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CONTENTS.

ORIGINAL COMMUNICATIONS.

The Birthplaces of Yellow Fever, 217.—Treatment of Yellow Fever..... 218

SOCIETY PROCEEDINGS.

Medico-Chirurgical Society of Montreal..... 219

PROGRESS OF MEDICAL SCIENCE.

A Lecture on the Treatment of Angina Pectoris, 224.—Retention of Urine from Enlarged Phosphate—Retention from Stricture of the Urethra—Chronic Enlargement of the Tonsils—Hydrocele, 227.—Anæsthesia in Obstetrics, 230.

—Cure of Abscesses without Cicatrices, 232.—Gargles, 232.—Hot Water in Therapeutics, 233.—Lactopeptine in the Gastric Disorders of Children, 224.

EDITORIAL.

The Cholera, 234.—Fehling's Test Tablets, 235.—Personal, 239.—Reviews, 239.

Original Communications.

THE BIRTHPLACES OF YELLOW FEVER.

(Translated from the Spanish).

By WOLFRED NELSON, C.M., M.D.,

Member of the College of Physicians and Surgeon, P.Q. Late Assistant Demonstrator of Anatomy Medical Faculty of Bishop's College, Montreal; Late Physician Accoucheur to the Female Home; Late Consulting and former Attending Physician to the Montreal Dispensary; Late Member Board of Health and Quarantine Panama, South America, &c., &c., &c.

Dr. Domingo Freire, of Rio de Janeiro, who was commissioned by the Brazilian Government to examine into and report on the subject of yellow fever, has presented the following to his Government, touching the birthplaces of yellow fever. It was translated from the Portuguese language into Spanish, for the use of the Chilean Government in Peru. As the subject is entirely new it may interest the many readers of the CANADA MEDICAL RECORD. The following is a literal translation:

"In the discharge of the commission that was confided to me by the Government I have met with facts of great interest touching the pathology and therapeutics of yellow fever, and which will be the subject of a separate report to which I shall specially devote myself. I consider it my duty, however, to make known, as soon as possible, a circumstance of great interest in connection with public hygiene.

"During a visit that I paid to the Cemetery of Jurujaba, where all are buried who die in the Marine Hospital of Saint Isabel, I gathered a handful of earth at a depth of one foot from the surface, over the grave of a person who had died, about a year previously, of yellow fever. This earth did not differ in color or odor or any external feature from the surrounding earth; but by examining a small quantity with a microscope magnifying 740 diameters, taking the usual precautions to avoid error, I found myriads of microbes, exactly resembling those met in the vomited matters, urine and blood, and other organic liquids from the bodies of those attacked by yellow fever, viz.,—the cells of *cryptococcus zanthogenicus* in various stages of growth, from the size of a black speck, difficult to recognize in the field, up to round corpuscles, more or less large, strongly reflecting light, some being grey, while others were black, and surrounded by a fringe or areola of that color. Many of the organisms moved spontaneously. There were yellowish masses marked by granulations that came out clearly in the field, likewise masses made up of the coloring matter of the cells; we also saw specks that were entirely black, being the remains of the *cryptococci*.

"I also observed vibrios. They moved with rapidity. These observations were verified in all their details by my assistants, Messrs. Chapot, Augustus Cesar, and Carminhva, showing clearly that the germs of yellow fever perpetuate themselves in cemeteries, and that cemeteries are birthplaces for the evolution of new germs, destined to devastate our city (Rio de Janeiro).

"Through the pores of the earth the germs escape and reach the atmosphere; others are carried by the heavy rains, so frequent among us, into the streets and squares, and there meet with conditions favorable to their evolution, and give rise to epidemics during the summer, the latter season being the most favorable for their appearance and spreading. The existence of the microbes of yellow fever is completely in accord with the observations made by Pasteur, touching the subject of malignant pustule.

"I take the liberty to recommend these facts to hygienists. It seems to me that, as a provisional measure, the cemeteries now existing should be removed, and placed as far away as possible from centres of population, where the prevailing winds cannot take up and scatter the different seeds of the microbes. As a radical and final measure the practice of cremating the bodies of those dying during epidemics would be the surest way of stamping out the poison and the epidemics that desolate year by year, with more or less intensity, the flourishing centres of our population.

"If every dead body is a storehouse containing millions of these organisms, the product of disease, imagine what a cemetery must be, in which new *foci* of disease are formed around every corpse. The imagination is incapable of estimating the literally infinite number of these microbes that multiply in these spots. Amid the silence of death, these worlds of organisms, invisible to the naked eye, are constantly working to make new poison for new victims, destined to serve them with food and for the fatal perpetuation of their species."

The above is all that has appeared in print, so far, of Dr. Domingo Freire's researches; when new material appears, I shall translate and forward it. The subject to us here is one of the greatest importance, as yellow fever is endemic, unfortunately, on the Isthmus of Panama, and its vicinity. The researches and observations made by Dr. L. Girerd, Surgeon-in-Chief of the Inter-oceanic and Canal Company, stationed at the Company's Central Hospital here, will form the subject of a future letter. He has examined the blood, etc., of a number of yellow fever patients, and has conducted a great many experiments by propagating the germs from one series to another successfully.

PANAMA, SOUTH AMERICA,

June 16th, 1883.

TREATMENT OF YELLOW FEVER.

(Translated for the CANADA MEDICAL RECORD).

By Dr. WOLFRED NELSON, Panama, South America,
June, 1883.

The following is a brief summary of the treatment of yellow fever in Peru. It was introduced there in 1868 by Dr. Wilson, an English graduate in medicine, when he was physician to the English Hospital in Callao. During the fearful epidemic of yellow fever in that city, in 1868, his success was something remarkable,—only three *per centum* of his patients died.

The report recently published in Peru, in the language of the country, Spanish, goes on as follows:—"When the patient feels that his skin is dry, and that he has a headache (they being infallible symptoms of the disease) he should be made to perspire profusely. The best way to produce the perspiration is by means of hot air. To do this, place a small spirit lamp, or a coal oil lamp, under a chair having a solid seat, let the patient sit on the chair perfectly naked, but well covered with a blanket; let him remain until profuse perspiration commences. Then put him in bed, where he should continue perspiring freely for one or two hours. Rectal injections should be given immediately, containing oil of Palma Christi, with soap suds and a small quantity of spirits of turpentine, the injection being warm. This treatment should be continued three or four days, and should always be followed by profuse perspiration and emptying of the bowels; following the above give three or four doses of four grammes each of sulphate of quinine at intervals of four hours exactly; then for two or three days more give six to ten drops of spirits of turpentine, in gum water, or with the white of an egg.

Further it has been noted, that the greater part of those who have had yellow fever have been constipated previously. As a precautionary measure, the bowels should always be kept open. The sun and dew should be avoided, stimulants should be used in moderation. No fruit of any kind should be eaten.

The best preventive that the local authorities can impose is to prohibit the sale of all fruits."

Society Proceedings.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

Stated Meeting, April 27th, 1883.

[Continued from our last.]

Puerperal Eclampsia.—Dr. Armstrong read a paper on this subject, reporting three cases. In the first case, a multipara, a fortnight before her delivery complained of the three symptoms regarded by Chaussier as premonitory indications of eclampsia, viz., cephalalgia, disorder of vision, and epigastric pain, together with œdema of feet, ankles and hands, with puffiness of eyelids. Although diuretics and occasional purges were given, a convulsion came on soon after labor began. Chloral Hydrat. was given every hour in doses of ʒi . After three or four doses the woman had a second convulsion, when chloroform was administered, and the first stage of labor being completed, the forceps were applied and the child delivered. The hæmorrhage following the birth of the child was considerable, requiring to control it a good deal of kneading of the uterus, and the application of ice to the cervix. The child was still-born, but the mother made a good recovery. In the second case, primipara, the convulsions first appeared a few minutes after the completion of a normal labor lasting fourteen hours. The comatose condition, which obtained after the first convulsion, persisted and deepened in spite of treatment, and the patient died sixty-four hours after she was delivered. No paralysis of face or other parts could be made out. The urine was highly albuminous. At the autopsy extravasated blood was found covering the superior surface of the brain, and dipping down in the sulci. Also a large clot, which measured four centimeters by four centimeters, was found in the substance of the left middle lobe of the cerebrum. It was situated in the parietal section of Pitres. The kidneys, microscopically, were found to be granular, and the veins were dilated. This dilatation of veins was found, in microscopic sections, of different tissue by Dr. Wilkins, who kindly examined them. The third case is of interest principally from the fact that gestation went on twenty-two days after the occurrence of two well marked convulsions. Labor then came on, and she was delivered of a living healthy child, without any recurrence of eclampsia. During the three

weeks interval between the eclamptic seizure and delivery, chloral in 3i doses was administered per rectum, as soon as any twitching of the muscles of the arms or disorder of vision with headache and epigastric pain appeared. This case shows how we can carry on a case until the completion of gestation, by careful watching, appropriate treatment, even after two puerperal convulsions have occurred. The fate of the children in the first and third cases favors the idea that the death of the child is due to carbonic acid poisoning, it, in its turn, being due to the interference with respiration of the mother during the convulsive seizures rather than the toxæmic state of the mother's blood.

Dr. Armstrong stated that the digitaline used was prepared by Parke, Davis & Co. of Detroit. He thought the dose of gr. $\frac{1}{4}$ not too large. In reply to Dr. Wilkins he thought that if the condition of the mother's blood killed the child, then the child in the third case should have died, for in this case for three weeks before the birth of the child the mother presented symptoms of profound uræmic poisoning. Her urine never containing less than 30 per cent. of albumen. But the child was born alive and well. The only time the foetal heart was weak was the day of the eclamptic seizures. The foetal heart sounds being stronger the next succeeding day.

Drs. Alloway and Cameron having raised the question of etiology, Dr. Armstrong stated that his impression was that puerperal eclampsia had a predisposing and an exciting cause. The predisposing cause might be, according to the theory of Dr. Barnes, an excessive nervous development, and an increased development of the spinal cord; or, according to the Traube-Rosenstein theory, increased aortic tension, followed successively by œdema of the brain, compression of the cerebral vessels, and acute cerebral anæmia; or the theory supported by Andral and Gavarret, that the blood of all pregnant women was hydræmic; or the theory of Kussmaul and Linner, of cerebral anæmia; or the theory of Braun that uræmic poisoning, due to Bright's disease of the kidneys, was the cause. Frerichs attempted to prove that the poison was due to ammonia carb., formed by the decomposition of the urea. Spiegelberg suggested that a reflex contraction of the vessels might cut off the blood supply to the kidneys, due to a peripheral stimulus. And Frankenhauser has demonstrated a direct connection between the ganglia of the kidneys and the nerves of the uterus through the sympathetic.

Or the predisposing cause might be any toxæmia or leukæmia. Probably all these theories apply in certain cases, but the exciting cause seemed to be some peripheral irritation, as held by Ohr and others.

Dr. Armstrong thoroughly believed in venesection where there was a distended right heart, and also in cases of high arterial tension, with a hard incompressible pulse, though the surface might be pale. Broadbent had proved venesection to be of the greatest value in this last class of cases. The use of large doses of morphia was undoubtedly useful in selected cases. But he had found bromide and chloral give very satisfactory results as a rule. In regard to chloral killing the child, there was no evidence to show that such ever was the case. On the contrary, chloral was often freely given in tedious prolonged first stages of labor without any injurious effect whatever upon the child.

Dr. Wilkins advocated inducing premature labor in cases where the convulsions appeared to be from uræmia or retention of whatever salt it is which poisons the mother, as he believed it poisoned the child also.

Dr. Alloway remarked that the etiology of puerperal eclampsia was interesting, from the different views entertained by eminent writers. He thought the theory of Lever—reported in the *Guy's Hospital Reports* of 1842—was the one generally accepted at present. Lever had shown that the urine in eclampsia was always highly albuminous, and that pathological changes in the kidneys, corresponding with those of Bright's disease, were frequently discovered. From these facts he contended that eclampsia was caused by the retention in the blood of urea and other constituents of the urine which it was the duty of the kidneys to excrete. The chief objection urged against the acceptance of this theory of uræmic intoxication was that there were patients suffering from chronic Bright's disease who were not attacked with convulsions during pregnancy or parturition. This objection was, however, easily met by the explanation, that if this chronic disease be of long standing the remaining healthy parts of the kidney will still secrete sufficient urine to prevent poisoning, and that eclampsia depended upon uræmic poisoning in consequence of deficient or total suppression of renal secretion. Dr. Alloway also spoke of the well-known Traube-Rosenstein theory, which claims that eclampsia appears when the arterial blood pressure in a highly hydræmic subject is suddenly increased.

