

Vol. #7

MEDICAL SCIENCE

ISSUED MONTHLY

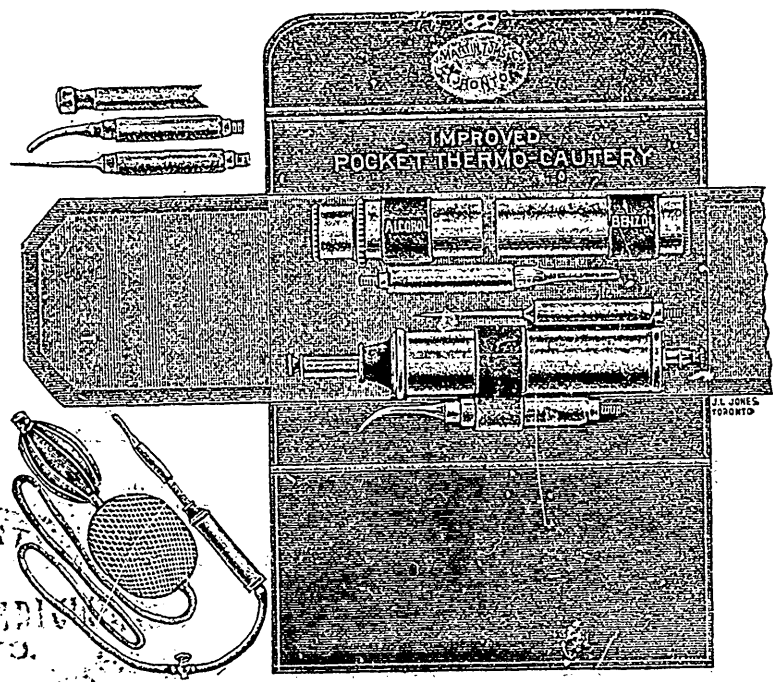
VIDEO MELIORA PROBOQUE

TORONTO, MAY, 1888

CONTENTS

	PAGE	PAGE	
ORIGINAL ARTICLES			
Eczema—By P. H. Bryce, M.A., M.B., Toronto.....	193	phanthus—Playfair on Apóstoll's Method—Antifobrin in Hemieria—Unabsorbed Pills—Antipyrin as a Hemostatic—Jalorandi in Hiccough—Cholera Infantum.....	211-213
Notes on Case of Left Hemato-Salpinx—By James F. W. Ross, F.R.C.P., London.....	195	NEUROLOGY. —Cause of Nerve Injury—Rabies in Man and the Lower Animals.....	213-214
Dispensary Work in New York—By K. F. Junor, M.D., New York.....	199	OTOLOGY. —Foreign Bodies in the Auditory Canal.....	215
EDITORIALS			
University Medical Alumni Society.....	200	REPORTS OF SOCIETIES	
Malpractice suits and the Lesslie Testimonial.....	200	Toronto Medical Society.....	217
INDEX OF PROGRESS			
SURGERY. —Simultaneous Triple Amputation for Railway Injury—Operations for Rectal Fistula.....	202-203	Ontario Medical Society.....	218
MEDICINE. —Notes on the Past and Present Mortality and Treatment of Pneumonia—The Tongue as an Indication of Disease—Italian Treatment of Pulmonary Tuberculosis—A Specimen of Hydro-Salpinx—Preliminary Symptoms of Phthisis—Dyspepsia.....	204-211	St. Louis Medical Society.....	219
THERAPEUTIC NOTES. —The New Heart Remedy, Stro-		Rideau and Bathurst Medical Association.....	221
		HOSPITAL NOTES	
		DoWitt Dispensary.....	222
		GENERAL NOTES	
		Trinity Medical School Examination—A Marine Biological Laboratory for New England—The Inter-State Conference of Health Officers—Cambridge Museum of Comparative Zoology.....	222-224

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EXCERPT FROM AN
ORIGINAL LECTURE

—O N—

The Treatment of Dyspepsia

BY WM. MURRELL, M.D., F.R.C.P.

Report of Lecture delivered at the Westminster Hospital, London.

“Pepsin was of great value in the treatment of dyspepsia, if certain points were attended to in prescribing it. It would not do to simply write down ‘Pepsin.’ Pepsin by itself unqualified had no meaning, and it was essential to indicate distinctly what brand of pepsin was required.”

The lecturer stated that “during the last two years he had carefully tested all the pepsins of which he had been able to obtain specimens. The results were simply startling. Of two different kinds of pepsin, equally popular and equally well known, one was found to be five or six times as active as the other.”

“The best pepsin was ‘Fairchild’s.’ Bullock’s came next and then Squire’s.”

“The French and German pepsins were a long way down in the list, and could not be compared for one moment with either the English or the American.”

“Of late years a great deal has been written about carica papaya as a digestive agent; but, as a matter of fact, papaw juice could not compare in activity with the best pepsin.

“The best papin examined had about half the activity of the best pepsin, as shown by experiments made both in acid and alkaline solutions.”

“The plan of predigesting milk and other articles of food with pancreatic extract answered admirably, and should also be resorted to in intractable cases.”

MORAL—Prescribe Fairchild’s Pepsin.

MEDICAL SCIENCE

VIDEO MELIORA PROBOQUE

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ISSUED MONTHLY
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TORONTO, MAY 1888

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ORIGINAL ARTICLES.

ECZEMA.

BY P. H. BRYCE, M.A., M.B., READ BEFORE TORONTO MEDICAL SOCIETY, APRIL 26TH.

SAYS Erasmus Wilson, "Eczema is neither specific in nature or in its cause." "It is hereditary only in the sense of the transmission of natural tendencies from parent to offspring, and not by virtue of any special virus or *causa morbi*." So impressed have we become with the truth contained in the above quotations, that we cannot forego the prompting to make them, in some sense, pegs, upon which to hang some arguments.

If our early clinical teachers had left us no other legacy, we would still have owed them a large debt of gratitude for the skill with which they tacked on a distinctive classical termination to every sign of the disease under observation. Nowhere have we got this dictionary of terms more graphically set forth than in the names which have been given to the varieties of eczema, from *E. erythematosum* to *E. hypertrophicum*; and never possibly a better illustration of the quotation, "That things are not always what they seem."

To the physician, who, in general practice, finds himself frequently called upon to relieve this distressing malady, must have frequently come the question, "What is it?" While we feel that Dr. Wilson's definition is most comprehensive and valuable, we must nevertheless confess that it is so general as to be, in some measure, lacking in specific statements of the phenomena of the disease. If, however, it should aid us in keeping the fact distinctly before us, that eczema has not a specific cause, but is the sign of a tendency, or tendencies, it will be of the greatest service in practice, since it will enable us to seek for and treat the internal condition rather than the outward signs. In a re-

cently-published article in the *Journal of Mental Science* &c. "The Hereditary Neuropathic Diathesis," were discussed some results of hereditary tendencies, taking the form of neuroses, or, as in eye diseases, of imperfect structural development; and the illustration of the differences as seen in the so-called temperaments, bilious, sanguine, etc., in the outward appearances of the skin, as regards color; circulation of blood in it, etc., are illustrative of varieties which doubtless may exist in the different internal organs of the body. Certain it is, at any rate, that we have constitutions which are related as genera, and species, and varieties, ending in the individual with peculiarities distinguishing him from all others.

Thus Frederick Roberts in speaking of lymphangectasis says, after speaking of the hypertrophy of different lymphatic trunks: "With regard to the causes of this condition it is often congenital, and has been attributed to a want of specialization in the lymphatic system of certain parts."

Formad has further pointed that in the scrofulous diathesis cellular tissue is marked by an unusual wideness of the lymphatic spaces and the structural development of surrounding cellular tissue. Similarly, we doubt not, were physical diagnosis sufficiently refined we might be able to recognize marked variations in structural conditions of nerve tissue, explaining their constantly varying influences and effects upon assimilation, nutrition, and excretion.

From these facts as a starting point, and knowing from physical experiment, as well as clinical experience, the peculiar and special influences exerted by the nervous system, and notably the vaso-motor, over the circulation, it is not difficult for us to understand how some one of several

causes, or several operating together, may provoke through reflex action, congestions of a very decided character, e.g. eczema. Experience has taught us that this nerve irritability in a variable quantity is the x of the equation, equally digestive, assimilative and absorptive force, etc., affected by other influences as bad air, filth, etc., externally and internally, unwholesome or unsuitable food, teething, menstruation, etc.

Wilson refers to this fact when he says, "That eczema is powerfully under the influence of agents which soothe and tranquilize the nerves." In the clinical study and treatment of eczema in infants we are much inclined to the opinion that this fact has in the past been too frequently overlooked; but its importance cannot be overstated when we remember how impressionable the child's nervous system is, and how, especially with the relation of greater importance of the glandular system, the absorbents hold a dominating influence as relative to health. In arriving at the causation of eczema in a child it becomes of much importance, while obtaining a clinical history of the case, to extend the enquiry to any hereditary tendencies, which may be present. We further would naturally endeavour to eliminate what might be called accidental causes, as superficial or local irritants, e.g. heat and moisture, friction, lack of cleanliness, etc. Having determined the relative importance of these, by their removal, we very naturally revert to the probable existence of some nerve irritability, either teething, unwholesome food, non-assimilable food, or over-feeding. The following will probably be generally regarded as a typical case. A child within a few weeks of birth will have had an erythema, occasionally recurring, followed by, or associated with a certain amount of crusta lactea; while growing well, its excreta will have given the usual evidences of imperfect digestion, as acid secretions, greenish coloration, etc. Approaching the period of teething a hyperæmia appears on the cheeks, which, becoming somewhat itchy, is rubbed by the child and ends in a serous exudation. This becoming a true vesicular eczema, tends to increase with the development of the teeth until it may extend to the forehead, and indeed the whole face, flexor surfaces of elbow and knee-joints, etc. Should local applications be made causing a temporary cessation of exudation it will probably be exchanged for a congestion of the air passages, and

a wheeziness in breathing. A persistent tendency to constipation, alternating with occasional diarrhoea, has accompanied other conditions; yet the child continues to grow, and is indeed often a large feeder. With the approach of each new tooth, is usually seen an exacerbation of the itchininess and restlessness until relieved by a diarrhoea, or oftener by a free weeping of the eczematous surfaces. Until the latter occurs the child is dull, or rather he is not playful, until temporarily relieved by a purge, as castor oil, which soon leaves him more constipated than before. As the child reaches an age when starchy foods can be digested fairly well, the exudat usually becomes less in amount but contains more cellular elements, and later the surfaces are covered with branny scales, *E. squamosum*. Sudden and severe onsets may, during this disease result, through cold in an *E. pustulosum*, hardly distinguishable from variola. In the case whose history has been thus given it is evident from what has been said, that digestion would seem not to have been perfect, but the evidences of growth, good appetite, and even good tongue, seem to indicate that the gastric processes at any rate are not greatly at fault. After carefully reviewing the phenomena, we are much inclined to the conclusion that the defects lie largely in the glandular system, whether in the secreting glands or in the lymphatics, or both. The first proof of this seems to us to lie in the fact of intestinal digestion being imperfect. Assuming that the pancreatic secretion is not yet developed to any great extent, we depend upon the secretions of the liver to regulate this important function. Manifestly from the character of the evacuations and the constipation its functions are defective. We have the fact as commonly stated, that obstruction of the portal circulation, whether due to tricuspid insufficiency or other cause, tends to infiltration of tissues with blood plasma, and Wilson gives as a cause of eczema, obstruction of the nervous circulation from whatever cause. Some recent effects from the use of potassium iodide in *E. infantile*, have led us to enquire why it has happened that in a case, where almost every other remedy had failed to produce more than temporary results, which had passed through several severe attacks, as of bronchitis, whooping cough, and pustular eczema, and in which this drug had been administered with the hope of reducing glandular enlarge-

ments of the parotid, submaxillary and cervical glands, these have not only become reduced but the general eczematous condition has steadily improved.

Ringer remarks that, "In health nutritive plasma escapes from the blood-vessels into the adjacent tissues and is afterwards absorbed by the lymphatics and possibly by the blood-vessels. Thus transfusion and absorption counterbalance each other." But if the balance be disturbed the parenchymatous tissue must become engorged either by excessive transfusion or deficient absorption. Where apparently the processes of nutrition are in the full vigor of activity, it appears that deficient absorption, must be the cause of serous infiltration. This may be due probably to nervous obstruction alone, but certainly, according to certain experiments on dogs, through an affection of the nervous system. Thus it has been found that the division of the nerves within the spinal canal (before the vascular nerves join them) does not produce dropsy, but inasmuch as cutting the sciatic plexus produces dropsy we must conclude that the paralyzing influence is due to the injury to the vasa-motor nerves. Assuming that irritative hyperæmias as by the teeth, etc., are produced, then the stasis and nervous engorgement mean similarly lymphatic engorgement with exudation.

After illustrating the manner in which digitalis reduces a dropsy, Ringer discusses the method in which potassium iodide promotes absorption of the fluid, and concludes that it does so largely by stimulating absorption. But inasmuch as its effects if continued are those of an arterial and cardiac depressant, it is not improbable that its influence in removing obstructions is by lessening arterial pressure (Stuart). If this line of reasoning be correct regarding the influence of potassium iodide in producing absorption, and should its influence in this form of eczema be borne out, we shall feel that in practice we are applying it to a set of conditions of daily occurrences, and that its use need not be limited to *E. infantile*. The well-known and constant benefits of iodides in glandular enlargements of a scrofulous character, will, we take it, be best explainable along this line, while its constant use in secondary and tertiary stages of syphilis, in which bubonic and periosteal thickenings and gummata in various structures are reduced, seems to connect in an unusual degree these various evi-

dences of imperfect excretory functions. We have it as the *dictum* of prominent syphilologists that fifty per cent. of all skin diseases are due to syphilis, but we imagine that the argument as derived from the use of remedies is upon the *post hoc ergo propter hoc* basis rather than upon any even tolerably accurate hereditary history.

If we look closely into the physiological basis of this glandular and lymphatic engorgement we find that vaso-motor irritation as a direct cause is very probable, since in the observations on the effects of drugs on the vaso-motor, as also of direct stimulation, the vaso-motors which supply the glands instead of contraction cause dilatation of the vessels in them (Brunton). Similarly in the paralysis of dentition, a case is recorded by Fleiss (Brunton on Infantile Paralysis) where the post mortem appearances (death having occurred by accident the same day the paralysis set in), showed no organic change in either the spinal cord or in the brachial nerves, but a striking turgescence of the veins of the shoulder and neck. Brunton thereafter adds, "This vascular congestion seems to point to vaso-motor disturbance of a somewhat similar kind to that which we have already noticed in occipital headache."

The reflex irritation caused by undigested food in the intestines thereby forcing the blood into other parts, similarly points to the same engorgement of the venous and lymphatic systems and to production of eczema, as also other dermatoses. It is hardly necessary to state in conclusion that the line of argument intended to point out the dominating influence which engorgement of the venous and lymphatic systems has in the causation of eczema with the resulting indications as to the line of treatment, does not in any degree lessen the necessity for either local treatment, or the still greater importance for removing, when possible, the many causes of vaso-motor irritation.

NOTES ON CASE OF LEFT HÆMATO-SAL-PINX—RUPTURE—ABDOMINAL SECTION—RECOVERY AND SUBSEQUENT PREGNANCY.

