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## Original Communications.

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### THE PLACENTAL INSPECTION: ITS UNCERTAINTIES AND ITS DANGERS.

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BY J. F. W. ROSS, M.D.,

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Parturition is a necessary sequel to impregnation. The dangers of the first stage of labor are but few; those of the second stage consist chiefly of traumatisms that may be inflicted upon the mother as a consequence of necessary or unnecessary obstetrical violence; but the dangers of the third stage, the delivery of the placenta, are to my mind of the greatest importance to both the life and the subsequent health of the mother.

For a long time puerperal fever, or the fever accompanying the lying-in period, was, and perhaps yet is, to a certain extent shrouded in mystery. As far as I have been able to demonstrate to myself, from the experience of a large number of cases seen in consultation, there are only four causes of puerperal fever; firstly, traumatism; secondly, the inflammation or rupture of some pre-existing intra-pelvic tumor; thirdly, the presence of the gonorrhoeal virus in the parturient canal; fourthly, retention of a portion of the placenta or membranes. The two most frequent causes of puerperal fever are the presence of the gonorrhoeal virus and the retention of a portion of placenta. I believe that these will be found to induce at least 75 per cent. of all the cases. Of this 75 per cent. about 35 per cent. will be found to be due to gonorrhoeal infection and 40 per cent. to retained placenta or membranes. I wish particularly to draw attention to the latter cause and discuss ways and means for its prevention.

Among the lower animals gonorrhœal infection is rather rare. We all know that the dread of the breeders of cattle and horses is "fever" after delivery of the calf or colt. This fever, even among those who are ignorant of medicine, is frequently considered to be due to some portion of the secundines retained in the cavity of the uterus. Many of us have left portions of placenta in the uterus without knowing it, notwithstanding the fact that we have most carefully examined the placenta by sight and touch after its delivery, and we are not ignorant.

I am convinced that it is impossible for any obstetrician to say positively that all the placenta has been expelled from a mere inspection of it. We may be able to make an approximate guess that all has been removed, but, as with everything else that is uncertain, we are apt by it to be led very much astray. How, then, is this danger to be avoided?

For many years the woman who miscarried was allowed to remain in bed and to bleed for days from a piece of retained placenta, without any attempt being made to remove it. It was supposed that such an interference was an extremely dangerous procedure. As time passed on the fact became recognized that the proper treatment of such cases was not tentative measures but a thorough riddance of the uterus of the dangerous material contained within its cavity. The introduction of chloroform into practice made this little operation much easier of performance and much more thorough in its execution, without, at the same time, exciting the dread of a timid patient. Thousands of women have lost their lives or have been sexually maimed as a consequence of the retention of placenta after miscarriage.

For some years I have been an ardent advocate of the administration of an anesthetic in each such case and a thorough inspection of the interior of the uterus with the finger, in the belief that prevention is better than cure. If we occasionally find the uterus already thoroughly emptied of its contents, we have done no more than our duty in exploring its interior and we need not feel in the least chagrined. Until this exploration has been carried out we are entirely in the dark, and nothing but the index finger can assure us that the uterus is empty. Curettes in such cases are valueless, and though they serve a certain purpose they must not be entirely depended upon. The man who uses a curette alone is increasing the danger of his patient. He is tearing down and loosening portions of decomposed material without affecting a complete and thorough removal of the same.

Chloroform and the index finger are two weapons with which we must prevent the occurrence of septicemia following miscarriages. When these two weapons are utilized the enemy will

scarcely, if ever, be encountered. Even after infection has taken place the thorough removal of all particles from the endometrium and the sterilization of its cavity by means of an antiseptic wash and an antiseptic packing will often bring to an abrupt termination the septic fever and secure a rapid and satisfactory convalescence.

If the physician, after considerable delay, is at last forced to administer an anesthetic and clear out the uterus, and the patient, as a consequence of this delay, has become profoundly septic, has received damage to her tubes and ovaries that can never be overcome, has not the husband some right to inquire why the doctor waited? Would not any man with common-sense say, "Doctor, if this procedure is necessary and is safe after my wife's health has been destroyed, why did you not carry it out sooner and prevent this baneful effect?"

But, unfortunately, the interior of the uterus has been looked upon as a "holy of holies," a sort of inner sanctum into which it is dangerous to enter. This has been due to the fact that there are two dangers constantly staring us in the face—the one is a dirty vagina, and the other a dirty finger. The dirty vagina can be, to a very great extent, disinfected; the dirty finger can always be cleaned. I have often heard the argument used that it is not safe to teach men to put the finger into the interior of the uterus because they do not know how to keep their hands clean. Because men do not know how to keep their hands clean is no reason why a proper treatment of a certain condition should be condemned. Men must learn to keep their hands clean if the women are to be protected to the fullest extent. If practitioners do not know how to keep their hands clean it is a reflection upon our teaching during their student days.

To prevent any contamination from the vagina I have always been in the habit of washing it out before passing my finger up into the uterine cavity. But, in the presence of the gonorrhoeal virus, even this precaution will not prevent subsequent infection. In my early experience cases of abortion were treated on the so-called "expectant" plan, a wretched makeshift and one that should never be entertained. This plan consists of daily visits by the doctor, who trusts entirely to dame nature, falsely lauded for her wisdom, without giving her any assistance. When fever sets in it is said to be unfortunate, it is looked upon as a calamity that could not be avoided, the mother dies from what is called a bad miscarriage, and a life is lost that could have been spared.

There is nothing simpler in the whole range of medicine and surgery than the removal of a placenta by means of a finger in the interior of the uterus when the patient is thoroughly

anesthetized, and there is nothing more difficult, more incomplete, or more unsatisfactory than the same procedure without an anesthetic. Time and time again I have removed remaining portions of placenta after house surgeons, or members of my class, have essayed to do so and have thought that they had reached every portion of the endometrium. One day I removed a whole saucerful of placenta after a very experienced professional gentleman who endeavored to carry out the procedure without an anesthetic.

Now I come to the portion of the subject that I wish particularly to discuss, and that is, our attitude in the third stage of labor.

We are told that there must be as little examination with the finger as possible. We are told that the interior of the uterus must not be meddled with except on certain special occasions when it is indicated (whenever that may be). We are told that it is a dangerous doctrine to promulgate among students that, while the patient is anesthetized (as in all humanity every woman should be during the second stage of labor) the fingers should be passed up into a depressed uterus for the purpose of inspecting its interior. I believe that this teaching is all wrong and that there is no danger to the patient from the introduction of the aseptic finger into the puerperal uterus. The real danger arises from what is left behind by an unskilled finger, and the introduction of the finger itself has received much blame that is not justly its due. With the natural instinctive dread that is born in us at the time of our birth in the obstetrical class rooms we are liable to be overtimid regarding this procedure, and, as a consequence, to be less thorough than we should be. The method has, therefore, received the odium of the results of this lack of thoroughness.

I often hear about the danger of the entrance of the atmosphere surrounding the patient into her uterine cavity. If any air enters it is very soon expelled by the uterine contraction. Later on, when the uterus has become paralyzed by septic infiltration, the gases of decomposition may be found in its interior, and this condition may be wrongly interpreted.

But some say, Why not wait until elevation of temperature occurs before making this routine exploration of the uterine cavity? I would like to ask a question in reply, Why should we wait until the patient's life is endangered? Someone asks, But would you recommend this routine treatment in each and every case? I reply that if I attended in confinement a very dear friend I should not trust to ocular demonstration, but would satisfy myself by the introduction of the finger into the uterine cavity that all secundines had been removed. Every precaution would be taken not to infect the patient.

The mere examination of the parts has too often been unjustly blamed for the septicemia that subsequently arises from the gonorrhœal invasion of a raw placental site, or the septic poisoning produced by retained placenta. Look at those cases that are met with, in which a finger has never been placed near the parts; in which the child has been forced into the world before the doctor's arrival; in which the placenta has rapidly followed the birth of the child, apparently intact, and in which we have all seen fever develop subsequent to labor. How can we account for the infection in these cases?

Then somebody says that the placenta comes away readily of its own accord even if it has been retained, and that it does not produce the mischief with which it has been credited. I would like to convert the holder of such a belief by giving him a few actual demonstrations, but he must take my word for it that, while it occasionally happens that the placenta remains attached to the endometrium and continues its life without giving rise to symptoms of septicemia, yet in the vast majority of cases retained placenta eventually produces a septicemic condition.