In this case acute œdema of the brain is produced, the exudations of serum causing anæmia by compressing the blood vessels. If this condition was confined to the hemispheres it was thought coma would be produced, and if it extended to the motor centres we would get convulsions. The principal objections to this theory were, however, that many young, healthy robust women became eclamptic, and that many hydræmic patients enjoyed an immunity from convulsions. Dr. A. spoke of another class of cases in which the albuminuria is absent during the entire duration of the disease, or only shows itself in very minute quantity for a very short period. Such cases had been called "eclamptiform attacks," caused by reflex irritations of vasomotor and spasmodic nerve centres by a peripheral excitation. According to Brown-Sequard the sciatic nerve plays a most important part in the production of these artificially excited epileptic attacks. Cases have been reported where an over-distended bladder in protracted labor had caused convulsive attacks; also a retained placenta has been accused of being the probable cause. Dr. Alloway drew attention to the recent treatment of puerperal eclampsia by very large doses of morphia, Dr. Glark, of Oswego, being, he believed, the first to practice it. In Dr. Clark's article in the *American Obst. Journal* of July, 1880, upon this subject, he recommended gr iiss and gr ii doses to be administered hypodermically, and repeated on occurrence of another fit. Clark also states elsewhere that it would be absolutely safe to give as high as three grains in same way. Dr. Alloway had used over grain doses in two cases in association with Dr. Rodger with very gratifying results. He had also used pilocarpine, but was not much impressed with it.

Dr. Rodger said he had seen quite a number of cases of puerperal eclampsia, and believed venesection, combined with the hypodermic use of morphia, to be the best treatment. He had been disappointed with chloroform and chloral in these cases.

Dr. Trenholme said the second case reported by Dr. Armstrong possessed some features of special interest. It showed that convulsions in the mother did not destroy the life of the unborn child. It was a question in his mind if the death of a child in the uterus was not generally due to detachment of the placenta, caused by the spasms of the uterus, rather than a vitiated state of the mother's blood. In rare cases it might be otherwise. As to treatment—this would vary with each case—no definite

rule could be followed. If the woman was plethoric and strong, blood should be promptly and largely abstracted; and then followed by a large dose of morphia, or bromide of potass, and chloral. In all cases chloroform was invaluable, and in some cases enough of itself. Where bleeding was not indicated, morphia in even gr. ii doses was good in its result. As to hastening delivery this would depend upon the results of the uterine contractions—if they caused the convulsive spasms, it was clearly our duty to empty the uterus and set it at rest. If otherwise, wait for natural delivery.

Dr. Roddick believed he had several times used chloral with benefit. Has ble but would only do so in suitable cases, such as those indicated by Dr. Trenholme. He said that Dr. Fuller, about eight or ten years ago, was the first to advocate the use of morphia hypodermically in puerperal convulsions; most of the members of the Society opposed him strongly on theoretical grounds. He (Dr. Roddick) on this occasion, being one of those to denounce Dr. Fuller's treatment. Now he was convinced of the usefulness of morphia hypodermically used in these cases.

Dr. Stephen had lately seen chloral in large doses combined with inhalation of chloroform act well. He advocated using the chloral when premonitory symptoms appear.

Dr. Cameron said that although the majority of these cases are renal in origin, yet convulsions frequently occur where careful examination fails to detect any appreciable signs of renal disease. Sometimes profound anæmia, sudden shocks or frights, or an over-excited condition of the nervous system, seem to precipitate the attack. He detailed a case where convulsions occurred in a nervous, hysterical patient, profoundly anæmic, after a severe attack of diphtheria; no symptoms of renal mischief being found either before or after confinement. He did not agree altogether with those who advocate the induction of premature labor, or the rapid completion of delivery by forceps or turning, when a convulsion occurs before the birth of the child. In many cases such practice does more harm than good, causing still greater irritation, and intensifying the convulsive action. Where the os is well dilated, or at least soft and dilatable, operative interference may be permissible; but where the os is hard, rigid and undilated, it is better to control the convulsions, and wait till the parts are in a more favorable condition. With regard to treatment, he believed that while venesection is

applicable to the robust and plethoric, especially where renal mischief exists, many patients can ill afford to lose blood. Where venesection is practiced, there is greater tendency to subsequent absorption of septic matters. He considered the best treatment for the majority of cases to be morphia, in sufficient quantities to control the convulsions (the heroic doses advocated by some being usually unnecessary, followed by chloral and potass. bromid.

Dr. Wood had recently used venesection, but his patient was afterwards troubled with anæmia, which caused her to lose her milk.

Dr. Osler said in Dr. Armstrong's second case death was due to extravasation in the brain, and that this was a cause of convulsions sometimes.

Dr. Kennedy had seen a good many cases of puerperal convulsions, in all of which uterine contractions existed, and were the immediate cause of a spasm. The os was in all cases dilatable. Had used and found useful chloroform, chloral, bromide of potassium, and hypodermics of morphia in large doses. Believed venesection valuable prior to delivery of the child. As a means of blood-letting he encouraged the flow at delivery by giving chloroform and afterwards ergot to ensure good contraction, and so stop loss. He agreed with Dr. Trenholme that the death of the child was due to separation of placenta by the spasmodic contraction of the uterus. Had delivered epileptics without their having convulsions.

Dr. Campbell related a case where convulsions came on between the 7th and 8th month; he bled and the spasms ceased until end of ninth month, when they returned; he now applied forceps and delivered safely. Had confined her several times since without any trouble.

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Stated Meeting, May 11th, 1883.

THE PRESIDENT, DR. KENNEDY, IN THE CHAIR.

Chronic Papular Skin Eruption.—Dr. Gurd exhibited a boy, aged 10 years, suffering from this disease, most marked about the wrists and knuckles. The boy was one of a family of five, all of whom are affected, the servant alone remaining free. All suffer great itchiness at night after getting to bed. Treatment appeared to be useless. Many of the members thought it to be itch. Dr. Gurd brought the case for diagnosis, but did not think it to be itch, as no furrows were present, and the progress of the disease was not like scabies.

Muscular Atrophy.—Dr. Wilkins brought before the Society a man, aged 21 years, who was under his care in the Montreal General Hospital, affected with muscular atrophy, limited to the upper arms and thighs. The muscles of the fore-arms and leg are well developed, and presented a remarkable contrast to the wasted appearance of upper arms and thighs. There are no disturbances of sensation, but with the wasted appearance is associated more or less complete loss of power in the affected muscles. Patient was able to walk by a sort of shuffling movement; could mount the stairs, but only with assistance, and when kneeling or seated on the floor can rise only by grasping some support, such as a chair, to aid his legs by the use of hands and arms. In this condition his one elbow (the right) must be raised above shoulders; the left elbow being held firmly on left knee. Patellar tendon reflexes are absent. The plantar reflexes are diminished. Faradic excitability is absent in muscles of thigh and front portion of upper arm. No bladder disturbance; no muscular tremors; nor does he complain of pain. Patient refers his trouble to a fall which he had about three years ago. He fell on his buttocks from a height of ten feet, after which time he noticed himself gradually becoming weaker. About a year subsequently he had another fall while carrying a heavy weight on his head. The lesion Dr. Wilkins considered to be strictly limited to the anterior cornua of the gray matter, and to only a few groups of ganglion cells, and histologically to be exactly the same as those in *anterior poliomyelitis* of children. The course of the disease and the grouping of the muscles affected, however, he considered presented no similarity to that affection; nor did feel inclined to associate it with *progressive muscular atrophy*, owing to the absence of tremors and the perfect development of all the muscles of legs and feet and forearms and hands.

Pernicious Anæmia.—Dr. Osler exhibited the spleen and bone marrow from a patient who died in Hospital. She was 60 years of age, profoundly anæmic, with lemon-colored skin. Examination of blood during life showed irregular ovoid and balloon-shaped red corpuscles; also many microcytes. No Schultze's granules. P.M.—The microscope revealed the marrow to be rich in lymphoid cells—that from the vertebræ had abundant red corpuscles, nucleated red blood corpuscles and also microcytes. Spleen, which was not enlarged, had an extraordinary number of microcytes, the

mode of origin of which was probably by buds from ordinary cells. Dr. Osler had watched this take place in three cases of this disease. There was atheromatous disease of lower abdominal aorta, the bifurcation was bony, and ulcers were found in the right common iliac. Dr. Osler said this was the oldest person in whom he had found Pernicious Anæmia.

Physometra.—Dr. Ross gave the following particulars: Was sent to attend a woman in labor; was told she had had a rigor some hours previous. Found she had fever and rapid pulse. Abdomen much distended, not much pain, but complained of distressing feeling of tension. Percussion over uterus was as resonant as the stomach. Said did not feel movements of child. Diagnosed dead foetus and uterus filled with gas. Patient was delivered same night. It was a breech case. Had some difficulty to get child through, as its abdomen was filled with gas also; had to use a fillet. With each contraction of uterus detonations of gas and gurgling took place. As the head was delivered, most frightfully offensive gas came away. The child was much decomposed. Had never seen a similar case, and why so in this case, or why not oftener seen when the foetus dead, he could not say. Patient recovered fully. No disinfectant was used at any time.

Dr. Roddick read a report of two cases of *Purpura Hæmorrhagica*, ending fatally, of which the following is a brief extract:

CASE I.—Early on the morning of Sept. 21st, of last year, I was called to see a child, aged 7 years, said to be suffering intense pain in one eye, which was also swollen. I learnt on the way that the little girl, who had just recovered from an attack of scarlet fever, had been brought from Quebec the day previous, and appeared to be pretty well, but on going to bed was noticed to be feverish, and had vomited. The mother was aroused about midnight by the cries of the child, and noticed immediately that the right eye was considerably swollen and the lids ecchymosed. I found the upper lid especially enormously distended with blood, while on the cheek was a discoloration of the same nature. She had not passed urine for some hours, if at all during the day. Pulse weak, but not rapid; temperature was not taken. Ordered iced cloths to be applied to the ecchymoses, and internally, gallic acid, with iced milk as food. 8 a.m.—Ecchymoses previously noted not increased in size, but others have

appeared over the body and limbs. Urine passed is found to be almost pure blood; slight epistaxis; no fever; pulse weak. Dr. R. P. Howard saw the case in consultation with me during the day, but in spite of the most strenuous efforts on our part, the patient rapidly sank, and died within twenty hours of the time I was first summoned. An autopsy could not be obtained.

CASE II.—Mrs. —, a widow in fair circumstances, aged 45, mother of six children, the youngest 10 years of age, consulted me for the first time on Feb. 26th, of this year, for a troublesome nose-bleeding. She had always enjoyed good health; menses regular; bowels in good order, but considerable flatulency and other dyspeptic symptoms. She stated that her teeth had been bad for some months, and on that account she seldom ate meat or other food that required much mastication. Ordered her suitable tonic treatment, and recommended an astringent douche for the epistaxis. She returned in about a fortnight, not much improved in general health, although the epistaxis was better. She now stated that she was spitting blood. On examination of the mouth, noticed a remarkably spongy condition of the gums, which bled on the slightest pressure. Suspecting the nature of the case, had the body examined, and found three or four ecchymotic spots, of the size of a sixpenny piece, on various parts. Ordered ice for the gums, and a strong solution of tannin, with gallic acid and ergot in large doses, internally; the food to be of the most nourishing and concentrated kind.

March 15th—18th.—Patient weak and blanched; the bleeding from the gums continues; requested Mr. McGowan, dentist, to see the case, with a view to having some pressure applied to the gums. At my suggestion, two loose teeth in the lower jaw were removed, and the bleeding from around them, which was excessive at times, was subsequently kept under control. Perchloride of iron was applied freely, and a cast of the gums was taken and adjusted so as to exert pressure. Vomiting and abdominal pain became now troublesome symptoms, and demanded special treatment. The spots of extravasation increased in size and number, appearing especially on the lips, eyelids, chest, buttocks, thighs, and upper arms. Up to this time there had been no blood in the urine; the stools were noticed to be black, but that may have been from the iron employed locally.

Turpentine was subsequently administered in ten minim doses. As the vomiting persisted, the food was introduced *per rectum*.

March 21st.—The patient died this evening, no change for the better having occurred at any time during the past two days. Drs. Fenwick and Howard saw the patient with me, and each gave a most unfavorable prognosis. During the last few hours of life, the urine, which was very scanty, contained a trace of blood. The patient died of asthenia.