BY JAMES F. W. ROSS, L. R. C. P., LONDON, PHYSICIAN TO WOMAN'S HOSPITAL, TORONTO.

S. A., age 38, married 16 years, 7 labors; first 1872, last 1882; first with instruments; 3 miscarriages. Has pain lifting, coughing or sneezing; hysterical when first married. Pain severe on

defœcation; catamenia now stopped; commenced Dec. 22nd, ceased Dec. 24th; began again Dec. 28th, lasted till Jan. 4th; dark brown color, heavy odor, very few clots, quantity large. No other discharge. Menses occasionally, stop for 6 weeks and then last 6 weeks.

Pain.—If coughed, suddenly stooped, lifted weight, pain came on in the left groin, low down, going round to the back. Increased at time of menses. Coition unbearably painful. Dysmenorrhœa.

Previous illness.—Had no dysmenorrhœa as a girl, unwell at 13; went to Dublin hospital between first and second labors, for treatment. Had fallen on a foot scraper. Supposed something had become misplaced. Took an anæsthetic and had some operation performed on uterus.

Present illness.—Since birth of child 4 years ago, never been well. Blood discharged per vaginam irregularly for 3 months after confinement. After child was weaned menses returned in 6 weeks. Been irregular ever since and always suffered pain.

On examination found a sausage-like boogy, elongated substance pressing down into left lateral fornix and post cul-de-sac of Douglas, very tender to touch. Used considerable pressure as examination was difficult. Patient complained greatly of pain. Had just left the house when was recalled to find her in a collapsed condition, perspiration standing out on face, respiration rapid, pulse rising. She gradually rallied from this. The thought struck me at the time that perhaps the dilated tube had ruptured. She was, as soon as possible (a day or two) removed to woman's hospital. Temperature and pulse kept up. She was very ill. Consultation called, and in view of facts of case, adominal section was done. Found large mass of blood-clot filling cavity of pelvis. Cleared it out. Found left hæmato-salpinx, a large hole in the wall of dilated tube at seat of rupture. Removed the one tube and ovary only. Washed out with plain boiled water, put in glass drainage tube and closed the wound. The patient made an uninterrupted recovery. As the case is a rare one and as far as we could make out, not tubal pregnancy, I give a little of the literature on the subject which may be of interest.

Hart and Barbour says: "This is a rare condition in which the blood from the congested mucous membrane of the tube is retained there and dilates it. It is often associated with retention of men-

strual blood in uterus. One plate given page 186 vol. II, of dilated uterus, and one fallopian tube, which had burst at its free end where it was changed into a thin-walled blood sac, due to atresia vaginæ. Accumulations of blood may take place in the fallopian tubes in the form of diverticula, usually situated towards the fimbriated end. These are not produced, Schrœder says, as we should suppose by a simple reflex of the blood from the distended uterus into the tubes, but by hæmorrhage from the mucous membrane of the tubes themselves. The uterine end of the tube is sometimes undilated or even entirely closed. Blood may escape gradually from the fimbriated end of the tube and set up a localized peritonitis, matting down the tube and uterus; a hæmatocele is sometimes thus produced. Diagnosis is difficult. Bandle records one case where the condition was diagnosed as a fibroid, and Lawson Tait one simulating an ovarian cyst. Rokitansky has said, "Gynæcologists diagnose this condition unfortunately too late." Tait says: "I have treated cases of hydro, pyo and hæmato-salpinx as I would cysts of liver or kidney, by stitching the edges to the edges of the parietal wound by a continuous suture so as to completely close the peritoneal cavity, and draining the cavity by a tube passing both upward and downward and into the vagina, that is, if they could not be removed. The progress is not nearly so satisfactory as when the uterine appendages are completely removed." Again he says, "Besides pus we occasionally find that an occluded tube may contain bloody fluid of menstrual origin. It has been completely established, especially by the observations of Bernutz and Gouple, that the tubes generally share in the secretion of the menstrual fluid, and when the clamp used to be employed in ovariectomy we constantly saw menstrual blood weeping from the stump." It is not therefore surprising that occasionally we should meet with a case of hæmato-salpinx. Meadows records the post mortem examination of one in 8th vol. of the "Transactions of London Obstetrical Society," in which it was found that both tubes were enlarged not regularly and uniformly, out so as to form a kind of cyst. On the right side there were two such enlargements; on the left, one. There was no evidence of any communication between these dilatations and the fimbriated opening. On the left side there was not even an opening into the uterus, the ostium

uterinum being completely occluded. They were filled with dark, thick grumous fluid of a prune juice color. It is evident that in this case we have an example of what Bernutz and Gouple contend for—menstrual retention within the fallopian tube. The one fact which is clearly revealed is that the tubes do, as well as the uterus, take part in the menstrual secretion; hence, when any obstruction occurs to the passage of that secretion into the uterine cavity and so externally, we get the resulting symptoms of menstrual retention.

Tait records the following case occurring in his practice:—"Miss M., *æt* 38, sent to me in beginning of 1877, by my friend, Mr. Alfred Greer. In Nov., 1876, she had an ill-defined illness, during which she had obscure pelvic pains, accompanied by fever. Previous to this illness she had been in good health and had menstruated regularly. After it she had severe pain during the whole period of menstruation, and she gradually increased in size until Mr. Freer discovered a pelvic tumor to be pear-shaped, quite moveable, to be attached to uterus at left cornua, evidently unilocular and about size of an infant's head. I diagnosed a cyst of parovarium, and advised tapping when sufficiently increased in size to warrant interference. She returned to me in May with the tumor increased so as to be felt above the umbilicus. I advised her to come again in a month. She came before the expiration of that period, on account of a sudden accession of serious symptoms; and when I saw her, June 20th, there could be no doubt she was suffering from peritonitis. Pulse 130, temperature 101.12, which rose to 103.38 in the evening. Excessive pain all over abdomen with flatulent distention. I gave opium freely and applied counter-irritation over the epigastrium. On morning of 21st, was easier, but temperature and pulse had not fallen. I proceeded to open abdomen. The tissues of abdominal wall were very vascular and it was necessary to use ligatures to arrest the bleeding. Peritoneum adherent to tumor and it became evident that the latter was not ovarian but had the red muscular appearance of the uterus. Passing the forefinger of my left hand down as deeply as I could in front of the tumor with that of my right in vagina, I made out distinctly that my original conception of the relations of the tumor to the uterus were correct. Under the suspicion that it might be a tubal pregnancy, I did not separate the

tumor further, as I had not opened the cyst by means of a knife. As soon as I reached its inner coat I passed my small trocar in and evacuated about six quarts of thick, dark brown fluid, having the peculiar smell of menstrual blood. After the cyst was emptied I passed my finger through the hole made by the trocar, and to my amazement I found that the cyst had contracted; moreover, as I kept my finger in the cavity I distinctly felt it contracting round and grasping my finger. Passing the forefinger of my other hand into the vagina I made out that what I had opened was without doubt the left fallopian tube and that I must have opened its fimbriated extremity. I could find no canal leading to the uterus and did not deem it advisable to make one. I washed out the cavity freely with a weak solution of carbolic acid, by reversing the siphon action of my trocar. A piece of wire drainage tube was fastened in and a piece snipped off for microscopical examination. This proved to be composed of an abundance of unstriped muscular fibre, conclusively supporting my view that this singular tumor was a dilated fallopian tube. Her temperature fell slowly. Wound suppurated freely and sheds of mucous membrane came away. She is now in perfect health and has never menstruated since the operation. The illness from which she suffered and which was undefined, was undoubtedly a localized salpingitis, resulting in closure of the two ends of the tube. The peritonitis was probably due to a threatening rupture of the tube, or possibly a slight escape of its contents." Arthur Farre quotes a case of this kind, in which the distention by the menstrual fluid advanced to rupture, followed of course by death.

Barnes says, "The tubes may be distended by accumulations of blood. One cause of this is menorrhagia. Usually the uterine opening gives it passage; but sometimes if this opening is obstructed as by a clot, the blood continuing to be poured out by the tubal mucous membrane, may overflow by the abdominal end and give rise to a retro-uterine hæmatocele." He also says, "The fallopian tubes in cases of atresia of uterus vagina or vulva, commonly undergo extreme dilatation and are liable to burst. He describes under the dangers of puncturing of the closed hymen the more common event, namely laceration of the tubes at the weakest part, caused by the sud-

den dragging upon them of the retreating uterus, the tubes being probably held back by adhesions." Again, "The distended fallopian tubes may burst, or without bursting an overflow of blood may escape into the peritoneum, causing peritonitis. The constitution suffers from hectic, the result of pain and the absorption of the altered blood."

In his classification of hæmatocele, he only mentions the fallopian tubes as concerned in connection with obstructed menstruation and does not say anything about primary dilatation of one tube with blood, with or without its rupture, into the peritoneal cavity.

I find in Spencer Well's work no mention of hydro, pyo or hæmato-salpinx. The work is unfortunately not indexed. On pages 18 and 19 I find under the head of what he calls tubo ovarian cysts, he relates a case that was evidently one of hæmato-salpinx. It was recorded by Dr. Lionel Beale, in the "Pathological Transactions for 1867-68." A married woman *æ*t 30, died of renal disease. For last year of her life she had not menstruated. Was no history of any uterine affection. She had never been pregnant; after death two tumors were found in the pelvis, one on each side of the uterus. The left one was circular, about size of a small orange, and distended with fluid; on its upper and inner surface was seen a tortuous, but not uniformly dilated canal, which was closed at the uterine end but opened freely into the larger cyst at its ovarian extremity, this was the uterine portion of the fallopian tube, while the cyst was the dilated fimbriated extremity. The tumor on the right side was smaller and the inner portion of the tube was uniformly dilated into a canal one third of an inch in diameter. Like the one on the other side it communicated with the cyst by a smooth circular opening. On each side the inner constriction was just outside the uterus where the tubes seemed to be merely fibrous cords. Externally the fimbriated extremities were also closed and dilated into roundish cysts. Each cyst had thin walls with fluid contents of a dark brown color. The left ovary could not be seen, the right was flattened out and lying in the wall of the cyst but not communicating with it. No traces of ovarian structure were left but a mere cyst with semi-fluid contents of a chocolate color. Uterus, normal in appearance, but no distinct opening, could be seen at the fundus where the tubes generally enter;

outside the peritoneal surface was normal. Dr. Savage says, "In some instances I feel sure there is nothing to be felt in the pelvis before operation, and we have nothing to guide us but the more or less constant pain and recurring attacks of inflammation; each attack making the adhesions stronger and more extensive, and rendering the subsequent removal by operation more difficult, and therefore, more dangerous." Emmet says, "Some writers make a third division (after speaking of pyo and hydro-salpinx), hæmato salpinx. I have never known an instance of blood accumulating in the fallopian tubes unless it was secondary to the retention of menstrual blood in the uterus, and as such should not be recognized as a distinct condition. The outline of a distended tube as felt from the rectum is unlike the accumulation of any other fluid to be found in the pelvis, for the tube, as it fills, twists upon itself like a distended intestine. If the collection is of a bland character but little disturbance may follow its rupture into the peritoneal cavity, and this may account for the rapid disappearance of supposed ovarian tumors, as the tube is not likely to refill. If the collection is of pus, rupture of the tube is of serious consequences. With pyo-salpinx a woman's life is in jeopardy each hour of delay, and we have no other means of relief than the removal of both tube and ovary. Again, he says, it can scarcely happen that one tube should be so diseased as to require its removal and the other be in a healthy condition."

Thomas says, "Extravasation of blood in the mucous membrane or bleeding in the canal of the tube from menstruation or following inflammatory processes in the uterus, or after acute infectious diseases, does not appear to be very rare. They are, however, of no very great importance, as the blood, as a rule, is re-absorbed, and thus rupture of the tube is prevented. Still, we cannot lose sight of the fact that they are important in this respect, namely, that the blood may escape through the abdominal opening and set up a peritonitis. If we except tubal pregnancy and hæmato-salpinx accompanying hæmato-metra, effusion of blood into the tube is seldom followed by death."

Schröder says regarding the diagnosis of a dilated tube, "The diagnosis in cases where the mass has attained large proportions is difficult and often, indeed, impossible. I would base it on the following points: The swelling is long, fluctuating,

movable, and somewhat toward one side in Douglas' pouch. The contour is irregular and the uterus does not remain in close connection with it." Scanzoni follows Kiwisch closely by saying that the presence of a sausage-like, elastic and long swelling lying in the neighborhood of the fundus to either side justifies the diagnosis of dilated tube.

I have now, months after the operation on my case, to record pregnancy, one tube and ovary were left contrary to general belief of disease in both, and soon after recovery the patient became pregnant and expects to be delivered in four or five weeks. From the time of rising from the operation until now her health has been excellent, she has done her own housework besides looking after a small garden.

DISPENSARY WORK IN NEW YORK.

BY R. F. JUNOR, M.D. VISITING PHYSICIAN TO DEWITT DISPENSARY DEPARTMENT OF GENERAL MEDICINE, ASSISTANT TO PROF. DELAVAN IN THE THROAT AND NOSE DEPARTMENT OF THE SAME.

THE great dispensaries in such a city as New York are great educational and training schools. The DeWitt is one of the oldest, largest, and best equipped in the city. There have served in their time Loomis, Sands, Draper, Sims, Parker, Starr, Delavan and a host of other celebrities. It stands on the corner of Twenty-third Street and Second Avenue. About 50,000 patients passed through it during the year. It is supported by voluntary contributions, is thoroughly equipped with instruments and appliances for minor work in all branches of medical science. It is divided into different departments: Surgery, Gynecology, Skin, Throat and Nose, Heart and Lung, Nervous Diseases, Children's Diseases and General Medicine. Each department is in charge of a physician having one or two assistants. Some of the departments have clinics in both the morning and the afternoon under different physicians, so that from thirty to forty physicians are working in the dispensary. There are two house physicians who classify the patients, one in the morning and the other in the afternoon. There is a pathologist and there are two visiting physicians, the latter taking all cases which are not able to come to the building. Va-

cancies in the staff are eagerly sought for, sometimes by a large number of applicants. Patients are sent from here to the great charitable institutions of the city by the physicians. DeWitt Dispensary may be said to be the most *loney* one in the city in some respects. It is so old, so many of New York's greatest physicians have held its clinics and it has been so carefully managed by its influential Board of Directors that all its positions are eagerly sought after. I doubt if there is a single Department which is not having constantly patients coming from other cities seeking relief, drawn by its reputation for efficiency. From morning till late at night the Dispensary is open and treatment is being given, for, having such a large staff of physicians, night as well as day, clinics are held. The treatment is free. Ten cents is charged for each prescription, and a dollar is charged for each visit of the visiting physician if they are able to pay. Milk is given out to sick ones when necessary. Everything is done in the most systematic and business-like way, so that it is a great hive of industry, and is a great boon to the city. Of course great operations are not undertaken in such a place, but all minor work and some very important surgical work is done in the departments of Surgery, Gynecology, Throat and Nose and Eye and Ear. Almost everything within the range of ills to which flesh is heir to is to be seen here. The physicians in charge of each department are allowed to have two or three students at a time under instruction. Records of the name, age, condition, nationality, disease and treatment of each case are kept, and just according to the careful record of the physician may valuable reports be made useful to the man himself, and no less valuable to the profession and to medical science. There can be little doubt that a great and well-conducted Dispensary is a valuable boon to a large city, but there can be just as little doubt that the great multiplication of petty Dispensaries is an injury. It belittles and somewhat demoralizes the profession both subjectively and objectively. When large and of good reputation it is a great charity, a great training school, and its fame is a spur to excellence and care. No better opportunity could a man have to improve himself in any branch than is presented in such an institution by successive service in its different departments.