I would have it clearly understood, however, that, while advocating the exploration of the uterus with the finger, I do so only on condition that it is carried out with very careful attention to septic and antiseptic details. The patient must be placed under the influence of an anesthetic. As I have already stated, in my opinion women should not be allowed to suffer the pangs of labor when we, whose work it is to assuage suffering, have within our reach a chloroform bottle. The patient will therefore only require a few more whiffs of the drug to place her in a condition of complete anesthesia. The finger and hands must be thoroughly cleansed, as for all the other procedures in connection with attendance upon a case of parturition. Doctors have surely begun to recognize the fact that every confinement is practically a surgical operation, and that it should be attended aseptically with all aseptic precautions. Unless these fundamental principles have been grasped, the practitioner is a menace to the lying-in woman. The external genitals should have been cleansed by the nurse.

In the next place the finger must satisfy itself that it has not, in its properly conducted search, overlooked any unloosened portion of placenta, and that none is allowed to remain behind. When there has been much handling of the interior of the uterus, an intra-uterine douche of a strong solution of bichloride of mercury can be used as an extra, though perhaps unnecessary, precaution. When the case is one of late infection, and placenta is removed ten, twelve or fourteen days after confinement, I always use iodoform gauze packing in the interior of the uterus. This packing is allowed to remain in for thirty-six hours. It assists

drainage, and removes small particles of debris that become entangled in its meshes.

I am fully aware that it is a difficult matter to overcome old prejudices. One of the first axioms of an obstetrician is to see that all placenta has been removed, and yet he is one of the first to object to such an innovation as the routine examination with the finger of the interior of the uterus. He sets up for himself an axiom, and condemns the only possible means by which this axiom can be carried out.

And now a few words regarding the so-called infective puerperal fever. I was a believer in the existence of such a fever, but a recent experience has somewhat shaken my faith. For some years I have received from the obstetrical department of one of our general hospitals, cases of sepsis occurring after labor. Some other cases, that have been septic on admission to the hospital, have likewise come under my care. Some cases have proceeded to the development of pus tubes; others have been afflicted with large abscesses, that have opened in different directions; some have recovered after prolonged convalescence; some have suffered from unilateral or bilateral phlebitis; some have had septic fever as a consequence of rupture of the uterus and extensive laceration of the cervix; many have had gonorrhoeal infection of uterus and tubes, as demonstrated but too plainly by the presence of purulent ophthalmia in the offspring; and from all of these I have had a somewhat large and varied experience.

On a recent occasion I was asked to see one case of fever that had developed in the lying-in ward. The child's eyes were affected with purulent ophthalmia. The case was removed from the lying-in ward to the medical side of the hospital. This was undoubtedly a case of gonorrhoeal puerperal fever. A few days later I was asked to see another case, confined in the same ward, that had developed a temperature on the eleventh or twelfth day after labor. Up to this time the case had run a normal course. There was no offensive odor from the uterus, there was no excessive discharge of blood, there were no symptoms to indicate the presence of placenta, and there was nothing to positively determine the presence of gonorrhoea. The attendants now began to look about for some explanation. The simplest explanation would have been the discovery of a piece of retained placenta, but this was not looked for. The classical symptoms of retained placenta, supposed as they are to be offensive discharge, cessation of the lochia, or increase of the lochia, were not present, and, moreover, the fever did not occur until the twelfth day after delivery, a fact that in most minds would be sufficient to indicate that the septic condition did not originate from the retention of placenta.

When I saw the patient I told the house surgeon that these signs amounted to but little in my estimation, and that in all probability there had been a piece of placenta retained. The cervix was closed, and the case had run on so long and was so ill that I determined not to interfere.

A few days later a young woman, who had been in the institution for some time before delivery, on the twelfth day after delivery, and with an afebrile interval, became profoundly septic. The night before I saw her the temperature had raised to 104. She was removed to the medical side of the hospital, and placed upon the table for examination. I passed my finger up into the uterine cavity and found a large piece of placenta. The house surgeon was called and asked to prepare himself for its removal. The patient was anesthetized, the vagina thoroughly douched, the uterus drawn down by a vulsellum forceps, the finger introduced through the patulous os and cervix, and slowly but surely the firmly adherent placenta was detached. The uterine cavity was then disinfected with a bichloride solution and packed with iodoform gauze. The vagina was also packed. Within twenty-four hours the patient's temperature dropped, and has never raised since. The subsequent convalescence was uninterrupted.

Before the placenta was discovered the fever in this case had been attributed to contagion. Preparations were being made to turn all the patients out of the lying-in wards, and to thoroughly disinfect them. After the discovery of the placenta a flood of light was thrown upon the matter and the contagion theory was abandoned.

I have never been able to understand how a contagion can float around the lying-in room and invade the genital organs of the parturient woman. One can readily understand the conveyance of poison by direct contact from basins and towels, from soiled bed-clothes and soiled fingers to the genitals, but I refuse to believe that this miasm, or poison, is carried in the air up to the closed labia, closed vagina and closed uterus of a woman from whom child and placenta have just been discharged.

I do believe that the introduction of foul air into the opened abdomen may have a very serious effect upon the subsequent course of the convalescence, but in this case the air is admitted, and comes in contact with the exposed intestines. The two cases are, therefore, not at all parallel.

It generally happens that, when the air of an institution is kept foul for want of proper ventilation, many other matters are just as carelessly looked after, and many other things are just as foul as the air, but the bad ventilation gets the blame for it all. The dirty obstetrician will have numbers of septic

cases, and the easiest way to excuse the fault is to set down all the trouble at the door of some mysterious miasm. The cleanly obstetrician will occasionally meet with a case of septic infection. If he does meet with such a case, after having taken every precaution, and after having satisfied himself that it does not arise from traumatism, from retained placenta, from inflammation or rupture of some intra-pelvic tumor, he must, in all justice to himself, put it down to the non-preventable cause, the cause for which someone else is to be blamed, namely, the presence of an acute or subacute gonorrhœa in the vagina of the mother from a recent infection.

Peculiarities oftentimes run in groups. When the hand of death steals into one's practice, it is oftentimes seen not in an isolated case, but several households are visited about the same time. When rare cases are met with they are often met with in groups of two or three, seen within a very short interval of time. It may also happen that when sepsis follows labor, it may occur in two or three cases within a short period of time. These invasions may be due to a temporary carelessness on the part of the practitioner, and this carelessness may consist in either unskilled delivery of the placenta, or a lack of proper aseptic precautions. That the germs of infection are carried about in the clothes of the doctor from one lying-in woman to another I can scarcely believe. If, however, the accoucheur is not particular about his dress, he will be equally careless about details of vital importance. A portion of retained placenta or membranes may have originated the febrile condition, and may have escaped from the uterus before a thorough examination of the interior of the organ is instituted. Occasionally it may remain for days and weeks without giving rise to any symptoms that indicate its presence, except purulent discharge or hemorrhage.

Before a conservative profession will be willing to adopt the routine practice of carrying out a digital examination of the interior of every uterus after delivery, many experiments must be carried out. The germs of the lochia must be studied and the discharge must be taken from the interior of the uterus for this purpose. The presence or absence of gonorrhœa and the germs produced by it must be ascertained in every case if experimental clinical research in this direction is to be of value. But, up to that time when we shall have sufficiently perfected our technique to permit of the introduction of the finger as a matter of routine, we must certainly place among the golden rules of obstetrical practice the following: **Whenever elevation of temperature takes place subsequent to delivery, explore the interior of the uterus with the finger to clear up the diagnosis of the case.**

## PUERPERAL SEPTICEMIA.

BY ADAM H. WRIGHT, B.A., M.D.,  
Professor of Obstetrics, University of Toronto.

The paper on "Placental Inspection," by Dr. Ross, published in this issue, contains certain statements to which I must take exception. I regret that I was not present when the paper was read; but, as I have seen the proof, I desire to take this opportunity of making some comments on it.

Four causes of septicemia are given, the first being traumatism. I don't understand what the author means, especially as traumatism is mentioned as one cause, and rupture of a pre-existing tumor another. In a case where septic infection is produced by the absorption of pathogenic organisms at the seat of a torn fourchette, would traumatism be considered the cause? The slight wound referred to must, of course, be considered, but I would say that absorption of septic matter was the cause.