Empyema, Discharging Through Lung, Recovery.—Dr. Osler related the following particulars of this case: Man admitted into hospital under his care with typhoid fever. During convalescence found dullness at base of right lung, which a week later reached to spine of scapula. Effusion well marked; with hypodermic syringe drew off about 20 minims of pus. Waited for a week before treating with canula, and when about to do so found him spitting pus in large quantities—as much as 10 to 15 ozs. in the day. Physical signs became less marked, dullness diminished, moist sounds over that base; resonance not yet natural. Pus not fetid. Diagnosed erosion of pleura and soakage of pus through lung tissue in the bronchi. There was no pneumothorax. Dr. Osler said that the late Dr. R. L. MacDonnell of this city was, he believed, after Hippocrates, the first to notice the occurrence of perforation into the lung in empyema, and recorded seven or eight cases. Traube in 1871-72 claimed to be the first, but was mistaken. Traube was fortunate in having a post mortem on one of his cases where the pus was seen soaking through the lung tissue.

Dr. Ross mentioned three cases of complete cure of empyema by erosion of pleura and soakage which had come under his care.

Dr. Wilkins believed in operating early in cases of empyema, had had good results from excising about two inches of a rib.

Drs. Molson and Gardner had each seen a case similar to Dr. Osler's.

Pyometra.—Dr. Gardner gave the following particulars: Patient, aged 60, complained of pain in hypogastrium; was losing blood and an ichorous fluid from the uterus; had good health till year previous. Uterus was large; probe entered through ragged tissue into uterus $3\frac{1}{2}$ to 4 inches. Nothing but blood coming away; put in a tent. Was inclined to think the case one of malignant disease. On removing tent next day, a teacupful

of pus, not foetid, was discharged. The curette brought away granulations from the cervix. The cavity was smooth. The nature of the granulations was obscure. The uterus was washed out with iodine lotion. Patient got perfectly well, and has had no return of the disease.

Dr. Osler mentioned having met "post mortem" with three or four cases of uteri filled with pus, and having occlusion of inner os.

Progress of Medical Science.

A LECTURE ON THE TREATMENT OF ANGINA PECTORIS.*

By PROFESSOR GERMAIN SEE.

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* Translated, with Professor Sée's permission, by E. P. Hurd, M.D., Newburyport, Ma.s.

GENTLEMEN:—Before instituting the treatment of angina pectoris, it is necessary to bear in mind that it may be only a transitory phase of heart disease, destined ere long to give place to the habitual symptoms of a regular cardiac affection. Angina pectoris is not, then, *per se*, always a cause of alarm, even when the attacks seem to be of a typical character. As it is impossible to predict a temporary duration of the malady, it is the duty of the physician, both during the paroxysm and in the interval, to act as though the return of the paroxysms and their attendant danger were inevitable. Above all, the cause should be sought for.

TREATMENT BASED ON ÆTIOLOGICAL CONSIDERATIONS.—If angina pectoris be due to a poison, it would seem to be a simple matter to prevent the attacks by suppressing the cause.

As for those anginas which have their origin in the abuse of tobacco, the remedy is obvious enough. It must, however, be borne in mind that angina pectoris from tobacco is a rare thing. Tobacco determines intermittences, arhythmia, etc., much oftener than the painful affection under consideration, which, when the result of smoking, is due to the slow action of the nicotine poison on the coronary arteries.

Angina of alcoholic origin does not yield to suppression of the cause. It is a sure sign, when spirit-drinkers have attacks of angina pectoris that arterial lesions already exist—that is to say, endarteritis of the coronary vessels, as well as degenerations or scleroses of the myocardium. It is vain to suppress alcohol in these cases; the evil is done, and is almost always irremediable. Gouty angina, which the Germans regard as the typical form, even identifying angina pectoris with gout, is in reality a cardio-vascular lesion, and resists treatment of the diathesis, just as alcoholic

angina persists in spite of the suppression of the cause. Even granting that there is a definite medication for the gouty diathesis, as there is for the arthritic manifestations, it is doubtful if one could succeed by such specific treatment in preventing gout from affecting the vascular system, or endarteritis from appearing; in fact, the so much vaunted alkalies can do little for the joint affections, and still less for gout of the heart, or the constitutional condition.

ANGINA PECTORIS OF ORGANIC ORIGIN.—Thus far the causal treatment has been practically nil, with the single exception of angina from tobacco. The anginas of organic origin are not any more amenable to treatment directed at the cause. What can we do to remedy alterations of the coronary arteries, degenerations of the cardiac muscle, dilatation of the cavities, and lesions of the aorta, which in reality oftener cause attacks of angina pectoris than mitral lesions? There is no cure for the thoracic angor that results from these grave lesions.

ÆTIOLOGICAL TREATMENT OF ANGINA PECTORIS OF HYSTERICAL ORIGIN.—It would seem that such cases might be easily remedied, that—bearing in mind the hysterical nature of the affection—a preventive treatment might easily be instituted. Practically, however, hysterical angina is very rare, and the cases which have been reported as such have generally been found to be simulated attacks, or real convulsive attacks, of common hysteria with painful irradiations; the diagnosis was at fault. These pseudo-anginas might almost certainly be benefited by hydrotherapy. Were I certain that I had to do with a genuine case of angina pectoris from hysteria, I would preserve the patient from cold douches, which might have a fatal result. These neurotic anginas, almost, if not quite as dangerous as those of organic origin, can be little benefited by the antispasmodics—*asafoetida*, valerian, musk, castor, etc.

RESUME.—The ætiological treatment of angina pectoris is unsatisfactory, and generally unsuccessful; the best that we can do, then, is to treat the paroxysms, and endeavor to prevent their return.

METHODS OF TREATMENT OF THE PAROXYSMS.—In the presence of a patient who is suffering from an attack of angina pectoris, you are to search promptly for something to calm the pain, relieve the breathing, and regulate the circulation. The principal means are, first:

Hypodermic Injections of Morphine.—Hypodermic morphine claims a foremost place by reason of the rapidity of absorption and of physiological action. A centigramme of hydrochlorate of morphine (about one-sixth of a grain) ordinarily suffices to alleviate the pain, which is the principal factor in the paroxysm. I am not afraid to repeat the injection to prevent a return of the angor: I have seen, with one of my hospital colleagues, an old man who was cured of his præ-

cardiac distress—the result of excitation of the cardiac nerves by organic disease—by the daily use, for several months, of morphine subcutaneously. With the same physician I treated still more recently an eminent political personage who finally succumbed to an attack contracted, in the chilly weather of March, by riding in an open carriage at nine o'clock in the evening in the Bois de Boulogne. As he died in spite of morphine it was reported that he died from morphine. Latterly, and since the experiments of Filehne, fear has been expressed that these subcutaneous injections might occasion dyspnœa, and even that dangerous form known as Cheyne-Stokes respiration. This fear can hardly contraindicate the use of the opiate for pain where the element of dyspnœa is absent; if there be any embarrassment of respiration, it is owing to the pain, and nothing else.

Nitrite of Amyl.—Recommended as far back as 1857 by Guthrie, then by Gamgee, Brunton, Wood, more recently by Pick, Guttman, Schram, Otto, of Germany, thoroughly studied in France in 1873, by Amez-Droz, then by Bourneville, and Dujardin-Beaumez, nitrite of amyl constitutes one of the most active and most useful means in the treatment of angina pectoris.

Physiological Effects.—Experimental physiologists—Filehne and Mayerin, Germany, Duceau and Franck in France—have very recently been occupied in investigating the effects of this singular toxic agent, whose *modus operandi* they have defined. First of all, the effects of nitrite of amyl on healthy animals and healthy human beings are as follows:

Action on the Blood-Vessels.—Reddening of the skin and internal organ. The first effect of nitrite of amyl, inhaled in the dose of from two to four drops, is reddening of the face and neck, with red spots on the chest and mottling of the abdomen, but no red markings of the lower extremities. The same reddening is seen in the internal cephalic organs, among others the pia mater, whose blood-vessels are markedly dilated, at the same time that the retina and the lungs remain in the normal state.

Dilatation of the Vessels.—The most remarkable phenomenon, then, is dilatation of the blood-vessels and this is attended with diminution of vascular tension, which may fall to 0.050 millimetre.

Causes of the Vascular Dilatation and Depression.—Either this is a result of paralysis of the vaso-constrictors and the blood-vessels which they innervate (the older and, perhaps, more general view) or it is produced by excitation of the vaso-dilators, as Franck supposes.

Is this paralysis of vaso-constrictors or excitation of vaso-dilators—whichever it may be—of peripheral or central origin? That it is of peripheral origin seems borne out by the experiment of dividing the spinal cord, in which even, the vessels continue to dilate under the influence of the nitrite. If the vessels of the head dilate more readily than the

others, this fact does not favor the hypothesis that the paralysis (or excitation) is of central origin. The blood-vessels of the head are more dilatable, because their middle membrane is more elastic and more muscular. Finally, the proof that it is all peripheral is that you may cut all the cerebro-spinal nerves, and the phenomenon of dilatation by excitations of the vaso-dilator nerves none the less persists.

Action on the Heart.—The heart's action is considerably quickened, and the number of beats rises to double the natural; the nitrite acts on the pneumogastric centre, which is finally paralyzed. At the same time, the force of the heart is undiminished, even if the vascular tension is diminished, which proves that the vascular depression is not an effect of primary enfeeblement of the heart.

Action on the Respiration.—In man one of the most remarkable phenomena from the very commencement is the facility of respiration, whose type, moreover, does not undergo modification; the patient feels that he can breathe more freely. In animals there is, first of all, acceleration of the respirations, which become deeper and more prolonged. With larger doses the respiration becomes slower.

To sum up: in the first period of the action of the medicament vascular tension is lowered, the vessels are dilated, the action of the heart is very much quickened, the respiration rendered more free and easy. At a more advanced period, the pressure remaining lowered, the heart becomes slowed as well as the respiration.

Practical Applications.—In its application to the treatment of angina pectoris, nitrite of amyl produces effects which are remarkable and immediate. I have verified this in two patients, one of whom was affected with Corrigan's disease, with severe nocturnal attacks of angina pectoris. This patient occupied No. 20 Ward, St. Christophe. From the very first exhibition of the nitrite—three or four drops inhaled from the open palm—the paroxysm ceased, instead of lasting fifteen minutes or more, as was the case when the medicine was withheld.

How does this remedy act? It suppresses pain; it facilitates the circulation by dilating the blood-vessels; it renders the respiration more free. And all this is done in an instant almost. Nitrite of amyl, therefore, constitutes the most efficacious and the most prompt of the modifiers of the heart, and especially of the circulation. The sanguineous irrigation by the coronary arteries is increased, is accelerated, like that of the other vessels; the cardiac ischæmia ceases, the heart resumes its tasks immediately, and the respiration, which before was embarrassed, becomes again free. But do not forget that, in going beyond the dose indicated, you expose the patient to the risk of cardiac syncope. Remember, moreover, that the patient, in a sufficiently brief space of time, becomes accustomed to the remedy, so that its good effects become less and less manifest.

Nitro-glycerin.—The physiological effects of this medicament are very much like those of nitrite of amyl. Dr. Murrell, an English physician, was one of the first to call the attention of the profession to this remedy. I have tried it in a few cases, giving internally one or two drops of a one-per-cent. solution; it has seemed to me to give relief.*

Chloral.—Chloral acts very promptly in procuring sleep and in facilitating respiration, but its effects on the circulation are almost nil in these cases. It is not to be depended upon, and I have abandoned its use.

Divers Excitants.—Colin recommends the acetate of ammonium, which is also a favorite with Vignier, in the dose of six grammes.

I shall speak of electricity under the means of prevention. It has no curative power during the paroxysm.

RESUME.—Morphine subcutaneously, nitrite of amyl in inhalations (three to four drops)—these are the medicinal measures which seem to me likely to be relied on in the future. Both diminish the intravascular pressure, and thus facilitate the circulation. But there is a physiological contrariety between these two medicaments which seems to demand elucidation. Morphine does, in fact, diminish the intravascular pressure by giving more tone to the blood-vessels which are made to contract under its influence, but in such a way as to help on the circulation, and thus re-enforce the work of the heart, whose tasks are lightened when the auxiliary vaso-motor forces are in their highest state of efficiency. Nitrite of amyl lessens the blood pressure by dilating the vessels, and thus removing obstacles to the free circulation, and in this way lightening the heart's labor. The circulation by the coronary arteries is thus favored by either mode of action, but in a more marked manner by nitrite of amyl. Moreover, the two medicaments assuage the pain which embarrasses the heart's action, and facilitate respiration, which is also embarrassed.