EDITORIAL

UNIVERSITY MEDICAL ALUMNI SOCIETY.

"To-day our Reverend Mother welcomes back
Her wisest scholars, those who understood
The deeper teaching of her mystic tome,
And offered their fresh lives to make it good."

"They love her best who to themselves are true,
And what they dare to dream of dare to do."

—*Harvard Commemoration Ode.*

THERE are those whom we have heard who have complained of the non-existence of a Canadian national sentiment, and who, too, may be inclined to deny that in the student life of our larger educational institutions there is any *esprit de corps* to any degree comparable to that which lends a charm and romance to the school days of *Tom Brown*, or which simulates in perennial freshness and exuberant joyousness the adventures of *Verdant Green*; but it occurs to us that such have forgotten the laws of ordinary growth and development and expect the coral island to appear in a night above the surface of the southern sea, or that every Canadian creation must perforce have so god-like an origin as to at once spring into full life, like Minerva, full armed from the forehead of Jove.

Remembering the history of our University since 1855, and especially of the vicissitudes which its Medical Faculty has undergone during the years which have passed, we are not surprised that up to the present there has been but little evidence that there existed a section of her graduates numbering some six hundred who, in their every-day lives, and as a profession, are bound together both by sentiment and interest to a greater degree than any other class of graduates; and who ought to take a more than ordinary interest in and exercise no small influence on the future of their Alma Mater. We, therefore, hail with no common pleasure the evidence of this growing interest and influence in University matters, in the formation of an association of medical men who are graduates, to be called, we believe, "The Medical Alumni Society of the University of Toronto."

Preliminary meetings for organization have been held, and a committee is at work arranging for the first general meeting to be held on the occasion of the Medical Convocation some time in May. We

understand that it is proposed to have a dinner in the evening, at which the social side of the Society will, doubtless, be fully cultivated. The scope of such a Society's work must necessarily be proportioned to the interest taken by members in their common profession and in one another. While it is true that

"Our slender life runs rippling by, and glides
Into the silent hollow of the past,"

nevertheless, to all of us come times when our greatest delight is to recall again the "dewy dawn of memory," and that past life unalloyed, as it now appears to anyone, with the cares and routine incident to our lives in the present. Whether we bring back "the tumult of the halls," "the high debate," or, like Goldsmith's pensioner,

"Shoulder our crutch and show how fields were won"
at football, the sentiment we desire to see developed, is fostered; and to this degree the individual influence in the community, which in so unusual a degree is possessed by physicians shall be unified in such a manner as to make the voice of the medical graduates to be heard in University affairs in a manner heretofore never dreamed of. Activity in a very remarkable degree is being exhibited in other directions in University matters, and if the medical graduates wish to obtain for the profession those rights and advantages which its importance in a national system of education demands, it behooves them to avail themselves of the opportunities presented by such an association as an Alumni Society, to press forward the claims of Medicine as a science to recognition as one of the most important professions, and one whose needs are to be measured rather by the uncomprehended infinite in nature than by the finite known. We urge most strongly upon all University men to at once take steps to become members of the new Society.

MALPRACTICE SUITS AND THE LESSLIE TESTIMONIAL.

THE increasing importance and value attached to a single human life have ever been recognized as the means of the degree of advancement of any nation, and especially of any Christian nation; and, when, by license, physicians are in-

vested with the privilege of practising medicine, they have attaching thereto a responsibility both moral and legal, which no conscientious physician can for one moment wish to have devolved from him. As, however, the every-day care which a physician gives to his profession and the moral regard for his duties toward his patients are for him the measure of his responsibility, it must be evident that any physician worthy of the name can never, after having been granted a license to practice by the State, be forced by legal fears to exercise more caution, than he otherwise would, did no legal responsibility attach to his actions. Remembering these facts and the issue by the State of a legal right to practice medicine, the existence of conditions by which a physician, no matter how conscientious he may be in the performance of his duty, is liable to suits for damages from malpractice, seems not only an anomaly but a travesty of common sense and justice.

We can understand how a lawyer, should he cause loss through neglecting to draw up a lease or title properly, with the materials before him, should be required to make good such loss, or how a physician, through intemperance or other act, rendering him temporarily incompetent, thereby causing physical damages, or even loss of life, should be liable to severe punishment; but we fail to understand how a physician licensed to practice, thereby having his legal competency established, should have his actions made the subject of scrutiny before a court, where special pleaders endeavor to impress upon a jury of persons wholly unfitted to arrive at conclusions, based upon lines of reasoning neither understood nor appreciated by either pleader or jury. To illustrate we have only to refer to a case not many years ago, where the jury was asked several questions by the judge, he fearing that the florid declamation of a leading counsel had had undue influence. In reply to one, the foreman answered: "Because the doctor did not give the nurse proper instructions, and that he had not seen that *these* instructions had been carried out."

The facts regarding the recent action against Dr. Lesslie, an old and much respected physician of Hamilton, for causing the death of a man named Routh, of 60 years of age, through the administration of chloroform, have been fully retailed in the daily press; and they only too strongly indicate

the position which a physician may be placed in at the hands of any unscrupulous persons who themselves, or through the influence of evil-disposed persons, may be induced to think that they have suffered damages at his hands.

A physician is called in to assist a brother practitioner in an operation on hæmorrhoids, and after a general examination, decides that it is safe to operate under chloroform. The patient, who had no history of rheumatism, ceased breathing after six or eight minutes administration of the anæsthetic, and could not be resuscitated by all the usual and available methods of restoration, as lifting the thighs, drawing forward the tongue and giving nitrite of amyl. Such is the history of the case. The jury in the first trial disagreed, positive statements being made in favor of the prosecution, by a witness from Toronto, of one year's registration in Canada, and a somewhat mixed registration in Britain. A second and recent trial in March, fully exonerated Dr. Lesslie from the charge, after which it is found that the plaintiff is *nullum respondum* in the matter of costs, and Dr. Lesslie, after months of anxiety, worry and indirect loss, is called upon to pay the costs of the suit to the tune of \$1,000.

There can be no good reason for altering the general principle of the presumptive right of every person to seek redress for grievances through courts of law, but it is a manifest absurdity to suppose that not only must every uncalled for or dishonest suit be allowed to be brought against worthy and upright citizens, but that the same, after having been proved guilty of the charge should be made to pay for another's privilege. The injustice done to Dr. Lesslie has been so flagrant in the eyes of the physicians of Hamilton that a considerable sum of money has been raised as a testimonial of the estimation in which he is held by his professional brethren there, and arrangements have been made by a resolution adopted at the Toronto Medical Society, whereby members of the profession throughout the Province may join with those of Toronto and Hamilton, in increasing the amount of the testimonial to worthy proportions. Such as wish to subscribe, may address their contributions to any of the members of the committee appointed by the Medical Society: Dr. J. E. Graham, Dr. W. B. Nevitt, Dr. P. H. Bryce, or Dr. J. Davison.

INDEX OF PROGRESS

SURGERY

Simultaneous Triple Amputation for Railway Injury, with remarks on the Technique of Multiple Amputation.

The following remarks made by John Ashhurst, Jr., M.D., before the College of Physicians, of Philadelphia, appear in the April number of *The Jour. of the Am. Med. Asso.*:—"This patient is brought before the College largely on account of the rareness of simultaneous triple major amputations. It is quite possible that some of the Fellows may not have had an opportunity of seeing such a case.

The patient is a Moor, 20 years of age. He was admitted to the University Hospital, November 28, 1887, having been run over on the Pennsylvania Railroad. I saw him within two hours after his admission. I found a compound comminuted fracture of the right leg, the laceration extending above the knee; complete avulsion of the left leg, the limb having been torn off in its lower third; and a compound fracture of a severe character of the right hand and wrist. There was also a compound fracture of the skull, involving the frontal bone. This, however, was an impacted fracture, of course without much depression, and did not require interference. In addition to these injuries there were numerous brushburns and contusions, some of a grave character. One upon the left buttock was so severe that the separation of the slough left a cavity fully two inches in depth. Notwithstanding these serious injuries, the patient's general condition was very good; he had reacted thoroughly, and his axillary temperature 99° F. Under these circumstances I felt justified in proceeding to the immediate removal of the injured limbs, and amputated successfully the right thigh by the antero-posterior flap method; the left leg, about the middle, by a modified Sédillot's external flap operation, the modification consisting in making both flaps from without inward, instead of cutting the external flap by transfixion; and the right forearm by an oval incision, making use of the uninjured skin of the back of the hand and wrist. Certain variations from the ordinary procedure in amputations I shall refer to when I come to speak

of what I have ventured to term the technique of multiple amputations. After the operations were completed, the temperature had fallen only to 98° F. The patient had no bad symptom and rapidly recovered, and as you see him now all his wounds are healed, and he is perfectly well.

I have collected some statistics of synchronous multiple amputations. I am able to find but one instance of *quadruple* synchronous amputation—a case in which the operations were done for frost-bite by Dr. George E. Jackson, of Dakota. There are several cases recorded of multiple amputations, not synchronous, the one which approaches nearest to a synchronous operation being that of Champeño, a French surgeon, who amputated three limbs on one day and the fourth a few days later.

Of synchronous triple amputations there have been reported four successful cases, not including that presented to-night: one by Dr. Kohler, of Shulyhill Haven, Pa.; one by Dr. Lowman, Johnstown, Pa.; and two referred to by Professor Agnew, in his *Surgery*, one occurring in the practice of Dr. Stone, of New Orleans, and the other in York, the name of the surgeon not being given. There are reported four or five triple amputations not synchronous. I have myself resorted to synchronous triple amputation in two cases. Several years ago I had occasion to perform this operation, removing both legs and the right forearm of a man *at* 45 years, of intemperate habits. The patient died on the tenth day, the fatal results being due rather to the visceral lesions resulting from alcoholism than to the operation.

Double amputations are comparatively numerous. I have personally performed fifteen such operations, this number not including two successful cases of double partial amputation of the feet. I have done fifteen double major amputations, of which five have ended in recovery. One of the patients who recovered I had the honor of exhibiting to the College some years ago; the amputations in his case were through the right hip-joint and through the left leg. In the fatal cases, seven of the deaths occurred in less than one day, the immediate result of the shock of the injury and of the operation. Three patients died, one in three days, one in four

days, and the third in eighteen days. The latter would probably have recovered but that he also had suppurative disease of the middle ear, which appeared to be the cause of the pyæmia which proved fatal; for when the stumps were examined, after death, they were found to be in good condition.

With regard to what I have termed the technique of multiple amputations, there are some points which my experience justifies me in urging upon surgeons as of importance in promoting success: *In the first place, it is very important that the time occupied by the operations should be brief; that the operations should be done systematically, so as to keep the patient under the anæsthetic as short a time as possible.* The next point, perhaps of even more importance, is to keep up the temperature of the patient during the operations. I have been led to think that this is, perhaps, of more importance than anything else. Of course, loss of blood must be scrupulously guarded against, and loss of blood directly causes loss of temperature. In this case, hot cans were kept around the patient during the entire operation, and in order to save time I operated systematically, the tourniquet and Esmarch bandage being both employed to prevent any loss of blood. I began with the most serious injury, and this is, I think, a point of importance. It may happen that, after the removal of one limb, it will be found that further operation must be postponed on account of the patient's condition, and then it is, of course, better to leave him with the less severe injuries. In this case I began with the thigh. After amputating the limb, I secured the main vessels, which were readily found. I attempted to tie the arteries with catgut, but as the ligatures broke, I substituted silk and, in order to save time, left both ends uncut. I next amputated the right leg, securing the vessels in the same manner, and then passed to the forearm. I then came back to the right thigh, screwed up the tourniquet and removed the Esmarch bandage, and secured all the vessels that required ligature, then passing to the other limbs in the same order as before. After the vessels had been secured in each case, a towel dipped in a hot antiseptic solution was placed between the flaps. The wounds were then dressed in the same order, and in this way the operation was completed in a comparatively short time.

The points which I have mentioned I believe to be of great importance, and I think that much of the disappointment of surgeons from these operations is due to want of attention to these matters.

I should also say that, in order to preserve the bodily heat, I did not use irrigation during the amputations. I think that this often seriously reduces the temperature, and even in comparatively slight operations where it has been used. I have seen the temperature fall to 97° F., and even 95° F. I think that in any grave case, it is better to omit it and to rely upon washing with hot antiseptic solutions before and after the operation. Also, the packing of wet towels around the seat of operation, as is very commonly done, tends to depress the temperature, and in grave cases should be omitted.

I think that it is to an observance of these precautions that I have owed success in this case, and in many other serious operations of various character.

Operations for Rectal Fistula.

Greffrath reports 61 cases of rectal fistula operated on in the Heidelberg Polyclinic. The fistula occurred between the ages of 20 and 40 years in 57.4 per cent. of all cases. The youngest patient was 6 months old. Only 1 case occurred in a woman. The fistula was incomplete external in 4.9 per cent.; and complete in 29.5 per cent. Of the incomplete external (33 cases noted) the fistula was lateral, between the anus and tuber ischii in right side, in 24.2 per cent.; on left side, same situation, 39.4 per cent.; around the anus, with different openings, 24.2 per cent., external opening in the middle line behind the anus in 12.2 per cent. The seat of the incomplete internal fistula was in every case just above the external sphincter. Of the the complete fistulæ (noted in 17 cases) the seat was on the left between the anus and tuber ischii in 41.2 per cent.; right, same situation, 17.6 per cent.; around the anus, with different openings, 5.9 per cent.; external fistulous opening posterior 23.5 per cent.; anterior 11.7 per cent.

Of the 61 cases 10 had symptoms of pulmonary tuberculosis, 7 had hereditary tendency to tuberculosis, 2 had diabetes. Of the patients 2 had had acute rheumatism, 1 attributed his trouble to long-standing hæmorrhoids, 1 to eczema, 3 to local injury. In 9 the fistulæ seemed to have come on spontaneously, and 43 gave the history of a

small abscess having formed and caused the trouble.

In 16 cases the fistula was operated on by means of the knife, in 43 with the thermo-cautery. Of the 16 operated on with the knife 11 had normal internal organs, 3 had symptoms of pulmonary tuberculosis, and 2 had hereditary tendency. Of the 11 with healthy organs 80 per cent. were completely cured. 1 died (of tabes?), and one was not completely cured. Of the three phthisics 1 died of sepsis, 1 was not cured, 1 lost sight of. Of the 2 with hereditary tendency 1 was not cured, 1 lost sight of.

Of the 30 cases with healthy organs treated with the thermo-cautery 4 were lost sight of, 22 were completely cured (85 per cent.), 3 not completely cured, 1 died (presumably of phthisis). Of the 5 with hereditary tendency 2 were completely cured, 2 died of phthisis (whether fistula was cured or not is not known), and 1 died, with questionable diagnosis. Of the 7 with phthisis treated with the thermo-cautery 2 were lost sight of, 1 completely cured, 2 not cured, 2 died of phthisis, uncured.