Gonorrhœal virus in the parturient canal is also mentioned as a cause. I think this is at least misleading, if not absolutely incorrect. If it is contended that the gonococcus causes a large proportion of those severe cases of puerperal septicemia which result in death within a few days after labor, I think we may say without any reservation that the contention is wrong. I think it has been proved beyond the shadow of doubt that the organisms which cause serious puerperal septicemia are the streptococcus, the staphylococcus, and the colon bacillus. The gonococcus is comparatively seldom found in such cases—even in those of mixed infection; and when it is discovered we have no evidence that it has materially affected the result.

I admit, however, that the presence of gonorrhœal virus in the parturient canal is a serious matter. The gonococcus is probably the only pathogenic germ which is not destroyed by the ordinary vaginal secretions. Streptococci and staphylococci if placed in the vagina are soon destroyed, while under similar circumstances gonococci are unaffected. The gonorrhœal virus certainly produces very serious results, which, however, should not be confounded with those of severe puerperal septicemia.

Retention of placenta or membranes is another cause mentioned. The statement that this retention, together with gonorrhœal infection, is the cause in 75 per cent. of cases is sufficiently precise; but what are the data on which to found such contention? I admit that retained placenta is bad for various reasons, but I deny that it always causes septicemia. In properly conducted cases it seldom does. From my point

of view the most important matter in this connection is that retained placenta seldom or never causes septicemia unless germs are introduced from without. This is so nearly correct that the so-called auto-infection hardly deserves serious consideration.

The uterine cavity of the pregnant woman is peculiarly well protected from the invasion of germs. The vagina is rendered sterile (excepting as to the gonococcus) by its own secretions, while an important barrier exists in the plug of mucus (sometimes called the operculum) in the cervix, which is absolutely sterile. At the termination of labor we have an aseptic uterine cavity, which may become septic under certain conditions. Dr. Ross says: "Unfortunately the interior of the uterus has been looked upon as a 'holy of holies,' a sort of inner sanctum, into which it is dangerous to enter." I am quite willing to endorse this sentence with a slight change, *i.e.*, I would say *fortunately* instead of *unfortunately*. The most common method of changing the character of this sanctum is by the introduction of the hands carrying septic matter, together with the introduction of air. We know but little as yet about the properties of anaërobic organisms; and therefore cannot speak so definitely as to their influence as we can respecting the ordinary pathogenic germs. When the germs are carried by the hands or instruments to the interior of the uterus we have septicemia. When air is introduced I think it is not "soon expelled by the uterine contraction," but stays long enough to produce sapremia through the influence of certain putrefactive organisms. Although we know so little about the nature of such organisms we know something about the results of their activity.

My main reason for making these comments is that I believe the advice to explore the uterus after every labor is wrong, and if generally acted on would cause incalculable harm; it is contrary to the teaching and practice of all the most modern obstetricians and hospitals in the world. The methods recommended are, to my mind, on a par with those of the worst forms of meddlesome midwifery of the pre-antiseptic era. The chief aim of my life as a practitioner and teacher of obstetrics has been to fight against such methods. Fearing that the views of a man of Dr. Ross' ability and position would carry sufficient weight to influence some young practitioners, I am entering this protest against the procedures which he advises. If I found an assistant who used such methods in the Burnside, I would certainly not allow him to touch any patient under my care. Taking the last 750 patients in the Burnside, the fingers or hands have been introduced into the uterus in about 3 per cent. of the cases. Of the 750 one died of puerperal septicemia, and she was one of the few in whom the

uterus was explored by the fingers. I may say that I have every reason to think the fingers were clean, and I know not how the poisoning occurred.

I can only add a few words as to treatment. Dr. Ross' methods in abortion are all right, but I may say that in some cases I adopt that "wretched makeshift" the *modified* expectant plan. As to treatment of the third step of labor I advise the obstetrician not to introduce his hand into the uterus unless there is some sound reason for such procedure, such as *post-partum* hemorrhage, suspicion of retained placenta or membranes, etc. In case of retained placenta I would say, certainly have patient anesthetized, introduce hand into uterus and remove its contents. I consider, however, that this is a grave operation on account of the danger of introducing pathogenic germs or air, and I consequently avoid it when I can.

With reference to the membranes I think Dürrssen's method of removing them, when it can be done, is better than the introduction of the fingers, *i.e.*, to seize them with dressing forceps where they project into the vagina, and slowly extract them by torsion.

In connection with the danger of the entrance of air I wish to refer to one practical point of great importance. Immediately after the birth of the child, or while it is being born, the mother should be turned on her back, and kept there, at least, until the binder is applied; or, better still, she should be kept on her back as much as possible for a week. When the patient is lying on her side, and especially when she gets into a position somewhat like the Sims position, air is very apt to be sucked into the uterus, and sapremia is apt to be induced. An elevation of temperature during the puerperal state may be due to various causes, such as influenza, indigestion, emotions, etc., as well as septicemia; but if one has the slightest reason to suspect that it is due to something within the uterine cavity, it is well to explore it thoroughly as recommended by Dr. Ross. Under such circumstances the intra-uterine douche is not sufficient. The patient should be thoroughly anesthetized, the hand introduced into the vagina and the fingers into the uterus. The walls of the uterus should be thoroughly scraped with the finger-tips, which make the best curette. The uterine cavity should then be washed out with hot water (medicated if you like), and afterwards packed with iodoform gauze which may be left in one or two days. This treatment is especially satisfactory if the patient has sapremia, but will be useless for septicemia, which is due to the absorption of septic matter in tears of the vulva or vagina.

## A CASE OF TUBERCULAR PERITONITIS, COMPLICATED BY INSANITY.

BY THOMAS OVENS, M.D., L.R.C.P., ETC., PARKHILL.

Miliary tuberculosis of the peritoneum, involving the intestinal walls and adjacent pelvic organs, is by no means as rare a disease as many practitioners imagine, nor is it by any means so little amenable to treatment as the teachings of the textbooks, particularly the older ones, lead us to infer. In many instances the symptoms are either so complex or obscure that an accurate diagnosis is made only on the *post-mortem* table. Nor is this surprising when we consider how frequently many organs, in some instances remote from one another and performing very diverse functions, may be simultaneously affected by tubercular deposits. To the gynecologist, especially, tubercular peritonitis will ever offer a field for study as interesting as his advancing knowledge of the disease in question will be beneficial to womankind. That the disease, frequently commencing in the pelvic organs, rapidly extends to the peritoneum, giving rise to many complex symptoms, is unquestionable. In this way many such symptoms, which cannot be referred to diseased pelvic organs as their primary cause, may be explained, and their real origin and nature indicated. Sometimes, even when this disease is of an extremely grave character, there may be no signs of other organs being involved than those of the pelvic or abdominal cavities. However, this is not usually the case; generally the brain or lungs or, may be, the kidneys will show signs of involvement, sooner or later.

The mode of invasion of the peritoneum is often difficult to determine, though usually the vagina, uterus and tubes afford the most rational explanation of the course taken by the invading bacillus to reach the peritoneum. The uterus alone may remain unaffected whilst its appendages may be attacked by the bacillus. A true explanation for the immunity of one organ in a cavity while the others may be invaded is, I believe, at the present status of medical knowledge, unattainable. Broken-down mesenteric glands may afford, in some instances, an explanation of the source of dissemination of the bacillus. A family history predisposing to the occurrence of tuberculous disease; a depression of the general health; residence in low, damp localities; confinement in close, ill-ventilated apartments; innutritious diet; close contact with known tubercular patients—all undoubtedly contribute to the production of a deteriorated condition of the pelvic and abdominal organs, rendering each of them, in varying degrees, peculiarly susceptible to the invasion

of the bacillus and to a rapid degeneration and destruction of the organs from the toxins generated by it.

