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# THE CANADA LANCET

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## Original Communications.

### UTERINE TUMORS.

A. B. ATHERTON, M.D., L.R.C.P. & S. ED., TORONTO.

(Formerly of Fredericton, N. B.)

CASE I.—Mrs. S—æt 40, multipara, widow, last child 10 years of age. The patient was sent to me Sept. 29th, 1875, by Dr. White, of Hartland, N.B. She had been always strong and healthy till three or four years ago, when she began to have an increased flow at the menstrual periods, and at the same time noticed a hard lump somewhat to the right of the lower abdomen. A year ago she suffered severe pain in the abdomen and back during two or three catamenial epochs accompanied with much flooding. Since then the quantity of blood lost has been gradually growing less, while there has been a constant watery and mucous discharge. For about two years micturition has been frequent, though the urine was natural-looking and the bowels had to be kept very loose in order to have any passage.

*Present condition.*—Fairly well nourished. P. 100 and rather feeble. She complained of an unusual amount of pain since her arrival in Fredericton, probably due to her journey in the cars. On examination a large, smooth, semi-elastic tumor was found completely filling the pelvis, its lower end being exposed to view on the separation of the labia. Its surface was found united in places with the vagina, but the adhesions could be readily separated with the finger. A firm hard mass was felt through the abdominal walls, occupying the hypogastric region and reaching fully up to the umbilicus. As the menses had ceased about a week before and the patient was anxious to have an operation at once I decided to accede to her wishes.

*Sept. 30th. Operation.*—Chloroform was adminis-

tered; assisted by Dr. Coulthard. As it was impossible to get fairly at the neck of the tumor on account of want of room for the hand, I first sliced off perhaps one-fifth of the thickness of the tumor longitudinally. I then could feel its base apparently attached to the left anterior part of the cervix, and being about three or four inches in diameter. Then by means of traction with very large toothed forceps, and the use of a curved blunt bistoury set in a long handle, about two pounds of the mass were removed, leaving rather more of a stump than I could have wished. The patient however became considerably collapsed, though the loss of blood was not so very great, and I was obliged to desist from further efforts. About two hours were occupied in operating. The abdomen seemed to have flattened down completely during the operation, so that little or nothing could be felt there. The vagina was plugged with cotton wool, and  $\frac{3}{4}$  gr. morphine administered as a suppository.

Oct. 1.—Rested fairly well; vomited a good good deal; passed water once; P. 112; some offensive discharge; cotton wool tampon removed. There has been very little hemorrhage. Vagina to be syringed with warm carbolized water every three or four hours, ʒ j. ad. Oj.

Oct. 2.—Vomiting continues troublesome. Not much pain. P. 108. Discharge very fetid. Injections to be continued frequently.

Oct. 3. Doing well. P. 100; discharge as before.

Oct. 4. Ate potato yesterday, and bowels are a little loose to-day. P. 108. Quinine mixture ordered, also careful dieting

Oct. 5.—Bowels better. P. 104. Three bits of sloughy tissue came away yesterday. Discharge still offensive.

Oct. 7.—Discharge less foul for last two days.

Oct. 11.—Discharge is lessening. P. 100. Patient sat up three hours to-day.

Oct. 18.—Discharge very slight. Patient sits up all day now, but looks rather pale and weak. Iron added to quinine.

Oct. 26.—Has been out of doors several times. Wishes to return home and may do so.

On examination I found the entrance to the cervical canal close to the right and posterior side of the upper vagina. The stump of the tumor filled up a good part of the latter and was adherent to

it in places. These adhesions were easily broken down with the finger. Directions were given to get Dr. White to separate any such that might re-form, a few days after getting home.

My patient was so much improved by the operation, that two or three years afterwards she ventured once more upon the sea of matrimony and became Mrs. D. She got along very comfortably until about a year ago, when she began to suffer from a nasty filthy discharge, accompanied by the feeling of something in the vagina. She has also had some irritability of the bladder. Her general condition however has been good. On examination I found a tumor filling the upper three-fourths of the vagina, and attached broadly and firmly to the latter at its posterior and lateral surfaces. I could not well get at the attachment to the cervix uteri on account of the size of the tumor and its extensive adhesions. The fundus of the uterus could be felt through the abdominal walls in the right hypogastric region, reaching nearly to the umbilicus.

*April 12th, 1883. Operation.*—Chloroform was administered, assisted by Dr. Coburn, of Fredericton. I first cut a slice from one side of tumor as before, in order to reach its uterine attachment, which I now found to be only about  $1\frac{1}{4}$  inches in diameter. This was first severed, then by dint of traction with forceps, cutting with scissors and knife, previously described, and tearing away with the fingers, the whole mass was slowly detached from the walls of the vagina and removed.

Great care was needed during this procedure to avoid penetration of the thinned recto-vaginal septum. The operation lasted about three hours, and I was ably assisted by Dr. Coburn in its successful accomplishment. Although the loss of blood was comparatively slight, yet the patient suffered considerably from the shock, as after the first operation. Her general condition, however, was better on this occasion previous to operating, and she rallied in a short time. The vagina was tamponed lightly with some pledgets of salicylic silk wrapped in carbolized gauze. The amount of tumor removed was about equal in size to a foetal head at full term.

April 13.—9 a.m. Doing well, had  $\frac{1}{4}$  gr. of morphine last night. Some vomiting, P. 76, T. 99°. Tampon removed. Vagina to be washed out three or four times a day with warm carbolized water.

April 14.—P. and T. as yesterday.

April 15.—Less discharge since operation than before. Some looseness of bowels, attributed to her taking some beef-tea yesterday. She states that she is always easily upset by changes of diet. P. 88, T. 99.5°. Paregoric in drachm doses pro re nata for the diarrhoea. Also to have dry farinaceous food.

April 16.—Bowels better. P. 84, T. 98.8°.

April 19.—Discharge is very slight. P. 80, T. 98.8°. May sit up a little, and can have a boiled egg and a potato every day.

April 24.—Catamenia came on to-day, being the regular period for them. P. and T. normal. Sits up several hours every day.

April 29.—Has been going about the house for two days. Menses have ceased. On examination the cervix felt large and expanded, the whole uterus also seemed heavier than normal. No trace of tumor found anywhere, unless it might be two or three small hard prominences at the upper and posterior part of the vagina, of the size of split marbles. Some purulent matter was also found in the vagina. The carbolic injections to be continued two or three times daily. Asks to go home to her family. May do so tomorrow. December, 1884, I received a note from the patient stating that she seemed perfectly well and entirely rid of the old trouble.

CASE II.—May 29, 1880. Mrs. H. æt 39, multipara. The youngest child is six years old. Generally healthy till eighteen months ago, when she began to have menorrhagia, and the intervals between her periods became shorter than usual. During the last six months a colored discharge has been present about half the time.

*Present condition.* Countenance pale, rather thin in flesh, complains a good deal of back-ache, pulse weak. On examination, a small, firm polypus was felt in the cervical canal, about the size of a large hazel-nut. The uterine cavity measured  $3\frac{1}{2}$  inches.

Operation. Chloroform was given because the patient was very nervous. The polypus was removed by the scissors, and a piece of cotton wool wet with carbolic acid and glycerine passed into the cervix, and one or two dry pledgets applied over it.

May 30.—Cotton wool removed. Warm carbolized injections to be used three or four times a day.

June 21.—Patient did perfectly well for a week

or two after the operation, but for a week past she has had pains in the back, accompanied with menorrhagia. On examination, a rather soft, solid mass was felt pressing down into the upper cervical canal anteriorly, which at first thought I suspected might be the somewhat inverted wall of the uterus. The sound however could be passed  $2\frac{1}{2}$  inches beyond its lower border of union with the body of the uterus, and I therefore decided that it was a tumor in the wall of the latter.

Operation. Chloroform was administered assisted by nurse. The presenting surface of the mass was seized with a vulsellum forceps, and with the help of blunt scissors and fingers, the tumor was gradually enucleated. It proved to be about the size of a small orange. The free surface measured about  $1\frac{1}{2}$  inches across, the remainder of the tumor of course having been embedded in the anterior uterine wall. Very little hemorrhage attended the operation. Pledgets of cotton wool were applied as before.

June 22.—Cotton wool removed, carbolized injections to be used three or four times a day. Little or no disturbance from operation, pulse and temp. being as they were previously.

June 25.—Doing well, very little color in discharge and she suffers no pain.

June 30.—Was up about the room two days ago without leave, and since then there has been some bloody flow.

July 2.—Discharge has ceased, the patient is up and dressed.

July 17.—Has continued free from discharge, and left for the country to-day.

## THE MANAGEMENT OF PNEUMONIA.

BY M. C. ATKINSON, M.D., BRISTOL, N. B.

Perhaps there is no disease about the treatment of which physicians differ more than pneumonia. There have been, and there still are, two general modes of treating this disease. The first, the antiphlogistic treatment: the second, the expectant plan. By the first it is hoped to cut short the course of the disease or stay its progress. To this end tartar emetic, aconite, and veratrum viride are administered and venesection performed. By the second plan we hope by careful watching, by restraining the violence of the fever—by good

nursing, dieting, and a careful attention to hygienic conditions, to guide the patient through the crisis back to health. In order to reach the subject in a practical way I shall narrate briefly the history and treatment of three cases, and conclude with a few remarks upon the same.

CASE I.—February 6, '84, I was called to see J. H., aged 30, a strong, full-blooded, vigorous man; found him suffering from pleuro-pneumonia. The day previous he was attacked with chills, violent headache, and sharp stitch-like pain in the side. Pulse 120, temp.  $105^{\circ}$ , resp. 36. The middle and lower lobes of the right lung were consolidated. Gave minim doses of tr. aconite rad every two hours combined with three grain doses of quinine; pulv. Doveri., grs. viii, to be given occasionally to relieve pain. Applied mustard over the whole of the right lung, to be followed by hot wheat-bran poultices, changed every two hours; bled to  $\bar{x}xx$ . Saw patient three hours after bleeding; resp. 32, temp.  $104\frac{1}{2}$ , pulse 112, very soft and full. Expectoration, which has been profuse and "rusty," almost stopped; cough much less severe; delirium and subsultus developed.

7th, Patient much more delirious; mouth dry and parched; pulse 133, temp. 103, resp. 32. Stopped aconite and ordered tr. digitalis and am. carb., continuing quin. sulph., grs. iii, every four hours; also to have six ounces of brandy in milk daily. For four days and nights the delirium continued; chloral hydrate and bromide of potassium, single and combined, within the limits of safety, failing to produce sleep till the fifth night after the bleeding, when he fell into a slumber so profound that he had to be awakened by his attendants. On the fourth day after the bleeding the consolidation had almost disappeared. Acute pain from pleuritic adhesions came on, which was relieved by strapping the chest with adhesive plaster. Under the digitalis the pulse fell from 133 to 112 on the second day after the bleeding, and on the third had fallen to 100. The patient was much exhausted on recovering from the delirium. The pulse remained at 100; tongue brown, dry and parched. He also suffered from moderate diarrhoea, which I did not think proper to check. As the delirium went on I increased the daily amount of brandy to eight ounces; also gave him all the milk he could be made to take. The recovery was very tedious.

CASE II.—On the same day that I made my

first visit to Case I, I was called to see a niece of his, a young woman aged 19, of robust habit. I found her suffering from the same disease, having also been attacked the day previous. Her pneumonia was but slightly complicated with pleurisy. There was extensive consolidation of the right lung, extending from the lower portion of the upper throughout the middle and lower lobes of the right lung. Sputa "rusty" and tenacious, tongue dry and brown, hectic flush on each cheek; resp. 44, pulse 130, temp. 104 $\frac{3}{4}$ . I also found congestion of the lower lobe of left lung posteriorly. The same treatment with reference to mustard and poulticing was pursued here as in the preceding case. I also gave the patient two grain doses of quinine every two hours, and am. carb., and tr. digitalis, in ten grain and ten minim doses respectively, every four hours.

*February 7.* Again saw patient; pulse 135, temp. 103, resp. 48. Crepitation over the upper lobe of the right lung becoming coarser; fine crepitation over a small portion of the left base posteriorly. Ordered four ounces of brandy in milk daily; digitalis and am. carb. to be continued.

8th. Pulse 144, temp. 102 $\frac{1}{2}$ , resp. 52. Taking a good deal of nourishment. Ordered all the brandy that she could take. Continued the am. carb. and digitalis; ordered frequent sinapisms to the whole chest. The pneumonia of the left base, luckily for the patient, did not extend.

10th. Patient remained in much the same condition, and I regretted that I had not used the lancet. I did not see her again till the 12th, when I found that a great change had taken place. Incredible, as it may appear, the pulse was 63 and occasionally intermitted, temp. 101, resp. 24; tongue beginning to clean. I immediately stopped the digitalis, am. carb. and brandy; kept up the quinine, and ordered free nourishing liquid diet. The patient made a very rapid recovery, and was able to attend her ordinary work a fortnight before her uncle got out of bed.

CASE III.—*F.b.* 27. Was called to see a man, aged 27 years. He was a large, full-blooded, powerful man, weighing over 200 pounds, somewhat addicted to drinking. He had been attacked that day with severe pain in the right side, embarrassed and painful breathing; pulse 112, temp. 102; some diminished resonance on affected side and tubular breathing, but no crepitation; an

occasional cough, but no expectoration. Gave a saline purge and bled fully twenty ounces; gave tr. aconite rad.,  $\mathfrak{m}$  iv., every four hours; ordered mustard and poultices to side alternately.

*March 1st.* Again saw patient. Crepitation now distinct over the anterior portions of the right lung, middle and lower lobes; abundant rusty sputa; pain in side somewhat easier; pulse 100, temp 102 $\frac{1}{2}$ .

3rd. Patient in much the same condition. Pulse, however, running up to 115, temp. 102, respiration laboured.

4th. Pulse and temperature the same, respiration very laboured. Marked nervous prostration, delirium and stupor; cannot answer intelligibly. Discontinued aconite; ordered ara. carb., vin ipecac and quinine, also six ounces of brandy daily.

5th. Pulse 95, temp. 100, respiration less laboured; patient more rational.

9th. Very great improvement in every way; still very weak.

13th. Convalescing. The patient recovered very slowly, the lung remaining consolidated for a long time.

So much for the history of these three cases. Now, I think the point upon which we differ most is the question of venesection. This question has been discussed, and is still being discussed, by some of the best men in the profession, and they differ very much in opinion. Now, what mainly are our objects in bleeding in pneumonia? To prevent death from suffocation; to unload the right side of the heart. Is it a common thing for death to occur in pneumonia from suffocation? For my own part, I have never seen death from this cause, and have read of very few, and I believe that the experience of the profession generally coincides very nearly with mine. But some claim that bleeding favours absorption? This is easily affirmed, but difficult to prove. In case first absorption occurred very rapidly. In my third very slowly. Both were good subjects for bleeding; in both I employed venesection. In case second, a good subject for bleeding, I withheld the lancet; but absorption occurred here also with extreme rapidity. Now, I have treated a large number of cases of pneumonia in the last two years, in two only have I employed venesection, and, of all my cases, these were the most prolonged and

tedious, and in these the nervous phenomena occurred in a manner most marked, when contrasted with those cases which I had treated upon general principles. Now, it is also said of bleeding that it cuts short the disease if employed in the congestive stage. To this I can say, it may sometimes; it does not always. In case third I employed it in the congestive stage, with the result narrated. The pneumonia went on. Still in the case of a strong, full-blooded young man, seen early, and having marked dyspnoea, with the blueness of the face and a turgid condition of the venous system; with a small pulse and laboured action of the heart, showing that the right ventricle was distended and, in the left, scarcely any blood upon which to contract, I cannot but think that the lancet should be used. But how much blood will you take? Some say eight, some say ten, some twenty, some thirty, thirty-five or forty ounces of blood at once. I consider this a point of the greatest importance. I believe that in pneumonia an exception must be made to the general rules laid down with reference to blood-letting.