Greffrath concludes thus :—

1. The eschar made by the thermo-cautery protects the wounded surface better from infecting material from the first day, and with care the patient may go to stool on the first or second day after the operation.

2. The operation can be done in a few moments without hæmorrhage of any importance.

3. Better granulations are obtainable from the thermo-cautery than after the use of the knife.

4. The eschar of the cautery makes the immediate adhesion of the wounded surfaces impossible.

After the use of the thermo-cautery antiseptics can be carried out more efficiently, and Greffrath recommends iodoform as an excellent antiseptic in these cases. At the conclusion of the operation the whole wound is disinfected with a 5 per cent. solution of chloride of zinc, and then iodoform is applied.

Greffrath's cases and results lead him to consider the question of operating on rectal fistulæ in phthisical patients. He concludes that :—

1. There is a causal nexus between tuberculosis and rectal fistulæ, but tuberculosis does not contraindicate operation on the fistula.

Fistulæ form in diabetics on account of inflammation of the cellular tissue, and patients suffering

from rectal fistulæ should have their urine examined for sugar.—*Deutsche Zeitschrift für Chirurgie*, Bd. 26, Hft. 1 and 2.

MEDICINE.

Notes on the Past and Present Mortality and Treatment of Pneumonia.

We have before us, in pamphlet form, a paper on the above subject by Henry Hartshorne, M.D., read before the College of Physicians of Philadelphia, February 1st, 1888.

The paper is a lengthy one, and comprises careful and extended compilations from the most reliable sources, showing the percentage of deaths from pneumonia, within a stated period, when blood-letting was in full sway, and for a similar period under the present system of treatment. These statistics go to show that better results were obtained by the *old* rather than the *new* "working theories" of practice in acute inflammatory diseases.

We give our readers Dr. Hartshorne's own abstract of the paper which appears in the April number of the *Medical News* :

"Observation and experience, beginning more than forty years ago, along with such attention as has been within my power to current medical literature, have made me acquainted with a process or transition going on in medical practice, especially in regard to the treatment of acute inflammatory affections, of which pneumonia may be considered as a type. Between 1845 and 1855, the accepted treatment of pneumonia was what was then called moderately antiphlogistic; including early and moderate abstraction of blood in patients of good strength and not over middle age, early purgation with some active cathartic medicine, and then the use of agents, chiefly mineral salts, to promote and maintain the action of the skin, kidneys, and bowels; very little use of opium being made, unless at a late stage, and quinine being reserved for that period as a tonic; alcoholic stimulation being resorted to only in cases of exceptional prostration, as in aged patients, or in those of enfeebled constitution, or when a severe and prolonged attack brought on decided exhaustion.

Under this treatment, in private practice, patients with uncomplicated pneumonia and pleuro-pneumonia very generally recovered; and in hospitals

their mortality was hardly more than one death in ten cases; often considerably less than in that proportion. In Suffolk Hospital, England, in 1836, there was only one death in fifty cases.

Between 1855 and 1860 a movement of reaction went on against bloodletting, in which Dr. J. Hughes Bennett was one of the most conspicuous leaders. This was shortly followed, in part, indeed, accompanied, by the introduction, under the leadership of Dr. R. Bentley Todd, of the early and free use of alcohol in pneumonia and other acute inflammatory diseases. Next came the era which still continues, of physiological rationalism in therapeutics; characterized by a general abandonment of previously approved principles and methods, and the substitution for them of the use of potent agents upon special indications in regards to the functional actions and conditions, these agents being first tried in the laboratory upon animals, either in a state of health or in various conditions of traumatism. Prominent among the agencies thus lately much used in practice are those designed, as 'apyretics,' directly to lower the temperature of the body when it is abnormally elevated in disease.

The 'working theories' of practice in acute inflammatory diseases have thus, with very little appearance of distinct formulation, undergone a gradual, but very positive change. To-day the predominant method of treatment of pneumonia may be said to be characterized by the following features: 1, the practically universal omission of venesection, and the very rare local abstraction of blood; 2, the general disuse of active cathartic medicines in the early stage; by many, perhaps a majority of physicians, the early and continued use of alcohol, to the extent of from 2 to 12 or more fluid ounces in 24 hours; quinine, mostly in 10 or 20 grain doses, once or twice daily; opium or morphia, from the start or near it, averaging perhaps sulphate of morphia gr. $\frac{1}{2}$ to gr. $\frac{1}{4}$, every 3 or 4 hours; with deviations from this general plan, or additions to it, by the use of antipyrin, antefebrian, aconite, digitalis, etc.; and warm applications, as poultices, or cotton batting to the chest; or counter-irritation with turpentine, etc. These last may be said to be common to the old and new methods of treatment.

For definite information sustaining this account of now predominant practice, I refer to Hospital

Notes, published last year, of hospitals in New York, Boston, and Philadelphia; also, memoranda furnished me during last year by a resident physician in one of our largest and best hospitals; and the *dicta* concerning treatment, of Dr. A. L. Loomis, in his article on 'Croupous Pneumonia,' in vol. iii. of the *American System of Practical Medicine*.

It is entirely legitimate to apply to these old and new, different, and in some respects opposed, methods of practice, careful *reasoning* as to the principles upon which they are based. Considerable attention is given to this kind of comparison in the paper of which this is an abstract. Yet it is also appropriate, and is more nearly decisive in importance to bring to bear upon them the testimony of *facts* concerning the *results* of the different modes of treatment which are compared. It is true that an absolute demonstration of therapeutical conclusions by means of statistics is not often practicable. My opinions on this subject have not been founded on statistics, but upon direct personal experience. But, when evidence of that kind, of a marked character and considerable in amount, can be adduced, it is manifestly worthy of careful attention, even when the conclusions to which it points are different from those which, in practice if not in theory, are in vogue, and which are approved by highly respected authorities, at the present time. Such evidence it is the principal purpose of my paper to bring forward, and apply to the question, how we ought to treat acute, uncomplicated pneumonia, in patients of ordinarily good constitution, not over middle age.

From sources and authorities which will be admitted to be reliable, and which are referred to in full in the paper of which this is an abstract, I have obtained and analyzed statistics, of which I will now give a summary account. I will say that, throughout my analysis of these statistics, I have made liberal allowance in favor of that construction of the facts which is most opposed to the conclusion which my judgment approves. On behalf of the latter, a much stronger case might be made out, if my aim were anything other than the actual truth.

First, a comparison is made of the results of different modes of treatment of pneumonia, within a few years prior to 1858, reported by between forty and fifty physicians, of 11,627 cases in Great Britain and Ireland and on the continent of

Europe. Of these, 2,751 cases were treated with bleeding, and 8,876 without it. Among the latter, however, 452 cases had exceptional modes of medication in the use of chloroform, lead, copper, or iron. Deducting these, the comparison rests between 2,751 cases treated with, and 8,424 cases without bleeding. The figures, in summary, are these:

With bleeding, either often, a few times, or once, with or without tartar emetic, altogether, 1 death in 11.1 cases.

Without bleeding, under all treatments except with opium—except, also, with chloroform, copper or iron, as before said—1 death in 9.7 cases.

Large and repeated bleedings, alone, 1 death in 11.6.

Bleeding a few times, or moderately, alone, 1 death in 12.3 cases.

Bleeding and tartar emetic, 1 death in 12.56 cases.

Tartar emetic, no bleeding, no opium, 1 death in 11.3 cases.

Opium, without bleeding, 1 death in 3.3 cases.

Tartar emetic and opium, without bleeding, 1 death in 3.8 cases. I would call attention especially to these last figures, for the greatest mortality obtained under any method was that under the opium treatment of pneumonia.

Next, I present a comparison of mortality from pneumonia in the United States Army, at two periods: one before the anti-bloodletting movement had fairly set in, and the other, when it had begun to make a decided impression upon general practice. Between 1840 and 1854 there were, in the United States Army, 1,416 cases of pneumonia, with 127 deaths—1 in 11.15; between 1855 and 1859, 657 cases, with 97 deaths—1 in 6.67: an increase of more than one-third in the proportion of deaths.

The testimony of Dr. George B. Wood, in the first edition of his *Practice*, published in 1847, was decided as to the favorable prognosis of uncomplicated pneumonia, especially in early life. Dr. Lewis P. Gebhard, of Philadelphia, whose practice began near the beginning of this century, and was extensive for many years, told me, near the end of his life, that he had never lost a case of simple pneumonia.

Examining the records of the Pennsylvania Hospital, as a representative institution, with a medical

staff excelled by none in reputation and ability, I have found the results to be as follows: In the three years, 1845, '46, and '47, from pneumonia and pleuro-pneumonia, 1 death in 16 cases—6¼ per cent.; in the years 1865, '66, and '67, 1 in 5½th, or 18½ per cent.; in 1884, '85, and '86, 1 in 5.2, or more than 31 per cent. To make sure the avoidance of the error of confounding cases of acute tuberculosis with pneumonia, in this comparison, I invariably took only those fatal cases in which the diagnosis of pneumonia was entered at the time of the *death* of the patient. In collating some other statistics of the same hospital, which were cited in the discussion upon my paper in the Philadelphia College of Physicians, I believe this precaution was not taken; and hence a greater mortality was inferred, throughout the time investigated.

Dr. A. L. Loomis, in his article on 'Croupous Pneumonia,' in the *American System of Practical Medicine*, states that the average ratio of deaths from pneumonia to those from all diseases together, in New York, was 15.2 per cent. greater between 1859 and 1877 than between 1840 and 1858:

Other figures are given more fully, with references to their authorities, in my paper. The figures may be altogether summarized thus: first, all prior to, or not later than, 1858.

Skoda estimated the average mortality of pneumonia, about 1841, as 1 death in 8 cases. Balfour, near the same time, reported his observation in a homœopathic hospital under Fleischmann (treatment probably *nil*), of a mortality of 1 death in 6½ cases; Dietl, with diet only, no bleeding nor medication, 1 death in 3.5 cases: in the British army, at home, and in various stations, average of all together, 1 death in 20.66 cases; hospitals in a number of different cities in Europe, from 1822 to 1854, average 1 in 9.54; United States Army, as already said, from 1840 to 1850, 1 in 11.15; Pennsylvania Hospital, as before mentioned, 1845, '46, '47, 1 in 16. Taking all these together, it is safe and fair to estimate the average mortality of pneumonia, during the second quarter of this century, as not more than 1 death in 12 cases, or 8.33 per cent.

Coming now to the recent and present mortality of the same disease, we find it editorially stated in *The Medical News*, of December 11th, 1886, that 'the rate of mortality' of pneumonia 'in the large general hospitals in this country is rarely below, more

often above 25 per cent., which represents about the average death-rate from this disease in the Northern and Southern armies during the Civil War.' It is added, that 'in this country extensive statistics of pneumonia in private practice are not available; but in the recent returns from the Collective Investigation Committee of the British Medical Association, the mortality was 18 per cent.' This last ratio, it will be perceived, is considerably more than double the carefully computed mortality of pneumonia before 1858, namely, 8.33 per cent. We have thus, I think, a *demonstration* of the large increase in the proportion of deaths from that disease in recent times, over what it was thirty, forty, and fifty years ago.

How is this increase of mortality to be accounted for? Three hypotheses are conceivable.

1. The records may be supposed to have undergone modification through improved methods of diagnosis. There is no ground for this supposition. The physical signs, as well as the symptomatology, of pneumonia, were well understood forty and more years ago, by those physicians whose reports have furnished materials for the statistics which have been cited. The use of percussion, in aid of diagnosis, dates with Auenbrugger, 1761; auscultation began with Laennec, about 1818.

2. 'Change of type' of the disease may be asserted; or a general change in the constitutions of men, affecting the character of all diseases. Reasons are given in my paper for believing that neither of these hypothetical assumptions has such support in facts as at all to meet the requirements of the case. While, at all periods it may be sometimes sthenic and sometimes asthenic or typhoid, pneumonia is practically the same disease that it was forty or fifty years ago.

Lastly, therefore, we are brought to dwell upon the coincidence between this great increase in the mortality of pneumonia and a marked change in prevailing methods of treatment.

What has brought this change of treatment about? Is it a better knowledge of the pathology of pneumonia? No. Autopsic and microscopic investigations have cleared up certain minutæ, as to the distinction, for example, between croupous and catarrhal pneumonia. But we still have, as ever, the first stage, of congestion; and, the second, of red hepatization of the lung; in other words, primary *stasis*, with interrupted nutrition, at the focus

of inflammation; concentric hyperæmia there, and general vascular excitement of the system; then exudation, whose changes chiefly determine the increased vascular tension following a local obstruction to the circulation, gave the indication for measures of relief in the older practice; and that *indication* still remains, in the presence of the most advanced researches as to either the crass or the minute morbid anatomy of pneumonia.

Attention is given in my paper, at length, to the opinion now ascertained by some pathologists, that pneumonia is a systemic fever, with lung changes as merely its local manifestations; especially in connection with the theory of the microbic causation of the disorder. Jaccoud, in France, and Dr. H. B. Baker, in Michigan, are cited as having not long since* given *demonstrative* evidence that the essential, necessary cause of pneumonia *cannot* be microbic; dry cold having the most to do with its production, in at least much the larger number of cases; while the bacilli and micrococci often found present may, no doubt, exercise a morbid action, affecting the character of the disease. If, however, it were even proven that pneumonia depends upon microbes for its causation, that would not decide the question of its treatment, while we are not in possession of direct and certain microbicidal measures of therapeutics.

By all these considerations we are led at last to the conclusion, that the change in practice that had been referred to, has no other origin than a fluctuation of opinion, not justified by facts or reasoning, concerning principles in therapeutics. This fluctuation involves:

1. A depreciation of the value of the early abstraction of a moderate amount of blood, locally or by venesection, for the relief of active inflammation, in persons of good previous health, and not advanced in age.

2. A like depreciation of the utility of early catharsis, especially as an eliminative agency, to prevent the accumulation in the system of the products of regressive metamorphosis of the tissues.

3. The same want exists of due valuation of salines, formerly called refrigerant medicines, for lowering blood-pressure and promoting the func-

*Jaccoud's paper was communicated to the Académie des Sciences, and was reported May 7, 1887, in *La France Médicale*. Dr. Baker's investigations have been made public in several places within a year or two.

tional activity of the skin and kidneys, as well as the bowels.

4. An erroneous, exaggerated estimate prevails of the beneficial influence of large doses of quinine, employed for the reduction of temperature. Testimony is accumulating as to the failure of the use of quinine in antipyretic doses in the treatment of pneumonia. Dr. Cartholow and Osler, in Philadelphia; Drs. Kinnicutt, Ripley, Putnam Jacobi, Castle, Billington, and Emmet Holt, in New York; and Drs. Shattuck and Minot, of Boston, are among those who dissent from the now common approval of this point of practice.

5. An especially injurious error consists in the administration of opium and morphia at an early stage of pulmonary inflammation. The tendency of opiates to *diminish bronchial secretion* stands right in the way of their utility in pneumonia. I may here recall the statistical fact, mentioned a little while ago, that in the reports of results of different modes of treatment before 1885, the worst record of all was attached to the opium treatment of pneumonia.