Pregnancy or abortion, as well as some acute diseases, may have a causal relationship to the development of tubercular peritonitis. In order to illustrate the benefit of operative treatment in this disease, I will briefly relate a case occurring in my own practice :

Mrs. P. N., a married lady, aged 26, consulted me July 1st, 1897. She said she had been married eight weeks; that previous to that event she had been in good health, but for the preceding month she had been sick in the stomach, particularly in the morning, and had vomited daily, and was suffering almost continuously from nausea. The patient was of medium height, fairly well developed, fair complexion, rather inclined to be flacid. She said she had never been ill, but, on close questioning, confessed to having had a miscarriage at the fourth month nearly a year previously. Her family are of a neurotic type. The patient also admitted that since the miscarriage her menses had been extremely irregular and attended with more or less pain, and that she was normally of a constipated habit. I suspected pregnancy, and prescribed oxalate of cerium with subnitrate of bismuth. About the 15th of August the patient called on me again, stating that she had been away on a visit in the meantime, but the nausea and vomiting had continued with more or less frequency and that she had menses lasting about two days. I prescribed again with a view of quieting her stomach and relieving the nausea. On the 1st of September the patient returned, this time complaining, in addition to nausea and occasional vomiting, of some pain in pelvis, of a stitch-like character, and had also observed that she was increasing in size over the abdomen. The patient stoutly maintained that she did not believe she was pregnant, but thought that a tumor was growing within the abdominal cavity. After a careful examination I concluded the patient was not pregnant, nor were there any indications of a tumor either in the pelvic or abdominal cavities. The abdomen was distended to some extent, which appeared to be due to intestinal flatus.

During the succeeding four months I saw the patient quite frequently. She was around attending to her domestic duties, but complaining of loss of appetite, nausea, morning vomiting, lancinating pains at times in pelvis and abdomen, and constipation. She was now considerably reduced in flesh and markedly paler. During this period she had not menstruated. On January the 5th I was hurriedly summoned to see her. Her temperature was 104 (hitherto I had never observed any elevation of temperature), pulse 120, vomiting frequently, abdomen

considerably distended, tender; patient complained of very severe lancinating pain in abdomen. For the ensuing three weeks her condition continued much the same, notwithstanding treatment, excepting that the abdomen became tense and tympanitic. At this time it was observed she began to manifest an inordinate affection for her nurse, her friends and her neighbors. Toward the end of the month the symptoms began to ameliorate, the abdomen lessened in size, pains almost ceased, temperature, which had been very irregular, varying from 99 to 105, now remained at about 100; vomiting almost ceased, pulse remained at about 120. During February she manifested but little desire to leave her bed, her appetite was poor, and she complained of weakness with occasional acute exacerbations of pain with some nausea and vomiting. Her friends observed that she now manifested extreme dislike to her husband and certain of her acquaintances. At this time she began to talk of her having been commissioned to preach the Gospel. On March 3rd she became suddenly and violently ill, the symptoms being similar to the attack in January, but more severe, her pulse ranging about 140, her temperature irregular and rising to 105. This attack, like the previous one, lasted about three weeks, when she made a partial recovery. She now began to lose her own identity, claiming to be the Virgin Mary, and, latterly, Jesus Christ himself. She was constantly pleading to those around her, coaxing, exhorting and threatening. She could not be kept in her room, nor in the house without resorting to force. From day to day she became more violent, until it was quite unsafe to approach her. She ate voraciously, complained of no physical ill, but kept on talking day and night. She was now very much emaciated, her abdomen retracted, and dull on percussion.

On the 15th of April she was committed to the Asylum for the Insane, London. Drs. Bucke and Hobbs, after watching her for a few days, and upon careful examination of the patient, notified me that in their opinion the case was one suitable for operation, and kindly invited me to be present. Accepting the invitation, I was present at the operation. On the 22nd April in the presence of Dr. Bucke and several other medical gentlemen, Dr. Hobbs performed an abdominal section. After making the patient, instruments and all appliances as thoroughly aseptic as possible, Dr. Hobbs opened the abdominal cavity. There was no fluid. The peritoneum was thickened and studded with miliary tubercles, small tubercular nodules were found on the intestines, Fallopian tubes and ovaries. All the pelvic organs were matted together, portions of the intestines were adherent to one another and to the peritoneum. The operator found it quite impossible to separate some of the

organs; they seemed glued together. Owing to the firmness and extensiveness of the adhesions it was quite impossible to remove the ovaries and tubes. The operator broke up as many adhesions as possible, washed the cavities with normal saline solution, drained and stitched up the wound.

Three months subsequently the patient returned home, sane, and, though weak, had none of her former symptoms. She is now, after the lapse of fourteen months, in excellent health, of sound mind, does her own work, has a good appetite, sleeps well, is quite fleshy, and says she was never better in her life. Dr. Bucke deserves the thanks not only of the profession, but of the whole community, for his wisdom in introducing into the London Asylum operative procedures for the permanent relief of the insane. I have no hesitation in stating that in Dr. Hobbs the Asylum possesses one of the boldest, cleverest and most skilful operators in Canada.

## Selected Article.

### CONTAGION IN LEPROSY AS OBSERVED IN SAN FRANCISCO.

BY DOUGLASS W. MONTGOMERY, M.D.,

Professor of Diseases of the Skin, University of California, San Francisco, Cal.

There are quite a number of lepers in San Francisco, many more than the eighteen or nineteen who are at present in the pest-house. The important question, however, before the city itself and before the United States is whether San Francisco and the Pacific Coast is merely a temporary abiding place for a few lepers who have come to it by accident, or whether this part of the United States is really becoming a leper focus where the disease may be contracted.

The difference between these two conditions is very great. London, Paris and Berlin, for instance, have always a number of lepers who have come to them either as returned officials or merchants who have acquired their disease in a leper country, such as Tonquin or India, or as patients seeking medical advice, but it is not considered that any of these cities constitute leper centres where leprosy is contracted,\* whereas Iceland, the Hawaiian Islands, the Province of Kwang Tung in China, for example, are undoubted leper centres where the disease is contracted not alone by the natives themselves but by immigrant strangers. To which class does San Francisco belong?

By San Francisco is meant the whole Pacific Coast, as the city is only mentioned because it is the point of view of the writer, and besides, being the largest port on the coast, it is the locality where the largest number of lepers is found. If San Francisco and the Pacific Coast constitute a district where leprosy may be contracted, the condition becomes infinitely graver than if the leprosy was altogether imported. It would appear from some of my observations that leprosy may be contracted on this coast.

In April, 1892, I published the case of an American, who died of tubercular leprosy in the San Francisco pest-house, and who, as nearly as I could find, had acquired his disease from the Chinese either in Nevada or California. This man was born in Massachusetts, and had never been out of the United States, except for a few hours in passing from Buffalo, N.Y., to Detroit, Mich., on a railroad. He had cohabited a great deal with Chinese, and at one time had had charge of a gang of Chinamen

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\*Hallopeau: "Annales de Dermatologie et de Syph." vol. viii, p. 996.

on the Central Pacific Railway, in Nevada. He died February 29th, 1892. He had noticed the first symptoms of his disease as areas of brown discoloration on the body and limbs about seven years before. His case has, up to the present, remained unique in my experience as being a native-born American whose malady was evidently contracted west of the Rocky Mountains. I have, however, run across several alien-born patients who, on account of their long residence in the United States before showing symptoms of their disease, might, therefore, be suspected of having acquired their leprosy here. A notable instance of this was a man named Samie Maiken, a Hindu, and a leper of the anesthetic type, who died in the San Francisco pest-house, July 9th, 1895, at sixty-nine years of age. He had lived in San Francisco for about ten years when he went to Virginia City, Nev., where he first noticed his hands were affected. He, like the before mentioned American, had consorted much with the Chinese, working with them as a laundryman. He had also cohabited much with Chinese prostitutes.

As far as the Chinese themselves are concerned, I have only found five who were long enough in America before the development of symptoms to allow one to infer that possibly they had acquired their disease in this country. One of these was a prostitute, twenty-nine years of age, who came from the village of Sun Ning in the See Yup district of the Province of Kwang Tung. She told a rather romantic story of how, in a raid of the Hak Kah, she had been stolen at fifteen years of age, and sold into slavery and brought to San Francisco, where she remained for six months. She was afterward sent to Salt Lake City, Utah, where, after a time, she bought herself free. She arrived in America in 1877, and it was not until 1888 that she first noticed the disease, which appeared as a small tubercle on the nose. She is still alive, a horrible picture of tubercular leprosy, in the San Francisco pest-house.

A Chinaman, named Chung Kan Foke, a native of the Province of Kwang Tung, came to San Francisco in 1876, where he remained for eight years. He then went to Nevada and worked in a silver mine, and it was in that State, in 1892, sixteen years after leaving China, that he first noticed tumefactions in the face, the first symptom of leprosy. When I examined him in February, 1894, he was suffering from tuberculo-anesthetic leprosy.