The average amount of blood in an ordinary man is eighteen pounds; in a full-blooded man of good size we might approximate the amount at twenty pounds. In an extensive pneumonia of one lung you will have four or five pounds of blood, or of material from the blood, thrown out as exudation; in double pneumonia nearly double that amount, viz., eight or ten pounds, leaving in a full-blooded man fifteen or sixteen in single, and ten or twelve pounds in double pneumonia. Now, this fifteen or sixteen pounds of blood in a single pneumonia is not only very much less than what is necessary to carry on the work of the economy, but it is also much deteriorated by the products of inflammation on the one hand, and by defective aeration on the other. Now, what must be the result if you take one and a-half, two, or two and a-half pounds of blood from the veins of a man when it has already been so fearfully drawn upon? The brain, we are told, requires one-seventh of the blood, viz., something over two and a-half pounds. Taking the amount in exudation and making a little calculation, you will find that you have a reduced blood supply to the brain of nearly one-half. Now, you will find, if you do this, the nervous symptoms, which may have been

mild before the bleeding, will become pronounced in a short time after the bleeding. Take a man in full health and bleed him to the extent of seven pounds—few of us would care to do it—and yet that man is able to reproduce the lost blood in a short time, because his powers of assimilation and absorption are unimpaired; but the man who suffers from pneumonia is in no such condition, the whole system is profoundly disturbed, and the blood-producing powers almost at zero; and yet there are some who would not hesitate to take two or two and a-half pounds of blood. Now, if this is a strong case in single pneumonia, what must it be in double pneumonia?

Here you have eight or ten pounds of exudation taken from the blood, ten or twelve pounds left in the body—say you have twelve pounds left in the body. You take away two more; you have ten left—just half the blood, and loaded with the products of inflammation and very improperly aerated. It does appear to me that a physician should be sure of his case before he would adopt such heroic measures. Bad as is the mortality of double pneumonia under the cautious, conservative, and I believe, judicious treatment of late years, I am persuaded that it would be woefully increased by such a measure. Even in the case which I have drawn as being one in which it would be appropriate to use the lancet, the quantity taken should not be large: not above eight or ten ounces, or, at the outside, twelve ounces. In the cases in which I adopted it I believe I withdrew too much. I am led to this conclusion by the very marked nervous prostration and tedious convalescence which followed the measure. Another point: When should you bleed in pneumonia? In the congestive stage. It is then that the right side of the heart is loaded; it is then, if at all, that you may hope to cut short the disease; it is then that you may hope to lessen its severity. If you wait till exudation is completed and then bleed, you only further debilitate a patient already sufficiently debilitated, and narrow his chances of recovery.

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AN ADDRESS READ BEFORE TRINITY  
COLLEGE MEDICAL SOCIETY.

BY G. A. BINGHAM, M.D., TORONTO.

Demonstrator of Anatomy.

MR. PRESIDENT,—When informed that your committee had honored me by appointing me to

read a paper before you to-night I was at first puzzled, and then a feeling of actual helplessness began to overcome me as I took in the full force of the situation. In order to read a paper one must have a subject. The subject upon an occasion such as this should be fresh and entertaining, for if I understand properly the object of these reunions—these open meetings of your society, we are not here to listen to the dull technicalities of science or philosophy, nor to have exhibited to us the awful niceties of the surgeon's blade, nor to endure panegyrics upon the virtues of Gossypium or Jaborandi. All these delicacies are, no doubt, done full justice to at your regular meetings. But upon occasions such as the present, whether as friends, medical students, or practitioners, we are for a time to throw aside the cares of everyday life, and banish from our minds all thought of the morrow's burdens, and while this hall resounds with the inspiring strains of old "Litoria," the physician is to fancy himself once more, as in "Auld Lang Syne," sacrilegiously carving his name in undying letters upon the furniture of his alma mater. And those friends who have honored us by their presence to-night are to wish that they, too, had been medical students. No wonder, then, that I was puzzled to select a subject suitable for such an occasion. In my despair I appealed to your worthy President, and he blandly suggested that in my paper I should attempt a solution of the conundrum of the nineteenth century. Fellow students you will perceive at once the inappropriateness of such a subject, for, while we all concur in the determination never to give up that conundrum, we are all equally agreed that its solution, like many other grand mysterious dispensations of Providence, is completely beyond our powers. Thus thrown upon my resources I thought of writing an essay on "How to prevent the cholera invasion," but, as my remarks would probably never have been even heard of by the International Convention, fortunately for you I abandoned that idea. Then the idea of writing up the trials of medical students suggested itself to me. The medical student! The professor's pride and the policeman's pet—that anomalous being so little understood by those among whom he lives,—accused of all the misdeeds in the calendar of crime,—persecuted, frowned upon and laughed at by those who may some day invoke the aid of his

skill to rescue them from an untimely grave (and it is needless for me to state that assistance will be magnanimously, I may say even cheerfully, extended at the maximum rate of two dollars per bottle). And yet, Mr. President, anyone who is thoroughly acquainted with the actual condition of affairs must acknowledge that we have no class of students who labor more assiduously to prepare themselves for future usefulness;—none who so honestly strive to master the details of that mighty principle which underlies the alleviation of human misery; and none, when occasion calls, who so willingly brave contagious disease and death for the benefit of their fellow-beings. Speaking of medical students one is naturally brought to the consideration of a subject which, did time and your kind patience permit, I should have liked more particularly to dwell upon—I mean the preparation of the medical student for his life work, and what share literary education should have therein." I have no doubt many will exclaim, "The science of medicine is of itself sufficiently extensive to occupy our whole attention." I thoroughly agree with you, my friend. My recollections are too painfully vivid for me to forget the midnight toil and the early hours of the medical student. I cannot yet obliterate from my memory the total absorption of one's mental faculties in the mighty volume of "*Gray's Anatomy*," until one's very hair threatened to partake of the nature of the subject and turn—*Grey*.

Nor do I forget the painful delvings for grains of diagnostic truth in the stony bosom of "*Flint*,"—and the steadily increasing burden of work as the session approached its close, until one had not even time for those devotions at the shrines of Bacchus and of Venus, which some well-meaning but misinformed people consider so essential to every properly constituted medical student.

Notwithstanding these facts I cannot but believe that, if the preliminary education of a medical student possessed more of a literary character, it would not only enhance his future usefulness, but would increase his facilities for attaining to prominence in the pursuit of his medical course.

We have, to-day, medical men occupying some very high positions in this country of ours. The legislative halls of Canada contain many representatives of our profession. We are all proud to know that a former graduate of our beloved Alma Mater now occupies a position in the cabinet of

Manitoba ; and another member of our profession is our representative in England as High Commissioner (some call him our *very* High Commissioner, whatever that may mean). In view of the fact, then, that our fellow-countrymen have been pleased from time to time to select from our midst men to represent them in the councils of the nation, it behoves us all so to prepare ourselves that, should it ever be our lot to be so chosen, we should do honor, not only to our country, but to our profession.

But in what way would literary training be of *direct* advantage to a student of medicine ? While the study of classics, ancient or modern, or the acquiring of the romance languages, or the research after great mathematical truths, may not have any direct bearing upon the study of medicine, yet who will deny their influence in strengthening the mind and expanding the intellect ? Who will deny that he whose intellect has been cultured and strengthened by familiar intercourse with the philosophers, the moralists, the statesmen, the historians, or the poets, of ancient or modern days, is better fitted to pursue the researches into the mysteries of growth and decline, of health and disease, of life and death ?

Undoubtedly a liberal literary education will inculcate habits of study, discrimination and discernment, all invaluable accessories to the student of medicine ; and he will indeed be a public benefactor, a servant who has nobly served his country, who will, by some means at present unknown, reconcile the laborious life of a medical student with the attainment of literary knowledge ; and he will certainly deserve to have engraved upon his tombstone the epitaph, suggested, I believe, by Mark Twain for his poor old servant, who, in a state of inebriation, fell upon the red-hot stove and, before being rescued, was burned to a crisp : "Well done, good and faithful servant."

In conclusion, gentlemen, I would say : Make the science of medicine your first love, and lovingly array her in the mantle of literary excellence, bedeck her with the gems of culture, adorn her with the priceless diamonds wrested from the bosom of literature ; and then, and not until then, will you have done justice to your heart's first love, your chosen science ; and then, and not until then, will that science stand forth flashing with the peer-

less rubies of truth, and, exalted upon a pedestal far above the petty tyranny of prejudice, will receive as homage, the appreciation and admiration of all men.

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### Correspondence.

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#### TO THE MEDICAL ELECTORS OF KING'S AND QUEEN'S DIVISION.

GENTLEMEN,—Ten years have now elapsed since I addressed you as a candidate for this division,—since which time I have closely attended to your interests as your representative in the Medical Council. Whether I have succeeded in fulfilling these duties—my record is before you ; you are the judges.

I have again been solicited by a highly respectable number of my professional brethren to offer myself as a candidate for your suffrage in 1885. It is very gratifying to me to have such a respectable number of my friends come forward, many of whom unsolicited have appended their signatures to my nomination paper. Some time ago I had every intention of retiring from the responsibilities of office, but was so strongly urged once more to enter the arena I could not do otherwise than allow my name to be used for that purpose. Many of you have certainly given me more credit than I deserved for alleged zeal in your behalf. Allow me to state that I have always been devotedly attached to the medical profession—not so much for the emoluments as for the scope which it offers for mental gratification in the cause of suffering humanity, although we sometimes receive the doubtful honor of unmerited abuse from many of those whom we often risk our own lives to serve without any reward whatever. However, we have hours of happiness in the thought of doing more real good to mankind than all the other professions put together. It is altogether unnecessary for me to say much on the duties devolving on the members of the Council. I might say, however, that it is in contemplation to have the Medical Act amended. Some of those amendments I approve of, others seem to me of rather doubtful propriety—such as the increase in our annual assessment. I have not yet seen a medical man in this division who approves of such a step. The law also ought to be amended whereby actions for

malpractice shall be brought within a limited time and security given by the plaintiff for costs incurred in the bringing of such suit. In the majority of cases tried the plaintiff is some miserable creature, with scarcely the coat on his back or even the will to earn it. To say nothing of the trouble and anxiety, the loss to the defendant is very great whether he is successful or not; not unfrequently ruin is entailed and probably his prospects blasted for life. There are other improvements that might be stated, the nature of which I shall not enter upon; but if you should feel at liberty to tender me your vote it shall be my pleasing duty to do everything in my power to promote the honor and dignity of the profession generally.

Thanking you for the confidence you have so long reposed in me, I have the honor to be, gentlemen,

Yours sincerely,  
W. ALLISON.

BOWMANVILLE, 9th March, 1885.

### Reports of Societies.

#### ONTARIO BOARD OF HEALTH.

The regular quarterly meeting of the Ontario Board of Health was held in Toronto on the 12th ult.; present: Drs. Coverton (Chairman), Cassidy, Rae, Yeomans, Oldright, and Bryce, the Secretary. The Secretary read a communication from Mr. Crown, of Sault St. Marie, relating to the proximity of the burying ground to the dwelling houses. A communication from Dr. Harris, Medical Health Officer of Brantford, asked if the municipal authorities in Ontario had power to regulate the cutting of ice. Dr. Bryce stated there was no provision in the Municipal Act regulating the cutting of ice, but he understood that Mr. Badgerow was going to submit a resolution to the Local Legislature making provision for the same. The question of preventing the existence of cemeteries within a certain distance of dwelling houses was also to be considered by the Legislature. The Secretary made his quarterly statement of the work done in connection with the smallpox outbreak in Hungerford township. When the Provincial Health Board authorities had entered the affected district the spread of the disease was most effectually stopped. The desirability of establishing a vaccine farm in connection with the Experimental Farm, at Guelph,

was discussed and a committee appointed to confer with the government in relation to the matter. The Board adopted the following memorial to the Dominion Government on quarantine regulations: That in view of the probable introduction of cholera into this continent, and of the fact that smallpox has been introduced into the province by immigrants several times during the past year, the Board would respectfully submit the following additions to the regulations already in force for preventing the introduction of contagious diseases:

1. Clean bills of health to be issued by the District Medical officers to emigrants purposing to embark at a foreign seaport.
2. Appeal to the Government at home for arrangements whereby the quarantine officers at the various seaports of our Dominion might by cablegram be advised of the departure of vessels from English ports having on board emigrants from infected countries. Provisions also at ports of departure for suitable buildings in which intending emigrants on whom infectious diseases have developed may be cared for until convalescent.

3. Precautions to be observed on board ships carrying emigrants during a time of prevalence of cholera or smallpox. In proportion to number of emigrants carried, space to be set apart in a suitable portion of the ship for an isolation hospital with greater provision for free ventilation.

4. During the prevalence of cholera the premonitory diarrhoea should be carefully attended to; excreta received in vessels containing one pint of a solution of mercuric chloride and permanganate of potash, of the strength of two drachms of each to a gallon of water; body and bed linen, if soiled, to be destroyed, or immediately placed in soak and boiled in same solution.

5. Quarantine stations to be supplied with boarding stations, consisting of suitable wharves and boats for (1) boarding vessels and for transportation of the sick; (2) places of sequestration for those that are well, but have been exposed to the disease during the passage and have not yet passed the period of incubation.

6. Hospitals for the sick with various infectious diseases, to be placed at distances apart, to prevent the germs of one disease being transmitted to another.

7. Vessels on arrival should have the following points established:—(1) Sanitary condition of port

of departure; (2) Sanitary condition at time of leaving; (3) History during passage; (4) Sanitary condition on arrival, with reference to cleanliness of quarters of steerage passengers and crew.

BRANT COUNTY MEDICAL ASSOCIATION.

The usual quarterly meeting of the Brant County Medical Association was held in Brantford, on the 3rd ult. There were present Dr. Marquis, Mt. Pleasant, President; Drs. Philip, Henwood, Griffin, Digby, Winskell, Secord, Branford; Dr. Kitchen, St. George; Dr. Fairchild, Mt. Vernon; and Dr. Davidson, Langford.

It was moved by Dr. Digby, seconded by Dr. Philip, That a resolution which was adopted at a former meeting of this Association in reference to contract practice be rescinded.—*Carried.*

Dr. Philip exhibited a tumor (steatoma) of large size and many years growth which he had recently removed from the shoulder joint. The wound had healed by first intention.

Drs. Digby and Kitchen were appointed to read papers at the next meeting of the Association.

After some routine business had been disposed of the Association adjourned until the first Tuesday in June.

**Selected Articles.**

**OVARIAN TUMOR IN A YOUNG GIRL.**

Clinic by Prof. Thomas, New York.