TREATMENT OF ANGINA PECTORIS IN THE INTERVAL OF THE ATTACKS.—Besides the ordinary recommendations to persons suffering from heart disease, spirit-drinkers in general, and smokers in particular, to abstain from customary excesses, it remains to do what can be done to prevent the attacks by hygienic and medicinal means. Jurine advises persons who are victims to this painful cardiac affection to live in the country, to keep as free as possible from all care and excitement, to inhabit a ground tenement, to walk and ride a little every day. This advice would be very good if it were practicable.

* Mr. Field, of Brighton, England, was the first to describe, twenty years ago, the physiological effects of nitro-glycerin. Dr. Murrell afterward repeated the observations of Field, trying it on thirty-five patients. The action of nitro-glycerin is a little slower than that of nitrite of amyl.
—TRANSLATOR.

The medicinal measures which I employ habitually are: 1. Bromide of potassium; 2. Digitalis; 3. Electricity (hardly habitually, but it deserves mention); 4. Arsenic (of which the same may be said); it is sometimes of use as a vaso-motor tonic, but its action is doubtful.

Hydrotherapeutics ought to be absolutely proscribed.

1. Bromide of potassium determines contraction of the blood-vessels, calms the nervous system (particularly the centres of special sense), and induces sleep; it is a regulator of the peripheral movements of the blood. Under its action the patient becomes less impressionable to the physical and psychical influences which might provoke a return of the paroxysm. But this medicine has the grave inconvenience of producing a debility which is more or less permanent, and can not be continued with impunity beyond a certain time.

2. Digitalis, when the thoracic angor results from cardiac atony or degeneration, presents a real advantage over the bromide; it fortifies and sustains the action of the heart, and is in every way the preferable medicament.

3. Electricity has been applied in divers way, and in accordance with the different theories which have been put forth as to the nature of the malady. If employed from confidence in the pneumogastric-nerve theory of Eulenburg,* and an attempt be made to galvanize this nerve, you run the risk of arrest of the heart's action, the unfortunate case reported by Duchenne is in proof of this.

If you desire to influence the sympathetic alone, in accordance with the theory of Martin and Hachard, there is a practical difficulty in the way, and, moreover, a physiological heresy lurks behind the theory. There is, in fact, no paralysis of the sympathetic to overcome. The disease is in reality attended with excitation of the cardiac sympathetic nerves, and the coronary vessels, the latter being in a state of erethism—there is no paralysis in the case; on the other hand, there is not even excitation of the sympathetic nerves in general, accompanied by a contraction of the blood-vessels in general. The disease (so far as the nerves implicated are concerned) being partial and limited, how are you going to benefit the pathological condition by electrical currents applied to the sympathetic trunk or plexuses? If it were possible to galvanize the cardiac sympathetic nerves, would you not augment rather than diminish vaso-motor contractility? The subject demands further study.—*N. Y. Med. Journal.*

* Eulenburg, "Traité des maladies nerveuses," 1878. He describes two forms of the disease, one of which is due to direct excitation of the vagi nerves, the other to reflex excitation of these nerves. He also describes two other varieties of different nerve origin.

RETENTION OF URINE FROM ENLARGED PROSTATE—RETENTION FROM STRICTURE OF THE URETHRA—CHRONIC ENLARGEMENT OF THE TONSILS—HYDROCELE.

A CLINICAL LECTURE DELIVERED AT THE HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA.

By JOHN ASHHURST, Jr., M.D., Professor of Clinical Surgery in the University of Pennsylvania.

[Reported by Wm. H. Morrison, M.D.]

GENTLEMEN: The first patient whom I shall show you to-day is one on whom I had intended to operate for stricture, but as he is not very well this morning, I shall postpone the operation until another occasion. I bring him before you for the purpose of making some remarks on retention of urine, which was the condition for which he was admitted. As I have told you on a previous occasion, I had in this case to tap the urethra behind the stricture to relieve the retention. I want now to use this patient in connection with one who presented himself about ten days ago, as an illustration of some varieties of retention of urine.

The latter patient came to us suffering, as he supposed, from incontinence of urine. His statement was that for a year his water had been running away from him, that he had required to urinate very frequently, and that it had been impossible for him to keep his clothing dry, and he supposed that he was suffering from paralysis of the bladder. Not only was this his own diagnosis but it was also that of the physician who had attended him, for he had been taking all this time one of the preparations of strychnia to give tone to his nervous system, and thus to relieve what was supposed to be incontinence. Whenever you find what is called incontinence in a man past middle age, you should suspect that there is something below what appears on the surface. True incontinence is a very rare affection in adults. In children we often have what is termed nocturnal incontinence, and sometimes such a weakness of the organs as will allow the urine to escape during the day, but we meet with this condition in adults only under exceptional circumstances. In disease of the spine there may be after a time complete paralysis of the bladder, and then true incontinence occurs, the urine flowing out of the urethra as fast as it flows from the ureter. These cases are, however, very rare, and whenever you have incontinence in an adult man past middle age, you should always suspect that there is enlargement of the prostate. Stricture of the urethra does not usually give rise to incontinence. There may be very frequent micturition, but there is not apt to be the constant dribbling which often attends prostatic hypertrophy. In enlargement of the prostate there is often great distension of the bladder. This condition may also be present for a short time in stricture, but the pain is then so great that the patient soon calls attention to his condition.

In enlargement of the prostate, however, the distension comes on gradually; the patient does not entirely empty the bladder; when he passes his urine a certain portion remains. This is called the residual urine and varies in amount from one to two ounces. You can easily understand that the bladder, never being able to completely empty itself, the accumulation may go on until the bladder becomes full. The retention comes on so gradually that the patient is usually not aware of it. When the bladder becomes entirely full, so full that it will hold no more, there is of course an overflow; so it is that a patient who really has retention, imagines that he has incontinence.

This was the condition in the patient of whom I am speaking. There was enlargement of the prostate, and the residual urine gradually increased until the bladder was distended to its utmost capacity. Then the water that passed into the bladder simply overflowed through the urethra. The patient was in this condition for a year, taking strychnia, but, as you can easily understand, without any benefit. Suspecting something of this kind I asked him to lie down. I then percussed above the pubes, and found marked dullness and a distinct tumor. Passing a catheter, which was done without any trouble, I drew off three and a half pints of urine, to the patient's great relief, and to his equally great astonishment. In a few days he again returned, having in the meantime purchased an elastic catheter. The instrument was again passed and showed that there had been some reaccumulation of urine, but not to the same extent as before. Dr. Dunn then instructed him how to use the catheter, and he was told to draw off the residual urine once or twice a day.

In all these cases of enlarged prostate; the urine should be drawn off at regular intervals. If this is not done, the urine undergoes change, becoming ammoniacal, cystitis is set up, and, at a later period, we have developed that form of renal disease which is called "surgical kidney." The cystitis not only causes chemical changes in the urine, but the very presence of ammoniacal urine increases the cystitis, so that the two conditions react one on the other. After a time a certain portion of the excrementitious matters remain in the blood, and we have the condition known as ammonæmia, and ultimately perhaps distinct symptoms of uræmia, with dropsical swellings and coma.

In this young man we had retention from a different cause. It was caused by a stricture of the urethra, the result of an old gonorrhœa. When first admitted he was suffering greatly from retention of urine. As I have said, the accumulation in the enlargement of the prostate is so gradual that the patient is not aware of it. Sometimes there will be a sudden enlargement of the prostate from cold or from some exposure, and then the patient will suffer from acute retention, but usually the retention comes on so gradually that it causes no pain.

In stricture, however, the onset is very different—it is sudden. There has been for a long time a gradual contraction of the urethra, until finally the patient passes but a very small stream. At last comes a day when, from spasm or from some inflammatory condition, the urethra entirely closes. There will then be great pain, constant efforts at micrurition, and the development of a large suprapubic tumor. In this patient we had dullness reaching almost to the umbilicus.

Before admission, efforts had been made to relieve the retention by the use of instruments, but they were not successful. Not only were they not successful, but a false passage was made. As I have said, when admitted to the hospital this patient was suffering greatly, and the question arose as to what should be done. Our resident surgeon, Dr. Dunn, made one attempt to pass the catheter, but not being successful he immediately desisted, put the patient into a warm bath, and gave him full doses of opium. This is the best palliative treatment that you can adopt in retention from stricture. Under this treatment, the patient in a few hours relieved himself. The congestion which had caused the attack had subsided. When I saw him he was passing water in a small stream, and frequently. Two days later, another attempt was made to pass an instrument into the bladder, but without success. Whether from the irritation thus produced, or from other causes, I cannot say but on the fourth day retention again occurred. When I saw the patient he was suffering greatly, and there was again a large tumor reaching almost to the umbilicus. The patient could hardly keep still on account of the pain.

I have learned from experience that when a patient is in this condition, it is not safe to leave him before securing the evacuation of his bladder. Some years ago a patient with retention from stricture was under my care in another hospital. I endeavored, without success, to pass the instrument. I divided one stricture in the anterior part of the urethra, but there was one farther back which prevented the introduction of the catheter, and which it was evident would require external section. As it was late in the day, I concluded to postpone the operation till the next morning, leaving instructions that if the symptoms became more urgent the bladder should be aspirated. My instructions were not carried out, but a few hours after midnight the information was sent to me that the urethra had burst, and that urinary infiltration was taking place. When I reached the patient, I found that the urethra had given way behind the stricture, that the urine had escaped into the cellular tissue of the scrotum and thighs, and that the scrotum was becoming gangrenous. There was nothing to be done but to make free incisions into the scrotum and soft parts of the thighs, and then to puncture the urethra behind the stricture. If the bladder had been full I should have aspirated, but as the urine had escaped into the cellular tissue it was necessary to make openings to drain it away.

The patient, unfortunately, did not recover; he lived for some two or three weeks. After the operation, he had no further trouble with his urine, but succumbed to the sloughing of the scrotum and other tissues.

Hence I tell you that it is not safe to leave a patient in this condition without relief. It is not safe to rely upon other people to do what is proper. It is better to anticipate by a few hours than to run any risks.

When I found that I could not pass the instrument in this present case, that its introduction produced urethral hemorrhage, I decided to relieve the retention by a more radical method. I should have aspirated, but that our aspirator was out of order. I, therefore, adopted the next best plan—it is really perhaps as good as aspiration—that is, tapping the urethra behind the stricture. This, which is known as Cock's method, is a very simple operation if you are familiar with the anatomy of the parts. The patient is placed in the lithotomy position. You first pass the index finger of the left hand into the rectum, and fix the apex of the prostate, the point where the membranous joins the prostatic portion of the urethra. An incision half an inch long is now made in the raphé, in front of the anus; next a slender knife with a sharp point is introduced into the wound in front of the anus, and with its back towards the rectum, and is passed backwards towards the bladder, being guided by the sensation of the finger of the left hand to the point where it is designed to open the urethra. We know, as has been pointed out by Sir Henry Thompson, that stricture does not affect the prostatic portion of the urethra, or that, if it ever does, it is an exceedingly rare occurrence. In this operation, therefore, you are pretty certain to get behind the stricture. This procedure, of course, would not be applicable to cases of retention from enlarged prostate. Having introduced the knife, as I have described, push it cautiously onwards, and then cut forward for about half an inch, thus making an opening into the urethra just at the apex of the prostate. A grooved director is to be passed into the bladder, and the urine will then probably begin to flow. It is better while the director is in the bladder to pass in through the wound a flexible catheter.

This is what I did in this case, and here I show you the wound half an inch in front of the anus and in the median line. The guides in this operation are the apex of the prostate as ascertained by the finger in the rectum, and the median line as marked by the raphé. There was a little oozing of blood, which we checked by packing lint around the catheter, just as we would in hemorrhage after lithotomy. The lint and catheter were removed in a few days. The patient has had no further trouble with his water. He now passes it as a woman does, through the perineum. He has complete control, because the sphincter is behind this opening. The only inconvenience is that he has to sit down to urinate.

As I said to you last week, it is proper when you have a patient in this condition to put the question to him, whether or not he wants anything further done. In a case on which I operated two or three years ago, where a portion of the urethral tract had been wholly obliterated, and where I established a new passage through cicatricial tissue, the patient found so much difficulty in keeping the passage open that he finally concluded to let it close again, and to be satisfied with urinating through a fistula in the perineum.