Another Chinaman, named Ah Lung, from the village of Sang Chow, in the district of Sun Ning, Province of Kwang Tung, by occupation a waiter, came to America in 1882, and it was not until 1895, thirteen years after he arrived, that he first noticed discolored patches in his face, the first symptoms of his

disease. When I first saw him, in March, 1897, he was suffering from leprous infiltrations and neural lesions.

Leong O You was a leper of the anesthetic type, forty-five years of age, who, when first seen in December, 1897, said that he had first noticed the disease, which at first affected his hand, in March of the same year. He had come to America twenty-eight years before.

Quan Chow, a cook, aged forty-four years, and a native of the village of Clack How, in the district of Hoy Ping, Kwang Tung, had come to America twenty-five years before, at nineteen years of age. He was a leper of the anesthetic type, with commencing leprous infiltration in the region of the left eyebrow. He had noticed the first symptom of the disease as a pain in the left knee-joint, extending down the front of the leg. This pain had come on after he had been in America nineteen years.

In drawing inferences from the foregoing aliens, consideration must be given to the long latency of leprosy. According to Hallopeau, even thirty-two years may elapse between contracting the disease and its first manifestations.\* Such very long latencies must surely be exceptional, however.

A. von Bergmann has recently made statements in regard to the increase of leprosy in Riga, and these are illustrative of what may be happening on the Pacific Coast. Riga a city of 250,000 inhabitants, is the most active trade centre of the Russian Baltic provinces. Von Bergmann says that undoubtedly in the Middle Ages there was leprosy in the city, but in the course of time it died out, and the last leper hospital was closed two hundred years ago, and Riga was for years as free of this scourge as either Berlin or Vienna. The very knowledge of it had vanished, and the writer says that when the older practising physicians are now shown a case of leprosy they claim never to have seen anything before resembling it. The registers of the hospital show, however, that since the beginning of the sixties, two or three patients a year have been admitted as lepers, but they were mostly from outlying districts. Between 1870 and 1880, however, inhabitants of Riga were registered as lepers, and after this the number increased rapidly, for in the years 1881 to 1886, twenty-seven patients were admitted, and from 1887 to 1890, sixty-four. According to von Bergmann, the facts seem to be that Riga was free of leprosy with the exception of a few patients who came in from outlying towns, and that these patients failed to spread the disease in the city because conditions were not favorable to its propagation. These conditions we do not know; we do not

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\* Hallopeau: *Cl. surr.*, p. 197.

know why certain contagious diseases spread with amazing rapidity in some years or in a series of years, then subside or die out altogether.

This is the very point of the present paper, for the region west of the Rocky Mountains seems not alone to be the recipient of a large number of lepers from outlying leper countries, but the disease appears to be capable of propagating itself in this country. The number of incoming lepers to the Pacific Coast from foreign countries must necessarily grow larger, with our increasing territory and increasing trade, but no statesman would ever think of curtailing trade or failing to annex territory for fear of the spread of such a mildly contagious disease as leprosy. The remedy must be in the segregation or deportation of those lepers we have, and the more stringent examination of immigrants from leper countries.—*The Journal of the American Medical Association.*

# Society Report.

## TORONTO CLINICAL SOCIETY.

STATED MEETING, FEBRUARY 7TH, 1900.

*Fellows Present:* Dr. W. H. B. Aikins, the Vice-President in the chair; Drs. Pepler, King, Silverthorn, Barrick, Lehman, Boyd, Trow, C. Temple, Ross, Fenton, Thistle, McIlwraith, Rudolf, Chambers and Elliott.

*Visitors:* Dr. Dunsmore, Oakville; Dr. Wrinch, St. Michael's Hospital, and Dr. Goldie.

### **Radical Cure of Hernia (Inguinal) in a patient seventy-five years old.**

Dr. W. H. Pepler presented this patient, an old man aged 75. He first presented himself to the doctor in the summer of 1898. Suddenly while walking on the street the man felt something give way, and observed a swelling in the right groin. On examination, a right inguinal hernia was found, and a truss was ordered applied. Several of these were tried for a time but all proved failures, as the patient was miserable all the time on account of the continual falling down of the hernia. As he was anxious for a permanent cure, Dr. Pepler decided to do the radical operation, which he performed in May, 1899, assisted by Dr. Bingham. The canal was opened and the sac tied off and let back into the abdomen. The ring and canal were then closed up with mattress sutures. During the night of the operation the patient got out of bed to go to the w. c. In the morning it was found that the stitches had broken away and the case really developed into an open operation. The wound was packed with gauze down to the ring, and it healed by granulation. The case went on without any further interest, and the patient is at the present time sound, and does not wear any truss, and has never had any discomfort. The points of interest are the age and the sound healing in this open manner.

Dr. King stated that a truss should not be worn after an operation of this character; and that in a large number of cases where there is a considerable amount of fat in the abdomen, you get better results by the open method. He spoke of a patient seventy-three years of age, in which he had done the double operation without any complications.

**Dislocation of Lower End of Ulna.**

Dr. E. E. King stated he could not show the patient as he had decamped, but presented a skiagraph instead.

**Fracture of Anatomical Neck of Humerus.**

Dr. King presented this patient, a man aged about fifty years. Three weeks prior to the 5th inst., the man was in the upper part of a house, somewhat the worse for alcohol, although he states he was not intoxicated. He got up to open the door, stretched out his hand to take hold of the latch, but touched something unawares instead, which he took to be a man, missed his footing on the first step, fell backwards and struck his arm about three or four inches before the shoulder joint; there were no other bruises on the body whatever. He got up and went back again into the room and remained there all that evening and night. The next day—he had used the arm all that time—he consulted a surgeon who thought there was a severe sprain of the shoulder joint and had applications applied. On the 5th inst. he came into Dr. King's service in St. Michael's Hospital, who found the condition around the shoulder joint like nothing he could recognize, and asked the Fellows for assistance in diagnosis and treatment. There is loss of motion to a considerable extent, atrophy, and the nerves are injured in the axilla.

Dr. Pepler thought the condition was a fracture in the head of the bone with probably a longitudinal one as well. The shortening would give history of dislocation, the pressure on the nerves would give rise to the other symptoms.

Dr. Chas. Temple considered there were some signs of impact fracture with dislocation.

Dr. King then presented a skiagraph of the shoulder, and described the conditions present. There were two fractures present, one a fracture of the shaft of the bone with displacement inward of the upper end of the lower fragment, which could be felt in the axilla, and which accounts for the shortening. Then from the skiagraph there appears to exist a fracture about the anatomical neck with what seemed to be a rotation of the head of the bone. The first fracture was more or less of a greenstick variety.

Dr. Ross, who examined the subject very carefully, stated that there may have been a fracture through the neck and head of the humerus, but there is another piece of bone quite distinctly to be felt high up in the axilla in the neighborhood of the coracoid process which he considered fractured as well.

Dr. Fenton stated also that he could find this bony process quite firm to the touch high up in the axilla. It was about as thick as the end of the finger.

Dr. Barrick thought that the case appeared very obscure, and that the skiagraph appeared more obscure still. He thought there was no doubt of there being a fracture in the neck of the humerus.

Dr. King did not think that the caracoid was fractured; the body felt would be a gland, or probably a portion of bone from the humerus.

### **The Treatment of Inebriety.**

By special invitation of the President (Dr. Bingham), Dr. Dunsmore, Assistant Physician Lakehurst Sanitarium, Oakville, read a paper on this topic. He stated: By the courtesy of your president I was invited to read a paper at this meeting of your society, and have taken for my subject "The Treatment of Inebriety," but as it would not be right to occupy much of your time I will confine myself to the treatment of alcoholism, and not touch on that of morphine or other narcotics. As resident physician at Lakehurst Sanitarium, Oakville, I will try briefly to outline the course of treatment we adopt in alcoholic cases. In the first place, let me make it clear that we do not depend on any so-called specifics or nostrums of any kind, as we all know that secret remedies and formulæ are simply impositions and appeals to ignorance.

The continued use of alcohol to excess sets up certain changes in the system; and, according to Payne, the poisonous effects in alcoholism of the chronic variety are manifested:

1. As an acute narcotic poison.
2. As a poison acting on the parenchymatous elements, particularly epithelium and nerve, causing slow degeneration and ultimately fibroid changes in the blood vessels.
3. It retards oxidation, thus leading to fatty changes.