6. An experimental administration is now being carried on of antipyrin, antifebrin, etc., as antipyretics, whose results do not correspond with what is desired of them as remedies for acute organic inflammation. They have another rôle, as neurotic medicines, in which they possess much value. I may remark incidentally, as an example, that in Dr. Pepper's interesting case, reported in the *Medical and Surgical Reporter* early in last year, it appears to me probable that it was the *neurotic* element in the case—the strongly marked tendency in convulsions—that received benefit from the antipyrin used rather than the pneumonia itself.

7. The practical ignoring must be noticed, in recent therapeutics, of the important difference between the *debility of oppression* in the early period of severe attacks of acute disease, and the *exhaustion* which belongs to a later stage of the same, or which is produced by other causes and conditions. The *treatment* of these two states, as was long ago recognized, is properly quite different.

8. Connected with this, the early and free use of alcohol is now common. In my judgment, except in previously enfeebled patients or those otherwise exceptionally prostrate, this is an injurious medication in pneumonia. Heart-failure during the early stage, in patients of previously good health, may be

best averted by so lightening the burden of oppression imposed upon the heart, as to make it possible for it to carry its load without exhaustion. It is under a prevailing so called 'supporting' treatment that not a few men in the prime of life have, within a few years, dropped off under less than a week's illness with pneumonia.

The relief often afforded by bleeding, without consequent exhaustion, even at a somewhat late stage, to the condition characterized by distention of the right heart (this being a practice approved even by many physicians who are otherwise opposed to bloodletting) should be remembered and set over against the excessive fear entertained by some of the production of debility by early bleeding.

I conclude, then, that there is reason for the judgment that the now current 'working theory' of the treatment of pneumonia and allied affections, by early and continued stimulation and narcotism, is not supported by the facts concerning the results of the treatment, as compared with those of the *moderate, early, sedative and eliminative* practice of forty and fifty years ago.

I do not assert that venesection is called for in nearly all cases; but I believe that early local depletion will do no good in the majority, in patients not old, and who were previously in good health; and that early active catharsis, with diaphoretics and diuretics afterwards, are rightly in place; quinine as a tonic, and alcohol as a stimulant, being indicated only exceptionally at the beginning, in persons of low vitality or bad habits, or old age; more often, when real exhaustion is imminent, at a late stage.

There is more room for question, on the basis of experience, between the older practice and pure expectancy, nursing the patient in bed without medication, than there is between the therapeutic methods now current, in regard to acute inflammatory affections, and those of the early part of this century. We want no return to any Sangrado extreme; but only to replace in their position of confidence, lost for a time, some of those measures of practice, which have been abundantly tested and commended by the experience of ages."

The Tongue as an Indication of Disease.

It must have required the courage of his convictions that all that is seemingly old and time-worn is not therefore necessarily useless, as well as the

reputation of the author, to have made it possible for W. Howship Dickinson to have taken the above title as that for his Lumleian Lectures before the Royal College of Physicians. In his introduction he says: "I am about to examine the subject with a fresh appeal to nature, and, putting aside for the present an ancient faith and modern scepticism, shall be content simply to collect the evidence of the wards and the dead-house and let the tongue speak for itself. . . . I look at the tongue as a physician, not as a surgeon, and regard it as symptomatic of disease rather than as the seat of it."

After stating how he had arrived, through both clinical and microscopic methods at the basis for classification, he states that "the first stage is when the papillæ are separately capped with a minute white patch, which consists mainly of horny epithelium: this tongue I called *stippled* or *dotted*. As the covering increases the spots coalesce, cease to be discrete and become confluent, or at least appear so to the naked eye. To this degree the term *coated* is applied, as indicating continuity." The term *plastered* is applied to the highest development of the tongue coated, while *furred* is applied to that where, with much coating the papillæ are elongated from each other, at least, at their extremities. Descending from these stages of complete covering we have the cleaning of the tongue, either gradually or abruptly, leaving the several forms of the red, denuded and raw tongue.

The method adopted by Dr. Dickinson was to arrange the cases coming before him in hospitals, in tabular form, annexing at the same time other details, as (1) the disease and its duration; (2) the general state as to strength, prostration and consciousness; (3) the temperature of the body; (4) the arrangements as to food and drink; (5) observations relating to bowels and stomach, to the nervous system, to respiration with regard to mouth and nose; (6) the presence of morbid discharges by diarrhœa, diuresis or suppurative; (7) the amount of the saliva and the moisture or dryness of the mouth. The tables include 366 cases.

Under his first class of healthy tongue we meet the statement at the outset that there are congenital differences in the number and prominence of the papillæ, and further that no absolute standard of cleanness can be set down as a gauge

of perfect health, applicable to every person. What is normal in one may be abnormal in another. To know the condition of the deep tissues is, he says, necessary to have a true idea of what these coatings mean. The papillæ are projections of the corium, while upon the corium is the epidermis with its three layers (*a*) the deepest or rete malphigii; upon this a stratum composed of lozenge-shaped nucleated cells, which correspond with a difference to the corium of the skin; and upon this a horny formation which is special to the tongue and which forms the whole coat. These epithelial cells, from being polygonal in the malphigian layer, grow, as they grow old, the surface flattening and elongating, till, as the horny layer, they have lost their cellular form and are become fibrous. "It is this horny layer which essentially constitutes the coat or fur." . . . On the surface of the tongue attached chiefly to the prominences of the epidermis, is a varying amount of parasitic growth, chiefly in the shape of micrococcus. This presents itself chiefly in the shape of rounded accumulations upon the outstanding papillæ. The total bulk of the accumulations, however, whether parasitic or accidental, bears but a small proportion to the epithelial structure of which the coat or fur essentially consists. In health, this mucous membrane must, we say, have the surface described, exposed, not concealed by any coat or accumulation, however derived and it must be normally moist. "There are local and chronic diseases in abundance, in which the tongue is normal; few involving pyrexia or any general disturbance."

In the *stippled* tongue the first indication of disease the apparent epithelial overgrowth means rather the retention of what is old than the development of what is new, attributed perhaps to the absence of food, connected with loss of appetite, and perhaps in some measure to the stillness of the tongue which illness engenders.

In this condition were found many tongues in patients whose condition, while not abnormal, was often a first departure from general health as in chronic heart disease. This tongue does not belong to pyrexia and seldom "concurs with grave constitutional trouble of any kind." As a general rule, a larger degree of constitutional disturbance is apparent when the tongue is dry than when it is moist.

The next stage is intermediate between stippled and coated. The white accumulation is not now limited to the papillæ, but partly, or wholly, fills up the depression between them, often coating the tongue completely at the back. This tongue is of frequent occurrence, often marking a slight departure from health.

In it we find a large proportion of chronic diseases, but not an increase of constitutional affections. Pneumonia often having the first is now not so often represented as typhoid and acute rheumatism. The change is due in part to the increase of pyrexia and partly greater use of liquid diet.

Of the next, or coated tongue, we have many degrees, but the strawberry and plastered are the most characteristic. With this stage, or the coated tongue, the saliva was noticeably deficient in a larger number of cases than heretofore. In the strawberry tongue the papillæ of the tip and edges are greatly injected, as for instance in scarlatina, when they show the increased vascularity of the organ due to its participation in the cutaneous eruption. The plastered tongue is clinically that of acute disease, as on the fourteenth day of typhoid, when it is often so smooth as to give the idea of plaster-of-paris. Each day of the disease the tongue became less white and drier up to a yellow brown. The saliva at this stage is not only decreased by evaporation, but secretion is also lessened, and this may exist with a tongue almost without coating.

Heat or increased temperature rather than specific blood poison, seems to be the potent influence, in lessening secretion while increasing cell growth. The shaggy or furred tongue usually shows greatly elongated filiform papillæ. Dry furred tongue has been noticed with disease of the brain, cirrhosis and indurated liver, in all of the instances with little or no pyrexia. In short, this tongue is essentially due to two causes connected together—want of saliva and want of wear. "Amongst the causes of want of saliva, the most important is a state of system which cannot be otherwise defined than as a failure of nutritive vital power."

The further discussion is continued in other lectures. We are curious to know the special explanation which the lecturer will attach to those varying conditions of tongue seen in typhoid conditions generally, and in those instances where with almost no coating is not unfrequently found a thin, brownish

film indicating often serious disorders. But we shall not anticipate many other tongue phenomena to be described in a series of lectures by one selected for the high honor of giving the Lumleian course.

Italian Treatment of Pulmonary Tuberculosis.

Prof. Enrico de Renzi (*Il Margagni*, abstract in *Centralbl. für d. gesammte Therapie*, February, 1888,) passes under review the influence of creasote by the stomach and by inhalation; of iodoform, turpentine, iron, sulphuretted hydrogen. Creasote in considerable doses greatly lessened the bronchial muco-pus and the purulent matter of cavities, and exercised a favourable influence over the general nutrition. The following formula was used:—

Creasote (pure).....	5 parts.
Alcohol	100 "
Balsam of Peru syrup.....	" "
Water	" "

Dose, 1 tablespoonful.

The rectal gas injections exercised a favorable influence on cough and expectoration, but had no effect on the existing pulmonary lesions.

He concludes that the most clearly curative effects are obtained by large use of iodine and iodoform. *Amer. Jour. of the Med. Sciences*, April 1888.

A Specimen of Hydro-Salpinx.

At the first of March meeting, of the Obstetrical Society, of Philadelphia, Dr. Goodell presented a specimen of hydro-salpinx. It was the largest specimen he had ever seen; although he had met with much larger specimens of pyo-salpinx. The case had been treated by many gynecologists, and the true condition had not been recognized. There had followed the operation a complete relief from pelvic pain, but menstruation had continued up to the present time. The periods were, however, becoming less frequent. Since it was contended by some eminent surgeons, that when menstruation continued after the removal of the uterine appendages, some of the ovarian stroma must have been left behind, he wished to call the attention of the society to the complete extirpation in this case of both ovaries and tubes. Although the former were more or less adherent, it was evident from the specimen that a particle of ovarian stroma was left behind.

Premonitory Symptoms of Phthisis.

The *Med. Reg.*, March 17, gives the following extract from a recent work of M. Rene Serrand, who has made a special study of the first symptoms of phthisis: In patients doomed to pulmonary phthisis there always exist very clear and decided pharyngo-laryngeal signs, which precede for some time the pulmonary symptoms. These signs are three in number: 1. Pharyngeal anæmia. The pharynx is pale, white, discolored, in place of having its normal color. 2. Impaired action of the inferior vocal chords through atony of the constrictors. 3. Local congestion of the arytenoid and inter-arytenoid mucous membrane, manifesting itself in swelling and a cherry-red inflammation of that locality. These three signs may exist simultaneously or alone. The presence of even one is a strong indication of approaching pulmonary tuberculosis; whenever a physician finds all three present, this prognosis is certain. Pharyngeal anæmia, impairment of the vocal chords, and congestion of the arytenoid region, symptoms which have nothing in common with laryngeal phthisis, are the heralds of pulmonary consumption. The physician who knows how to read the larynx of his patient can avoid a great many missteps. For, warned of the danger ahead, he can institute a prophylactic treatment, and arrest phthisis in its first stage.

Dyspepsia.

Professor German Sée in his treatise on "Gastro-Intestinal Dyspepsias" says: I have endeavoured to demonstrate two facts: 1. That dyspepsia is always and necessarily a defective chemical process, due to some alteration of the elements of the gastric juice, and especially of the hydrochloric acid; the gastric juice may, moreover, be imperfect by reason of inertness of pepsin, or by reason of excess of peptones formed, or of mucus preformed, all of which retard the digestion. This constitutes dyspepsia proper. At the last three Congresses of German physicians, Van-der-Velden, Leube, Riegel, Ewald and Boas, Edinger and Jaworski, have endorsed, without giving me credit for my own researches and conclusions, this chemical view of dyspepsia, adopting principles of pathogenesis and a classification which I have long taught. 2. The second fact which I endeavoured to bring prominently to light at the epoch when I published my book, was this: All the properties of the stomach

which do not belong to the domain of chemistry, such as the sensory and motor innervation, are simply auxiliaries to true digestion; they may, in fact, undergo grave modifications without any real digestive trouble resulting. When the gastric innervation is impaired, there ensues a series of perturbations which often simulate the phenomena of dyspepsia, and to such an extent as to render the distinction very difficult; we have, however, to do in these cases only with *nervo-motor* states, with atony or spasm of the stomach.

THERAPEUTIC NOTES

The New Heart Remedy—Strophanthus.

The British Consul at Zomba (East Central Africa) gives the following notes which he has obtained from Mr. Buchanan, in reference to this plant:—

"Strophanthus is considered the most powerful poison the natives possess. It is found at a low level, and, as far as I can gather from personal observation and native sources, it is not to be had on high land. The supplies hitherto obtained have been drawn from the right bank of the River Shiré, below the Murchison Rapids. There is, apparently, more than one species, or, at least, variety; the distinguishing feature being a much smaller pod and fewer seeds. At present, information relative to these other varieties is scant."

The *British Medical Journal* reports the experience of Mr. Montague D. Makuna, in the use of strophanthus in heart disease. The doctor bears testimony to its action as a certain cardiac tonic and powerful diuretic. He says:—

"I have used it, firstly, in four cases of angina pectoris, in two cases associated with dilatation of the heart. A fortnight ago I was called to see a young man, aged twenty five, in an agony of pain, with tumultuous action of the heart. Within five minutes of the administration of a five minim dose his breathing became quiet, pain disappeared, and the rhythm of the heart's action was restored. In cases of dilatation of the heart, the patients took five minim doses three times a day with marked benefit.

Secondly, I have used it in two marked cases of fatty degeneration of the heart. I had a patient, aged forty-five, under treatment when Prof. Fraser read his paper, and whose life was altogether de-

spaired of at the time. The state of degeneration was much advanced, and she had some general dropsy. She lived to take it for eight months—five minim doses three times a day; but about six months after its first administration the cardiac response became more feeble, until she succumbed. I believe her life was prolonged with some comfort by the use of strophanthus. I have at present a case of fatty degeneration of the heart in a woman, aged forty-nine, accompanied by an attack of angina, much dyspnoea, and palpitation. I have administered to her five minim doses every hour till the action of the heart is quieted, and the breathing rendered easy. She now takes it three times a day in the form of a mixture, which can safely be trusted to the patient, namely:—Tincture strophanthus, one and a half fluid drachms; extract ergot liq. six fluid drachms; spirit chloroform, one and a half fluid ounces; aquæ lauraceræ ad. four fluid ounces; a teaspoonful three times a day in a wine-glass of water. The latter patient has taken this mixture during the last week with marked benefit.

I have had, unfortunate experience from the use of tincture prepared from other parts of the plant than the seed, in two cases which eventually proved fatal. Judging from actual observation at the bedside, I can not but pronounce it as uncertain in action and totally unreliable, notwithstanding the assurance of the druggist of its equal efficacy when the supply of seeds had gone out of the market at the end of last year."—*Leonard's Illustrated.*

Playfair on Apostoli's Method.

The *Nash. Jour.* gives the following reply by Dr. Playfair to a letter of enquiry from Dr. McKee of Cincinnati: That it is a therapeutic agent of great power and considerable promise I am sure. I doubt, however, if it will accomplish all of Apostoli's somewhat enthusiastic estimate. Roughly speaking, I have hitherto found the most satisfactory and remarkable results from the use of the negative electro current in cases of membranous dysmenorrhœa and chronic endometritis with glairy, glutinous discharge. One or two of my cases of this kind have been quite remarkable, and have yielded to two or three applications when all other treatment had failed. The hemostatic effect in hemorrhagic fibroids has so far disappointed me.