CHRONIC ENLARGEMENT OF THE TONSILS.

The next patient is one on whom I expect to perform an operation which I am not in the habit of doing, and one which I do not recommend; but we must judge each case by itself. This young man has enlarged tonsils. He wishes to enter the navy, but has been rejected on that account. I have no doubt that in the course of a few months, we could reduce the size of the tonsils without an operation, but I think that the particular exigencies of the case justify the use of the knife in this instance. Some surgeons do this operation with great freedom, but I do not like to perform any operation when I think the case can be cured without it. The old plan of performing this operation, and a good plan it was, was described by the older surgeons in the words, "volsello excipere et scalpello excidere," that is to say, catch the tonsil with the fulsellum forceps, and cut it off with a blunt-pointed knife. The only precaution to be adopted is to cut towards the median line, and not towards the side. If you cut towards the side, you run some risk of wounding the carotid artery or the internal jugular vein. The modern plan is to use a guillotine; the best is the one devised by Fahnestock, and since modified by various French instrument makers. It consists of a ring which surrounds the portion of the tonsil to be removed, a fork which is pushed forward and holds the tonsil, and a concealed knife which cuts off the slice intended to be removed.

These tonsils are so large that I can remove but small portions of them, but this will be sufficient to start the process of involution. Occasionally there is troublesome hemorrhage after this operation. For this bleeding, one of the best applications is a gargle of turpentine. This has been recommended by Prof. Erichsen, and is, I believe, as good a mode of stopping the hemorrhage as can be adopted. The plan which I recommend, and which I believe to be always successful if properly carried out, is the application of iodine. If you simply paint the tonsils with the tincture of iodine, you give a great deal of pain, and the application is not effective, because the patient has to wash away the iodine on account of the pain. The application which I use is composed of equal parts of tincture of iodine and glycerine. The glycerine renders the iodine less painful, and at the same

time it is retained longer in contact with the tonsil. You may, in addition, use iodine internally in the form of the iodide of iron. I have never failed by this method (the application of iodine and glycerine and the internal administration of iodine) to reduce the enlargement. The tonsils may be painted about twice a week. This requires several months to effect a cure, and if the patient is in a hurry you will have to adopt some other plan.

HYDROCELE.

This patient presents an affection with which you are all familiar. You say at once that this is a hydrocele. You see the pyriform shape, which is characteristic. It has also an elastic feel, and, perhaps more distinctive than anything else, its weight is not great in proportion to its bulk. The differences between hydrocele and hernia are marked. If you invaginate the scrotum with the finger, you will find in hydrocele that the external ring is clear; but in hernia you will feel a tumor extending into the inguinal canal, and find that the ring is not clear. Sometimes you have a source of confusion in the existence of hydrocele of the cord in connection with hydrocele of the tunica vaginalis. In these cases you have to resort to other tests. Another test for hydrocele is that by transmitted light. It is not always practicable, however, to make use of this test, which may fail on account of several sources of error. Thus, the pigment of the skin may prevent the passage of light. If the patient be a colored man, or deeply pigmented, this test may fail. Again, the tunica vaginalis may undergo such changes as will prevent the transmission of light. Many years ago, when I was a house surgeon, I remember a patient who came to the hospital with a scrotal tumor. It was examined by transmitted light, but no light could be seen through it. The surgeon, therefore, decided that it was a tumor of the testicle and proceeded to remove it; but at the first incision there was a gush of fluid which showed that it was a hydrocele after all. The tunica vaginalis had undergone calcareous change, and the plates of calcareous matters had prevented the transmission of the light. This patient does not wish to have the operation for radical cure performed. It is not convenient for him to remain in the hospital at present, but at some future time he will return. The only precautions to be observed in tapping a hydrocele are, in the first place, to have the trocar in working order. I have seen a surgeon tap a hydrocele, and then find that the trocar was so firmly rusted to the canula that it could not be removed. The second precaution is to avoid the superficial veins. The third is to introduce the trocar perpendicularly to the surface of the hydrocele, and as soon as the trocar has entered the tunica vaginalis, to depress the handle of the instrument. If you push

it straight forwards, you run the risk of puncturing the testicle, which does no particular harm, but certainly does no good, and you may bury the trocar so deeply that no fluid will flow. The rule is, as soon as you have the instrument well into the tunica vaginalis, to depress the handle. Another precaution is to remove all the fluid, and allow none to escape into the cellular tissue. It may do no harm—in fact one of the methods of treatment is to allow the fluid to escape into the cellular tissue—but it may produced suppuration.

You now see the fluid escaping. It is of a straw color. Occasionally you have fluid of a different appearance. After a hydrocele has been tapped more than once, a marked change in the character of the fluid may occur. It may coagulate spontaneously. This is not met with unless the hydrocele has been tapped before, and is probably the result of a slight inflammation. The fluid is always coagulated by heat.

Then we have encysted hydrocele, in which you may have present a milky fluid contained spermatozoa. Many cases, but not all, of encysted hydrocele are properly called spermatocele. These are cysts formed in connection with the spermatic structure. One form of encysted hydrocele is that in which the fluid is contained in a portion of the tunica vaginalis, separated from the rest by adhesions; such a case is not properly called a spermatocele. If in any case the fluid which escapes after tapping gives you reason to suspect spermatocele you should caution the patient how he goes about afterwards. Some years ago I tapped one of the largest hydroceles I ever saw, and found the fluid of this character. Although I cautioned the patient against moving about, he went to market, and carried a heavy basket. The result was that he had inflammation of the sack, and was confined to bed for five or six weeks. This might have been avoided if the patient had kept quiet for a few days. While in a case of simple hydrocele, you may safely allow the patient to go about after tapping, you should, if you find that peculiar character of fluid which indicates a spermatocele, caution him to keep quiet.

It is said that the radical cure of hydrocele may be effected by the use of pressure. It is said that if the parts are strapped with adhesive plasters or the gum-elastic bandage further accumulation will be prevented. But simple tapping, without any other treatment, will sometimes effect a cure; and it is possible, therefore, that those cases which, it is alleged, have been cured by pressure, would have been cured by tapping alone.

I now apply a little strip of plaster over the opening made by the trocar. The patient should wear a suspensory bandage. If the sack again fills and he desires a radical cure, he will return.—*Med. Bulletin, Phil.*

ANÆSTHESIA IN OBSTETRICS.

By DR. JUST. LUCAS CHAMPIONNIERE.

(Translated by D. C. Holliday, M.D.,

The administration of chloroform to women in labor is one of the most interesting subjects to obstetricians in general practice.

It is a well-established fact that if the majority of our confrères are obliged to allow a large number of their female patients to go through labor without assistance, there is a certain number where the use of chloroform would be easy, and others when its use becomes a necessity.

It must be admitted that we are at present without a recognized and satisfactory guide on this important point.

Many trifling publications have appeared. *Campbell* published the first part of an interesting-pamphlet on this subject, but, unfortunately, death prevented its completion.

A number of articles have appeared from time to time; some good ones among them we might mention, especially an excellent thesis by one of our former pupils Dr. Despian, entitled "*Etude Clinique du Chloroform dans les Accouchements Naturels*, 1879."

The question, however, is somewhat neglected, and we hail with pleasure the recent publication of an excellent thesis of 350 pages on this interesting subject by one of the distinguished pupils, of our Parisian Hospitals, *Dr. Dutertre*, entitled "*de l'Emploi du Chloroform dans les Accouchements Naturels*."

This work treats fully of the history, the physiology, and all details of the use of anæsthetics in obstetrics.

The author, with singular tact, has purposely and wisely avoided too extended clinical discussion for the excellent reason of his own youth; nevertheless, this volume contains all that is necessary for any one to make an exhaustive study of the subject. Everything is clearly expressed, with great originality in style, which in nowise detracts from its interest.

M. Dutertre, having carefully studied the physiology of his subject, clearly demonstrates the great necessity of the use of *pure chloroform*, an idea which we ourselves have recently called special attention to.

The perusal of this work brings forcibly to our minds the similarity of our teachings on this subject, and we cannot but think that our readers will thank us for the further discussion of those practical and clinical facts bearing on this subject without a repetition of what we have already published.

Those authors who deny the practicability and usefulness of producing in a woman during labor a semi-anæsthetic condition compatible with consciousness, have done so without sufficient practical experience.

All discussion falls to the ground when disproven by extensive clinical trial and experiment; such has been my course not only in private practice but in the wards of one of the most extensive hospitals in France.

The method of using anæsthetics must differ essentially from that usually employed during ordinary surgical operations. In exceptional cases the inhalation must be slow and progressive.

Ordinarily from ten to twenty minutes is required to produce calmness, and a semi-anæsthetic condition; this is a result extremely difficult, not to say impossible to obtain, unless the patient is docile and willing.

Some women require but an extremely small quantity of the anæsthetic—twenty to thirty grammes for several hours. However, should the condition of semi-anæsthesia be required to be kept for many more hours, from 60 to 100 grammes up will be necessary.

When I order chloroform I usually divide it into two vials, 50 grammes each, and I rarely find it necessary to employ more than one vial, unless operative interference is required, and it becomes essential to make anæsthesia complete.

For a long time I taught that some women required much larger quantities of chloroform to produce the same effects, say 100, 150 to 200 grammes. But since I paid attention to the *quality* of the chloroform used, now only prescribing the purest to be obtained, I find these differences far less marked.

Indeed, the attempt to produce semi-anæsthesia by the use of ordinary chloroform is to court failure.

There are some women, in whom, without producing positive muscular relaxation, it is necessary to push the anæsthesia to a partial loss of consciousness before perfect calm is reached.

In case of necessity this is productive of no ill effects. I have myself maintained a state of complete anæsthetic insensibility, or coma, varying from three to seven hours, without danger.

Among other cases I will cite one, where I performed Porro's operation, on a woman who had already been fully under the influence of chloroform for three hours; the operation required one full hour for its completion, and the patient recovered without a bad symptom. Here, there was the absorption of 370 grammes of chloroform.

I merely mention this to show that large quantities are often tolerated. I have already stated that the period of dilatation of the uterus was frequently appreciably shortened by the early use of chloroform; hence my rule is never to wait for the expulsive stage only, for commencing its use.

No definite time can be fixed for the continuance of anæsthesia; this necessarily varies in different cases. Two or three hours are usually sufficient; eight or nine hours or more, may become necessary.

In many of those cases requiring a prolonged use of the anæsthetic I have carefully followed up their subsequent history, and in no single instance have I been able to discover any injury either to mother or child.

Is the use of chloroform during labor absolutely without danger? This may be positively affirmed, if used in the manner we have pointed out.

Does this mean that no precautions are necessary in its use? Most certainly not. It is not, however, because death is at all to be dreaded in its use.

M. Dutertre in his excellent thesis shows with what eagerness the opponents to the use of chloroform, detail facts and observations in support of their position, which upon careful examination are proved to be fallacious, and often even ridiculous.

Those, however, who make a daily use of chloroform recognize that they often meet with threatened accidents which should never be neglected, showing individual idiosyncrasies forbidding its use.

No one more than myself has insisted upon these peculiarities, and our readers are already fully aware of my views, elsewhere expressed.

According to their peculiar willingness to adopt or reject the method of using chloroform advised, some authors recognize more or less cogent reasons for its indication.

It may be stated briefly, that pain is the only true indication; where pain is really severe, or where it is really unbearable; whenever pain is *excessive*, no matter at what stage of labor, recourse may be had to chloroform.

Its early employment undoubtedly accelerates, rather than retards, the progress of labor, for the excellent reason that the uterine contractions subsequent to the use of the anæsthetic, soon revive after a period of marked relief, and continue with more regularity and force.

A certain degree of rigidity of the cervix readily yields to the effect of chloroform, but this happy effect cannot always be expected if this rigidity has been allowed to continue for many hours. When a woman in labor has suffered intense pains for a long time it becomes the duty of the medical attendant to administer chloroform. Often in these cases the necessity for *immediate* effect renders it imperative to push the chloroform to perfect anæsthesia, for it is a recognized fact that in a woman thoroughly enervated by long suffering it is much more difficult to obtain the satisfactory effect of chloroform.

The contra-indications to the use of chloroform have been detailed by many authors with such fanciful precision as to show that they are not the result of experience.

Thus a cardiac affection is considered a contra-indication to its employment.

It has been my good fortune to have had many excellent opportunities to prove the contrary, and I shall proceed to mention one among many cases.