The effects on the nervous system are best seen in the tremor of the hands and tongue. No characteristic changes are seen in the nervous system. Hemorrhagic pachymeningitis is not uncommon. Opacity and thickening of the pia-arachnoid membranes with more or less wasting of the convolutions generally occur. The most striking effect on the nervous system is the production of alcoholic neuritis. Osler says that alcoholism at first sight may bear a striking resemblance to general paresis, especially in those cases when the pathological findings consist of opacities in the pia mater and congestion of the cerebral substance.

The effects on the digestive system are shown in the catarrh of the stomach and definite changes in the liver leading to various forms of cirrhosis. The effect is probably due to primary degeneration of the liver cells. The typical granular kidney seems to result indirectly from alcohol through arterial changes.

Having outlined some of the most common effects of chronic alcoholism, I will try to give a sketch of our method of treatment, and would say that it is a condition very difficult to treat when the habit is once fully established; most obstinate cases are those with marked hereditary tendency.

Withdrawal of the alcohol is the first essential, and the most trying period is the first week or ten days of abstinence. The absence of temptation in institution life is of special advantage. For sleeplessness bromides or hyosine are useful; quinine and strychnine may be used in tonic doses. Great care must be taken not to reduce the daily quantity of alcohol too quickly, especially if the patient shows symptoms of delirium tremens. It is often very beneficial to wash out the stomach. If collapse symptoms occur, the limbs should be rubbed and hot applications made to the body. Tincture capsicum in about 5-minim doses, given occasionally at this period, has a good effect. The average case of chronic alcoholism can be in this way removed from his liquor in about a week.

Some cases require longer periods of treatment than others, but a course of five or six weeks is usually found long enough. I would like to emphasize especially the importance of moral tonics in treatment of alcoholism. We put all our patients on their honor and do not place any restrictions on them. They are at perfect freedom to come and go as they please. Under these circumstances, a man taking alcohol clandestinely would find himself regarded as a traitor to his trust. The natural beauty of the situation of the institution, with the lawns sloping to the banks of Lake Ontario, lends a soothing influence and gives a most delightful and healthful situation. The tone of cheerfulness is kept up by healthful amusements. In summer there are lawn-bowling, cricket, tennis, boating and bathing. In winter curling is the outdoor amusement chiefly indulged in. The institution itself is large, well lighted and heated; ventilation and sanitary appliances excellent. These cheerful, homelike surroundings, all have their own influence for good. I submit this paper, gentlemen, not trying to convey the impression that this is the only or best plan for treatment of alcoholism, but simply as a method which has proved very successful in my own limited experience.

I will conclude by stating that intemperance in all its stages may be not only checked and mitigated, but in many cases permanently cured, and the subject fully restored to his former condition of health and sobriety. Such results may not be reached by the final and utter extinction of the morbid desire for alcohol, so much as by a development and cultivation of opposing and ennobling qualities, which, by their vital action, hold the depraved mental tendencies of the subject in constant

and absolute subjection, so that they may become as inoperative as though they did not exist.

Drs. Fenton, Thistle, Mellwraith and Rudolf discussed the paper.

#### **Placental Inspection—Its Uncertainties and Its Dangers.**

Dr. J. F. W. Ross read a paper with this title. (See page 113.)

Dr. Mellwraith thought the condition was generally due to an infective germ, and that no doubt the retained placenta formed a good growing ground for the micro-organism, and then there was the fact that cases of septicemia occurred without any retained placenta at all.

Drs. Aikins, Silverthorn and Barrick further discussed the paper.

GEORGE ELLIOTT,  
*Recording Secretary.*

# Editorials.

## DOMINION MEDICAL REGISTRATION.

We find in the last number of the *Kingston Medical Quarterly* a carefully prepared article on this subject. This journal probably represents the views of the "Queen's" men, and deserves consideration on that account; but it is fair to add, that apart from any local influences it has for years taken a very intelligent and broad view of the subject. In the first place, it refers to the fact that it has supported a Dominion Council with a Dominion license, rather than inter-provincial registration for three years.

In reference to Dr. Roddick's proposed bill, the first objection raised is the one which was made by Dr. Powell, of Toronto, last summer, that the apportionment by representation to the various provinces and territories was unfair, *i.e.*, three representing each of the seven provinces and the territories (the territories ranking as equal to one province) respectively. Thus Ontario and Quebec, with an approximate population of four millions, would have six representatives, while the rest of the Dominion with a population of one and a half millions would have eighteen. It is claimed that a fairer division would be to have the allotment as follows: Ontario and Quebec, six each; the other provinces, and the North-West Territories, two each. This would not mean representation by population in its entirety, but would give to the four millions of Ontario and Quebec twelve representatives, and to the million and a half in the rest of the Dominion a similar number.

A suggestion is also made that the method of appointing the representatives be changed. Let the clause making the various presidents of councils *ex-officio* members be modified as follows: In those provinces having two representatives, let one be appointed by the Governor-General in Council, and one by the Provincial Council, and in Ontario and Quebec one for each by the Governor-General in Council and five for each by the Council of each province.

As one of the duties of the new Dominion Council would be to prescribe the course of studies, the writer thinks that the

Council should be increased by adding one representative from each university in Canada having a teaching medical faculty. He also objects to the rule which would make all the representatives physicians, and recommends the appointment of some laymen. A quorum of seven—less than one-third of the whole Council—is considered too small. The proposal to give both a deliberative and a casting vote to the president or to the vice-president when in the chair, and also to the chairman of any meeting of the Council or of any committee of the Council is thought to be unwise as it places too much power in one member.

The proposal to have all the examinations held in Montreal or Toronto alternately, is regarded as highly objectionable because it would be unjust to the medical colleges of Halifax, Kingston, London and Winnipeg. The article contains a counter-proposal that all the written examinations be held simultaneously under presiding examiners at the various centres, the papers being sent under seal; and that the oral examinations be conducted by the regular examiners who shall go to the various centres for that purpose.

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#### DR. RODDICK'S PROPOSED BILL.

We have given in the preceding article a brief *résumé* of the editorial which appeared in the *Kingston Medical Quarterly*. It raises many points which are worthy of careful consideration, and which have already been discussed in other parts of Canada, especially Ontario. The question of representation is an important one, for many reasons; but, at the same time, its importance has been unduly exaggerated in certain sections. Without discussing the matter at present, we may simply state that there is a fairly strong feeling that the proposals in the bill in this connection should be modified to some extent.

Many of the objections in the Kingston editorial refer simply to matters of detail, without affecting the main principles of the proposed legislation. The idea of having lay representation in the Council is rather a novel one, and such a departure would scarcely be popular. The proposal to hold

the annual examination at Montreal and Toronto would be strongly opposed, and we think that the plan proposed by our contemporary would be much more satisfactory. The suggestion to add to the Council representatives from the universities having medical teaching faculties, is one that is not likely to meet with a hearty response from the great mass of physicians in Canada; and, still, we think that a few university men in the Council would be found useful.

It is satisfactory to note in connection with the great number of objections that have been raised against the proposed bill, that we appear to have got much nearer the goal of Dominion registration than we were two years ago. Dr. Roddick has given us something tangible to discuss, and has also shown a disposition to be thoroughly fair, and to consult the interests of the various provinces of Canada. We hope he may be induced to remain in parliament until satisfactory legislation has been enacted, although we have now no great hope that such will be effected during the present session

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### MILITARY SURGERY IN SOUTH AFRICA.

We have every reason to believe that the medical service in South Africa has been, and is now magnificent. The British Government, appreciating fully the vast importance of properly caring for the wounded, added a large number of non-military surgeons to the regular staff. Sir William MacCormac has evidently done a great deal of useful work since he reached the seat of war. After a careful inspection of all the hospitals in Natal he proceeded to Cape Town. He then spent some time in the spacious base hospital at Wynberg near Cape Town, after which he visited the various field hospitals with the armies of Gatacre, French and Methuen, and certain hospitals at DeAar, and other places. While he was going the rounds in Cape Colony, Mr. Treves was giving his personal attention to the seriously wounded from General Buller's army. The conduct of the members of the army medical corps seems to have been such as to command the admiration and respect of all who have witnessed their work. Many of them, unhappily, have lost their lives on the battle-field while unflinchingly doing

their duty. Frequent mention of the coolness and gallantry of the stretcher-bearers has been made in the various despatches. One of the most remarkable instances of such bravery was that of the battle of Modder River, when the heroic members of the corps faced the hail of Mauser bullets in the open ground in their efforts to succor the wounded. There is a general consensus of opinion that never before in the history of warfare have the wounded been cared for as they have been in this campaign. The various hospital ships at Durban and Cape Town, including the *Maine*, "that magnificent contribution of our American cousins" (the *Graphic*), have been a great source of comfort to a large number of the wounded who could ill endure the dust storms and heat to which they were exposed.