Our first patient to-day is Margaret H—, born in Nova Scotia, aged eighteen and single. The history which she gives of herself is a very striking one in many respects. She says she has been sick for two years, and that up to two years ago she was perfectly healthy. At that time she had a very hard fall, striking flat on the abdomen, and the next day there came on a very severe uterine hemorrhage. This flowing continued for several months—three at the least—and she says she then called in a physician, who gave her some medicine which gradually stopped it. Since then, however, there has never been any return of the menses; but, as time went on, she noticed that her abdomen was gradually growing larger. She is now as large as a woman ordinarily is at the eighth month of utero-gestation, and she says there has been no menstrual discharge for at least eleven months.

The abdomen of this young girl presents, then, a large hard mass, and she comes here to-day to find

out what the trouble is. Suppose that, instead of coming to the college, she had gone to the private office of any one of you. You can see at once that very delicate questions would have arisen for you to decide, and that a great deal would have depended on the diagnosis which you made; for the case is one of importance in many ways. In the first place, she might have slipped on a sidewalk of a city like this, and, attributing all her trouble to the fall, might have called upon you for an opinion which would justify her in bringing suit for damages against the municipal authorities for the condition of the streets. Thus, next week I shall have to make an examination in the case of a woman who slipped and fell three years ago, and who ever since has suffered so greatly from dyspareunia, that marital life is a serious burden to her. In consequence of this she is bringing suit for \$12,000 against the city, and I shall have to be extremely careful in expressing an opinion as to whether or not the trouble of which she complains is really attributable to the injury incurred in the fall.

Another important point to decide here is, what sort of an abdominal tumor is this, and what connection has the amenorrhœa with it? Perhaps the amenorrhœa may be natural, and the tumor a living one. As to the statement of the patient that it has continued for eleven months, that should have no weight whatever in affecting our opinion of the case. Many instances have, unfortunately, occurred in which the abdomen has been opened and the trocar plunged into a tumor supposed to be ovarian, which proved, to the operator's chagrin, to be nothing more or less than a gravid uterus. If utero-gestation should really exist, and you should express the opinion that this was not the case, or if just the opposite of this should be true, you can readily see in what an unpleasant position you might place yourself. Let me show you, then, how I would advise you to conduct your investigation in a case like this, in such a way as to avoid error and arrive at the truth. The problem you have to solve is, what is the character of this tumor, and what its connection with the uterine hemorrhage and the subsequent amenorrhœa?

What, now, might it be? It might possibly be any one of thirty or forty different things; but the most of these conditions are so exceedingly rare as to render it unnecessary to take them into account at all. What, then, are the things it is really likely to be? First of all, in every such case you should always, without any exception whatever, think of utero-gestation. Even if it were one of the vestal virgins themselves, let this be the first supposition on which you proceed with your examination.

At the period of pregnancy, when the abdomen is as large as in the present instance, the cervix ought to be quite soft and a little patulous, and the markedly protuberant anterior wall of the uterus

bulging in front of it ; while through the os something hard (whether the head or the back of the child) should be felt moving up and down. Instead of this state of affairs, I found on examination here the cervix and uterus of a virgin, and venturing, on account of this, to pass the probe, it entered the cavity, which I ascertained to be empty for two and a-half inches, and in a direction which showed the uterus to be turned backwards. But, notwithstanding all this, the patient might still be pregnant ; for this might possibly be one of those rare cases where there is a double uterus. I began therefore, my examination on the outside of the abdomen. If in a case of pregnancy you keep your hands steadily upon the uterine tumor for some time, you cannot fail to detect a hard mass and the movements of the child. Then, with careful auscultation you ought to be able to distinguish the foetal heart-sounds, the so-called placental *bruit*. The latter is in reality a uterine *bruit*, however, as the sound is caused by the rushing of the blood through the uterine sinuses. Nothing of the kind was found in this case ; nor were there any mammary indications, or any other sign of utero-gestation whatever. This hypothesis is, therefore, to be discarded.

Secondly, the abdominal enlargement might be caused by a uterine fibroid ; but in that case the tumor would be very hard and unyielding. Here, on the contrary, I can get a distinct wave on palpation. Has the patient, then, ascites, which might perhaps too be due to disease of the liver, or of the peritoneum ? If this were the case, there would be perfect resonance on percussion at the upper part of the tumor, from the fact that the intestines would float on the top of the water. There is, however, not a trace of resonance at the top, the percussion-note being perfectly flat at that point, while there is resonance at the sides, much more marked on one than on the other. She has not, therefore, ascites.

We arrive at the conclusion, then, that she is probably suffering from some form of cyst. This might possibly be of the liver, the kidney, or some other organ ; but there is one kind of cyst that is so vastly more common than any other that we will be hardly likely to err if we conclude it to be of this character, and that is the ovarian. There are special reasons also for supposing it to be an ovarian tumor. The mass extends fully down to the pelvis, and it has pushed the uterus backward and downward, as we have previously ascertained. To show you how valuable I regard the former of these signs, I will mention that in a case in which I operated about six months ago, as soon as I found that there were intestines between the tumor and the iliac fossa, I confidently asserted that whatever else the growth might be, it was certainly not an ovarian cyst. The result proved it to be an enormous cyst of the kidney, its size being one and a-half times as large as my head.

So much for the diagnosis of the tumor : now for the question of its etiology. Let me caution you in the first place to beware how you give your support to the hypothesis (on which a suit for damages may be based) that because a certain difficulty from which a patient is suffering came after a fall or other injury, that it is the result of that injury. Some time ago a lady consulted me who said that she had a severe fall upon the back, and that profuse uterine hemorrhage had immediately followed. From her account, I supposed that it was probably a typical case of acute retroversion of the uterus ; but when I made a vaginal examination, what was my surprise to find that instead of this there was advanced carcinoma of that organ. Yet the patient until that time had never had any hemorrhage or other symptom to indicate the presence of malignant disease. You must be on your guard, therefore, in regard to *post hoc, propter hoc*. I doubt not that the fall was the exciting cause of the hemorrhage here, but do not believe that either the hemorrhage or the amenorrhœa would have resulted if the ovaries had been in a healthy condition at the time of the accident. I am speaking only from experience ; but in the light of that I do not hesitate to say that this girl's trouble is not due to any such cause. On the contrary, I believe that at the time she fell she had cystic degeneration of both ovaries. The fall, however, probably did cause the rupture of one or more of the ovarian cysts, and thus gave rise to the hemorrhage ; while as the hemorrhage continued, the ovary went on increasing in size.

Finally, as to the prognosis. Unless ovariectomy is performed, it is a completely hopeless one. I need not say how fully established is the point that drugs are utterly useless in this affection. You will doubtless hear of many cases of ovarian tumors which have been cured without resort to the knife ; but the explanation of this is that they have not been true ovarian cysts. It not unfrequently happens that a patient comes to an ovariectomy with a tumor of considerable size, but because he thinks it is not at the time sufficiently large to demand removal, he tells her to return to him in six months ; yet when she comes back to him at the end of that time the growth may have entirely disappeared. This is because it was a par-ovarian cyst, a simple cyst of the broad ligament, which contained nothing but pure serum ; and it is the cases of this character in which the recovery takes place spontaneously, though the cure is generally attributed to whatever medicine the patient happens to be dosing herself with at the time.

This being, without doubt, however, a true cyst of the ovary, ovariectomy becomes imperatively necessary. When, then, shall the operation be performed ? At once, I should say. The late Professor Peaslee, one of our highest authorities on the subject, was in favor of postponing the opera-

tion to the last possible moment, on the ground that the patient ought to be permitted to enjoy life as long as she could. But the fact is, that the patient cannot enjoy life with such a tumor. Its presence makes her utterly miserable, and after it has attained a certain size the sooner its removal is accomplished the better; not only because of the inconvenience and suffering which she will be spared, but because her chances of recovery will be much better than if it is postponed too long. The tumor in the present case now, no doubt, weighs twenty-five or thirty pounds, and it is high time that it should be gotten rid of.

I feel almost certain that double ovariectomy will have to be performed here; and for the reason that the patient has not menstruated for eleven months. The fall, certainly, had nothing whatever to do with this, for women are continually meeting with all sorts of accidents and injuries, but they go on menstruating just the same if the ovaries are healthy. It is the cystic degeneration of these organs, and not the fall, which has put a stop to this young woman's menstruating.

#### CYSTS OF THE UTERO-VAGINAL GLANDS.

Mrs. Ann R—, thirty years old, has been married three years, and has had one child. This is a very acute case compared with most of those that we meet here, as she says she has been sick only eight days. Eight days ago she began to suffer intense pain, accompanied with a burning sensation, whenever she attempted to pass urine, and yesterday she noticed, for the first time, a lump gathering within the vulva. This is the history.

One of the great advantages of a clinic like this is, I think, that many of the cases which you see here are likely to present themselves to your minds when in the future you meet with similar ones in your own practice; and it may be that many years from now the memory of some special case here at the clinic may enable you to successfully treat one of the same character which you then meet with for the first time yourself, and which might have otherwise proved a puzzling one to you. Thus the present case may fix itself in the memory of some of you, just as one that I will now mention did in my own. Twenty years ago a lady from the South consulted me for aggravated dysmenorrhœa; the pain coming on during the first day of the flow and being excruciating. It was before the days of the hypodermic syringe, and her suffering was so agonizing that nothing seemed to give her much relief. After remaining in New York for a number of months without receiving any permanent benefit she returned to her home in the South, where some time afterward her physician removed a small fibrous polypus, hanging by a pedicle from the uterine canal; and after that she had no further trouble. The explanation of the case was, that this little fibroid, being comparatively free in the cavity, had acted like a ball-valve in preventing the

escape of the menstrual blood, and thus set up the uterine contractions which caused the patient such extreme pain. Gradually, the fibroid worked itself downward along the uterine canal, until it was finally extruded from the cervix, when its removal became a very trifling matter.

Since then I have never met with a case in which the symptoms were quite the same as in this case until this very day, when a lady came to my office who suffers in precisely the same manner. Whether the trouble is due to the same cause I do not know; but, with the experience of the other case in mind, I shall at all events take the precaution of dilating the cervical canal with sea-tangle, and examining to see whether there is not such a fibrous polypus present; and it probably would not have occurred to me to do this if I had not come across the other case twenty years ago.

In the case now before you which, perhaps, may recur to some of you many years from now, there is a cyst of considerable size under the right *labium majus*, which is excessively painful to the touch; and under the left arm there is a similar, though smaller, cyst.

So much irritation have these cysts caused that there is now quite a severe vulvitis in consequence. If you did not make a correct diagnosis, this case might give you a good deal of perplexity; but, if you recognize its true character, you would find it one of the most curable cases to be met with in practice. These cysts are due to a degeneration of the vulvo-vaginal glands, whose excretory ducts have been closed by inflammatory action. The vulvo-vaginal glands were first described by Bartholinus, after whom they are often called; but, strangely enough, his description was lost sight of for a long time, and they were rediscovered, as it were, by M. Huguier, of Paris, in 1841. When they become inflamed vulvitis, urethritis, and more or less vaginitis, are the results, as in this case, and coitus becomes utterly intolerable. In this condition all sorts of lotions and soothing applications are often ordered; but such treatment is absurd, for the reason that the ducts of the glands, as has been mentioned, are closed by the inflammatory action. If we could probe them with the same skill that the oculist does the lachrymal duct, good results might perhaps be secured by the operation; but I have never heard of such a thing being done. The treatment that I unhesitatingly recommend in such cases is to snip off a section of the cyst (having first anæsthetized the patient), and then stuff it with carbolized cotton. This cures permanently, because the gland soon disappears entirely after the operation. The French writers advise dissecting out the gland; but the great objection to this procedure is that a branch of the pudic artery is very likely to be severed in it, and as the artery lies very deep under the ramus of the pubes it is difficult to control the hemorrhage that results.—  
*Medical and Surgical Reporter.*

## GASTRALGIA.

Clinical lecture by Dr. William Pepper, published in the *Medical Times* :

This man a farmer, aged 39 years, has been sick for two years. His principal complaint is of pain in the left side. He has lived in a healthy locality, and has never had chills and fever. The pain begins in the left side and runs back to the left shoulder-blade. If he eats too much he suffers, but the kind of food taken does not appear to influence the pain. An ordinary meal does not make the pain worse, and eating sometimes takes away the bad feelings. Active exercise or riding over a rough road is apt to bring on the pain. The appetite is fair. The bowels are sometimes constipated, but as a rule he has diarrhoea about twice a week, there being two or three loose stools, but these contain no blood. He weighs one hundred and fifty pounds. His best weight was one hundred and sixty-two pounds, but during the summer he goes as low as one hundred and forty pounds.

Let me here refer to this matter of variation in weight. Many persons will be met with who have a wide range of what may be called normal weight. I never like to see this symptom, for it seems to me that those persons who lose flesh so rapidly cannot be made of very good stuff. A person whose flesh is solid and who is living a correct life should maintain pretty nearly the same weight summer and winter, varying perhaps from three to five pounds. Persons will however, be found whose weight varies twelve or fifteen pounds at different periods of the year. With such persons I have observed that sickness goes hard; on the other hand, loss of weight in them is not to be regarded as of such serious moment as it would be in a person who was thoroughly in training and whose flesh was solid and well organized.

In reference to the pain complained of, when this pain is in the right side, we naturally suspect some trouble with the liver—a gall stone in one of the smaller ducts or in the gall-bladder; some congestion in the liver, causing dragging on the suspensory ligament, or irritation of the capsule of the organ. When the pain occurs on the left side, we think of the spleen, the pleura, and the heart, and when, as in this man, the pain associates with some shortness of breathing and overaction of the heart, we are apt to think more particularly of the heart. Examination of the heart shows it to be perfectly normal. There is no enlargement of the organ, no displacement of the apex-beat, and the valvular sounds are free from murmur. Neither is there any evidence of chronic pleurisy. There is good respiratory murmur and resonance over the left side. Examination of the spleen shows that the organ is not enlarged and that the man has not lived in a malarious district

Before satisfying ourselves that this is merely a

neuralgic trouble (possibly a form of gastralgia), some obscure conditions must be thought of. One of the most insidious of these, and one against which we should be continually on our guard, is caries of the spine. Caries of the anterior surface of the vertebræ constantly reveals itself by pain and distress in the neighborhood of the spinal column. Many cases of sciatica or intercostal neuralgia will be found to be due to caries of the anterior surface of the vertebræ, and the diagnosis should not be made until a sudden increase of the symptoms, with some numbness and failure of power in the lower extremities or the appearance of an angular projection, calls attention to the real cause of the trouble. You will do well to be on your guard against the occurrence of this obscure lesion. Aneurism of the descending aorta is another condition to be excluded.

There is no tenderness along the spine, neither is there any projection of the vertebræ, and jumping does not cause pain. No pulsation, thrill or abnormal dulness can be detected. Caries of the spine and aneurism may therefore be excluded.

You observe that the pain is described as occurring in the right side and over the stomach; it is not markedly affected by eating, although radishes and some other vegetables make it worse, and it is worse when the stomach is empty than after an ordinary meal. It is associated with evidence of derangement of intestinal digestion, as shown by flatulence and irregular action of the bowels, sometimes constipation and sometimes transient attacks of diarrhoea. Having excluded the graver causes for this pain, we must conclude that it is neuralgic and occupies the stomach, and therefore a form of gastralgia.