The subject was a lady affected with a congenital affection of the heart, when, by the judicious use of chloral, pregnancy had been prolonged to full term, after a series of previous miscarriages. Thanks to the early use of chloroform every stage of labor was accomplished with ease and rapidity, notwithstanding a rather stormy beginning, and by

the application of the forceps at the inferior strait she was delivered of a child, weighing upwards of 4 kilogrammes.

It is very certain that to relieve fruitless effort, and prevent continued muscular contractions, is a positive benefit to the heart.

A dense pulmonary affection may be a contra-indication; here the physician's responsibility becomes much greater.

Pulmonary lesions may be rendered threatening, if the anæsthetic be pushed too far. Nevertheless, I have frequently used chloroform freely in different stages of phthisis, and once even during the course of pneumonia with the best possible result both for mother and child.

Are any accidents to be feared? I have mentioned phenomena of apnoea, many of which are undoubtedly attributable to the bad quality of the chloroform.

However, I have no doubt that rare and exceptional cases may be met with.

Inciting the thorax and insisting upon free respiratory efforts, on the part of the patient, are followed by their rapid disappearance.

Can vomiting be the result of its protracted use? This is not absolutely impossible, yet I have rarely seen it; but I have frequently seen chloroform put a stop to obstinate vomiting during labor.

Possibly the most important objection made against the use of chloroform is that it favors the occurrence of hemorrhages.

A careful examination of the testimony of various authors proves that their opinions are simple allegations rather than established facts.

A careful review of our own observations does not at all corroborate the truth of these allegations.

On the contrary, if we did not hesitate to assert facts without proofs, we would be inclined to believe that chloroform rather prevents the repetition of useless uterine contractions, and puts the patient in better condition for permanent uterine contraction. This appears to be the result in a number of cases.

The same may be said with regard to the puerperal condition. Not only has it been equally satisfactory, but the return to health has often been more easy and rapid.

Another *theoretic* objection has been raised, claiming the deleterious effect of chloroform on the infant. First, the patient rarely takes much chloroform; however, admitting that she took a great deal, I have never, in a single instance, noted any injurious effects on the child. A fact too, worthy of remembrance, is that a new-born infant bears chloroform very well.

It is probable that anæsthesia in obstetrics might be produced by the greater number of recognized anæsthetics. I, myself, have only tried ether, and the bromide of ethyl.

Both have appeared to me inferior in action to chloroform. Ether, without a special apparatus, fills the room with dangerous vapor, its action, too, is too slow. Bromide of ethyl emits a nau-

seous vapor, very disagreeable even to the accoucheur himself; its action is much slower, and not by any means less dangerous than chloroform; on the contrary, notwithstanding the hopes entertained of its many advantages, by its early advocates, the record of its use in general surgery has been that of frequently producing most formidable accidents.

In general practice, it should be borne in mind, that chloroform used to produce partial anæsthesia, and pushed to *complete* anæsthesia where occasion requires it, is of such great use that the accoucheur should never be without it. The chloroform used should always be chemically pure.

At the same time that I always have pure chloroform at my disposal, I also provide myself with reliable *ergotine*—whether we simply use it hypodermically in case of hemorrhage, or where you make a systematic use of it as I do, after all deliveries.

After complete anæsthesia, the use of *ergotine* is far more reliable than any preparation of ergot.—*N. O. Med. and Surg. Journal.*

CURE OF ABSCESSSES WITHOUT CICA-TRICES.

Dr. Quinlan recommends the passage through the abscess of a fine silver wire, which, with the ends tied outside, will act as a drain. This must be done before the pus reaches the surface, when it is, say, half an inch from the external surface. No poulticing must be used, and when the abscess is evacuated a compress applied. This procedure has never failed in his hands.—*Med. and Surg. Reporter.*

GARGLES.

GARGLE IN TONSILLITIS AFTER THE ACUTE STAGE AND IN RELAXED SORE THROAT.

℞. Acid. hydrochlorici dil., $\frac{3}{4}$ 3; mellis depurati, $\frac{3}{4}$ 1; infus. rosæ acidi, ad. $\frac{3}{4}$ 8. M. Sig.—As gargle.

GARGLE IN APHTHÆ AND ULCERATIONS ABOUT THE FAUCES.

℞. Boracis, grs. 160; tr. myrrhæ, $\frac{3}{4}$ 1; aquæ, ad. $\frac{3}{4}$ 8. M. Sig.—Gargle.

IN ULCERATION AND FISSURE OF THE TONGUE.

℞. Boracis, grs. 60; glycerini, $\frac{3}{4}$ 12; aquæ rosæ, ad. $\frac{3}{4}$ 4. M. Sig.—To be painted over the fissured surface.

GARGLE IN CHRONIC INFLAMMATION OF THE FAUCES.

℞. Boracis, grs. 180; syrupi scillæ, $\frac{3}{4}$ 1; aquæ, ad. $\frac{3}{4}$ 8. M. Sig.—Gargle.

IN CHRONIC GINGIVITIS, ULCERATION, LOOSENING OF THE TEETH.

℞. Tinct. myrrhæ, $\frac{3}{4}$ 4; acid. tannici, gr. 35; Eau de cologne, $\frac{3}{4}$ 12. M. Sig.—Sponge the gums with this preparation three or four times a day.—*Med. Gazette.*

HOT WATER IN THERAPEUTICS.

Several years ago I learned in my personal experience that no agent relieves nausea and vomiting so satisfactorily and promptly as water as hot as can be drunk. Since then, I have used it in a large number of cases, and it has been uniformly reliable. The following classification may be made of the cases in which it has been used :

(1.) Cases in which nausea and vomiting occurred at the onset or during the course of acute febrile disease.

(2.) Cases in which these symptoms were caused by overloading the stomach when its functions had been impaired by protracted disease.

(3.) Cases in which they were produced by nauseous medicines (not emetics) at the time they were taken.

(4.) Cases of acute gastritis caused by the ingestion of irritants.

(5.) Cases in which these symptoms were purely reflex.

(6.) Cases of chronic gastritis.

(7.) Case of colic in newly-born infants.

(8.) Cases of flatulent distention of the stomach.

Among the cases of Class 1 was a case of diphtheria and one of puerperal septicæmia, as well as one of tuberculosis, in which the stress of the disease fell upon the digestive apparatus. In each of these a half-glass of hot water always gave prompt relief when every other remedy failed. The most impressive and permanent results of this remedy seem to be in cholera infantum—hot water being retained when everything else was rejected; and it would so compose the stomach that food could be given almost immediately afterward.

The nauseant medicines mentioned in Class 3 are often retained if given in hot water as a vehicle. When an enormous quantity of whiskey has been drunk, and the stomach will not tolerate anything else, hot water will be retained, and then food can be given.

Hot water is less satisfactory in vomiting of pregnancy, yet it is of considerable value in many cases.

In the various manifestations of indigestion, classed 6, 7 and 8—hot water is almost invariably followed by good results. In dyspepsia it may be given before each meal, as well as at other times, to cause the discharge of any undue amount of gas in the stomach by eructation. In this way it affords relief to young infants suffering colic, and it is rarely necessary to prescribe anything else. It has been used successfully in a case of severe palpitation of the heart from dyspepsia.

The *decongestive* and hæmostatic action of hot water have been variously accounted for by gynecologists. Dr. Pitcher, of Detroit, thought that when applied to a bleeding vessel, the immediate effect is dilatation, which sufficiently slows the current to form a clot; and constriction occurring, afterward, the clot is firmly held and the lumen of the vessel closed.

Dr. Emmet says that the direct result is relaxation of the coat and vascular turgescence; afterward, if continued, reaction follows and contraction occurs.

Carl Ritcher, of Berlin, thinks "the contact of the hot water with the partially denuded inner wall of the uterus causes a slight inflammatory irritation, an oedematous transudation, and a swelling of the tissues, principally the submucous, intermuscular, and perivascular connective tissue, by which the blood vessels become compressed and their lumina thereby occluded."

The action of hot water upon the uterine or gastric mucous membrane or upon abnormally full or bleeding vessels in any part of body, may be readily and simply explained by a well-known physiological principle, viz: That of watching a frog's foot while a needle is drawn across without injuring the membrane. The vessels will presently contract and close, and after remaining so for a few minutes, will dilate to respond no more, or only partially, to such stimulus. With a stronger stimulus, as that of gentle heat, they will again contract, and such contraction may be lost a day or two.

Wharton Jones found that cold causes speedy constriction, quickly followed by dilatation.

Beaumont, in his observations on St. Martin, found that the ingestion of cold water was followed by blanching of the gastric mucous membrane, quickly followed by more than normal redness. Now, from whatever cause nausea and vomiting may arise—from the direct contact of an irritant, or the effect of an emetic, or from reflex nervous influences, it is certain in many instances, and probable in all others, that the vaso-motor centers controlling the gastric blood supply are also influenced and gastric hyperæmia produced; and this condition being the link in the causal chain which is broken by the contact of the hot water on the gastric lining, the effect fails to follow. In flatulent distention of the stomach the muscular coat, impeded by the gaseous pressure, is excited to extraordinary work, and the gas is expelled. Patients who begin taking hot water to allay nausea, can not only take large quantities without inconvenience, but get to liking it; and at times, when little or no water can be taken, by drinking it hot, enough can be retained to fully meet the requirements of the organism. This fact has an important bearing in therapeutics. Often in both acute and chronic diseases, the issue depends solely on the amount of work that the kidneys will do. In many diseases, the structure of these organs, though not primarily affected by the morbid process, is liable to damage secondarily. The injury may be due rather to the concentration of the urine—the small amount of water—than to the absolute amount of solids; so that the kidneys become clogged with destructive, effete matter if sufficient water fails to flow through them. But dilution of the urine is not the only good resulting from the free drinking of water. The skin is put to work and carries off a large portion of the effete matter that would otherwise have to pass through the kidneys.—*Dr. Douglas Morton, in Louisville Medical News.*

LACTOPEPTINE IN THE GASTRIC DISORDERS OF CHILDREN.

By AMREY HUSBAND, M.B., C.M., B.Sc., F.R.C.S.,
Medical Officer to the Royal Dispensary, Edinburgh.

Of all the disorders to which young children are liable, those affecting the digestive organs are at once the most common and the most fatal. It has been calculated from the Registrar-General's report that one-quarter of the deaths among children under five years is due to diseases of the digestive organs, and this fatality is considerably greater under one year. Passing from these general considerations, I would specialise one or two diseases which, from their constant recurrence, cannot fail to attract attention, and in which I was enabled to watch the effect of LACTOPEPTINE.

The cases were those of rickets, and of so-called infant atrophy with dyspepsia and diarrhoea. The following cases are of this type :

"1.—C. D., æt. 3. The little patient had all the symptoms of rickets. She had a heavy, stupid look, the chest much contracted laterally, and the bones of both legs and arms much affected. She vomited occasionally. She was ordered 5 grs. lacto-peptine after each meal, and under this treatment the child gradually—and then rapidly—improved."

"2.—M. H., æt. 2. This child was found suffering with symptoms of gastric derangement, colic, vomiting and loss of flesh. As the diet had always consisted of anything that could be obtained from dried cod and cheese, and as there was no chance of providing more suitable food for the child it was hoped that, by the aid of lacto-peptine, the diet might be made more digestible and nourishing. Accordingly, 5 grs. lacto-peptine was given daily after food, and the result was more favorable than was expected, the little patient after a short period becoming quite well.

"3.—I. M., æt. 7½ years, was evidently of strumous habit, losing flesh rapidly; felt pain after taking meals. He could not take cod liver oil. There were no chest symptoms. He was ordered 5 grs. lacto-peptine three times daily, which was continued for a month, then he was able to take the oil, and speedily recovered.

The above cases serve to demonstrate the value of LACTOPEPTINE in the treatment of gastric disorders of young children. In two cases of children of a mother in the last stage of phthisis, the lives of the babes were saved by its use.—*Medical Press and Circular, London (Eng.)*.

THE SWALLOWING OF A SILVER HALF-DOLLAR.

A peculiar case is that described by Dr. C. E. Webster in the *Boston M. and S. Jour.*, May 31, 1883. The coin lodged transversely in a vertical plane, so that a sound could pass it without obstruction, thus giving rise to the opinion that it had passed on into the stomach. The patient died from hæmatemesis, the result of two small ulcerations and consequent perforations into the aorta at the site of lodgment of the coin.

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THE CHOLERA.