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### THE CANADIAN ARMY MEDICAL SERVICE.

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Military surgeons in all parts of Canada, so far as we can learn, regret exceedingly the sudden and unexpected, not to say unceremonious, departure of the late G. O. C. General Hutton from this country. There was abroad in the militia a new feeling of hope that great changes for the better would be made in the near future; but now hope has given way to bitter disappointment, dismay, and even anger. We believe this sense of hope deferred actually maketh sick the heart of the medical branch of the service for whom particularly improved position and better opportunity of service seemed almost a realized condition.

Soon after we heard of General Hutton's resignation an order from the Militia Department appeared, which has caused intense surprise and indignation among military officers. Our sense of what is fair compels us, in behalf of those who are in the service, to protest without reservation or qualification against the order in question, which says that hereafter any medical officer may be compelled to recoup out of his own pocket any expense to which the public may be put on account of transport, etc., of a recruit who turns out subsequently to be physically unfit for service.

Such an order may seem very fair to some, but how will it

work out in practice? It is well known that recruiting officers are very sensitive as to any contravention of their wishes by the medical officer: A rigorous rejection of certain doubtful recruits may lead to friction which will one day be visited upon the medical officer when old scores come to be settled. Again, who is to determine the accuracy or carelessness of the medical officer's work, or apportion the blame, in any given case contemplated by the order referred to? The following examples will show the difficulties that are apt to arise. In one case a man died of *delirium tremens* shortly after he had passed inspection. To shield his memory and spare his friends, the cause of death was published as heart failure. Many people at once blamed the doctor who knew so little of his work as to pass a man with a heart so crippled that it could not stand ordinary routine drill. In another case the cause of death was said to be *locomotor ataxia*, while the real cause was probably a tertiary syphilitic growth in the spinal cord. Here, again, the medical officer was harshly criticised for accepting a recruit with a chronic nervous disorder. Thus do the members of our profession frequently have to bear the blame in silence, while endeavoring to spare the feelings of friends and the memory of the dead.

We hesitate to believe that the Minister of Militia, himself a medical man, has authorized such an order, and prefer to think that it emanated from a lower source. We beg respectfully to direct the attention of the Hon. the Minister, to it, and to request that it be cancelled, as an undeserved evidence of lack of confidence in a branch of the service already in all conscience laboring under disabilities enough.

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### ONTARIO MEDICAL ASSOCIATION.

The next meeting of the Ontario Medical Association will be held in the Normal School buildings on June 7th and 8th. The Committee on Papers and Business have decided to have a somewhat extended discussion on Dominion Registration, a subject which is of great interest to practitioners in all parts of Canada, especially to those who live in the premier province. It is also hoped that there will be a symposium on "Military

Surgery in South Africa" by well-known surgeons in the volunteer force. Arrangements have been made for a large exhibit of surgical instruments, drugs, and physicians' supplies generally. The general secretary requests those who intend writing papers to send titles of such to him as soon as possible. The Association dinner will be held on the evening of June 7th.

*Officers:* 1st Vice-President and Acting President, Adam H. Wright, Toronto; 2nd Vice-President, M. J. Beeman, Newburg; 3rd Vice-President, R. J. Trimble, Queenston; 4th Vice-President, A. F. McKenzie, Monkton; General Secretary, Harold Parsons, 97 Bloor Street W., Toronto; Assistant Secretary, George Elliott, 129 John Street, Toronto; Treasurer, George H. Carveth, College Street, Toronto.

*Chairmen of Standing Committees:* Credentials, A. T. Hobbs, London. Public Health, D. Gilbert Gordon, Toronto. Legislation, J. C. Mitchell, Enniskillen. Publication, W. H. B. Aikins, Toronto. By-laws, G. H. Burnham, Toronto. Ethics, A. McKinnon, Cuelph. Advisory, J. D. Macdonald, Hamilton.

*Temporary Committees:* Papers and Business, Albert A. Macdonald, Toronto. Arrangements, Allen Baines, Toronto. Audit, A. B. Welford, Woodstock. Necrology, J. L. Bray, Chatham. *Re* Interprovincial Registration, J. A. Williams, Ingersol. *Re* Hospital Abuse, W. J. Wilson, Toronto. *Re* Health of Public School Children, William Britton, Toronto.

## Personals.

Dr. Frank Porter succeeds Dr. Thomson in Waubaushene.

Drs. Drake, of London, and Laurence, of St. Thomas, leave about the middle of the month for a continental tour.

Dr. Robert William Bell (McGill, '73) has been appointed to succeed Dr. Ezra H. Stafford in the Asylum for Insane, Toronto.

Dr. Walter Proudfoot Thomson (Tor. '92), who has been practising for some years in Waubaushene, has removed to Toronto.

Dr. Price-Brown, of Toronto, attended the meeting of the American Laryngological Society held in Philadelphia in February.

Dr. John L. Bradley (Trin. '94) of Creemore, and Dr. V. A. Hart, of Sault Ste. Marie, sailed from New York for England, February 10th.

Dr. Wallwin, of Barrie, after spending some months in post-graduate work in New York, intends to visit the hospitals of England and the continent.

Dr. Campbell Brown Keenan (McGill, '97) was appointed Surgeon to the Strathcona Contingent. His former home was Ottawa, but at the time of his appointment he was one of the resident surgeons of the Royal Victoria Hospital of Montreal.

## Obituary.

J. R. ROSEBOROUGH, M.D.—Dr. Roseborough, a graduate of Trinity University, '93, died suddenly at his home in Michigan, in January.

HENRY CHAPPLE, M.D.—Dr. Chapple (Trin. '89), who had practised for a number of years in Billings, Montana, died of Addison's disease in Arizona, January 10th.

Dr. LESLIE E. KEELEY, of "gold cure" fame, died suddenly at his winter home near Los Angeles, California, February 21st. His ordinary home was in Dwight, near Chicago, Ill.

THOMAS WRIGLEY GRIMSHAW, M.A., M.D.—Dr. Thomas W. Grimshaw, Registrar-General for Ireland, ex-President of the Royal College of Physicians of Ireland, died from the effects of pneumonia following la grippe, January 23rd, aged 61. He was one of the most prominent and popular physicians in Ireland.

SIR THOMAS GRAINGER STEWART, M.D., F.R.C.P.E., F.R.S.E., LL.D.—Sir Grainger Stewart died February 3rd, at his house, 19 Charlotte Square, Edinburgh, aged 62. He was Physician-in-ordinary to the Queen for Scotland, Professor of the Practice of Physic, University of Edinburgh, and President of the British Medical Association at the Edinburgh meeting of 1898.

ALFRED SALES OLIVER, M.D.—Dr. A. S. Oliver, of Kingston, died suddenly at his home, February 13th, of heart disease. He graduated M.D., University Queen's College, in 1863, and for some time after served in the American civil war. After the close of the war in the United States he went to Kingston, where he practised until the time of his death. He was highly respected by all classes, and was for many years a member of the teaching staff of Queen's Medical Faculty.

# Progress of Medical Science.

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## MEDICINE.

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IN CHARGE OF W. H. B. AIKINS, J. FERGUSON, T. McMAHON, H. J. HAMILTON,  
AND INGERSOLL OLMSTED.

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### Amenorrhœa.

Dr. William Murrell (*Med. Press and Circular*, December 20th) states his experience with the preparations of manganese. One patient seven years ago began to lose flesh and become pale. She generally improved on iron pills, but had three or four attacks of anemia each year. When admitted to the hospital there was neither constipation nor leucorrhœa. The blood was examined by Dr. Lazarus Barlow, who found it of fair color, but thinner than normal. The red corpuscles were 4,520,000 per cmm., normal in shape and appearance, but pale. The white corpuscles were 7,500 per cmm., chiefly oxyphile, polynuclear cells and lymphocytes. There was, therefore, no oligocythemia, and the condition was one of oligochromenia. Was retained in the hospital for two weeks under rest and good diet, without improvement. She usually went three to five months without menstruating. She was placed on citrate of manganese in 5 gr. doses three times a day. Prior to treatment she had not menstruated for seven months, nor done work for about eighteen months. She menstruated in two weeks after the use of the medicine. In another case red corpuscles were 3,800,000; white, 3,000. She was ordered manganese citrate, gr. 5, to be increased. She rapidly improved.