This, however, may be only a temporary conclusion. Some of my cases have done really well, others have not improved. Keith's remarkable statement that he has not once performed laparotomy in such cases since adopting this treatment is of the greatest moment, and makes me certain that my own cases are, as yet, not numerous enough to decide this point. I have had, at least, one very remarkable case of rapid absorption of a large fibro-myoma under negative electric puncture. I had known and watched the tumor for years. After three applications of currents of 100, 150, and 200 milliamperes, it reduced from the size of a large human head to that of a shaddock (a large orange). There was, however, a good deal of pyrexia and constitutional disturbance that at one time caused me considerable anxiety. I am sure that electrical treatment must be very carefully and not indiscriminately used, otherwise serious mischief may accrue.

Antifebrin in Hemicrania.

Ott (*Prager Med. Wochenschrift*, No. 47, 1887), has found that antifebrin exerts an extremely prompt action in hemicrania, even in obstinate and old cases. He gives seven and one-half grains at the beginning of the attack. The result is said to be admirable. The drug also did good service in a woman suffering from trigeminal and optical neuralgia, with dysmenorrhœa.

Gen Paragraphs

Unabsorbed Pills.

We constantly read or hear about cases in which pills have not been digested and absorbed, being not unfrequently passed in the same condition as far as rotundity of form and perfection of coating are concerned as when first ingested.

The eternal "Why?" has been put in requisition here as in everything else, and various theories have been advanced as to the cause, probable, or more often fanciful, of the non-absorption of that beautiful and most elegant *looking* pharmaceutical preparation, the "Sugar Coated" Pill.

The following excerpt from Remington in his "Practice of Pharmacy" has suggested to us a very probable solution of the question, why are sugar coated pills passed unaltered? In the description of the process of putting a finish or polish on the pill he says:

"A polish is given to the pills by agitating them in a bag or rolling them in a shaker in contact with a piece of *wax* or *paraffin*."

Now, how even a pill manufacturer could imagine a combination of ferments, peptic, pancreatic, or biliary in the human economy which would be possessed of sufficient strength to dissolve a *paraffin* coated pill we fail to perceive.

Antipyrin as a Hæmostatic.

Dr. W. M. Powell, in a communication to *Daniel's Texas Medical Journal*, March, 1888, says that he was sent for in haste to see a woman who had a frightful hæmorrhage from a sore leg which had been struck, and when he arrived he found her nearly exhausted. A four per cent. solution of antipyrin was applied, and he had the satisfaction of seeing the bleeding quickly checked. A light compress and bandage was then applied, and the extremities elevated on pillows in bed. No more hæmorrhage occurred.

A few days later he operated on a boy seven years old, for phimosi, removing nearly one inch of prepuce; the hæmorrhage was profuse. Before removing the clamp forceps he applied a four per cent. solution of antipyrin, and also immediately after removing them. All bleeding was promptly arrested and mucous membrane and foreskin were neatly brought together with numerous stitches without the least annoyance from further hæmorrhage. A simple water dressing completed the operation, and on redressing, the following day, he says he does not think he ever saw a cleaner, nicer wound.

Jaborandi in Hiccough.

The following from the *Nederlandische Tijdschrift voor Geneeskunde* may prove useful: In a case of obstinate hiccough which continued day and night and brought the patient fearfully low, all possible means—bromide of potash, morphine, belladonna, galvanism, pressure upon the trunk or the vagus and phrenic—were employed without relief. Kiiithe, however, secured prompt success from a decoction of jaborandi, 8 parts to 180. The hiccough did not recur.

Cholera Infantum

Dr W. H. L. Hale recommends the following formula in cholera infantum, and many other diarrhoeal disorders in children:—

R. Bismuthi salicyl., . . . ʒij
 Tr. capsici, gtt. xij
 Spts. ammon. aromat., . . . fʒiiss
 Pulv. acaciæ, ʒij
 Aq. cinnamomi, q. s. ad. fʒij M.

Sig.—Teaspoonful every two hours, for a child from three months to one year of age.

NEUROLOGY.

Cause of Nerve Injury. Recovery with operation.

The *Med. Rev.* gives the following from Dr. H. H. Fotheringham: A lady, aged about 35 years, sustained a fracture of the right humerus by a fall upon the elbow. The fracture was situated just below the insertion of the deltoid muscle, was oblique, and the displacement extreme. The patient complained bitterly of pain in the forearm and hand, which was not relieved by reduction of the fragments of bone. Morphine in large doses was necessary in order that any sleep might be obtained. Two days later the pain was somewhat diminished, and was referred by the patient to the area of distribution of the musculo-spiral nerve below the elbow. Five days after the injury motion of the wrist and fingers seemed to be impaired. Seven days later the extensors and supinators of the hand and forearm were found to be completely paralysed and there was œdema of the back of the hand. One month after injury the condition was as follows: There was strong bony union of the fracture, there was cutaneous anæsthesia of the back of the hand with œdema and glazed skin, complete paralysis of extensors and supinator muscles.

Under a diagnosis of compression of the nerve an operation was suggested to the patient, who demurred. Faradism as a next resort, to exercise the muscles, was advised. About this time the patient left the city and placed herself under the care of a specialist who applied both galvanic and faradic currents to the arm several times a week, but without improvement.

Two months later the lady returned unimproved and ready for any measures that promised relief. Accordingly, the nerve was cut down upon and found just as it reached the front of the internal inter-muscular septum; from this point it was traced backward through what had been the musculo-spiral groove but now corresponded to the line of fracture and was filled with callus, against which

the nerve was found compressed by a band of cicatricial tissue about an inch in width and one-fourth of an inch thick. This cicatrix was the result of laceration of soft parts, dependent upon the extreme displacement of fragments of fractured bone. The nerve was not caught in bony callus, but was found free in its sheath, though diminished to about one-third of its normal size and tinted a yellowish brown at the point of constriction, this tint shading off into light yellow below, and clear white above.

The cicatrix was excised and the cut triceps muscle united by catgut sutures, bone drainage introduced and the wound closed. The incision healed by first intention. Within twenty-four hours after operation acute pain appeared in the hand and forearm but gradually subsided, lasting perhaps ten days. Two weeks afterwards very slight extension of the wrist could be accomplished, sensation having returned nearly to normal. Improvement from this time on was constant, and twelve weeks after operation the patient had resumed her former occupation, that of fancy embroidery, requiring a high degree of skill in the use of fingers, and was apparently as skilful as ever. At the present date the hand and arm seem perfectly normal with the exception of the scar left by the operation.

In this case, after twelve weeks entire loss of function the nerve showed unmistakable signs of recovery within two weeks from date of operation, and in ten weeks more had entirely recovered.

Rabies in Man and the Lower Animals.

Our interest in this disease referred to by "The Select Committee of the House of Lords on Rabies in Dogs," in the following terms: "The frightful character of hydrophobia in man naturally engenders horror at the bite of a dog, and unreasonable dread very often occurs; it is clear that panic attributes rabies to many dogs which are free from it, and there are indeed so few which really have the disease, that the great probabilities are in favour of persons bitten escaping the consequences so readily feared," is increased by the report just published by the Agricultural Department, regarding an outbreak of the disease amongst the deer in Richmond Park in 1886-87. The investigation was conducted by Mr. A. C. Cope, Chief Inspector, and Victor Horsley, F.R.S., of the Brown

Institution. By April 1887, 160 animals had died at the rate of four per week, all of them presenting decided symptoms of some form of nervous disease. Analysis of the stomachs of some of these animals, at the suggestion of Local Authorities, having failed to detect any evidence of poisonous food, the matter was brought before the Government Authorities. Separation of the animals and feeding on different pastures not having limited the disease, it was concluded that it could not have been due to poison. With the uncertainty as to the cause, several animals were transferred to the Brown Institution for examination and experiment.

Of these a buck became so wild and violent that the persons in charge were unable to enter the loose box in which it was placed. This animal died two days after its arrival, and some rabbits were inoculated with portions of its spinal cord, with rabies as a result.

These animals, usually so timid, would rush at any person looking at them, and bite at a broom or a stick if put through the bars of the door.

Although the inoculation of the rabbits resulted in their death from paralytic rabies, I suggested, says Mr. Cope, to Professor Horsley the desirability of inoculating a dog to see if true rabies could be produced in that animal. Accordingly, on May 26, a dog was inoculated with part of the spinal cord of another affected deer which had been sent up from Richmond Park. Eleven days after the inoculation, *i.e.*, June 6th, the dog presented symptoms of rabies and died on June 12th; the autopsy was conducted by Professor Horsley, who found all the characteristic symptoms of rabies present.

It having now become certain that the disease among the deer in Richmond Park was true rabies, it was considered desirable to stamp out the disease as soon as possible. The animals were still confined to the enclosure in which they had been placed, and Mr. Sawyer was advised to forthwith shoot any animal presenting the least indication of the disease. This was accordingly carried out.

The earliest symptom observed in most cases was that of throwing their heads back on the shoulders and keeping their noses pointed to the sky; the animals are then seen to make sudden starts and gallop right away from the rest of the herd.

After a few days illness the animals invariably die, some presenting violent paroxysms, while in

other instances paralysis of the limbs becomes most marked before death.

Further, it is now clearly established that rabies can be transmitted from herbivora to herbivora by the ordinary means of infection, viz., the saliva.

This assertion, says the report, is, I think, warranted by the fact that although these animals were isolated for a period of six months, a time far beyond the recognized period of incubation in rabies, the disease continued to progress in the herds after all possible means by external infection had been cut off.

The most important question, however, which arises out of this outbreak, is the means by which the virus was transmitted from animal to animal.

It has been found that although the deer attempted to bite one another, they did not really penetrate the skin with their teeth, but only produced sores thereon; at the same time the diseased animals left a certain amount of saliva on the skins of those which were bitten. It was observed on several occasions when a healthy deer had been bitten by a rabid one, that the animal bitten licked the spot, no doubt with the desire to soothe the irritation caused by the pinch or bite, and Mr. Sawyer informed me that it is a common practice for deer to lick the coats of other deer.

From the clinical report we extract the following:—

Deer No. 4.—Admitted into the Brown Institution 20th June 1887. This animal, a buck, had been separated from the herd for three months, till the 1st June when, as described by Mr. Cope, Deer No. 3 was placed with it and attacked it severely. On the 19th June (thus 19 days, incubation period) it showed the premonitory symptoms, and was at once forwarded to the Institution.

20th June 1887.—Animal very excitable and most aggressive. It made attempts to eat and drink, but it was very difficult to determine whether it actually swallowed food.

June 21st.—Worse, much more vicious. It stood with its head thrown back, the eyes staring, and it charged everything which suddenly attracted its attention. This day I observed for the first time in these animals a genuine pharyngeal spasm on its attempting to swallow water. It plunged its muzzle deep in the water, made champing movements with its jaws, and tried to swallow. The larynx could be seen rising in jerks just as in the human being,

while the water ran out of the angles of the mouth. It did not eat.

22nd June.—Paresis set in this day. Every charge the animal made was accompanied by staggering, and not infrequently fell, the hind quarters sinking and the hind limbs collapsing.

23rd June.—Animal died in the night.

In the pathological and experimental report we find it stated that from these two animals the medulla oblongata was removed and sent to the Brown Institution. In each case a portion of the medulla was crushed in sterilised bouillon, according to the method described by M. Pasteur, and a small quantity injected into the subdural space of two rabbits.

The four rabbits thus inoculated all died of typical rabies, the incubation period varying from 10 to 14 days. The post-mortem appearances were most characteristic, as I have elsewhere described to be found in these animals when dying of this disease. (Report to the President of the Local Government Board of a Committee of Inquiry into M. Pasteur's treatment of Hydrophobia.)

From a pregnant doe, dying of the disease, inoculation experiments were made with the fœtus as to whether the virus could be transmitted by it. The spinal marrow was cultivated in bouillon and inoculations made from the solution. The results must be regarded as having been negative.

OTOLOGY.

Foreign Bodies in the Auditory Canal.

The *International Medical and Surgical Synopsis* reports the following from Dr. Charles Barck, of St. Louis:—Several cases happened to come into my hands lately, where the removal of foreign bodies from the auditory canal had been attempted in vain, and serious damage done to the tympanum. This leads me to the conclusion, that the rules for proceeding in such cases are generally not as well known as they ought to be. Yet they occur in the practice of every physician and he is summoned to act immediately. But rough and ill-advised experiments at extraction are much more dangerous than the presence of a foreign body itself, as already emphatically expressed by Wilde. There are several cases on record which ended fatally. Wendt reports a case where a pit of johanisbrod (?) (cannot find the English term) had been

driven into the tympanum and labyrinth, and caused meningitis and death. Sabatier a similar one, where the object was a simple plug of cotton. Levi cites the case of a soldier, who had put a stone into his ear to simulate disease. After the removal there was found a large perforation of the drum-membrane. The next day otitis media, paralysis of the facial nerve, fatal meningitis. Fraenkel and Moos have each reported a case lately where the extraction of a stone by inexperienced hands led to the same end.

On the other hand it is a well known fact, that foreign bodies may remain in the external canal without giving rise to the least inflammatory symptoms. Rein removed a carious tooth from it which had remained there for forty years. Politzer a piece of graphite one inch long, after twenty-two years, and Brown found both auditory canals of a boy filled with a number of small stones, which had been lodged there for seven years.

But in most instances the foreign bodies give rise to disagreeable symptoms from the beginning, to pain, irritation and inflammation of the walls of the canal and the drum membrane, and the aid of the physician is asked in haste, especially so, as our patients are chiefly children. The ear is a clever pocket in which to insert foreign substances, and those cases are therefore the most frequent ones. Besides, we find divers articles introduced by adults, as remedies against disease. In some regions of Europe there prevails a superstitious belief that small onions worn in the ear are panaceas against toothache.

The point to be remembered in our procedure for the removal is, that the width of the auditory canal is the smallest at the end of the first third from the entrance; then it widens again, and forms especially a kind of fossa below, in front of the drum-membrane. This is the place where the foreign bodies are mostly found, and more or less fixed, after they have been driven by some force through the narrow ring. If they remain in the external half of the canal, or if they are so small that the narrow place is easily passed, one simple bending of the head to the side, and some shaking, will suffice. If this fails, our *sovereign remedy is the syringe*. No instrument now, as the first inclination of so many seems to be.

Syringing is not painful to the patient, harmless, and successful in eighty to ninety per cent. of the

cases. Lukewarm water may be used, or an anti-septic solution. Bulb-syringes are, in my judgment, far superior to the stem-syringe. They require only one hand, hold a larger amount of fluid, and the pressure can be readily regulated.

This ought to be a mild one in the beginning, and increased gradually. The stream should be directed against one wall, generally the posterior; if the previous examination with the reflector shows a space between the foreign body and the wall, this side is chosen, of course. The injected fluid passes the impediment and acts from behind, and this steady pressure is a most effectual agent. The attachment of a small rubber tube, half to one inch long, to the end of the syringe is sometimes useful, as it allows a deeper introduction and direction of the stream to the desired place. Try the syringe again and again. Do not lose patience. You will often succeed after many fruitless trials. But I cannot agree with Kramer, who says *that every foreign body can be removed with the syringe*. There remain undoubtedly a number of cases in which this is impossible. There are, on the one side, bodies which swell, like peas, beans, etc., or hard bodies with very irregular surfaces. Then in cases of longer standing, where the extraction with instruments has been tried, and the walls are swollen and inflamed.