Although it is not probable that cholera will visit Canada this summer, yet in view of its rapid spread in Egypt, its prevalence in India, and its reported presence in London, our sanitary authorities should bestir themselves to prepare the city against its possible advent. By being forewarned, we should in this matter be forearmed, especially when we reflect that in the tide of emigration now pouring into the country, lies the element of greatest danger. Though apparently secure, we must not forget that any day an emigrant ship may bring the cholera to our very doors. A recent article in the *Pall Mall Gazette* gloomily prophesies the rapid spread of cholera over the whole world. The writer, Dr. Jenkins, maintains that two types of cholera, the *Arabian* and the *Indian*, occur in the East. The *Arabian* variety is the one which has hitherto spread over Europe, and, according to Dr. Jenkins, it is this type which is now raging in Egypt. But be that as it may, it is now generally admitted that thorough sanitary organization affords the best means of preventing the entrance of cholera, modifying its virulence, and limiting its spread. To the Government belongs the important duty of securing the careful medical inspection of all incoming vessels, the detention and prompt isolation of suspicious cases, and thorough disinfection of infected vessels; while upon the civic and municipal authorities devolves the no less important duty of maintaining the sanitary condition of towns and cities as perfect as possible. And it is here in order to ask our Health authorities, what special efforts they are making to improve the sanitary condition of Montreal. Can nothing more be done to remove filth from court-yards and lanes, reform the system of scavenging, and improve the drains?

Much remains to be done, but, unfortunately, the City Council and Board of Health do not seem to realize the danger or understand what is expected of them, while the sanitary officials are unable to carry out needful reforms, because they are not adequately supported by the civic by-laws. Quite recently a man who has the reputation of owning some of the worst-drained and foulest-smelling hovels in the city was prosecuted by the Health authorities for refusing to remove some open sewer-troughs, which were rendering pestilential the air of a whole court-yard. The facts were undisputed; but, as the law did not quite cover the case, the delinquent was discharged, his pestiferous troughs still remain polluting the air, and he practically defies the Health authorities. Such things should not be, if we expect our sanitary condition to be satisfactory; the Health Department must be sustained in its efforts for the general good, not crippled or embarrassed. If we are to be prepared for the cholera, now is the time to act, not when the epidemic is raging. We commend this matter to the serious consideration of our civic authorities.

FEHLING'S TEST TABLETS.

For the rapid and accurate estimation of Sugar in the Urine of Diabetic Patients.

The methods generally followed in detecting the presence and determining the quantity of diabetic sugar in urine by the use of an alkaline solution of cupric tartrate and other liquid reagents, though in the main giving correct results, are neither convenient nor very rapid of execution, and Physicians, who usually have a large amount of such testing to do, find it especially so.

In compliance with requests from several medical friends extensively engaged in urinary analysis, J. Wyeth & Bro., Philadelphia, are now manufacturing, on a large scale, Compressed Chemical Tablets, representing the solid constituents of the well-known test solution of Fehling, which is that most frequently employed, and yielding by far the most correct results.

Each Tablet is equivalent to 16 minims (1 cc) of Fehling's Solution, and when dissolved in that quantity of distilled water, the Solution is decolorized, with precipitation of red oxide of copper, by the addition of 1-12 gr. (0.005) of glucose contained in urine, &c.

THE TRIENNIAL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS, P. Q.

The Triennial meeting of this College was held in the buildings of the Laval University at Quebec, on the 11th inst. The President, Dr. R. P. Howard, took the chair at 10.30. There were present:—Drs. R. P. Howard, Leonidas Larue, A. G. Belleau, Chas. Verge, Z. Gravel, A. Larochelle, Jos. Theberge, G. B. Lafleur, W. Lamontagne, F. W. Campbell, W. H. Hingston, Jean L. Leprohon, H. Sauve, Wm. Osler, Geo. Ross, T. A. Rodger, J. A. Ross, P. Lachapelle, D. B. Desaulnier, Tancrede Fortier, G. Lachance, Regis Latraverse, C. E. Lemieux, sr., J. A. Sewell, G. O. Beaudry, Jos. Lanctot, N. H. Ladouceur, Arthur Robitaille, A. Marois, Jos. Langlois, V. P. Lavallee, E. P. Chevrefils, Malcolm Guay, G. H. Dufresne, W. Marsden, J. P. Lavoie, Achille Gauvreau, L. Catellier, Geo. Bolduc, E. Gervais, Chs. Gingras, Alf. Dion, N. Lacerte, J. E. Ladriere, J. B. Bolduc, E. A. de St. George, C. S. Parke, S. Gauthier, J. B. Gibson, J. A. S. Brunnelle, David A. Hart, F. E. Roy, Jos. Marmette, Alf. Morrisette, Falardeau, S. Bolduc, Emm. E. Duquette, Edward Belleau, E. Badeau, J. B. A. Lamarche, J. M. Turcot, Gasp. Turcot, Edwin Turcot, J. B. Bolduc, R. F. Rinfret, A. Jackson, F. R. Rinfret, F. D. Gilbert, P. Wells, A. Waters, W. A. Verge, O. Mazurette, J. Marceau, P. A. Shea, M. J. Ahern, F. J. Austin, Henry Russell, V. St. Germain, Luc Beauchesne, M. Fiset, Aug. Hamel, E. Morin, A. Vallee, C. Cote, A. Poliquin, F. X. Gendron, Nap. Lavoie.

The minutes of the last Triennial meeting were read and approved. The Treasurer's report, showing a very satisfactory state of the finances, was read and adopted.

The President then read the following address:—*Members of the College of Physicians and Surgeons of the Province of Quebec,—Gentlemen:—*The terms of office of the present board of governors of the College terminates to-day, and a short retrospect of the proceedings of the Board during the past three years, and of any events of importance in the history of the institution of which we are all members, may be of some interest to you—and is doubtless expected from me as your presiding officer.

The last triennial period of the College history has not been characterized by any remarkable events. The Medical Act of 1876 (40 Vict. chap. 26), which was the model and basis of the existing

Act, and the joint product of the Medical Board and the Medical Institutions of this Province, was, as you know, further amended, and passed almost exactly in its present form in October, 1879; and its by-laws were sanctioned by His Honor the Lieut.-Governor on the 3rd Sept., 1880. It has been, therefore, the humble but important function of the retiring board during its three years of office to administer the affairs of the college in accordance with "statutes, rules and regulations," which had been just completed and transmitted to it by its predecessors.

One of the first acts of the Board at its first semi-annual meeting was to appoint an officer whose special duty it is to institute legal proceedings against persons infringing the provisions of the Medical Act, and, as will presently appear from the report of that officer, a *systematic* effort has been maintained during the past three years, for the first time in the history of the College, to prosecute persons practicing the medical art without legal qualifications in the Province of Quebec. As a summary of that report I may here state that 49 suits were instituted by the agent of the College; 35 of which were successful, and 9 were lost through want of evidence; 2 through exception to the form; 1 through the plaintiff's lawyer failing to appear in court; and 2 because the defendant possessed the Governor's license, and the court was of the opinion that that was a Royal privilege and exempted him from the operation of the Medical Act.

When the many difficulties which attend the establishing of criminality in courts of justice—I was going to say in a legal way, when these many difficulties, some of them legal, some of them social, and, I regret to say, some of them of our own making—are borne in mind, it will be admitted that something has been done; at least a good beginning has been made to protect the members of the College in the enjoyment of their professional rights. And I have the hope that with the experience of the present system during the last three years to serve as a guide, this department of the College work will be yet more satisfactorily carried on during the coming triennial period. Mr. Lamirande has collected \$367 for registrations, \$260 for licenses, and \$3,092 for annual subscription—making a sum of \$3,719.

From the reports of the Matriculation Examiners it appears that 142 candidates have been admitted to the study of medicine during the last three years.

The efficiency with which this important function of the College is performed is proved by the considerable number of young men who are remanded to their studies at the preliminary examinations—and there is little doubt that under the present system the educational qualifications of persons entering upon the study of medicine must gradually attain a higher general average than under the old system.

One hundred and fifty-three (153) licenses to practice in the Province have been issued during the triennial period now under review. One hundred and forty-four (144) of these were given to graduates of the Medical Institutions of this Province; two to licentiates of Ontario; two to graduates from Great Britain; one under clause 24 of the Medical Act to a practitioner over thirty years practice in the Province; and four to gentlemen presenting themselves before the Board for examination. Two candidates for the license were referred to their studies.

A medical tariff adopted by the College, after due consideration, on Sept., 1880, was approved by the Lieut.-Governor in Council on May, 1881; but was repealed by the Provincial Legislature early in 1882, owing to the opposition made to it in some districts by the electors, on the ground that the tariff was too high. The governors resident in the cities of Quebec and Montreal made a vigorous effort to have the Medical Act amended by the insertion of a clause giving power to the members of the College to form distinct associations, which should have the right to make a tariff for their respective districts, subject to approval by the Provincial Medical Board; but this also failed. The Act, however, remains unchanged, and the College has the right to make a tariff subject to approval by the Lieut.-Governor-in-Council.

It is quite possible that hereafter a tariff which shall embrace only a few of the ordinary items, such as visits, consultations, certificates, mileage, etc., may be prepared that shall be acceptable to the Lieut.-Governor-in-Council—*i.e.*, the ministry of the day; but may I be permitted to remind my colleagues that while a tariff under such sanction has important uses, the chief of which is to protect alike the interests of the public and of their servants—the physicians—the profession must after all make its own rate of charges; and there must be no undermining of a brother's reputation, no underselling to attract patients, no contracts for wholesale attendance and cheap medicine; such

practice: may do for hotel touters, for representatives of bogus insurance companies, but are unworthy of the members of a liberal profession.

If a medical society were established in the various districts, a fair scale of fees might be agreed upon amongst its members as adapted to the social condition of the inhabitants, and usage would give such scale the force of law, if the members of the profession would favorably assist one another. I do not mean to overcharge, but to charge a reasonable fee for valuable service.

As becomes a body representing the profession of medicine—a profession the constant aim and desire—*raison d'être* of which is to preserve life, prevent disease, and avert death; the Provincial Board, at its May meeting in 1882, passed a resolution approving of a Bill then before the Provincial Parliament, dealing with the great subjects of Public Health and Vital Statistics, and respectfully recommending the Legislature to give the principles of the Bill its most serious consideration. Perhaps in no way, outside the discharge of their professional duties to their patients, can members of the College and of the Provincial Board do more for the general good than by using their respective personal and official influence with our legislators to pass laws dealing with questions of public health and vital statistics.

During the session of the Provincial Legislature held in 1882 a few amendments to the Medical Act were suggested by the gentleman who was acting as the legal adviser of the College, intended to facilitate the methods of procedure in the courts against persons infringing the provisions of the Act. These amendments will be found in the 2nd, 6th, 23rd, 28th and 32nd sections of the existing Act; and another at the end of section 15, which was based upon a resolution of the Provincial Board, passed at a semi-annual meeting. This last amendment secured the important principle that medical students shall attend a course of lectures during the fourth year of their professional studies, and shall not pass an examination upon the great final subjects of the curriculum until the close of the session of their fourth year.

These several amendments were submitted to the Governors residing in Quebec and Montreal; and having received their approval were introduced by the Hon. Mr. Mercier, and were passed by the Legislature.

A correspondence having appeared in the public papers some time ago to the effect that private

examinations are given by Professors connected with a medical school in this Province, and that on these examinations certificates are issued purporting that the bearers are entitled to a diploma, and are in fact medical practitioners; a Committee of the Governors was charged with the duty of investigating the statements, and it is gratifying to be able to report that no evidence could be elicited to substantiate them, and that the Board unanimsly voted them untrue.

The importance of watching closely the proceedings of the Provincial Legislature has been upon former occasions brought before the College, but the insertion of the following clause in an Act passed last session entitled, "Acte pour amender et refondre l'Acte Incorporant l'Association des Dentistes," etc., is such an obvious disregard of the rights and welfare of the medical profession in the interests of one or perhaps a few individuals that it ought not to be overlooked in a review of the history of the College during the last three years. The clause is as follows: "Et nonobstant les dispositions de la Section 8, de l'Acte 42-43 Victoria, Chapitre 37, (that is the Medical Act) toute personne pratiquant légalement l'art dentaire depuis dix ans et plus, avant la passation du présente acte, serra par le fait considéré comme admis-étudiant en médecine et propre à suivre le cour et subir tout examen requis pour la pratique de la médecine dans les Universités ou Collèges de cette Province en ce conformant aux règlements des dit Collèges ou Universités." That is to say, any person who shall have legally practised as a dentist for ten or more years before the passing of the Dental Act of 1883 shall be exempt from a preliminary examination, and may at once enter upon the study of medicine. That this piece of *modest* legislation was really intended to serve private interests further appears probable from the fact that a letter was received by the Quebec Secretary of the College from a dentist applying for enregistration under the Act in question. I need hardly say that a committee of the College has been appointed to examine and report upon this subject.