As to the cause of this; the family history is good, and he has good health until this affection developed. He does not use liquor or tobacco; he has not been overworked, but has gotten into the habit of eating his meals hurriedly. The gastralgia has probably been brought on by this rapid eating.

In the treatment of gastralgia the regulation of the diet is the chief element. The stomach is rarely able to receive and handle enough of food in three meals to support the system; consequently it is important that such patients should take more than three meals in the twenty-four hours.

Again the stomach is so hyperæsthetic and the mucous membrane so irritable that unless some digestible substance is in the stomach the acid juices are apt to excite pain, and hence the pain is more marked when the stomach is empty, and the ingestion of food affords relief; so that for this purpose, also, it is desirable to give food oftener than three times a day. Meals of smaller amount, and of extremely simple character, and at shorter intervals, is the rule for the nourishment of gastralgic patients.

The character of the food requires close very close attention. In general, it will be found that milk is one of the best ways in which to give nitrogenous and albuminoid food. The starchy foods are, as a rule, well borne, particularly as they do not require much gastric digestion, being digested as you know, by the salivary, intestinal and pancreatic fluids. At times, however, the starchy foods lead to the development of secondary acids in the stomach, in which case it becomes necessary to diminish the amount of starch allowed and increase the amount of skim-milk, the patient being practically placed on an exclusive milk diet for a certain length of time. Alkalies are often desirable, and lime-water mixed with milk is a convenient way of administering these.

I shall recommend for this man the following dietary :

*Breakfast.*—Soft-boiled egg, oatmeal, bread and butter, and milk with lime-water. Between breakfast and dinner, a glass of milk and lime-water.

*Dinner.*—Potatoes, bread and butter, and milk and lime-water, but no meat. Between dinner and supper, a glass of milk and lime-water.

*Supper.*—Mush and milk with milk and lime-water to drink.

In selecting the remedies to be associated with this diet, you will be governed by your appreciation of the state of the mucous membrane more than by anything else. If there is no evidence of gastric catarrh, if there is simply the hyperæsthetic neuralgia and anæmic condition of the stomach, iron, arsenic and belladonna may be given at once with confidence, the stomach being sheathed with bismuth taken at proper intervals after eating. Under such circumstances, a pill containing the following might be given : R. Quiniæ sulph., gr. j. ; acidi arseniosi, gr.  $\frac{1}{10}$  ; pil. ferri carb., gr. j. ; ext. belladonnæ, gr.  $\frac{1}{10}$  ; M. et ft. pil. no. i. Sig.—To be taken after food, three times a day.

Any of the vegetable salts of iron may be substituted for the pill of the carbonate. In addition to this, ten grains of bismuth should be given two hours later to protect the stomach when most empty.

If there be a catarrhal condition of the mucous membrane, as shown by a coated tongue, distress in the stomach, in addition to the paroxysmal pain and evidences of dyspeptic trouble, we are obliged to adapt our remedies to this condition, postponing the use of anti-neuralgic remedies until the inflammation of the mucous membrane is relieved. In such cases bismuth with pepsin, dilute mineral acids, carbolic acid, and salts of silver become exceedingly valuable for their antacid, sedative, and alternative properties.

For this patient, having directed a careful diet with alkali, we shall order minute doses of nitrate of silver with belladonna.

Two weeks later, the patient reported much improved, and the pill of quinine, arsenious acid, and iron above given was substituted for the nitrate of silver, the same diet being continued.

### FOREIGN BODY IN THE PHARYNX.

Walter F. Atlee reports the following case in the *Med. Times* :

It is not at all an uncommon occurrence to have a visit from a patient who complains of having swallowed something that is still sticking in the throat. In almost every one of these cases there is no foreign body in the passage. Those patients have a local pain, in some cases the result of injury by a hard body hurriedly swallowed, and they are so entirely convinced by this sensation that a foreign body has lodged there that it is impossible to make them believe otherwise. The surgeon himself may make a mistake, and think he feels a something that ought not to be there. I heard even Nélaton say that in a certain case, after pushing his finger deeply into the pharynx, and feeling a small resisting body, he made several attempts to seize it with the forceps before discovering it to be the great horn of the hyoid bone.\*

I made observations somewhat similar to these to a man who came, in great excitement, on the evening of the 30th of last December, to take me to consult with a well-known and experienced physician in the northern part of the city in the case of a child in a dying condition from the presence in the throat of a pin, as the father protested, but which the doctor had not found and did not believe to be there. On the afternoon of Christmas day, five days before, the father said his child, just seventeen months old, most certainly had a pin in her mouth, that it had disappeared when he went to take it out, and the symptoms of throat trouble began at that time. For five days the child had taken food with great difficulty and reluctance, keeping the hands in the mouth as if striving to pull something from the throat.

It will here be called to mind that while more bulky objects generally become arrested at the junction of the pharynx with the œsophagus, where the tube is narrowest and least easily expandible, a thin and pointed body, such as a pin, generally sticks between one of the pillars of the fauces and the tonsil, or thereabouts. Again, when such a body stops in the pharynx, that which takes place is owing less to its size than to its shape: it is a body that, as a rule, cannot be pushed farther instead of being extracted, as is often done with bodies of another kind. *It must always be extracted.*

On reaching the house, the child was found ly-

\*See Clinical Lectures on Surgery, by M. Nélaton, p. 64.

ing in a cradle, on her left side, the head thrown back, in a state of stupor, from which she could be roused but very imperfectly. She had had during the day several convulsions. The lips were bluish, and the whole countenance extremely pale, with a bluish tinge. There was a swelling in the neck on the right side, which was the uppermost, below the mastoid process, posterior to the line of the ear. This swelling was not so hard as in cases of diphtheria: it had the feel of cellular tissue affected by acute œdema and not by phlegmonous inflammation. In the mouth was some ropy mucus tinged with blood, but there was no repulsive odor. While examining these appearances it was suggested that the child had the mumps. There was no swelling, however, about the temporomaxillary articulation, nor anywhere anterior to the ear. It was posterior to the ear and inferior to the mastoid process. Moving the head, the left side of the neck presented a condition similar to that on the right, though not so marked.

The attending physician said his treatment had consisted mainly in the administration of the chlorate of potassa in a syrupy solution. He did not believe in their being any foreign body in the child's throat but was very willing to have search again made for it. When searching for it himself, he had made use of his eyesight only, and had never passed his fingers into the pharynx.

The child was taken up and held in the nurse's lap in a convenient position for the examination of the pharynx. The doing of this roused her somewhat, so that a few drops of chloroform were used to quiet her. The mouth was then opened, and the jaws kept apart by a large cork. Then the finger was passed into the throat a pin was encountered, firmly fixed there, and seemingly stuck, one end between the right tonsil and the pillars of the fauces and the other in the posterior wall of the pharynx. The extremity of the forefinger of the left hand being kept in contact with the pin as a guide, a dressing forceps was made use of; and on the second attempt to seize it, and with the use of some force and some manœuvring to dislodge it, the pin was withdrawn. The pin was exactly an inch and three-sixteenths in length, and it was bent in the centre at an angle of about a hundred and twenty degrees. This bending could scarcely have been produced by the force used in extracting it from the throat.

As there was, of course, great difficulty, even impossibility, in making the movements of deglutition, and every attempt to swallow must excite reflex movements in the pharynx and retard cure, it was advised that no food or medicine should be given by the mouth. In order to try to nourish and stimulate the patient, appropriate enemata were ordered. The child, however, never revived, the stupor became more and more profound, and she died the following day,—just twenty-four

hours after the removal of the pin. The cause of the trouble, the source of the irritation, having been gotten rid of, hopes were entertained that the patient might recover, but, as is often the case in children when the exhaustion and the enfeeblement of the nerve centres have been so great that repeated convulsions are the result, she never again became conscious, and life gradually went out.

The history of this case teaches nothing new, but it is well at times to be reminded of what may occur, and of the extreme care and watchfulness that are at all times demanded in the practice of our profession, in order to avoid sad and even fatal mistakes.

### FRACTURE OF THE LOWER END OF THE RADIUS.

BY R. J. LEVIS, M.D., PHILADELPHIA.

The correct nature and mechanism of the ordinary form of fracture of the lower end of the radius is now, after much controversy, generally admitted and properly comprehended. With this proper understanding the indications of treatment become rational and decisive. In the usual and very characteristic fracture of the carpal end of the radius the primary line of the fracture is, with little tendency to deviation, *transverse* in direction. Associated lines of fracture are generally those of comminution of the lower fragment, and are caused by the upper fragment being driven vertically into it and splitting it, usually in directions towards its articular surface. The displacement of the lower fragment is towards the dorsal aspect of the forearm, and its articular surface is inclined in the same direction, abnormally presenting backwards and upwards.

The mechanism of the fracture is its production by falls upon the palm of the hand, which, with the carpus, undergoes extreme extension, and the fracture is caused by an *act of leverage* or *transverse strain*. This direction of force has also been called *cross-breaking strain*. In this fracture, actual displacement of the lower fragment may not exist at all, or it may be to the extent of complete separation from contact with the broken surfaces, varying with the amount of force applied and with the retaining influence of the surrounding dense structures.

The first essential of the treatment of fracture of the lower end of the radius is *the complete reduction of the displacement*. The action of replacement must be directed to the lower fragment itself. The reduction of the fracture can usually be thoroughly effected, under anæsthesia, by *strong extension applied to the hand, associated with forced flexion of the wrist, and with pressure applied directly on the dorsal surface of the lower fragment*. Unless vertical splitting or comminution of the lower fragment

exists, the maintaining of partial flexion of the wrist, with pressure of a pad on the dorsal surface of the fragment, will prevent return of deformity. With the object of retaining the apposition of the fractured surfaces, by overcoming displacing forces, I have practiced for many years on the principles involved in the splint here illustrated, the application of which will not require much description. In the treatment of fracture of the lower end of the radius it is essential that proper allowance be made for the curvature of the anterior or palmar surface of this part of the bone. This is insured in the splint which I have devised, which follows correctly the radial curvature; and the fixing of the thenar and hypothenar eminences of the hand in their moulded beds, maintains the splint immovably in its correct position with reference to the radial



curve. To neglect of complete primary reduction of the displacement of the lower fragment, and to inefficient restoration and retention of the normal radial curve, are due the frequent unfortunate sequences of this fracture.

The splint is made of copper, so as to be readily conformable by bending to suit the peculiarities of size and form of forearms. The slight roughness left on back of splint from perforations is for the purpose of keeping the bandage from slipping. It is nickel-plated to prevent oxidation. The splint will usually fit the forearm so accurately that but little padding will be required, and a piece of woven lint, or of cotton or woolen flannel is all that is necessary for its lining. No dorsal splint is needed, but, as before referred to, a small pad will, in most

cases, be required over the dorsal surface of the lower fragment. For retention of the splint an ordinary bandage, two inches and a half to three inches wide, is all that is necessary. This splint has the merits of being applicable to all cases of fracture of the lower end of the radius, and also to many other injuries involving the forearm and wrist, and, as now supplied, is very inexpensive. It is manufactured by J. Ellwood Lee, 435 Walnut Street, Philadelphia, Pa.

**ERRORS IN THE DIAGNOSIS OF PREGNANCY.**—Professor Pajot, in a clinical lecture, observed that he wished to refer to a case which would prove of great value to the pupils, as putting them on their guard in relation to faults in the diagnosis of pregnancy. Such faults have been committed by men of the highest eminence, for if in 95 cases out of the 100 diagnosis is quite easy, in some others it is attended with extraordinary difficulty. In this case, of recent occurrence, such a fault had been committed by men in a high position, one of them enjoying great celebrity. In place of hesitating to communicate the case Professor Pajot brings it prominently forward, as it exhibits the precise rule which should be observed on these difficult occasions, and may save the reputation of the practitioner and even the life of the patient. A lady, thirty-five years of age, had a child when she was twenty, after a laborious labor requiring the forceps, and followed by a vesico-vaginal fistula. Since then she has had two labors, both quite easy. After the last of these, eight years ago, she suffered greatly from menorrhagia; but having five years since begun to introduce a large sponge into the vagina, for the purpose of sustaining the uterus, which had descended considerably, and absorbing the urine from the vesico-vaginal fistula, the menorrhagia ceased and was succeeded by irregular and sparing menstruation. Having become a widow she re-married, and coition was always performed with the sponge at the bottom of the vagina. Last summer she consulted Professor Pajot because her abdomen had greatly enlarged and she wished to know whether she was pregnant. Having removed the sponge he proceeded to examine her, and found the perineum very lax and easily depressed, a small vesico-vaginal fistula still existing. The cervix, in the erect posture, descended to within a few centimetres of the vulva, and was flattened, small, hard, atrophied and colorless. The orifice was but slightly developed. The uterus rose largely out of the pelvis and was very mobile, but its oscillations were not communicated to the cervix. Professor Pajot delayed giving his opinion on the case for a fortnight, when the patient declared that she felt the child move; but the foetal heart could not be heard and the opinion was still withheld. Meanwhile an accoucheur and hospital surgeon was consulted, who, after an atten-

tive examination, declared that an ovarian cyst existed. This alarming the patient, a celebrated laparotomist was consulted, who stated that a large fibrous tumor of the uterus existed and advised an operation. Three weeks after this last consultation, the patient having taken some very violent purgatives, gave birth to a child between seven and eight months old, all traces of the tumor disappearing. "Faults like these are committed only because old counsels which I have long since delivered have been forgotten. In these difficult and obscure cases, I said there is a simple line of conduct to be followed, which is both useful and prudent, and never compromises the health or life of the patient nor the reputation of the practitioner. This is *expectation*; we must know how to wait. If there is some pressing indication, of course we must fulfil it; for, when life is menaced, what matter is it about the pregnancy? But, as a general rule, neither the health nor the life of the patient is in question. The woman desires to know whether she is or is not pregnant. And as long as the problem does not appear to be soluble with certainty we should make no resolutions. Let us wait, and above all things wait without acting, if nothing creates an absolute necessity for action. Time is the best of all our means of diagnosis."—*Press Med. Belge*, Sept. 7, 1884; *Med. Times*.

**FEVERS—GENERAL TREATMENT.**—Professor Da Costa gives the following general rules for the treatment of fevers:

1. Reduce the temperature. The cold bath will do this most rapidly and certainly, but it is troublesome, and not altogether free from danger, and should therefore only be used as a last resort. Quinine in full doses is safer, and may usually be relied upon. It should not, however, be repeated too often, as it may produce alarming cerebral symptoms, with diarrhoea and general perturbation.

2. Lessen the rapidity of the circulation. Aconite is the best remedy here, especially if the pulse is full and frequent, but if the circulation is weak, digitalis will act better. Professor Da Costa does not, however, often give either. He prefers to endeavor to reduce the temperature, and so indirectly to control the circulation.

3. Keep up the secretions. Remove the waste of the tissues by diuretics, diaphoretics, and laxatives.

4. Nourish the patient. "Don't starve a fever." Give milk, beef juice, and other light nutritious food in small quantities, but at frequent intervals. Give the patient plenty of fluids also. Slightly acidulated drinks will be found to be both grateful and beneficial.

