following are the officers of the Association:—President, J. E. Graham, M.D., Toronto; President elect, George Ross, M.D., Montreal; Secretary, James Bell, M.D., Montreal; Treasurer, Charles Stuart, M.D., Toronto; Vice-Presidents—For Ontario, Dr. Eccles, London; Quebec, Dr. Christie, Lachute; New Brunswick, Dr. Currie, Fredericton; Nova Scotia, Dr. Wickwire, Halifax; Manitoba, Dr. Blanchard, Winnipeg; British Columbia, Dr. True, New Westminster. Local Secretaries—For Ontario, Dr. J. A. Grant, jun., Ottawa; Quebec, Dr. Armstrong, Montreal; New Brunswick, Dr. Lunnan, Campbellton; Nova Scotia, Dr. Trueman, Sackville; Manitoba, Dr. Chown, Winnipeg; British Columbia, Dr. Neilin, Victoria.

THE NEW MEDICAL BILL FOR QUEBEC.

Petitions, largely signed by the Profession, have been presented to the Legislature against the new Medical Bill, and, so far as we can judge, the prospect of its being rejected by a considerable majority seems to increase every day. In our next issue we will be able to give the definite result.

THE CODE OF ETHICS OF THE AMERICAN MEDICAL ASSOCIATION.

ART. II.—*Professional services of physicians to each other.*

1. All practitioners of medicine, their wives, and their children, while under the paternal care, are entitled to the gratuitous services of any one or more of the faculty residing near them, whose assistance may be desired. A physician afflicted with disease is usually an incompetent judge of his own case; and the natural anxiety and solicitude which he experiences at the sickness of a wife, a child, or any one who, by the ties of consanguinity, is rendered peculiarly dear to him, tend to obscure his judgment, and produce timidity and irresolution in his practice. Under such circumstances, medical men are peculiarly dependent upon each other, and kind offices and professional aid should always be cheerfully and

gratuitously afforded. Visits ought not, however, to be obtruded officiously, as such unasked civility may give rise to embarrassment, or interfere with that choice on which confidence depends. But, if a distant member of the faculty, whose circumstances are affluent, request attendance, and an honorarium be offered, it should not be declined; for no pecuniary obligation ought to be imposed, which the party receiving it would wish not to incur.

SACCHARINE TABLETS.

This chemical substitute for sugar, now prepared by W. A. Dyer & Co., Chemists of Montreal, possessing nearly 300 times the sweetening properties of cane sugar, can be used with perfect safety by those suffering from Diabetes, Bright's Disease, Dyspepsia, Obesity and every ailment where sugar is forbidden. The tablets are guaranteed as being perfectly free from cane or grape sugar, or anything a diabetic patient should avoid—and will impart to tea, coffee or any other substance a sweet and delicate flavor, which has been by many preferred to that obtained from commercial cane sugar.

PERSONAL.

Dr. S. A. Thomas (C.M., M.D., Bishop's College, 1888) has settled in Escanaba, Wisconsin. On St. Jean Baptiste day, by invitation, Dr. Thomas delivered the oration, which was well prepared and well delivered,—so say the local papers, and we can well believe it.

Drs. Wilkins, Wm. Gardner and Stewart, of the Faculty of Medicine of McGill University, have left for a three months' trip in Europe.

Dr. R. Palmer Howard, Dean of the McGill Faculty of Medicine, has gone for a much needed rest, and salmon fishing on the Cascapedia.

Dr. Richard MacDonnell of McGill Faculty of Medicine, who has been ill, is, we are pleased to say, rapidly improving. He proposes leaving for Europe shortly.

The Rev. J. B. Saunders (C.M., M.D., Bishop's College, 1885) has resigned the chair of Botany, which he held in his Alma Mater, owing to his removal to the pastorate of the Methodist Church in Pembroke, Ont.

Dr. McClure, late Superintendent of the Montreal General Hospital, has been ordained by the Presbytery of Montreal, as a Medical Missionary to China.

Dr. Clark (M.D. Bishop's College, 1888) is pursuing his medical studies in Edinburgh.

A few weeks ago, the Senior Editor of the RECORD being in London, England, called upon his old friend, Dr. Donald Baynes (M.D., McGill 1876, L. R. C. P. Lond.), who for some years filled the position of Professor of Laryngology, in Bishop's College, Faculty of Medicine, Montreal. We found him located in Harley Street, in the midst of London's most fashionable Physicians. Dr. Baynes has already acquired quite an extensive clientèle, and if we are not mistaken, there is a bright future in store for him.

It is reported upon excellent authority that Dr. W. Geo. Beers, Dentist, purposes leaving Montreal, and commencing the practice of his profession in London, England.

BOOK NOTICES.

It has been said that the success of specialists is in great part due to their attention to details. In order to master these latter in all their minuteness, it is generally necessary for the practitioner to devote some months, or weeks, at least, to the observation of the Hospital practice of the great specialists at some of the centres of medical teaching. And certainly this is the best way to acquire such information. But for those who are unable for various reasons to do so, the next best thing is to provide oneself with such a work as "the Rules of Aseptic and Antiseptic Surgery," by Arpad Gerster, M. D., Professor of Surgery at the New-York Polyclinic, visiting surgeon to the Mount Sinai and German Hospitals.

As the work is profusely illustrated with 251 engravings or photo-lithographs, taken in the operating room, during the progress of the operations, one almost imagines in reading the book that he is standing beside the operator. The text runs in such a clear and easy style, that perusal of this book is not only not a trouble but a relaxation. True to its title, it deals exhaustively of Sepsis and the means of preventing it, giving information which is not yet to be found in any other book. It is published by Appleton & Co. of New-York, in their well known style, on the most beautiful of paper

and with the clearest of type. It may be had from Dawson Bros., Publishers, Montreal.

For those who have not enjoyed the advantages of a full classical education, and who are about to commence the study of medicine, the whole course of their professional studies would be made very much easier by the perusal of a treatise entitled "The Language of Medicine," by Prof. F. R. Campbell, of Niagara University. It gives the exact meaning and derivation of nearly every word met with in Medicine, as well as complete rules for correct prescribing in Latin. Incidentally a very interesting history of Medicine is introduced. On this latter account, as well as for the amount of erudition displayed in its preparation, it will be read by even the oldest practitioner with satisfaction. There are chapters on the "Latin Element in the Language of Medicine," "on the Origin of the Language of Medicine," "on the Greek Element in the Language of Medicine," and "On Elements Derived from the Modern Languages.

The book is published by Appleton & Co., of New York, and may be had of Dawson Bros., of Montreal.

The applied anatomy of the Nervous System, by Ambrose L. Ranney, Professor of Anatomy in the University of New York. The name of Ambrose Ranney is a sufficient guarantee that whatever he undertakes will be thoroughly carried out, and the present work, which although a second edition, is really a new work, having been entirely rewritten, is no exception to the rule. As a work of Anatomy alone it should be in the hands of every teacher of Anatomy, while as a work on Applied Anatomy it is invaluable to those who have anything to do with the diagnosing and treatment of nervous diseases. Nervous symptoms puzzle us more than any others in tracing them to their origin, and it is in interpreting them that this work would be of the greatest help. Since we first read Hilton's classical work on "Rest and Pain," we have not experienced as much pleasure in the perusal of any book of the kind as we did in reading this,—the latest and perhaps the best work on the anatomy of the nervous system.

It is profusely illustrated, and the type is large and clear. It is published by Appleton & Co., of New York, and is for sale by Dawson Bros., Montreal.