Instruments should not be used without illumination with the reflector. The introduction of a speculum is not always necessary. I have met with several instances where the removal was easier after the withdrawal of the speculum. But whenever the inefficiency of the syringe, after repeated trials, compels the use of instruments, this *should be done in chloroform narcosis*.

The firmly imbedded body is near to or upon the drum. Every little movement, or attempt to free it, hurts this very sensitive membrane, and is so painful, that even adults cannot hold still. As soon as the foreign body is touched they move the head, and your view is gone. You work in the dark. What can you expect of children? They will cry and fight when you have once caused severe pain. This working in the dark is not only difficult, but exceedingly dangerous. Perforation of the drum membrane, purulent otitis media, and their sequelæ and even fatal meningitis may be the consequence, as in the cited cases. On the other hand, in narcosis the removal is an easy one. You

see easily where and how you manipulate, and can complete the work without danger to your patient. What proves successful after laboring for hours without chloroform, is often done in a few minutes in narcosis.

As to the instruments used, the best ones are hooks, blunt or hard, and sharp ones for soft bodies. They are brought behind the foreign body along one wall, then turn and move it slowly by cautious manipulations. In case of want of a long hook, a silver probe may be used, the end having been bent in a right angle.

The use of the forceps or pincette can not be recommended. They are far inferior to the hook, and dangerous, being liable to pull the foreign body deeper, especially when it is a hard one with a smooth surface. In some varieties of seeds a kind of drill has been used to advantage.

The rules from the foregoing are, therefore: Remove foreign bodies from the ear with syringe; if this fails and the use of instruments is necessitated, do this *only* and *at once* in chloroform narcosis.

REPORTS OF SOCIETIES.

Toronto Medical Society.

STATED MEETINGS, *March 22nd, 1888.*

The President, Dr. Nevitt, in the chair.

Cases in Practice.—The first case presented was that of a boy 18 years old, complaining of pain for the past two years in the right shoulder joint, which had recently become much worse. Dr. Doolittle, whose patient he was, said the pain was greatly increased by movement. It was easy when hanging loosely by the side and when in bed, excepting when in a strained position. Family history good.

Dr. Atherton could detect no movement in the joint and believed the head of the humerus enlarged as the result of some inflammatory process. He recommended fixation of the joint for two or three weeks at least, when, if no benefit resulted, an exploratory incision would be justifiable.

Dr. Spencer also presented a boy 14 years of age. Until a year ago this boy had enjoyed perfect health, and the family history was good. He never had convulsions. At school he was bright and could read and write. About that time his mother noticed that he grew dull and walked in a stooping position. His face gradually assumed a stupid look. He began to fall suddenly forward, frequently injuring his nose and face. His mother cannot leave him by himself for fear of his falling. His memory is fair, and he will write but cannot read. He does not speak except when addressed, and then answers in a stupid, abrupt way. His sight is fair, but the pupils are widely dilated and do not respond to light. Taste appears to be defective and there is no appetite, but the boy is stout and well developed. Occasionally he takes

wildish fits, but generally he is quiet, well-behaved and cleanly. The fingers and toes twitch occasionally. Further examination by the members showed that he was knock-kneed. In walking, the gait was shuffling, the left leg being thrown out. The patellar reflex present in the right leg, absent in the left. When the eyes were shut and knees and heels together he swayed a little but maintained his equilibrium and could turn around. The trouble was believed to be tubercular in its origin.

March 29th, 1888.

A lengthy discussion followed upon the reading of a very able paper on *Suprapubic Lithotomy*, by Dr. McCullough.

Dr. Cameron said that in adults the peritoneum was frequently low down and it was well to follow Paterson's method of injecting at least 12 oz. of fluid into the bladder and 10 oz. into the rectum so as to raise the peritoneum out of the way. Recently, Annandale, of Edinburgh, had elevated the stone with a lithotrite, bringing it against the vesical wall when he then cut down upon it. Hæmorrhage, as a rule, was due to the cutting into the large plexus of veins which lay in front of the bladder. It was not advisable to suture the wall of the bladder to that of the abdomen. If the former were sutured at all, the stitches should not penetrate the mucous membrane.

Dr. Atherton, while appreciating the advantages of this operation, believed the perineal operation would eventually be the favorite, especially in children. It had been urged that impatience wa

a result of this old operation, but he did not consider the case proven.

Dr. Oldright had a case where incontinence remained after a lateral lithotomy in a child of six years. Belladonna would only relieve this for a time.

April 5th, 1888.

Pathological Specimens.—Dr. Machell presented a coccyx removed by him in March. The fracture occurred in Dec. 1887. Good recovery.

Dr. Peters showed two small pieces of wood removed from the head where they had remained eight months without causing trouble. He also presented for Dr. Cameron, a stomach with a round perforating ulcer on the anterior surface from a patient who died shortly after symptoms of rupture. At the post mortem the abdominal cavity was found distended with fluid but the stomach was almost empty. There was little or no pus found. Dr. Ianson gave the following history of the case:—The patient was a servant girl aged 19. While washing up after dinner was seized with an agonizing pain, followed by vomiting. The pain was located in the abdomen and under the shoulder blade. She passed into a state of collapse and died twenty-one hours after, during which time she drank quantities of water and vomited frothy stomach contents tinged with blood. There was no history of gastric trouble or vomiting. Slight tympanites appeared before death. The gastric ulcer was not diagnosed.

Dr. Cameron presented a specimen of nutmeg liver. The following is the history of the case:—Patient was a man 40 years of age. One year ago he was struck on the abdomen; an abscess resulted, leaving a scar over the stomach and two fistulæ over the lung. The blow had probably caused a cellulitis which passed upwards. The lung was sodden and pultaceous. There was no history of liver trouble and the cause of death was bronchitis. The pleural cavity was obliterated at the point of adhesion.

April 12th, 1888.

Cases in Practice.—Dr. G. S. Ryerson presented a patient, a female, with congenital dislocation outwards of both lenses. This is an infrequent lesion. There was no history of injury and the dislocations seemed due to non-development of the suspensory ligaments. The vision of the patient

was imperfect. As a rule, in these cases the lens affected became cataractous subsequently. Dislocation of one lens was much more frequently met with.

Dr. F. W. Cane read a very able paper entitled "The relation of Goitre to Insanity." In the discussion which followed, Dr. Nevitt remembered that Mr. Andrew Smith, V. S., had lately told him that over 90% of the city horses became goitrous. In his experience very many people were afflicted by double or single enlargements without other symptoms.

Ontario Medical Society.

This rapidly growing Association will hold its next meeting on the second Wednesday and Thursday in June, in the theatre of the Normal School. We are all acquainted with the past work of this association than which there is no better in Canada, and especially the splendid representation of talent, American and Canadian, at last year's meeting. It is to be hoped that every one will make it their personal business to use every effort to make the meeting of this year excel by far anything of the past. A number of American practitioners have been invited to attend. In our next issue we will be able to give fuller particulars, but the following will give an indication of the working of the association:—

The following gentlemen have been appointed to open and continue the discussions:—

In Medicine.—Dr. Mullin, Hamilton, selects the subject and opens, followed by Drs. Barrick and Geikie, of Toronto; Digby, Brantford; Waters, Cobourg; Kaines, St. Thomas; and Forbes, Beachburg.

In Surgery.—Dr. Grassett selects the subject and opens, followed by Drs. Sullivan, Kingston; Harris, Brantford; McFarlane, Toronto; Groves, Fergus; Burt, Paris; and Dupuis, Kingston.

In Obstetrics.—Dr. Powell, Ottawa, selects subject and opens, followed by Henwood, Brantford; Odgen and Macdonald, Toronto; Fenwick, Kingston; and Hunt, Clarksburg.

The following gentlemen have been named to discuss the subjects opposite their respective names:—

Dr. Daniel Clark, on some functional disorders of the nervous system of frequent occurrence in general practice.

Dr. J. H. Richardson, on any medico-legal subject.

Dr. Temple, on the use and abuse of pessaries.

Dr. Sheard, on the pathological changes in the blood or tissues wrought by bacteria.

Dr. Oldright, on the sections and sutures in bullet wounds of the intestines.

Advisory Committee, the members of which, members of the Association may consult in cases of unjust suits against them for mal-practice :

Dr. Thorburn, Toronto, Chairman ; Drs. Moore, Brockville ; Sullivan and Henderson, Kingston ; Day, Trenton ; Richardson and White, Toronto ; Malloch, Hamilton ; Harrison, Selkirk ; Eccles, London ; and Taylor, Goderich.

St. Louis Medical Society.

Dr. I. N. Love read the following paper on "The Practical Application of Glycerine :"

There is no one disturbance that superficially viewed, seems so trivial, and yet which may be the cause, directly or indirectly, of such positive injury to the human anatomy as constipation. In infantile life, and during all ages, particularly among women, it is a prevalent disorder. The number of cases of hæmorrhoids, prolapse of the rectum, fissure and fistula of the anus, not to speak of the cases of fever due to absorption of ptomaines, all traceable to constipation, cannot be reputed. Any procedure that promises relief for this dire disturbance should be thoroughly tested, and if efficacious, adopted.

In the *British Medical Journal*, of December 24, 1887, Dr. Julius Althaus reports, with the endorsement of his own experience, a procedure recommended by Anacker for the relief of habitual constipation, viz., the injection by means of a small glass, or hard rubber syringe, of a teaspoonful of glycerine into the rectum. An evacuation of the bowels usually occurs immediately, or within a few minutes.

The rationale of its action given by Anacker is that glycerine, in consequence of its pronounced affinity for water, when placed within the rectum, abstracts moisture from it, causing hyperæmia and irritation of the sentient nerves of the rectum, which leads reflexly to active and prompt peristaltic contractions, ending in defecation. The greater the accumulation of fecal matter in the rectum, the more decided the effect. There is no unpleas-

antness or pain, but the action takes place *cito, tuto et jucunda*. Sometimes a little fullness and throbbing is felt in the rectum for a few minutes afterwards.

Althaus expressed the opinion that this plan, on account of its simplicity and readiness, would be found to constitute a veritable improvement in the therapeutics of constipation. The simplicity and practical value of the idea impressed me the moment my eye fell upon the article of Althaus, and I demonstrated its value within an hour, and from that time to the present, a period of over six weeks. I have applied it many times daily where the conditions suggested it, and no matter what the age, or degree of constipation, the response has been uniform and prompt. In a large number of infants and mothers where habitual constipation had been present from the birth of the former the remedy produced instantaneous relief, and coupled with broken doses of the mild chloride to stimulate the secretory system, I believe it furnishes a key to unlock the constipated condition which can be depended upon. I have directed the use of the glycerine injection at a definite hour each day, and have succeeded in establishing regularity in almost every instance.

There is no question about the securement of an evacuation almost immediately after the glycerine injection. The main point in order to obtain a result that will be lasting in character is to impress the patient or attendant with the importance of giving the injection at a certain time each day. In a few cases of piles and severe rectal irritation accompanying constipation, both conditions were more satisfactorily relieved by the glycerine than they had been previously by purgatives and sedative ointments. This remedy is a valuable one in being efficient, simple, and convenient. It is surprising that some one had not thought of and applied it before.

Apropos to this subject, Dr. Edward R. Mayer, of Wilkesbarre, Pennsylvania, reports in the *Medical News*, of February 25, the use of an injection of two fluid ounces of warmed glycerine through a large flexible rectal tube, inserted at least seven inches, for the relief of intestinal obstruction due to paralysis of the muscular coat of the bowel, superinduced and accompanied by peritonitis. All other means for securing an evacuation of the bowel having failed. Dr. Mayer having been uni-

formly successful in the application of the Anacker-Althaus plan of using glycerine, it suddenly occurred to him to extend and amplify the method as above stated. The insertion and the injection produced no distress or immediate effect, and he left the invalid with directions to her nurse to cause the hips and knees to be elevated for a time. Upon his return after several hours, he found a greatly changed condition of affairs, comfort where there had been agony, and an anxious and pallid countenance replaced by beaming smiles and hopeful expression.

He was informed that about ten minutes after the administration of the glycerine enema, the patient felt a warm thrill and glow extending itself and permeating all through her intestines, followed by the vermicular movements which precede peristalsis, by audible and sensible displacements of gas, and finally by acute colicky pains. Within twenty minutes after the injection, there was an urgent call to the stool, with the result of the escape of a large amount of flatus, and later, of a pint of semi-liquid evacuation of mingled yellow and green color, with some small scybala and a very pronounced odor. This evacuation was succeeded in an hour by another of a similar character. Considerable tympanites and tenderness still existed, but the abdominal distention was decidedly reduced and the distress greatly relieved. The temperature, which had been kept depressed to about 100° by the antipyrin, soon fell to 99°, and the thready, jerking pulse of 120 had descended to 100, and the next day was not above 90, becoming rapidly soft and full. The nausea abated, and in a few hours disappeared and did not return.

Enemata of warmed glycerine to the extent of two ounces each, were now administered night and morning during the next three days, each one resulting in a copious fecal evacuation, at first liquid, and then formed. The temperature varied during several days between 99° and 99.6°, the pulse soon dropped to 80, the tenderness gradually disappeared and the distension slowly melted away. Milk punch, beef-tea, and revalenta arabica were greedily taken in small quantities, retained and digested, and upon the ninth day of the illness, the patient, while feeble, was entirely convalescent, a salutary diarrhoea having set in after the enemata were discontinued, and soon ceasing. The only gurd

treatment employed after the symptoms improved, was a single, very small dose of saline laxative and a nightly hypodermatic of six minims of morphia solution, to secure rest.

The result in this case was extremely satisfactory, and very important in its suggestion of possibilities.

Dr. Mayer further says: "If glycerine, injected by the method described, does really penetrate and permeate the upper colon or even the small intestine, it remains to be ascertained whether drugs combined with it as their vehicle, would measurably remain in the site to which they would be conveyed, or would be too completely washed away and extruded by the pouring out of large quantities of liquid, and by the violent expulsive efforts of the muscular coat of the intestines to exert their specified influence. Should it be that any considerable portion of such drugs would remain *in situ*, it is manifest that an improved method of internal medication is near at hand, and that such drugs as antifebrin, antipyrin, aloin, belladonna, calomel, croton oil, colocynth, ergotin, hydrastia, hamamelin, naphthalin, physostigma, the terebinthines, and even nitrate of silver, and some of the germicides may be introduced by an entrance into portals hitherto closed to them excepting by a devious journey through the ordinary avenues. He would be a rash man who, with our present knowledge, should attempt to sterilize typhoid bacteria by a direct attack upon the agminate glands, but stranger things than this have happened, particularly of late, in the direction of gaseous rectal medication."

Dr. Robert Barclay: I am glad to hear the doctor's testimony added to that which already exists as to the efficiency of glycerine as an aperient. He speaks of its use by rectal injection, which to my mind is a very disagreeable method of administering it, except in the case of helpless patients, where there are large fecal accumulations, or in very young infants. The aperient properties of glycerine have been known for years; it has been in use as an adjuvant to other aperients. It has been my custom to prescribe castor oil and glycerine in equal parts—an ounce of each—with a few drops of oil of wintergreen added to give a pleasant flavor. This often has a good effect where castor oil will not answer. I give it by the mouth and not by the rectum. It is just as well

to give it in an agreeable way and by the natural passage.