Professor Da Costa's experience has been that typhoid-fever patients do better, as a rule, on the dilute nitro-muriatic-acid treatment than on any

other of the many that have been proposed. It controls the diarrhoea to some extent and aids digestion. He generally orders twenty drops of it to be taken every four hours in water or syrup. The circulation is to be sustained at the same time, and the heart's action steadied by the administration of quinine in tonic doses—gr. vi-x daily; or, better still, by alcohol in small and frequently repeated doses. If the discharges from the bowels exceed three a day, or if they are excessive in quantity, they must be lessened by opium or opium and bismuth; or if the stomach be irritable, by opium and carboic acid, or carboic acid and bismuth. If these remedies prove unavailing, a combination of nitrate of silver or sulphate of copper with opium will usually be found effective.

For the tympanites, Professor Da Costa recommends cold-water applications to the abdomen, injections of vinegar and water, or turpentine stupes externally, combined with the internal administration of ol. terebinthinæ gtt. v-x and morphiæ sulph., gr.  $\frac{1}{3}$  every two or three hours. The latter plan will be especially valuable if the tympanites co-exist with a dry, glazed and fissured tongue. The very high temperature that sometimes develops can be most safely and efficiently lowered by either the cold bath or by ice-water cloths on the abdomen.

The other complications are to be treated as they arise.—*Med. Bulletin*, January.

**COMPLETE ASPIRATION.**—David Christie, L. R. C. P. Ed., etc., Medical Officer of Rossguill Dispensary, writes:—

For some years past there has been much written regarding the use of the aspirator in cases of pleuritic effusion, and the talent displayed on this subject is creditable to the medical profession; but in using the aspirator there has been one thing omitted that mars or nearly destroys its utility. I have waited more than two years for some one to find it out, but, strange to say, in vain.

The thing is as simple as making an egg stand on its end *when you know it*, and the only mystery about it is that no one seems to have thought of it. I have tried partial aspiration as it is usually performed, and find that the pleural cavity refills in a short time; after complete aspiration it does not. The way it is managed is very safe and simple. I put a broad bandage round the chest that can be laced behind like a corset; then as I pump the fluid *out*, I press the ribs *in* by tightening the bandage. I think when I do so it is unnecessary for me to explain that I prevent any internal organ from being displaced (at the same time keeping them at a proper pressure), and the ribs by their elasticity from acting as a suction pump to cause a re-accumulation of fluid. I allow the bandage to remain on for some days. Any one who understands the action of a pump and a

siphon requires no further explanation. Many imagine they do, but are mistaken; these I would advise to consult "Ganot's Physics." After a certain amount of fluid has escaped, dragging pains set in. Tightening the bandage instantly gives relief. Alternate aspirating and lacing should be continued until all is removed; then there is likely to be a fit of spasmodic coughing; the patient may spit some frothy mucus tinged with blood, but all such symptoms pass off in a few minutes, and do not return—at least, that has been my experience.

I may add that the needle should be put in at such an angle that, after piercing the costal pleura, the point can be made to touch it again, so that when the pleuræ approach each other the lung may not be wounded; and when necessary the pleural cavity should be made antiseptically clean. *Med. Press, Jan. 28th.*

**TREATMENT OF BRONCHITIS—WOOD.**—It is not generally known that alkalies in large doses are amongst the most efficient of sedative expectorants. The citrate of potassium is much the most eligible for administering alkaline expectorants; of it half to one ounce should be given in 14 hours. The following prescription has been tested during four to five years, and found to be much the most reliable and sedative cough mixture that I have ever used:—*R.* Citrate of potash, one ounce; lemon-juice, two ounces; syrup of ipecac, half ounce; syrup enough for six ounces. Dose—Tablespoonful four to six times a day. When there is a good deal of cough or any excessive susceptibility of the bowels to loosening medicine, paregoric should be added in small quantity. The ipecac should be varied according to the susceptibility of the patient's stomach. Sometimes it can be advantageously substituted by tartar emetic. Usually two to three days of such medication will establish free expectoration. Then the stimulant expectorants are required, or squills and seneca, the former being the more valuable, though I cannot affirm that I have obtained positive results from their use, and think much of their reputation is based upon tradition and natural tendency of the disease to subside. Even squills is inferior to the mur. of ammonia. Like all ammoniacal preparations, this must be given at short intervals to maintain constancy of effect. The action of the single dose can scarcely last over two hours. Its acidity and disagreeableness may be somewhat covered by glycerine. In very large amounts all ammonia salts are capable of acting on the crasis of the blood as alkalies, and causing great vital depression. The value of copiba in chronic bronchitis has been long recognized, and it may sometimes be used with advantage in obstinate subacute bronchitis. When the "cold" in children is obstinate, "syrup of garlic" is very efficacious. But the stimulant expectorant which in my hands has almost replaced others of the class

is the oil of eucalyptus. It may be administered in ordinary cases of adults to the amount of about forty minims a day. Its taste is so pre-eminently disagreeable that it should be given in capsules, each of which may contain ten minims; or, if the patient prefer, two capsules of five minims each may be taken at a dose. The oil appears to be slowly absorbed and eliminated, so that four times a day is often enough. In emulsion it is very apt to cause unpleasant eructations, but in capsules is usually well borne. Some stomachs will not tolerate it. Counter-irritation is very useful; the oil of amber, an old remedy, is especially valuable in young children who have so often marked nervous disturbances and a tendency to collapse, diluted with one to three parts of sweet oil, applied to chest upon saturated flannel; it sometimes acts very happily in allaying nervousness as well as internal congestion.—*Ther. Gaz.*

**VACUOLATION OF THE BRAIN.**—Dr. J. C. Shaw read a paper before the New York Neurological Society, Feb. 3, 1885, on this subject, and showed a specimen.

Dr. Peters stated that very interesting cases were to be found on record in the "Transactions of the Pathological Society of London."

Dr. Parsons had never seen vacuoles of the brain of the size of those shown in the specimen. He had seen smaller ones. His impression was in accordance with the views expressed in the paper with regard to the origin of the enlargement of these perivascular spaces.

Dr. Weber thought that the vacuoles in this brain might be connected with septic fever, which certainly must have taken place during the man's life. He was inclined to think that there might have been infarctions in the brain which might have something to do with such immense vacuoles. He wished to know if Dr. Shaw had examined the brain soon after death.

Dr. Shaw said that he had done so the next day. He had cut into the brain afterward and found these cavities. There was nothing on the outer surface of the brain to indicate them.

Dr. Weber asked if Dr. Shaw really believed the larger-sized ones to be real vacuoles.

Dr. Shaw said that he really did.

Dr. Weber then asked if vacuoles as large as these had ever before been seen by Dr. Shaw or by any one.

Dr. Shaw stated that no one had seen them so large. He had not, at all events. The largest he had ever seen were of the size of a small nut.

Dr. Weber stated that the largest he had ever seen were as large as a pea, drawn out. They were of the size of the smaller ones surrounding the large ones in the brain that had been shown. In this respect he considered the specimen unique.

Dr. Shaw said that the reason he had presented

it was because it was an extraordinary specimen ; a great many cases were reported where there were no vacuoles. This man had certainly been subject to septic trouble. Dr. Shaw asked if those cyst cavities were not due to hæmorrhage.

Dr. Weber thought that the man probably had septic pleurisy. There might have been emboli carried into the brain ; certainly there was septic matter coursing through the arteries. In the cases he had known of there had been no structural disease going on.

It had struck Dr. Shaw that possibly thrombosis might have taken place in some of the small vacuoles, and that a large number of them might have been blocked up in that manner. The explanation that the perivascular spaces had been dilated was not a very good explanation for cavities of such large size.—*N. Y. Med. Journal.*

**ADDISON'S DISEASE.**—The details of the post-mortem and the microscopical appearances in a case of Addison's disease are given by Professor Cacciola, of Padua. (*London Med. Record*, Jan 15, 1885.) The patient, a man-servant, thirty-five years of age, died a year and a half after the skin had begun to bronze. The discoloration, with muscular weakness, had steadily increased. Febrile attacks occurred from time to time, and the patient died in one, delirious and convulsed. After death, beyond a certain softness of the brain, the nervous system, including the brain, the spinal cord, and sympathetic nerve, was found absolutely normal. The semilunar ganglia and solar plexus especially were carefully examined. The suprarenal capsules, on the contrary, were greatly altered. They were enveloped in a mass of fat and fibrous tissue, closely adherent to them. Each capsule was about the size and shape of a hen's egg, and weighed about thirty-five grammes. On section, the organs were seen to consist of a thick fibrous capsule of lardaceous appearance and tendinous consistence, sending prolongations inward. Between these prolongations were caseous substance and calcareous masses. The fibrous capsule and septa consisted of a thick connective tissue, with accumulations of leucocytes in course of degeneration. The contents of the spaces between the septa were made up of albuminoid detritus and oil-globules. In the central portion of the fibrous mass the connective tissue was calcified. Schizomycetes were looked for without success, but it is especially mentioned that some fat globules looked like Koch's bacilli colored by Weigert's method. There was little noteworthy amongst the other pathological conditions. There was, however, engorgement of the lymphatic follicles and of the agminated glands of the intestinal mucous membrane. The kidneys also were enlarged.—*Boston Med. Journal.*

CAFFEINE AS A SUBSTITUTE FOR DIGITALIS.—

Dr. J. Stewart, in *Can. Med. and Surg. Journal*, says : In the form of a double salt, as natrobenzoate, its action may be summed up as follows :

1. It strengthens, slows and steadies a weak fast, and irregular heart.

2. It quickly acts as a diuretic in cardiac dropsy, owing to its power of (a) raising the blood-pressure, and (b) of stimulating the secreting structures of the kidneys.

3. It is of marked use in the same class of cases as digitalis is. It differs, however, from that drug, in the following particulars : (a) It is less powerful as a cardiac tonic ; (b) it is a more powerful and prompt diuretic, and for this reason it gives relief quicker from all the troublesome subjective symptoms of cardiac failure.

It is probable that results obtainable from neither of these drugs, when given singly, could be brought about if caffeine was given first and its effects kept up until the cumulative action of digitalis could be made manifest. By combining the power of digitalis with the rapidity of action of caffeine we may get the advantages of both drugs with little of the disadvantages of either. There is no published evidence relating to these points, however.

*Dose and mode of administration of Caffeine.*

The dose of any of the double salts should not exceed thirty grains in the twenty-four hours, this quantity being equal to about twenty grains of the pure alkaloid. Usually half the above dose will answer all purposes. The double salts are prepared by Merck, of Darmstadt, but have not as yet found their way to this side of the Atlantic. They, however, can be prepared extemporaneously. The following formula contains in each tablespoonful about one gram (fifteen grains) of caffeine :

Caffeine.....	15.00 (gr. 230);
Benzoate of Soda.....	15.00 (gr. 230);
Water.....	250.00 (ʒviiij).

The doses of caffeine (two or three grains) usually ordered are quite inadequate to act either as diuretics or cardiac tonics.

**SO-CALLED SPECIFIC TREATMENT OF TYPHOID FEVER.**—Dr. J. W. Hawkins, *Kansas City Medical Record*, Feby, 1885, says: It is said by medical writers of the present day that there is no known specific treatment for typhoid fever. We are gravely told that "the abortive plan by the use of calomel is the only treatment that can be considered ætiological or casual." To this statement I respectfully demur. If calomel aborts the fever in fifteen to twenty days, the bromide-of-potassium treatment will do it in seven to ten days. The bromide of potassium is a medicine (unlike calomel) attended by no bad results, and upon it we can confidently rely. It may be given in any and all stages of the fever—first, second, third, fourth,

fifth or sixth week. If you see the patient on the first or last day of the fever, begin at once to administer the antidote—bromide of potassium. In the whole metasynergetic cycle of remedies for typhoid fever the bromide of potassium stands at the head. It accomplishes what no other known remedy has done, when properly administered. It usually arrests the fever in from seven to ten days after beginning its use. If the treatment is commenced at the beginning of the attack, five-grain doses administered every three hours during the day only, and repeated daily, will usually be sufficient. But if in the last stage, from fifteen to forty grains will sometimes be required. In the last stage of a very severe case, when death seemed almost inevitable, I gave more than two hundred grains in twenty-four hours, producing no gastric disturbance whatever. The patient recovered. Hence from this and other like cases I am led to believe that we have a specific for enteric fever.

The truth of this has since been verified in the treatment of ten additional cases, the fever in every case being arrested in from seven to ten days. I think I am not talking too forcibly when I say that bromide of potassium is as much a specific for typhoid fever as the sulphate of quinia is for (ague) intermittent fever.

HOW TO SEE ONE'S OWN RETINAL VESSELS.—Dr. Maher, of Sydney (*Australasian Med. Gazette*, Nov. '84), describes a new method by which this may be accomplished.

Standing a short distance (ten or twenty feet) from a light gas jet, in a dark room, and covering one eye, say the left, with the left hand, the observer takes between the forefinger and thumb of the right a strong convex lens, and holds it at about its focal distance in front of the right eye. Then, steadily gazing at the light through the centre of the lens, he shakes the lens rapidly backward and forward along its axis, or up and down or from side to side. After a few seconds the shadow of the fovea centralis appears in the axis of vision as a light yellow patch studded with dark coarse granules. Simultaneously the retinal vessels in the region of the yellow spot, including the finest capillaries, appear as dark cords against the yellow light. This appearance according to Dr. Maher, is not unlike plate 72 in the last edition of Nettleship's book on "Diseases of the Eye," except that the difference between the arteries and veins is not so marked, and that one gets a more extensive view, seeing the shadow of the retinal vessels as far as the optic disk. The outline of the shadow of the fovea centralis, which falls upon the most sensitive part of the retina, the yellow spot, is well defined, while the outline of the shadow of the optic disk cannot be distinctly seen, as it falls upon a much less sensitive part of the fundus. The shorter and more rapid the movements of the

lens, the sooner the shadows of the retinal vessels and fovea centralis appear, and the more distinctly are they seen.

Dr. Maher claims that this is a simple and easy way of demonstrating :

*First.*—That there are no blood-vessels in the fovea centralis.

*Second.*—That the structures in which the visual impulses originate must be behind the retinal vessels.