The hand of death has not been idle amongst our colleagues during the last three years. Perhaps in no former like period have so many men of mark been removed from our ranks. Several of them have been distinguished as teachers as well as practitioners, and have left their personal stamp upon many of us—such were Francis

Hubert Larue, Jean Gaspard Bibaud, Peter Munro, George W. Campbell, Aaron Hart David, and William E. Scott. Some of them had been presidents of the College, such was the last named, and Joshua Chamberlain and Henry Russell. And some had been governors, as kind old Alexis Thomas Nichaud, Chas. Timothe Dubé. And the following the list of members belongs to that useful and honorable body, the general practitioners of the Province: W. Boswell, Quebec; Ed. D. Belleau, Ste. Michel; J. P. Coutre, Montreal; Philippe Charest, Beauport; Alphonse Deschamps, Montreal; Isaie Demers, St. Jean D'Orleans; Fiset E. P. Morrison, Nicolet; G. E. Fitzpatrick, St. Jerome; L. Ephraim Olivier, Ex. M.P., St. Ferdinand d'Halifax; François Amic Paradis, Ste. Isidore, Dorchester; Onesime Pelletier, Ex. M.P., St. Charles, Bellechasse; E. H. Paquet, Montreal; Gaspard H. Turcot, St. Hyacinthe.

These our brethren are gone before us, and we are left to carry on their work. Whether it be in watching over the interests of the profession we love, or in teaching the *Ars Medica*, or in the humble but God-like work of healing the sick and relieving the suffering, let us prove faithful to our trust.

It was resolved, that the President's address be printed and circulated amongst the members of the College.

It was then moved by Dr. Osler, seconded by Dr. Lachapelle, that it be a suggestion to the incoming Board of Governors to consider the question of having such changes made in the present method of conducting the elections, that at the next Triennial meeting each separate district shall elect their own representatives. It was moved in amendment by Dr. Fiset, seconded by Dr. Ladouceur, that the mode of election be not changed, but that it be suggested to the new Board that the Medical Act be so amended as to give to each existing judicial district, a number of representatives proportionate to the number of practitioners therein.

A second amendment was proposed by Dr. Gravel, seconded by Dr. Roy. That the practitioners of each judicial district shall elect their own representatives, who shall be chosen from amongst the members resident in such district.

In speaking to the original motion, Dr. Osler explained that this was a matter which had been thought of for some time. That many were

strongly of opinion that the change would be beneficial in the way of creating a stronger interest, in the country members especially, in the affairs of the College—in affording an opportunity for the election of a representative by those best acquainted with the merits of the several candidates, and in preventing the control of the election from falling virtually into the hands of a small number of city men. Many of those present expressed similar views, and favored the principle of territorial representation. Great opposition, however, was made to taking any definite action before the matter was once more laid before the general profession. After a long discussion it was moved by Dr. George Ross, seconded by Dr. Brunelle, That the proposals contained in the motions of Drs. Osler, Fiset and Gravel be referred to the incoming Board of Governors, be considered by them, and that a report with their views thereon be submitted at the next Triennial meeting.—Carried.

The ballot was then opened and continued until 5 p.m.

At 8 p.m. the meeting was re-opened. The following were announced as the representatives sent by the various Universities:

Laval University, Quebec.—C. E. Lemieux and J. A. Sewell.

Laval University, Montreal.—E. P. Lachapelle and A. Lamarche.

McGill University.—R. P. Howard and George Ross.

Victoria University.—E. H. Trudel and W. H. Hingston.

Bishop's College.—F. W. Campbell and R. A. Kennedy.

Dr. Marsden, on behalf of the scrutineers, read the following list of elected governors:

City of Quebec.—L. Larue, A. G. Belleau, W. Marsden, C. S. Parke, E. A. de St. George and Henry Russell.

District of Quebec.—Lieut.-Gov. Robitaille, Côme Rinfret, Chas. Gingras, Malcolm Guay, P. E. Grandbois, Jos. Marmette and L. T. E. Rousseau.

City of Montreal.—T. A. Rodger and J. L. Leprohon.

District of Montreal.—Jules Prévost, P. E. Mignault, D. A. Hart, N. H. Ladouceur, J. A. Duchesneau, Jos. Lanctot, E. Lafontaine, H. A. Mignault and E. Marciel.

District of St. Francis.—Thos. Larue, F. X. Paré and F. J. Austin.

District of Three Rivers.—D. B. Desaulniers, Hon. J. J. Ross and F. B. Dame.

A vote of thanks was then passed to the retiring president, Dr. Howard, and the late Board of Governors, for the energy and faithfulness with which the affairs of the College have been conducted during their term of office.

A meeting of the new Board was held immediately afterwards, and the following officers were elected :—

President, Dr. C. E. Lemieux ; Vice-President for Quebec, Hon. Dr. Ross ; Vice-President for Montreal, Dr. Hingston. Secretaries.—Quebec. Dr. A. G. Belleau ; Montreal, Dr. F. W. Campbell, Registrar, Dr. L. Larue ; Treasurer, Dr. E. P. Lachapelle. Examiners for the preliminary examination, Professors Miller, Howe, Verrault and Laflamme. Assessors.—For McGill University, Drs. Church and E. P. Mignault. For Bishop's College, Drs. Rodger and Leprohon. For Victoria University, Drs. Angus McDonnell and Ladouceur. For Laval University (Quebec), Drs. Marsden and Roy ; (Montreal), Drs. John Reddy and O. Raymond.

The Board then adjourned until September next in Quebec.

PERSONAL.

Dr. George W. Nelson (C.M., M.D., Bishop's College, 1879) has been appointed Resident Surgeon to the Central Hospital in Panama, belonging to the Universal Inter-oceanic Canal Company. Dr. Nelson's many friends will be glad to hear that since going to Panama his health has improved considerably.

W. K. Ross, M.D. (McGill, 1883), of Goderich, Ont., has gone to London to pursue his studies.

Dr. Logan, of Ottawa, has been elected President of the College of Physicians and Surgeons of Ontario.

George Herbert Burnham, M.D. (Trinity, 1875), F.R.C.S. Edin., has returned to Canada, and intends practicing his profession in Toronto as an oculist and aurist.

It is with much pleasure that we congratulate Dr. Osler, Prof. of Physiology in McGill University, upon his election as a Fellow of the Royal College of Physicians of London, Eng. This is the highest honor the profession can bestow. The Canadians who have succeeded in winning this coveted degree are very few.

REVIEWS.

The Dispensatory of the United States of America.

By DR. GEORGE B. WOOD and DR. FRANKLIN, BUCHER. Edited by H. C. Wood, M.D., Joseph P. Remington, Ph. G., and Samuel P. Sadler, Ph. D., F.C.S. Fifteenth Edition, re-arranged and largely re-written, with illustrations. Philadelphia ; J. B. Lippincott & Co., 1883.

It is just fifty years ago since the first edition of the *United States Dispensatory* was published. During the half century which has elapsed it has passed through no less than fourteen editions, and the fate which awaits all men has come to its authors, although one survived to see the issue of the last edition. During all this lengthened period the book has held its place as the standard work of its kind. Its sale has been numbered by hundreds of thousands, and wherever the English language is spoken there it is found. But at last the time arrived when, owing to the wonderful strides made in therapeutics, and the re-arrangement of the *American Pharmacopœia*, a corresponding change was required in the *Dispensatory*. These changes are found in the present volume, and necessitated the re-writing of a very large portion. This task has occupied the attention of the editors during all their spare moments during the past three years, and a gigantic task it has been, consisting, as it does, of over nineteen hundred pages, a large part of it solid type. A review by us is out of the question. We have, however, given it very careful examination, and an intimate acquaintance with previous editions enables us to say that the present volume is up to date in everything concerning Medicines and their Medical uses. It is just one of those volumes which should be in the hands of every Medical man, and a Medical library is incomplete without it.

The Diseases of the Liver, with and without Jaundice, with the special application of Physiological Chemistry to their diagnosis and treatment.—By GEORGE HARLEY, M.D., F.R.S., Illustrated. Philadelphia : P. Blakiston, Son & Co., 1883.

Whatever else Dr. Harley's critics may say, they cannot accuse him of being a copyist ; he boldly assails many of the most cherished pathological theories, and in consequence has drawn down upon himself the wrath and indignation of their exponents. He upholds the old classification of—

1.—Jaundice from obstruction,
 2.—Jaundice from suppression,
 and entirely disagrees with Frerichs, Murchison
 and Legg, who reject the theory of suppression, and
 give three causes for Jaundice—

- 1.—Obstruction,
- 2.—Abnormal Diffusion,
- 3.—Diminished Consumption.

While the author is inclined to be dogmatic, his
 book is readable, and contains much valuable in-
 formation. This edition, published simultaneously
 with the London edition, contains the original
 text and illustrations, and is the only authorized
 American edition.

*Diagnosis of Ovarian Cysts by means of the
 Examination of their Contents.* By HENRY
 JACQUES GARRIGUES, A.M., M.D., pp. 112.
 New York: Wm. Wood & Co.

Dr. Garrigues' views are so well known to the
 profession, particularly to those who take a special
 interest in Gynecology, that they call for little
 comment now. The present volume, which is
 copiously illustrated, gives a full exposition of the
 author's views upon the subject.

*The Untoward Effects of Drugs—A Pharmacolo-
 gical and Clinical Manual.* By Dr. L. LEWIN
 of Berlin. Translated by J. J. Mulheron, M.D.
 Second Edition, revised and enlarged. Detroit:
 George S. Davis, 1883.

Another translation of this book made by Dr.
 W. T. Alexander, and published in 1882 by Wm.
 Wood & Co., has already been favorably noticed
 in the *Record*. The publishers of the present
 volume claim that it is the only English translation
 having the Author's endorsement, and that, hav-
 ing been revised and corrected by Dr. Lewin
 before being issued, it is virtually a second edition.

A Manual of Histology. By THOMAS E. SATTERTHWAITE, M.D. Second edition, enlarged and revised. New York: Wm. Wood & Co.

A few alterations have been made in the text,
 and a short appendix added, treating of the lym-
 phatic system and the salivary glands. We can
 only repeat the favorable opinion expressed when
 noticing the first edition, and commend it in its
 revised form as one of the most useful manuals of
 Histology published.

*The Transactions of the American Medical Asso-
 ciation.* Instituted 1847. Vol. xxxiii. Phila-
 delphia, 1882.

This volume contains the proceedings and
 papers of the meeting held at St. Paul's, Min., in
 1882. Some of the papers are full of interest,
 and one or two are beautifully illustrated by
 Micro-Photographs.

*The Lectures on the Physiological Laws of Life,
 Hygiene, and a General Outline of Diseases
 Peculiar to Females,* with seventy-seven illu-
 strations. By H. S. Cunningham, C.M., M.D.,
 Member of the College of Physicians and
 Surgeons, Province of Quebec. First Edition.
 Indianapolis, Indiana, George F. Borst & Co.,
 Publishers, 1883.

Dr. Cunningham is a man of clear intellect,
 and has succeeded in producing a book intended
 for families in the country, which, while not free
 from faults, is exceedingly creditable to him. It
 is not the function of a purely Medical Journal
 such as ours to criticise a work of this description;
 some may even deny their necessity. The world,
 however, would seem to require them, and, though
 we have known cases when dependance on them
 has resulted in harm, we must in justice also add
 that we also know many instances when the
 timely application of rules laid down in similar
 books has effected good. The interest of Cana-
 dians will be increased in the work by knowing
 that its author is a Canadian graduate.

Brain Rest. By J. LEONARD CORNING, M.D.
 New York: G. P. Putnam's Sons, 1883.

This little book treats of an important subject
 in an interesting manner. The author points out
 the value of periodicity in sleep, and insists upon
 a due amount of sleep, and a regular hour for
 retiring, "as soon after sunset as possible." He
 lays down the rule never to thwart the drowsy
 impulse, which in health should recur about the
 same time every night. He describes fully his
 own method of inducing sleep by applying instru-
 mental compression to the carotids, thus mechani-
 cally regulating the cerebral circulation. While
 we do not agree altogether with the author's
 pathology or some of his therapeutic recommend-
 ations, there is much in his book which is instruc-
 tive and suggestive.