Dr. Dean: I had occasion to treat some cases of oxyuris vermicularis, and I used glycerine with good effect. I related this to Dr. Hermann, of this city, and sometime afterward he brought me two children who were troubled with oxyuris vermicularis, they were little girls, and the worms had gotten into the vagina, which is frequently the case. And he used glycerine in these cases with good effect. I advised him to be careful in the use of glycerine, however, but he got an excellent result. I have often seen the good result of the use of glycerine injected into the rectum of children for this trouble. The worms shrink and shrivel up, and it is only a few minutes until the bowels are emptied of the worms. The astonishing feature to me is that the beneficial effect of glycerine in the condition mentioned by Dr. Love has not been discovered before. I have for many years used glycerine injections for these worms that I have mentioned, but it is only within a few days that I saw this use of glycerine in constipation suggested.

Dr. Frank Glasgow: Some years ago I read an account of a series of experiments which had been instituted by some Frenchman, who made various applications of medicine to the surface of the body for the purpose of determining whether they would be absorbed or not. He found that remedies in glycerine solution were not taken up into the blood. This is probably because there is an exosmosis going on, of the watery particles of the blood, to the glycerine. It occurred to me that this was the same process which caused the result, which Dr. Love mentions; and if so it seems to me it would render inoperative the use of glycerine *per rectum* as a vehicle for the conveyance of systemic remedies.

Dr. Love: The suggestion which Dr. Glasgow has made is a very good one, and it is probable that the use of glycerine for the purpose suggested by Dr. Meyer would be contra-indicated. I want to say that Dr. Barclay failed to grasp the main idea in the paper; that is that the glycerine by injection on account of its affinity for water produces an irritation of the sentient nerves followed by a peristalsis, and this secures a prompt action, the impulse being given from below upward securing a prompt effect.

The administration of glycerine by the mouth has no bearing on the subject whatever.—*Journal of the American Medical Association.*

Rideau and Bathurst Medical Association.

The regular semi-annual meeting of the Association was held at Ottawa, on Feb. 22nd. There were present, Doctors Sir James Grant, Hill, Sweetland, Macdougall, W. R. Bell, Powell, Robillard, Chipman, Small, Horsey, Rogers, Mark, Hurdman, Baptic, H. P. Wright, O'Brien, Kelly, Cousens, Baird, G. H. Groves.

The President, Dr. Cranston, Armprior, not being able to attend, the chair was ably filled by the Vice-President, Dr. Powell.

In his opening remarks the attention of the Association was directed to the loss it had received by the death of three of its most active members, since its last meeting—Drs McFarlane, of Almonte, Beatty, of Richmond, and Whitford, of Ottawa. A resolution of condolence was passed, copies to be sent to the family of each deceased member.

The question of illegal practitioners was brought up and complaint made that the Council made no effort to protect this portion of the province. The Secretary was directed to communicate with the Registrar on the subject. After further general business the reading of papers was proceeded with.

Dr. Horsey presented a carefully prepared paper on *Pyrexia*, discussing the various theories regarding this phenomenon in a thorough and comprehensive manner.

Vote of thanks was passed unanimously.

Dr. Rogers read a paper entitled "*Rapid dilatation of cervix uteri*," in which he advocated the treatment of sterility, flexious and dysmenorrhoea by this method. He described the operation and the instruments to be used and reported a number of cases treated successfully. A lengthy discussion followed on the dangers and complications likely to influence the operation.

Dr. Chipman read some clinical reports of cases of *pneumonia* occurring in the City Hospital and Dr. H. P. Wright reported a case of persistent *hernatemesis*.

Carleton Place was selected as the next place of meeting.

HOSPITAL NOTES

DeWitt Dispensary.

BY DR. R. F. JUNOR.

Case 1.—M., age 28, piano tuner, tuberculosis. History of two or three years of cough and periodic attacks of what he called bronchitis. A few weeks ago was laid up with his most severe attack. Had seven somewhat severe hæmorrhages. On examination after he had been in bed for two weeks found the lungs so blocked up with mucus and such distress in breathing that little could be discovered, and the patient seemed in danger of suffocation. Nothing seemed to relieve it. A few hours later he was seized with a most violent fit of coughing, which led to such suffocation that the patient sprang out of bed, grew black in the face and with great difficulty could be held from injuring himself. All at once he got relief. There came slipping up into his mouth a large lump of mucus which on examination proved to be a large calcified tubercular nodule. It was as large as a bean, spherical and with ragged projection. It was a miracle that such a mass succeeded in passing the vocal bands. The patient has passed a large number of nodules since that time and had coughed up a few before. Next day on examination the lungs were found pretty clear of the accumulated mucus, which had been deprived of egress by the blocked bronchial tube. Several larger cavities were found in both lungs. Large plates of calcification have been found in the lungs at post mortems, but this is the largest nodule that I am aware of as having passed the larynx.

Case 2.—A boy, twelve years of age came to the throat clinic with quinsy. The mouth could only be opened a short distance. There was a large peritonsillar abscess on the left side which I opened. A

large amount of pus was emitted. I sent him home to bed and instructed the mother that she had better send for the visiting physician, unless the boy steadily and decidedly improved. He was so much better the next day they failed to send for the physician, and at 9 a.m. the day after the boy suddenly threw up his hands, gasped a few times, and in a few minutes was dead. No post-mortem, but it was quite evident I think that the boy died of suffocation from the rupture of a post pharyngeal abscess and the flood of pus into the larynx. That, of course, is not certain, but it is most probable.

Case 3.—A woman, 35, four days before gave birth to a fine child. No physician present. I was asked to go and see her, as she was supposed to be dying. Found temperature 105½, pulse 135, feeble. Abdomen very tender. Uterus soft and large. Vomiting severe. For vomiting gave

R. Tr. Iodine Co. min. iv.
Aqua ʒi.

M. Sig. ʒi every fifteen minutes.

No vomiting after the first dose. For pain and tenderness gave a hypodermic of $\frac{1}{3}$ morphia and flax seed poultices. For fever gave ten grains of antifebrin every three hours but every hour for the first three hours. For nourishment raw beef and thin milk. Next day temperature was 102½, pulse 120° Far. Next day temperature 99, pulse 100. Once or twice during next week pulse and temperature went up, but in ten days the woman was up, Convalescence slow but steady to recovery. I recommend the tr. iodine in the above strength as the most effectual and easiest remedy for vomiting and especially catarrhal.

GENERAL NOTES.

Trinity Medical School Examination.

FIRST YEAR.—1. *Certificates of honor for first year's work.*—Candidates who obtained 75 per cent. and over:—Sutherland, Jas., Knechtel, R., Fairchild, C. C., Mackay, Chas., Fairfield, C.A.D., Farmer, G. D., Herriman, W. D. D., Johnson, D., Shaw, J. W., Third, Jas.

Candidates who have passed the first year's examination.—*First class*—70 per cent. and over:—Hough, A. H., McKee, J. G., Moore, J. J., Martyn, J. B., Porter, H. W., Rogers, J. F. B. *Second class*—60 per cent. and over:—Alexander, D. B., Archer, R., Abraham, C. F. P., Broberg, B. H., Bell, A. W., Bentley, D. B., Crooks, J., Damby, J. J., Doyle, C. S., Fenton, Fred., Farncombe, T. S.,

Glenn, T. S., Hicks, J. S., Hunter, A. C., Heaven, Robert, Irwin, T. C., Langstaff, R. L., Murray, A. J., McQueen, Jas., McLelland, M., McDowell, G. K., Nixon, A. W., Reid, H. A. L., Robertson, P., Sutherland, A. A., Spilbury, F. C., Sprague, W. G., Tweedy, G. J., Temple, C. A., White, R. H. *Passed*—Alexander, G., Allison, A., Ashball, Bolster, L. E., Burrows, J. G., Dougan, R. P., Coughlin, C. B., Dickson, G. J., Easton, G. F., Elliott, S. B., Fairbanks, W., Finch, C. L., Gray, H. H., Henry, A. E., Ireland, W. M., McArthur, E. L., McBrien, F. R., McPherson, W. A., Martin, E. P., Montgomery, W., Nattress, J. L. Quay, F. A. W., Thomas, A. J., Thomson, W. A., Walls, J. R., White, Jas., Wilson, G. B.,

Irving, L. W., passed in Practical Anatomy, Physiology, Chemistry, and Botany. Guthrie, J. B., passed in Chemistry. Fotheringham, J. F., passed in Botany. Mundie, J., passed in Practical Anatomy. Nicholson, J. D., passed in Practical and Descriptive Anatomy, and Botany. Johnston, H. McN., passed in Descriptive Anatomy, and Physiology.

PRIMARY (SECOND YEAR).—*II. Certificates of honor, for standing in the Primary Branches.*—Candidates who obtained 75 per cent. and over:—Harris, J. S., McCullough, J. W. S., Macdonald, J. R., Clarke, F. R., Niddery, R. J., Murchison, A. J., Allingham, L. W., Penhall, F. W., Sifton, J. M., Oliver, C. B., Hill, R., Cummings, H. J. First, second year's Scholarship, value \$50, Harris, J. S. Second, second year's Scholarship, value \$30, McCullough, J. W. S. *First class*—70 per cent. and over:—Boyes, E. J., Drake, F. A., Alexander, W. J., Speers, A. H., Arnall, H. T., Richardson, B. F., Preiss, F. *Second class*—60 per cent. and over:—Hilary, R. M., Fletcher, W. J., McCarty, O. E., McEdwards, T., Newberry, W. F. H., Hargreaves, G., Dolan, J. F., Harrison, G. M., Dinmoody, J. W., Morton, E. R., Gee, J. J., McGregor, J. A., Morgan, L. E., Rogers, J. F. B., Sargent, W. A., Cunningham, J. W. *Passed*—Berry, J. D., Beatty, A. C., Boyes, E. T., Ewing, F. J., Honsberger, J., Hay, R. T., Jones, W. A., Mills, J. A., McGee, R., Strathy, H. E., Thomson, W. A.

Laurie, C. N., passed in Anatomy, Physiology, Chemistry, General and Practical, and Toxicology. Sweeny, M., passes in Chemistry, General and Practical, and Materia Medica. Smith, H. A., passes in Anatomy, Chemistry, General and Practical, Physiology and Toxicology.

FINAL "FELLOWSHIP DEGREE."—*III. Certificates of honor for standing in the Final Branches.*—Candidates who obtained 75 per cent. and over:—Wade, W. R., Cline, L. F., Wardlaw, J. S., Bowlby, G. H., Fisher, J. H. C. F., Neff, J. A., Meyers, D. C., Campbell, D. M., Crawford, Jas. *First class*—70 per cent. and over:—Anderson, C. N., Ardagh, A. E., Baird, J., Burns, R. A. E., Bishop, E. R., Campbell, Jos., Cowan, F. P., Emmerson A. T., Ferguson, F. F., Howitt, J. A., Harding, W. E., Hotson, A. N., Hamilton, C. H., Jones, D. E., James, C. Jeffs, W. H., Kalbfleisch, F. H., Karn, C. J., Lammiman, B., McClinton, J. B. H., McCordick, A. W., McNaughton, P., McDonald, R. J., Marling, J. H. O., Merritt, W. H., Minchin, H. A., Odgen, J. P., Palling, J. F., Rowan, J. W., Steele, M., Thompson, F. G., Topp, R. U., Walker, R. E., Wade, R. J. *Second class*—60 per cent. and over:—Ellicot, H. C. S., Fitzgerald, T. A., Garratt, A., Hixson, L. J., Meiklejohn, H. J., Millman, M. G., Rogers, J. P., Thompson, H. B., McFaul, J. Henry.

SPECIAL PRIZES.—The special prize for the highest in Physiology of the first year, value \$25, Jas. Sutherland. The "Dr. John Fulton Memorial Prize" for the highest standing in Surgery, where the student has spent four complete winter sessions at the College, value, \$50, D. C. Meyers. Special prize given by "Trinity Medical College" for very High Standing in the recent Primary Examinations at Trinity University, value \$30, A. Ross.

SCHOLARSHIPS.—The 1st first year's Scholarship, \$50, James Sutherland. The 2nd first year's Scholarship, \$30, Robert Knechtel. The 3rd first year's Scholarship, \$20, C. C. Fairchild. The 1st second year's Scholarship, \$50, J. S. Harris. The 2nd second year's Scholarship, \$30, J. W. S. McCullough.

MEDALS.—The Second Trinity Medal, Jas. S. Wardlaw. The First Trinity Silver Medal, L. F. Cline. The Trinity Gold Medal, W. R. Wade.

A Marine Biological Laboratory For New England (Boston).

Several thousand dollars have already been subscribed toward the erection of a building, its equipment and maintenance. A course of eight lectures have been arranged for at Boston, to be given by prominent American Scientists, the proceeds to be devoted to this object.

The Inter-State Conference of Health Officers.

This important meeting of Executive Officers meets in Cincinnati on May 4th and 5th, at the time of the meeting of American Medical Association. Dr. P. H. Bryce, Secretary of the Ontario Board, has been appointed to attend. He is chairman of the Committee on Inter-State Notification of Disease, and presents the report on this important subject.

Cambridge Museum of Comparative Zoology.

Additions are being made to the present building to accommodate the growing needs of the botanical department. It will contain laboratories for studying both cryptogamic and phænogamic botany.

THE tenders for the new biological building in the Queen's Park, have been received and accepted. The building is to cost about \$45,000, is to be a grey stone gothic structure. It is understood that the building is to be completed to the extent of being utilized for lectures next summer.

STOPPAGE of the natural flow of urine, says Ultzmann, may be caused by:—

1. Occlusion of the smaller urinary tubes, as in cholera and any of the renal diseases.

2. By occlusion, twists, and turns in the urethra.

Ultzmann records the case of a man, æt. 43 years, with calculus of the kidney, who suddenly developed anuria, which caused death in two weeks. The autopsy showed a cyst of the left kidney as large as a goose-egg, with obliteration

of the ureter, and on the right side an enlarged kidney, with three small stones filling the ureter.

2. By a tumor of the bladder.—*Internat klin. Rundschau*, Nos. 7-17, 1887.

THE three English Societies of Medical Officers of Health, have amalgamated, and held their last meeting in London, March 16th. A large number of papers on practical subjects were read. Among these being one by Percy F. Faulkland, F. C. S., on "The Beneficent and Malignant Functions of Micro-organisms."

WE should imagine that the days of active principles were fast approaching the millenium, as we see by the Philadelphia *Inquirer* that Wm. R. Warner & Co. have on exhibition in their window a mass of coffeine, 200 lbs. in weight, this being the active principle of no less than ten tons of coffee to be used in the manufacture of that elegant preparation Bromo Soda.

SIR ANDREW CLARKE has been appointed president of the Royal College of Physicians, London. The appointment has given general satisfaction to the profession who have long recognized his professional skill as physician.

OUR readers will see facing the first page of reading a change in the advertising matter of Fairchild Bros. & Foster. As we have always specified their ferments we cannot but feel pleased that they should, unsolicited, have received a tribute from so high an authority as Mr. W. Murrell.