*Third.*—That the fovea centralis differs in structure from the other parts of the retina.—*Med. Record.*

PHLEGMASIA DOLENS.—It appears that notwithstanding the numerous works and discussions on phlegmasia alba dolens the subject has not yet been exhausted. Dr. Brun, of Paris, has just written a work on the subject which throws some new light on its symptomatology. He considers the disease under two forms. The first occurring as a malignant affection from the onset, and causing speedy death; the second appearing as incidental in the course of a general pathological condition. The first, or infectious form, has been well known since the time of Velpeau. The second form the author sub-divides into latent, common, and lymphangitic. The latent form comprises those cases of sudden death from dyspnoea in severe diseases and after childbirth, in which the autopsy shows venous thrombosis of the limb, from which the detached particles have been carried into the circulation and obstructed the pulmonary artery. The common form is passed over as it has been so often described. The lymphangitic form is described as presenting a bright rosy color, diffused pains, which disappear slowly, great increase in the temperature of the limb and long-persisting œdema. The complications are: periphlebitis, consecutive arteritis, gangrene, and especially pulmonary emboli. The author regards a pre-existing lesion of the vein as the pathogenic cause. It may be due to vitiated nutrition, cachexia, or some severe febrile condition. A part of his observations, however, show that the nervous system deserves a share of attention. The views advanced by other recent writers on this disease are also of interest. Dr. Esler reports in the *British Medical Journal*, September, 1884, two cases of phlegmasia dolens occurring on the right side of patients who had, during and after labor, lain continuously on the right side. Dr. Dill, of Belfast, believes that one position long maintained may have something to do with the affection, but holds that the wearing down of the system from hemorrhage and irritation of the womb often induces it. Dr. Macartney relates in the *Indian Medical Gazette*, of November, 1884, the case of a young soldier, who, after suffering pain in the iliac fossa with obstinate constipation for ten days, during which time his temperature rose regularly

each evening, suddenly experienced a severe pain in the left groin and the limb began to swell, reaching nearly twice the size of the normal leg. The pain was excruciating and not relieved by hypodermics of morphia. The swelling was uniform, elastic, but not pitting on pressure, there was œdema about the ankle. After four days improvement began, but was very slow, the limb being powerless, and attempts to move it causing dull aching pain. The author regards the case as one of phlegmasia dolens differing in no essential point from the disease as it occurs in lying-in women. The obstinate constipation, with pain in the left iliac fossa appears to have been the exciting cause, just as pressure of the fetal head in this region, followed by pain and malaise, is believed to produce the disease in puerperal woman. Another case is mentioned as having occurred in the same hospital a short time before, in a man recovering from enteric fever.—*Med. Record.*

**PORTABLE ANTISEPTICS.**—Dr. T. E. Hayward of Haydock, writes: Professor Lister has recently recommended as a portable antiseptic, a saturated solution of corrosive sublimate in glycerine; a fluid drachm of this solution being sufficient to convert about four pints of water into one in a hundred solution. The glycerine solution, doubtless, occupies a comparatively small bulk, and is readily mixed with water; but it is not very convenient to manipulate in measuring small quantities, and, if the bottle containing it should be broken, or become uncorked while being carried with other things, the result is unpleasant. A much more handy way of carrying the corrosive sublimate is to prepare powders, each containing ten grains of the salt and chloride of ammonium. One of these mixtures will dissolve in a little water in a few seconds; and, on diluting up to a pint, a solution is obtained of the strength of one to nine hundred and sixty. A few of these powders, wrapped round with gutta percha tissue to avoid deliquescence, can readily be carried in the pocket-case. The well known fact that ammonium chloride aids the solution of corrosive sublimate in water, renders the above suggestion so obvious that it has, doubtless, occurred to many; and it has probably already appeared in print. In view, however, of the very great advantage to all surgeons in country practice of having so ready a means of preparing an antiseptic solution, it may be pardoned if attention is drawn to the matter.—*British Med. Jour.*, Oct. 18, 1884.

**PHOSPHATIC CONCRETION OF THE BOWEL.**—Some weeks ago a young girl of about 18 years presented herself at Prof. Pancoast's clinic, with an opening in the abdominal walls on the right side, at a point near the middle of a line drawn from the umbilicus to the anterior superior spinous

process of the ileum. The history of the case developed the fact that the wound was the result of an injury received some four years ago, and that during this time more or less pus had been discharged through the sinus. The patient having been anæsthetized and the wound slightly enlarged, it was found that the finger could be carried directly into the peritoneal cavity. This was rather an unexpected disclosure, and so antiseptic had not been provided for. Prof. Pancoast found upon a coil of small intestine a hard mass, which, upon removal and examination, proved to be a phosphatic concretion. The intestine was brought up to the mouth of the wound, a few bleeding orifices were secured by some fine black silk ligatures, and after all hemorrhage had ceased, the opening was dressed. The patient bore the operation remarkably well; on the second day a localized peritonitis set in, but this was soon controlled. The wound began to heal rapidly, except at its most dependent part. This occasioned the reopening of the parts, and another similar concretion was removed. From this time on the young woman did exceedingly well, the wound healing kindly, and before her discharge from the hospital she was presented to the class, apparently looking none the worse for the operation and her consequent protracted stay in the hospital.—*Col. & Clin Record.*

**TRACHEOTOMY WITHOUT A TUBE.**—The danger and inconvenience connected with the tracheotomy-tube *per se*, are sufficiently great to have aroused a desire for some device which would obviate them. The matter was the subject of discussion before a late meeting of the Philadelphia Academy of Medicine. Dr. J. B. Roberts said he had had so much difficulty in keeping the tube clear that he had discarded it entirely, and instead cut out a rectangular piece of the trachea and stitched the edge of the opening to the skin. He found this to answer better than the double canula which is liable to become choked with the secretion. Dr. Packard had operated in this manner, but feared to adopt it as a general rule lest constriction of the trachea occur through cicatrization of the opening on healing. He instanced one case in which this had occurred. He thought the testimony in favor of tracheotomy without a tube was, however, very strong. Dr. J. H. Brinton recalled two cases in which the tube had been dispensed with. The membrane was readily ejected, and there was far less trouble than from the tube. Both cases, however, died from diphtheritic infection. Dr. Nancrede regarded the danger from ulceration from the irritation of the tube as sufficiently great to warrant the adoption of such a substitute for it as had been suggested, and the sentiment of the meeting was in favor of according a trial to the method of performing tracheotomy

which should dispense with the canula.—*Med. Age*, Jan. 10th.—*Analectic*.

ACUTE BRIGHT'S DISEASE.—In Professor A. L. Loomis recent treatise on "Practical Medicine," the author reviews the subject of treatment by diaphoretics and hydragogue cathartics. He states that he has been convinced for some years that the depurative method was wrong, and gives as the three indications: the elimination of urea and its allies, the removal of inflammatory products from the tubules, and the counteraction of the effect of urea and its waste products upon the nervous system. For this purpose the patient is put to bed, frequent dry cups are applied over the loins, and infusion of digitalis is given internally. This may be supplemented with acetate of potassium, spirits of nitrous ether, or some other mild diuretic. The bowels are of course kept open, and the skin moist. If severe uræmic symptoms appear, hydragogue cathartics and hot-air baths may be temporarily resorted to. Milk should be the only article of diet, and water is the best diuretic.

The view taken as to the utility of digitalis and the potash salts in nephritis, is sustained by the clinical experience of nearly all English observers from the time of Bright.—*N. Y. Med. Record*, January 3rd.

LANCING CHILDREN'S GUMS.—In the discussion of this subject before the Medical Society of London, Mr. Hamilton Cartwright (dentist) was distinctly of opinion that both diarrhoea and convulsions might be caused by dentition. There were two conditions under which lancing the gums is indicated: 1. If the gum is tense and glistening at the epoch when the tooth is about to come forward, by cutting into the sac of the tooth great and immediate relief is afforded. 2. In an inflammatory condition of the gums with tumidity, but without the extreme tension of the first class of cases, incision gives relief. In the latter class of cases the treatment is empirical but none the less successful.

Dr. C. J. Hare said it was to him a matter of great surprise and regret that the profession should so blindly give way to fashion as it had done on many points. Hundreds of lives had been lost by abandoning the use of bleeding; and among the forms of bleeding, the practice of lancing the gums, that is, bleeding from the gums, is one that deserves to be revived or continued. Dr. Webb had seen so many children on the point of death saved by lancing the gums that he regards it as a most valuable method of treatment.—*Mid. Med. Four.*, Jan. 31st.

HINTS ON THE USE OF DRAINAGE TUBES.—In the *Journal of the American Medical Association*, Jan. 3rd, 1885, Dr. H. L. Getz, of Marshalltown, Iowa says:—"Some months ago we had occasion

to evacuate a pelvic abscess, and use a drainage tube for through drainage. Not having at hand at the time a regular drainage tube, we constructed one out of a piece of plain (small size) rubber tubing. After being in the opening for several days, we desired to replace it by another tube; we attempted to remove it; but found that the openings in the tissues through which the tube had passed, had contracted so as to hold tightly the tube, and although we made but slight traction, anticipating the possibility of the tube's breaking, to our extreme discomfort and dissatisfaction we soon realized that our anticipations were realities, a portion of the tube, an inch in length, remaining within the pelvic cavity.

We succeeded in removing it by dilating the opening through which the tube passed; then introducing a small blunt hook, we succeeded in drawing the piece of tube into position, so that it was easily grasped by a pair of forceps and extracted, much to our satisfaction, and with a vow that in the future we shall *select with caution our material for drainage tubes*.

A hint on the removal of tubes, and also upon their introduction, may not be out of place here; under circumstances as above described where the tissues firmly hold the tube, we should adopt the plan of inserting within the tube a dilator of some kind, with which to dilate the tissues before we attempt to withdraw the tube.

As a satisfactory method of introducing drainage tubes, we have found that where a trocar-canula was necessary to evacuate the contents of a cyst or an abscess, by taking the precaution to use a canula a trifle larger than the drainage tube to be used, the latter could be conveniently passed through the canula to position, and then the canula withdrawn.

PARALYSIS FOLLOWING HYPODERMIC INJECTIONS OF ETHER.—Arnozan ("Gaz. hebdomadaire de médecine et de chirurgie.") contributes a long article on this subject, in which he cites a number of interesting cases. In several instances in which injections were made under the skin of the posterior aspect of the forearm, paralysis of the extensors was noted within a few minutes. Under the use of the constant current the condition eventually disappeared. In one case a deep injection into the thigh was immediately followed by darting pains, which persisted for two weeks. The leg became livid, and wasted away, and the reaction of degeneration was observed. The patient subsequently developed a trophic ulcer on the heel, and improved very slowly, though under treatment for a year. The writer thinks that the phenomena described are really symptomatic of neuritis, which is due to the irritating action of the ether that has been deposited in the neighborhood of the nerve. [It is to be hoped that the publication of these will lead to more caution in those who are accus-

toned to resort freely to hypodermic injections of ether, brandy, and even ammonia, in cases of collapse.] Ed.

**TREATMENT OF NASAL POLYPI.**—Dr. Richardson, in the *Asclepiad*, recommends the use of sodium ethylate in the treatment of nasal polypus. The caustic agent is applied by means of a probe made of soft cotton-wool, twisted into shape on the points of a pair of forceps. The cotton probe is saturated with the ethylate, and then plunged into the substance of the polypus. On removing the cotton it commonly happens that the patient can expel the whole mass of destroyed polypus in a semi-fluid form, by blowing the nose sharply. A second application ought to be made with a view of destroying the base of the polypus. The mode of action is said to be sufficiently clear. The ethylate is decomposed by contact with the water of the polypus into caustic soda and alcohol; the latter coagulates the albuminoids, and the former acts as a powerful caustic. With the exception of some burning pain, no unpleasant effects seem to follow the use of this method.—*Weekly Medical Review*, February 28, 1885.

**LAPAROTOMY FOR GUN-SHOT WOUND.**—The first successful case of laparotomy for gun-shot wound done in this country, and the second on record, is reported in the *New York Med. Journal*, of Feb. 14, by Dr. W. T. Bull. A man shot in the abdomen by a bullet from a revolver (caliber No. 32), was admitted into the Chambers St. Hospital, New York, where, twelve hours after the accident, Dr. Bull saw him. The wound was situated at a point an inch and a half below the navel, and an inch and a half to the left of the median line. Seventeen hours after, having convinced himself by probing the wound that the bullet had entered the abdomen, Dr. Bull made a median incision through the abdominal wall. The gut presented, and on careful examination seven perforations were found. These were all closed with silk sutures. The search was continued, and the bullet was at last found lodged in the wall of the sigmoid flexure. The wound in the abdomen was closed after the cavity had been thoroughly cleansed with a solution of carbolic acid (two and a half per cent). As a preliminary to the operation carbolic acid by means of the spray was diffused through the room, in which was maintained a temperature of 80° F. All solutions were used warm.—*Med. Review*.

**EXTIRPATION, BY LAPAROTOMY, OF A HYDATID CYST OF THE LIVER.**—Dr. Gutierrez reports this curious case in *El Diccamen (Le Progrès Medical)*. A boy, 8 years of age, suffered from a tumor situated in the right iliac fossa and as large as a foetal head. Capillary puncture gave a clear fluid con-

taining numerous hooklets, which were insignificant. It having been decided to extirpate the tumor, the right side of the abdomen was opened by an oblique incision, and the tumor dissected from its adhesions to the epiploon, of which a portion was also removed to avoid its mortification. After opening the cysts, which had increased rapidly in size after the exploratory puncture, there was discharged with the fluid the great pouch or hydatid, which had as its external envelope the thickened capsule of Glisson, which the hydatid had by degrees disengaged from the external surface of the liver until it had lodged in the iliac fossa; the operator extirpated the fibrous envelope from its hepatic attachment to prevent any suppuration that might compromise the result of such a brilliant operation. He then applied three sets of sutures, very fine catgut, including first the peritoneum, then the divided muscles, and, finally the skin, using Lister's dressings. There was not the slightest trace of peritonitis, the reaction from the effects of the operation was slow; the wound healed perfectly, however, and digestion was normal.—*Four. Am. Med. Association*.

**IODOFORM IN THE TREATMENT OF COMPOUND FRACTURES.**—Bach (Inaug.-Diss., "Centralbl. f. Chir.") speaks highly of the direct application of powdered iodoform to open fractures. The powder is sprinkled upon salicylic cotton, and placed over the wound. Over this is applied a quantity of iodoform gauze, and the whole is secured with a plaster-of-Paris bandage. Of twenty-eight cases which were thus treated, sixteen ended in perfect recovery. The bandages were not disturbed during the entire process of healing. In another series of twenty cases, twelve were cured. The writer arrives at the conclusion that the treatment with "iodoform-scabbing" (*Iodoformschorftherapie*) without drainage, is to be recommended in all cases of compound fracture in which the laceration of the soft parts is not too extensive. A neglected wound, in which there are numerous pockets filled with pus, is a contra-indication to this method of procedure.—*N. Y. Med. Journal*.

**ERGOT AS A MEANS OF DIAGNOSIS.**—Dr. J. W. Elliott in reporting five cases of ovariectomy in the *Boston Medical and Surgical Journal*, January 29, notes a use of ergot, which seems original with him. There was a very large immovable tumor, larger than a hen's egg, in the hollow of the sacrum somewhat to the right side. The uterus was three and a half inches deep and in left lateral retroversion. The tumor and uterus seemed blended into one mass. It was very difficult to determine what the tumor was and to what it was attached. To assist in determining this point Dr. Elliott administered ergotin pills until the uterus became fully and firmly contracted, when he found

that organ harder than the tumor and of decidedly different consistency, from which he was led to conclude that the tumor was not growing from the uterus, but only crowded against it.—*Med. Review.*

FOLLICULAR PHARYNGITIS.—E. S. Billings, M.D., writes: Will you please inform me through the columns of *The Monthly* what I shall do for an old case of follicular pharyngitis? It is one of the most obstinate cases I have ever dealt with, and I have exhausted all the means I know of, and oblige.

[Wipe the diseased surfaces well with a solution of bicarbonate of soda, three drachms to the ounce of water. After this is thoroughly done, removing all the secretions, spray it well with a solution of nitrate of silver, from twenty to forty grains to the ounce of water. This should be repeated once or twice a week as the indications call for. As a rule we have no trouble in curing the cases we have met with in this manner.—ED.]—*New Eng. Med. Mo., Jan.*

CARBONATE OF AMMONIA IN SCARLET FEVER. Dr. A. W. Jackson, of Brooklyn, writes calling attention to the treatment of scarlatina first brought prominently into notice by Dr. Peart, of England. This consists in the administration of from three to seven grains of carbonate of ammonia every hour for the first day, and then at longer intervals. Purgatives are to be avoided during the early stages of the disease. The writer states that he has had occasion to test this mode of treatment, and can endorse it heartily. In addition he employs the fluid extract of eucalyptus internally and as a gargle. When there is much exudation a mixture of carbolic acid and iodine in glycerine is painted over the parts. In too rapid recession of the rash, Dr. Jackson applies cloths dipped in thick mustard water, or wraps the child in blankets wrung out in hot water.—*Med. Record.*

PIN SWALLOWING.—In the *New York Medical Record* of Jan. 15th, 1885. I noticed an article on "Pin Swallowing." I paid very little attention to it, as the case was treated contrary to my teachings. On Feb. 2nd, about 4.30 p.m., Mr. G. H. E., came to my office in a great hurry and stated that his daughter Nettie, about 8 years old, had swallowed a large shawl pin. She placed the pin in her mouth to arrange the shawl around the shoulders, and while doing this threw back her head and down went the pin. I told him I was taught to give a brisk cathartic in such cases, but I believed it better to give plenty of bulky food, as I had read an article to that effect not long ago in some journal. He told me the child lived almost exclusively on bread, of which she ate enormously. I advised him to give plenty of food, no purgatives, and watch the stools. The pin was swallowed

February 2nd, 4 p.m.; evacuated in the centre of a mass of fæces February 4th, 2 p.m., forty-six hours afterward. It measured  $2\frac{3}{8}$  inches in length, with very sharp point, and a glass head somewhat larger than a buckshot. It passed away as it entered the mouth, head first.—*Dr. Wagner, in Col. & Clin. Record*

DANGER OF DIPHTHERIA CONTAGION.—Prof. Jacobi, (*New York Med. Journal*) says that many sore throats regarded as trivial are, in point of fact, diphtheria; especially those known as follicular tonsillitis. What to-day looks like one or more points covering the outlet of ducts, to-morrow may be a continuous membrane. Some mild cases of diphtheria are prolific of danger because they are apt to assume a chronic course without losing contagiousness. The throats of servants, nurses, and others who are in constant contact with the children of a household or school, should be from time to time inspected. There is as much diphtheria out of bed as in it; nearly as much out of doors as in-doors. Diphtheria is contagious, and probably has no spontaneous origin.

INJECTIONS OF ETHER AND IODOFORM IN COLD ABSCESS.—Professor Verneuil obtains a rapid cure in almost all his cases of cold abscess, abscess from diseased bone or from congestion, etc., by ethereal injections of iodoform of the strength of one in twenty. The abscess is first emptied by means of Potain's aspirator, and then receives from 100 to 300 grammes of the iodoform solution. By not exceeding this quantity (*i.e.*, five to fifteen grammes of iodoform) no fear of accidents need be felt. The liquid penetrates into all the anfractuosités and diverticula of the abscess, the ether becoming absorbed or evaporated, and the antiseptic agent being deposited uniformly on the pyogenic membrane, the action of which it modifies. This simple means, so exempt from danger and for ease of applications has proved highly successful, very large abscesses having yielded to three or four injections.—*Revue de Thérapeutique*, August 15, 1884.

SAVE THE FINGERS.—Dr. William D. Ronaldson of Philadelphia, writing to us on the subject of conservative surgery, reports two cases which show it is often better not to yield to the impulse to cut off a bad-looking finger. A. B., a brakeman on a railroad train, had his finger caught between the bumpers of the cars while endeavoring to couple them. The nail and flesh were torn completely off, leaving the distal extremity of the bone exposed. The injury was of such a nature that amputation of the unguis phalanx would have been permissible; but having cleansed the wound thoroughly with tepid water, a dressing of carbolized oil (1 to 15) and cosmoline was applied. The finger healed in three weeks, and, except for the loss of the nail,

was as serviceable as before. The second case was similar to this one, in treatment and results.—*Medical Record, Feb. 14th, 1885.*

IDIOPATHIC ANÆMIA.—A favorite prescription of Prof. DaCosta in marked idiopathic anæmia is :

R. Ferri sulph . . . . . ʒj.  
Potassii carb. . . . . ʒj. M.  
Ft. pil. No. xl.

SIG.—One after meals for first week ; increase dose in second week, etc.

If the patient is a female suspend treatment during menstruation.—*Col. and Clinical Record, January.*

ALCOHOL IN THE TREATMENT OF INSANITY.—Dr. W. B. Fletcher, Superintendent of the Indiana Hospital for the Insane, and Dr. R. M. Bucke, of the London, Ontario, Asylum have entirely abandoned the use of alcohol in any form in the treatment of the insane. They believe that their patients do just as well as before, and perhaps better.—*Med. Record.*

HIMROD'S ASTHMA CURE.—Dr. A. J. Campbell writes in the *Brit. Med. Journal* : “In Martindale's *Extra Pharmacopœia* there is an excellent substitute for Himrod's asthma cure, which I have tried and found very useful. Dissolve two ounces of nitrate of potassium in two ounces each of lobelia, stramonium leaves, and black tea well powdered ; mix well and dry thoroughly. A tea spoonful burned, and the fumes inhaled, generally gives immediate relief.”

AN APPLICATION FOR OZÆNA.—The following is Vidal's formula, as employed at the Hôpital St. Louis (“*Jour. de med. et de chir. prat.*” ; “*Pratictioner*”) :

Solution of chloride of zinc, 5 per cent. . . . . 1 ounce ;  
Boric acid . . . . . 14 grains ;  
Water . . . . . 28 ounces ;  
Ammonia-water, enough to neutralize the solution.

FORMULÆ.—Prof. Bartholow has frequently prescribed the oil of wintergreen in rheumatism, with excellent results. A useful combination is :

R. Ol. gaultheriæ . . . . . ʒj  
Acidi salicylici . . . . . ʒiv  
Sodii bborat . . . . . ʒj  
Syrup. picis liquidæ,  
Aquæ anisi . . . . . aa f ʒij M.

Sig.—Dessertspoonful every four hours.

In chronic bronchitis with asthmatic breathing, Professor Bartholow prescribed, in the clinic :

R. Ext. grindeliæ fluidi . . . . .  
Ext. quebracho fluidi . . . . . aa ʒxx  
Ammonii iodidi . . . . . gr. v. M.

As a tonic in the asthenic type of fevers Prof. Gross advises the following :

R. Quiniæ sulphat. . . . . gr. ij  
Tinct. ferri chloridi . . . . .  
Acid. hydrochlor. dilut. . . . . aa gtt. xv  
Tinct. nucis vomicæ . . . . . gtt. x  
Syr. zingiberis . . . . . f ʒij. M.

Sig.—This amount ter die,

Instead of nux vomica  $\frac{1}{10}$  grain of strychniæ sulphas may be employed.—*Col. & Clin. Record.*

In lymphadenoma, following scarlet fever, in a girl of seventeen years, Prof. Da Costa prescribed

R. Acidi arseniosi . . . . . gr.  $\frac{1}{10}$   
Ferri sulph . . . . . gr. ij ʒi.

Sig.—The pill ter die.

Over the enlarged glands rub :

R. Ung. iodi . . . . .  
Ung. belladonnæ . . . . . aa ʒ ss.  
Camphoræ . . . . . gr. v. M.

In atonic dyspepsia, Professor Da Costa prescribed.

R. Tinct. nucis vomicæ . . . . . gtt. x  
Tinct. capsici . . . . . gtt. j  
Tinct. cinchonæ comp. . . . . f ʒj M.

Sig.—Ter die.

To this was added pepsin, gr. iij-v, with each meal.

DR. OSLER'S GULSTONIAN LECTURES. — This year's lenten lectures at the Royal College of Physicians, London, were opened on Thursday, February 26th, by Dr. Osler, of Philadelphia, who choose for the subject of his Gulstonian Lectures the fascinating disease known as ulcerative endocarditis. His first lecture was devoted to the naked eye and microscopic pathology of the affection, its clinical history and etiology being left for discussion in the lectures to be delivered on Tuesday and Thursday in the following week. The lecture was mainly *ex tempore*, lasted the ideal forty-five minutes, and was unusually well attended. Dr. Osler, as might have been expected, was most cordially greeted, and there can be no doubt that his lecture was such as was well worth while his coming across the water to deliver.—*London Medical Times, February 28, 1885.*

KAIRIN.—Kairin, although comparatively little used as an antipyretic, has grown in favor particularly in France and to some extent in Germany. Its use has been more general in febrile diseases. Having been satisfactorily employed in pneumonia, scarlatina, measles, erysipelas, septicæmia, peritonitis, etc., it is considered a safe and valuable antipyretic, worthy of further trial. The usual dose of sulphate of kairin is about eight or ten grains every two hours till the temperature is reduced.

# THE CANADA LANCET.

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*The LANCET has the largest circulation of any Medical Journal in Canada, comprising four-fifths of the entire Medical Profession.*

## LACERATION OF THE PERINEUM.

A good deal, no doubt, of what even the most gifted medical journalist feels called upon to say is very stale and incipient to some of his readers. In this connection it is always well to remember that all are not specialists, nor have all reached the acme of universal medical knowledge. Moreover the bulk of the profession is scattered over the face of the country, far away from the centres of learning and concrete mental activity. What may be stale, and even incipient, to the college professor or hospital physician may be interesting and profitable reading to the general practitioner. Besides, the journalist does not pretend to write for the benefit of the specialist, or the few, but for his readers as a whole. This is our apology for referring to so common-place a subject as laceration of the female perineum.

The race of obstetricians just passing away gave themselves but little trouble or anxiety about the perineum. A partial rupture was regarded as of small consequence, while a more extensive one—if not complete, however deplored, yet was a thing to be patiently endured. Indeed, there is good ground for the belief that ruptures, both great and small, were not uncommon, all unknown to the learned attendant. Nor is it certain that even extensive lacerations do not occur without the knowledge of the supposed accomplished obstetrician of the present day. The former had some excuse for his lack of watchfulness, but the latter,

who is constantly admonished from every side, is scarcely able to furnish a valid excuse for his carelessness. Without doubt, lacerations of the perineum are becoming more frequent. It is not enough to say that, in the present day, cases which formerly were undetected, or, if detected, were not reported, are now more frequently discovered and made known, both to the patient and the profession. That is quite true, but, in addition, we know full well that artificial causes operate more extensively than formerly in producing this accident. The forceps is a great boon to woman and no one would abolish it, yet it is to its more common use that we must attribute the increased frequency, and often the more aggravated nature of perineal laceration. Of course, the perineum may be, and often is, torn by the natural efforts alone. Most of us have often been consulted by some old woman suffering, all unconsciously, from an ancient rupture of the perineum. She complains of falling of the womb, difficulty in making water, some kind of trouble about the lower bowel, besides a score of other troubles, but is utterly oblivious as to the real cause of all her suffering. Yet such a one might never have been delivered with forceps, and sustained the injury without any instrumental or undue interference.

No one will deny that the use of the forceps tends to greater liability to rupture. This arises from three causes at least. The first is the tendency under the excitement, and demoralization of the moment perhaps, to deliver too rapidly; secondly, delivery of the head while still grasped by the forceps; and thirdly, slipping of the instrument. Someone may be ready to exclaim that all these causes are avoidable. We think the experience of the most skilful contradicts such a position, and that the perineum will sometimes be ruptured while the forceps are held by the most "cunning" of hands. Rapid distension may be called for, or the tissues may have but little cohesion; uterine effort may be feeble or extinct, and the head may have to be delivered contrary to general rule, still grasped by the forceps; and a contracted pelvis, or a large, unyielding head, may render accurate manipulation impossible, and so cause a slipping of the instrument, an accident, of course, not always, though sometimes, followed by laceration. Few practitioners of extended experience, we feel convinced, but have had occasion to lament more

than once the presence of laceration, more or less serious, after a forceps delivery. Even Professor Goodell is not above confessing that such a casualty has occurred in his hands on several occasions. These remarks are not made in the interest of bunglers, but rather to make good the statement that the more frequent use of the forceps tends inevitably and unavoidably to an increase in the occurrence of the accident under consideration. After making due allowance for unavoidable cases, there is much room for the belief that a good deal of suffering is inflicted by the unskilful use of the forceps. It is manifestly the bounden duty of every obstetrician to study to maintain a cool head, a steady hand, and an avoidance of all the causes known to lead to this untoward accident.

When laceration occurs, as occur it will now and again, no one in his senses will leave the woman to her fate, that is, if the laceration be at all serious. The train of evil consequences following a considerable perineal rupture outstrips by far the consequences of an equal breach of continuity of tissue, not associated with the vital organs, in any other part of the body. Prolapse of the uterus, vesical and rectal protrusion, unhealthy vaginal and uterine discharges, erosions of the cervix and other uterine complications, difficult micturition, constipation, besides a host of general troubles, as neuralgia and indigestion, having their seat in reflex action, are a train of evils of so aggravated a nature as to call for the prompt execution of the measures best calculated to ward them off. The safest, best and only treatment, is the restoration of the part. Immediate closure of the breach is now insisted upon by the profession everywhere. For this several cogent reasons may be advanced. Delay in closing the wound exposes the patient to blood poisoning; experience shows that the primary operation carefully performed is almost always successful; the primary operation is comparatively easy, and can be readily performed, when necessary, without the aid of a skilled assistant. In the secondary operation the necessary dissection is the most painful and delicate part of the work; in the primary operation nothing of this kind is called for; the parts are simply brought into their natural place and held there by approved supports. Lately new methods have been proposed but the quilled suture still holds its place for all extensive rents. In slight rents a single simple suture is all that is re-

quired. Dr. Alloway, of Montreal, first recommended the single suture operation in all cases we believe, not involving the sphincter or bowel. Perfect coaptation is the great secret of success in union by first intention, in all wounds, and nowhere is this more true than in wounds of the perineum. The after treatment of these cases is of great consequence. The wound must be carefully guarded against the action of the urine and lochia, and some approved antiseptic should be used, not only as an application to the wound but also as an injection. The conclusion of the whole matter is, that the obstetrician of the present day must be on the alert for perineal rupture, and be prepared to repair it on the instant when it occurs.

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#### SANITARY INSPECTION.

The history, character and progress of former epidemics of cholera in Europe point to the probability of an invasion of the disease in this country during the coming summer. It is therefore high time for the authorities to be aroused to the necessity of adopting such means as will prevent its incursion or mitigate its severity should it unfortunately reach our shores. The State Board of health for Illinois, in view of the expected invasion, has ordered a sanitary survey of the State and a house to house inspection, so that all sanitary defects and evils may be corrected as expeditiously and with as little expense as possible. The inspectors are authorized to request the prompt correction of all defects, and the removal of all nuisances as soon as they are discovered, and all persons neglecting or refusing to comply with the request shall be prosecuted according to law. The inspection will be conducted under the supervision of the health authorities wherever such exist, and where there is no such organization a health officer shall be appointed.

This action of the Illinois board is worthy of imitation, and we trust that immediate action will be taken by the authorities in our own city and elsewhere in the Dominion. It is important that this work be begun as soon as the weather will permit; *and it is especially desirable that certain details be attended to at the earliest practicable moment.* For example the emptying, disinfecting, filling with clean earth, or other necessary treatment of privy vaults, should be completed before warm weather

comes to interfere with such work, or before the appearance of a case of cholera makes it dangerous to attempt it. To this end, wherever the conditions make such action necessary, a proclamation or health notice should be issued, directing the immediate prosecution of such work.

### THE ONTARIO ANATOMY ACT.

The bill before the Legislature of Ontario bids fair to become law, and we trust that no unforeseen circumstance will arise to prevent its passing in the shape in which it was amended by the special committee to which it was referred. The bill is in Dr. Baxter's hands, and we have every reason to believe that no serious opposition will be raised against its provisions when it reaches the third reading. There is very great need of such a measure; the supply of material obtained under the old act was wholly inadequate to the demand. The number of medical students has greatly increased while the amount of anatomical material remained about the same; during the past session the supply was wholly insufficient, and the teaching of practical anatomy was greatly retarded in consequence. The Act provides that the bodies of those found dead, or dying in public institutions, (Lunatic Asylums excepted), and not claimed by relatives, or friends who are willing to bear the funeral expenses, shall be handed over to the medical schools for anatomical purposes. This is the essential clause, and if passed, will, it is confidently believed, give an abundant supply of material. The remaining clauses provide for the appointment of inspectors and in a general way secure the machinery for the proper working of the Act.

"UNPROFESSIONAL" ADVERTISING.—An epidemic of diphtheria in Halifax, N.S., is made the occasion for a fresh outbreak of "unprofessional" advertising among our confreres down by the sea. A disgusted M.D. writes to the Halifax *Mail* in regard to the matter in the following terms:—"I was surprised to see by your issue of last night that this serious question has begun to be made a pretext for puff and quack advertisements by some few of our medical brethren in this city. This action on their part is reprehensible in the extreme, and most derogatory to our profession, and would not be tolerated

in England, or elsewhere in this country; it is also most prejudicial to the matter under consideration and the public good. All praise is due to Dr. Campbell for the stand he has taken in ventilating this important subject, but the same cannot be said respecting others, who are too palpably endeavoring to foist their names before the public in this irregular manner; and it is to be hoped that the press of Halifax will not prostitute their columns by allowing them to be channels for this discreditable system of spurious medical advertisement. It was only very lately that the leading medical journal of Canada had occasion to censure severely one or two medical men in this province for a similar offence, and it is to be sincerely hoped that this stain on our profession in these parts is not about to be increased by a repetition of these improper and unprofessional practices."

PNEUMONIC FEVER.—In an article on relapsing or intermittent pneumonia in the "British Medical Journal" of recent date by Sir Andrew Clark it is said: "Every one appears to have asked if pneumonia is not a fever, but scarcely any one has asked if pneumonia is really an inflammation." In this connection Andrew Clark refers to a lecture delivered by himself at the College of Physicians in 1866. These views were long since advanced by Professor Austin Flint, of New York, and are still held by him in his valuable work on the practice of medicine. He says that pneumonia is the local manifestation of a fever, and should be called "pneumonic fever." He gives the following reasons, with others, for the belief that it is a fever: The large quantity of exudation which is derived from the pulmonary artery—hence from carbonized and not from oxygenated blood—this exudation being ultimately completely absorbed, the air-cells returning to their normal condition. Moreover, pneumonia is never caused by the extension of any local process, such as abscess, gangrene, or any kind of local injury. Again, the disease is ushered in by a distinct rigor, and the temperature rises rapidly before there are any local manifestations. The spleen often becomes enlarged, and the patient becomes jaundiced.

MEDICAL JOURNAL ADDRESSES.—We have just received from the Illustrated Medical Journal Co., of Detroit, Michigan, several sets of their perfo-

rated, adhesive medical journal labels. The list includes besides the journals of the United States that are devoted to medicine, pharmacy and hygiene, those of the Provinces of Canada as well. Four complete sets will be mailed postpaid for fifty cents, on addressing the publishers above named. They are just what every physician needs for addressing his reprints for journal notice, and medical colleges for addressing their announcements for a similar purpose.

**HYPOSULPHITE OF SODA AS A DISINFECTANT.**—The difficulty of finding a satisfactory disinfectant with which to destroy fœtor in cases of cancerous ulcers, is well known. We have used a saturated solution of hyposulphite of soda added to an equal quantity of water, and found it exceedingly efficacious. The ulcerating surface was well syringed and washed with the solution, and was then covered with rags steeped in the solution. The granulations were kept clean, and the fœtor was well kept under. It is cleanly, has no smell, does not stain, and is not expensive.

**CLIMATE OF COLORADO.**—Dr. R. B. Teller of Aspen, Colorado, writes that the climate and mineral waters of Glenwood and vicinity are exceedingly well adapted to the cure of rheumatism and phthisis. Phthisical patients have been benefited to an extent that would seem perfectly incredible to those not familiar with the climate. Persons suffering from either of the above diseases, or with asthmatic affections, he says, may rely upon obtaining certain relief in Colorado.

**HALIFAX MEDICAL SOCIETY.**—A meeting of the medical profession of Halifax, N.S., was held on the 14th ult., to organize a medical society. After some discussion the following officers were elected for the ensuing year:—President, Hon. Dr. Parker; Vice do. Dr. Rigby; Secretary-Treas. Dr. Lathern; Committee on by-laws, Drs. Cowie, Rigby and Campbell; Executive Committee, Drs. Tobin, Cowie, Farrell, Almon, Wickwire.

**THE TREATMENT OF RINGWORM.**—Mr. Alden Smith, in the "British Medical Journal," speaks very highly of a solution of chrysophanic acid in chloroform for the cure of ringworm. The chloroform will dissolve the fatty matter in the hair follicles, thus facilitating the acid in getting to the

parasite, which it destroys. The prescription is used in the strength of seven grains of the acid to the ounce of chloroform. The hair, if there be any to speak of, should be closely clipped.

**NIGHT COUGH IN CHILDREN.**—The occurrence of a troublesome night cough in children is met with frequently. Dr. McCoy, of Philadelphia, in an article in the *Med. News* draws attention to this affection and claims that it is due in most cases to nasal catarrh with its accompanying secretion, etc. During the day the discharge passes away, but during the night it accumulates and causes irritation, or passes down the posterior nares and into the pharynx. The treatment recommended is to cleanse the nose before the child is put to bed by means of a spray composed of an aqueous solution of an alkali.

**LOCAL ANÆSTHESIA.**—It is said upon good authority that local anæsthesia may be readily produced by applying with a camel's hair brush the following mixture:

R Chloral,  
Camphor, . . . . aa ʒ j,  
Morph. sulphat. . . . ʒ ss,  
Chloroform, . . . . ʒ j. M.

Sig. To be applied with a brush to the area to be incised.

**ONTARIO MEDICAL COUNCIL ELECTIONS.**—We publish in another column the address of Dr. Allison to the electors of King's and Queen's territorial Division. So far there does not appear to be any opposition to the worthy doctor's candidature, and we hope to see him elected by acclamation.

Dr. A. S. Fraser, of Sarnia, has been appointed Returning Officer for the Western and St. Clair Territorial Division, *vice* Dr. Richardson, of Chatham deceased.

**A CONJOINT SUMMER SESSION.**—A summer course of lectures, clinical and practical, will be given by the acting staff of the Toronto General Hospital connected with the two medical schools. The session will commence on the 1st of May, and continue ten weeks. The lectures will be delivered in the theatre of the hospital. See announcement in another column.

**CASE OF TRIPLETS.**—Dr. Phelan, of Kingston, reports a case of confinement in which a woman

gave birth to three healthy living children, two girls and a boy—all living. She was 12 hours in labor before the first birth; 25 minutes later, the second child was born; and 35 minutes later, the third was born. Each child had a distinct placenta.

**APPOINTMENTS.**—Dr. A. C. Panton, (Trinity) has been appointed to the chair of materia medica, and Dr. K. A. J. McKenzie, (McGill), to the chair of clinical surgery in the Medical College of Portland, Oregon. Dr. A. Robillard has been appointed a commissioner under the Liquor License Act.

Hon. Dr. Parker, of Halifax, Dr. Page, of Truro, and Dr. McGillvary, of Sydney, have been appointed members of the Nova Scotia Medical Board.

**CORONER.**—Dr. C. Sinclair, of Aylmer, has been appointed coroner for the Co. of Elgin, and Dr. A. C. Bowerman for the Co. of Prince Edward, Ont.

**INDEX MEDICUS.**—We are pleased to notice that this valuable monthly publication is to be revived. It will be published by Mr. Geo S. Davis of Detroit. The editors are Drs. Billings and Fletcher of Washington.

THE death of Prof. Frerichs, of Berlin, in announced in our Foreign exchanges. He was a man of great ability and his death is a serious loss to German medicine. The death of Dr. Ellerslie Wallace, of Philadelphia, is also noticed in our exchanges.

### Notes, Queries and Replies.

#### BRITISH QUALIFICATIONS.

To the Editor of the "CANADA LANCET."

SIR,—In reply to Queror in last number of the "LANCET;" I wish to say that I spent one month in the London hospitals, obtaining great insight into special and general diseases. There are some forty hospitals in the Metropolis, but the material is not presented to the best advantage *i. e.* for a graduate to learn much in a short time—more especially in the special sub-divisions of the science.

I attended the Edinburgh New Royal Infirmary for four months devoting four hours per diem to practical work, one hour to grinds and the remainder of the day to study, etc. I succeeded in passing the first conjoint examination of the R. C. P. & S., Ed., and the Faculty of P. & S. of

Glasgow. I may say the feeling of equality extended to a Canadian confrere, materially assisted my chances of gaining practical knowledge. I believe Glasgow also to be a good place to obtain practical instruction, as students are requested to familiarize themselves with the ward work.

I next took Cook's tickets from Scotland to Hamburg, Berlin, Vienna, Paris, London and intermediate points, costing \$75.00, with \$2.00 per day for hotel coupons, and extras additional while on the road. The expenses, when a permanent stay is made in any one place, can be made to suit circumstances. Much was seen that I never expected to see here, and my experience and confidence was advanced many years. Expenses on the ocean can be arranged to suit individual taste. I purchased a first-class return via Allan Line by Quebec and Halifax with R. R. reduced rates for an unlimited season. Expenses in Great Britain I should judge to be about \$5.00 to \$7.00 per week for a long period, with \$130.00 for examinations, \$25.00 for registration, and a few pounds for hospital fees. Extras according to special requirements. For the regulations of the respective corporations write to Dr. James H Albyn Place, Dr. J. Wyllie, R. Infirmary, Mr. Bell, F.R.C.S., Edinburgh, the secretaries of the triple, physician and surgeon qualifications.

The conjoint examination is written, clinical, and oral and lasts a week or more. The subjects are: Medicine (including Therapeutics, Medical Anatomy and Pathology), Clinical Medicine and Surgery, Surgery (including Surgical Anatomy, Operative Surgery and Surgical Pathology), Midwifery (including Gynæcology), Medical Jurisprudence and Hygiene. The ward examinations include both medical and surgical cases, besides testing urine and recognizing urinary crystals, etc., bandaging and the use of surgical instruments.

A Canadian must produce his diplomas and other certificates which they demand. The advantages received from the practical work should be the primary and the examinations the secondary object to take one's time and attention. In case of failure at the examination one has the privilege of trying again in three or six months after paying \$25.00 entrance fee which many are obliged to do.

W. F. FREEMAN.

WALKERTON, Ont.

## USE OF PICROTOXINE.

To the Editor of the "Canada Lancet."

SIR,—Would some of your readers give their experience in the use of Picrotoxine in the sweating of phthisis, and also in what liquid it is best dissolved.

THERAPEUTIC.

New Brunswick, Mar., 85.

**Books and Pamphlets.**

THE LAW AND MEDICAL MEN, by R. V. Rogers, Jr. of Osgoode Hall Toronto, Barrister-at-Law. Toronto: Carswell and Co.,

This little work consisting of about 200 pages, fills a gap in the library of both the physician and lawyer. It deals with the laws relating to the practice of medicine, fees, (who should pay the same), civil and criminal malpractice, privileged communications, expert testimony, defamation, relations with patients, dissection, resurrection, etc., etc. In discussing the subject of malpractice he cites the following, page 61, (J. Woodward in *McCandless v. McWha* 22 Pa Rep. 261) "A patient is entitled to the benefit of the increased knowledge of the day. The physician or surgeon who assumes the healing art is bound to be up to the improvements of the day. The standard of ordinary skill is on the advance, and he who would not be found wanting must apply himself with all diligence to the most accredited sources of knowledge." Where would the fossilized members of the profession who never read a medical journal or any new work on medicine be found in the face of the above ruling?

The book is a very interesting and readable one and should find a place in every physician's library, in view of the fund of information it contains. The statements of law contained in the book are in nearly every instance the rulings of the judges in the particular cases, with citations. We would suggest to the author the propriety of printing the code of medical ethics, as an appendix, in the next edition.

THERAPEUTICS OF THE RESPIRATORY PASSAGES.—  
By Prosser James M.D. London.

This is one of the best of the monthly issues of "Wood's Library of Standard Medical Works." Every valuable medicament employed in the treatment of the affection of the respiratory passages is

subjected to impartial consideration. The chapters on alcohol, denutrients, and antipyretics are peculiarly instructive, clearly indicating that the author whilst free from the sentimental prejudices of the extremists, is yet gifted with that spirit of candour which should ever be the dominating influence in medical science. The book cannot be read by any practitioner without great profit.

DISEASES OF THE URINARY AND THE MALE SEXUAL ORGANS.—By W. T. Belfield, Chicago. W. Wood and Co: New York.

Dr. Belfield has had the advantage of practically studying the above diseases in a prolific region, and his book presents abundant proofs of his careful observation. In a large city like Chicago, teeming with a very fast population, with strong propensities to illicit pleasures, and exempt from abhorrence of facile divorce, the diseases treated of by Dr. B must constitute no trivial part of daily routine, and and if they are sedulously cultivated, the pecuniary results must be very enticing.

DOCTRINES OF THE CIRCULATION, by J. C. Dalton, M.D., Emeritus Prof. of Physiology, College of Physicians and Surgeons, New York. Philadelphia: Lea Brothers & Co. Toronto: Williams & Co.

This is a most interesting and well written handbook of the doctrines of the Circulation from Aristotle, Praxagoras, School of Alexandria, Galen, Period of Renaissance, to the dawn of light on this subject, following the discoveries of the Professors of the Universities of Padua, Pisa, Bologna, and Rome. The author also gives the subsequent opinions of Servetus, of the transfer of the blood from the right side of the heart to the left, taking place in the lungs, and not through the septum of the ventricles; also the discovery of the valves in the veins by Fabricius ab Aquapendente, their form, and speculations on their use. He next refers to the doubts of Harvey regarding the correctness of these theories, and his subsequent discovery of the peripheral circulation from the arteries to the veins, and of the return circulation of the blood through the veins to the heart. Space will not permit further notice of the scope of this work, which is of great research, and one that we welcome as a valuable addition to medical literature.

**Births, Marriages and Deaths.**

On the 2nd ult, J. B. Howell, M D., of Thornbury, aged 34 years.

On February 9th 1885, wife of Dr. A. McTavish, Staffa, Ont., aged 39 yrs.