### The Craving for Stimulants.

Dr. Harry Campbell (*Quarterly Journal of Inebriety*, January, 1900) refers to the fact that the world-wide desire for stimulants is the manifestation of a very widely operating physiological principle, namely, that stimulants are present in the animal organism and exercise a beneficial influence on function. A stimulant is something that does not yield energy, but renders it available, or converts potential to actual energy. The whip or spur is an example of this. But some stimulants act through the blood, as alcohol. Those stimulants that act through the blood may or may not intoxicate, as instanced by alcohol and strychnine. Certain foodstuffs yield a great deal of stimulating products. In certain diseases there exist in the

system certain substances that give rise to a feeling of well-being, as seen in general paralysis of the insane. Normal blood contains those products which act upon the nervous centres and create that feeling of ease and comfort and energy that conduces to the best work. The great remedy for drinking is to improve the health and purify the blood so as to furnish the brain with its normal stimulation.

### Narcolepsy.

Dr. D. J. McCarthy, in *American Journal of the Medical Sciences*, February, 1900, studies this subject. After a careful review of the literature on the subject and the observation of some cases, the clinical of which he records, he comes to the conclusion that narcolepsy is not a distinct neurosis. Hysteria and epilepsy furnish us with the majority of the cases of morbid sleep. Close study excludes those of epileptic origin, leaving narcolepsy hysterica to account for most of the remaining cases. In all such cases attention must be given the elimination of waste products from the system by regulating well the action of the bowels, the skin, and the kidneys, and by a well-advised course of massage. Complete rest and judicious feeding are needed to build up the nervous system.

### Effects of Influenza on the Heart.

Dr. A. Ernest Sansom (*Internat. Med. Mag.*, November, 1899) in his article adopts the germ theory of influenza, and thinks the micro-organism described by R. Pfeiffer, in 1892, is the real germ of the disease. The poison of the germs belongs to the group of proteins which occur in the bodies of the organisms. The influenza germ is confined to man, and spreads along the surface of the respiratory tract. The poison from the germs is absorbed into the system and acts specially on the nervous system.

In many cases of influenza there are mixed infections, such as the presence of the staphylococci, streptococci, pneumococci, the bacillus of diphtheria and others. The toxins from these germs give rise to much variation in the symptoms. In this way may be explained the occurrence of otitis-media, pulmonary consolidation, sore throat and meningitis during attacks of influenza. The influenza germ also may complicate the progress of typhoid fever and phthisis, often rendering the course of these diseases very rapid and fatal.

In rheumatic and gouty patients where there is such a strong tendency to cardiac trouble, an attack of influenza often causes great irregularity, and adds vastly to the danger of these cases by disturbing in some way the metabolism of the body. On the other hand, there is no evidence to show that influenza

alone ever gives rise to endocarditis, but it may cause dilatation and mitral insufficiency.

Acting through nervous system influenza may give rise to a syndrome-like, exophthalmic goitre. There are palpitations, flutterings, flushings, perspirations, faintness and tremors. There are attacks during the night of flatulence, nausea, gastralgia, dyspnea and a sense of failing heart. These attacks might be called vagus storms. The tachycardia of influenza may be prolonged and obstinate. In these cases the eye symptoms of exophthalmos are often well marked. The drug treatment of the rapid heart of influenza is not very successful. Small doses of Fowler's solution is the best tonic treatment. The most important means of treatment is the weak continuous current through the course of the vagus. The anode should be moistened and applied to the nape of the neck, while the cathode, also moistened, is applied along the course of the nerve. This should be done for six minutes, three or four times a day, on the sides alternately.

The treatment of the irregular heart after influenza is even more difficult than that of the rapid heart. The galvanic current is of value. Massage, exercise, baths, bathing are of considerable utility. Change of climate, sea voyages and means of securing the purest supply of air are rightly esteemed. The patient should be trained into conditions of comfort and regularity; but the habit of studying his own condition is bad.

Bradycardia may follow influenza, and is even more obstinate to treat than the previous disorders. Massage of the extremities and tincture of belladonna, 10 minims three times a day, seemed in a number of cases to do good. Pain in the heart sometimes follows influenza. The pain may be of a dead character or extremely sharp, and radiate as in angina pectoris. These cases derive benefit from the use of phenacetin, antipyrin and morphia for the relief of the pain. In the intervals of the attack, the best drug is iodid of sodium in doses of five to ten grains. This may be combined at first with ammonia, and later with Fowler's solution.

### Acute Edema of the Lungs.

M. Le Dr. H. Huchard (*Gazette des Hopitaux*) contributes an article of interest on the above affection. He reviews carefully the opinions of Andral where it followed scarlet fever, those of Lund and Bouveret where it followed affection of the aorta, and where due to paralysis of vagus origin. The attacks are sometimes extremely sudden, and may be accompanied by a characteristic expectoration, at others there may be no expectoration. Suddenly, or rapidly, there is intense dyspnea, extreme respiratory tightness; there is a great abundance of

rales over both lungs, but more at the bases. The expectoration may amount to two quarts in a few hours, and is usually frothy and albuminous, as after a thoracentesis. While there is this abundance of rales there is increased resonance of percussion. The person dies with the symptoms of intense asphyxia. At the commencement, and often during it, the pulse retains high tension; but at the end of the crisis the pulse tension drops, and there is sudden cardiac asystole. The enormous hypertension in the lungs weakens the right ventricle rapidly. There is derangement in the cardio-pulmonary innervation. There is frequently renal impermeability with intoxication of the system. For the purpose of relieving the right side of the heart, drugs are too slow, and copious bleeding is the only course open. The cardio-pulmonary paralysis is best prevented by subcutaneous injections of strychnine, and caffeine. The action of the kidneys may be maintained by a milk diet and the administration of theobromine in doses of gr. xx. to gr. xl. When pulmonary edema comes on in connection with arterio-sclerosis, the iodides are useful, but not rapid enough in action in the acute cases.

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## THERAPEUTICS.

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IN CHARGE OF GRAHAM CHAMBERS AND J. T. FOTHERINGHAM.

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### **The Prevention of Vomiting after Anesthetics.**

Blumfeld (*Lancet*) states that a large proportion of the cases of sickness after anesthetics might be prevented by adopting the following rules: 1. Use as little of the anesthetic as possible. 2. Wash out the stomach at the close of the operation when much mucus has been swallowed. 3. In long operations substitute chloroform for ether after three-quarters of an hour. 4. Place the patient on his or her right side, with head slightly raised. 5. Move the patient as little as possible. 6. Keep the temperature of the room the same for several hours. 7. Give them hot liquids in small quantities for the first eight hours.

### **Parotid Gland Extract in the Treatment of Ovarian Disease.**

Mellett (*New York Medical Journal*) finds that the parotid gland extract is the most efficient sedative in dysmenorrhea. It relieves both the pain in the back and in the ovarian regions. Menstruation when deranged becomes more regular, less in quantity and of shorter duration.

### Treatment of Sciatica.

Eulenberg has published a long paper on this subject (*Therap. d. Gegenw.*, Berlin u. Wien, 1899). The cause of the neuralgia may depend on a neuroma, or other local tumors inside or outside the pelvis, and these demand surgical measures. In numerous cases it depends on distention of the abdominal veins, and here a vegetable diet and local blood-letting are indicated (leeches to anus, and over sciatic nerve), with habitual use of a purgative mineral water, or a course of spa treatment. When severe constipation is the cause, it must be energetically treated by the usual methods. Sciatica sometimes occurs as a consequence of gonorrhoea, syphilis, gout, diabetes, alcoholic, lead, and mercury poisoning, and then general as well as local treatment must be resorted to. In ordinary cases, rest and with severe pain, rest in bed is necessary, with warm applications and the local injection of a 2 per cent. solution carbolic acid, or of morphine. In specially painful cases, cocaine may be injected. The injections should be made deeply, so as to reach the more superficial branches at least of the nerve. The faradic current applied to the painful places and along the nerve temporarily abolishes the pain in most cases. The galvanic current has a more lasting and curative effect. The positive electrode should be a large plate of lead applied over the exit of the sacral plexus and the sacrum; the negative electrode can be applied to the sole of the foot, or at some other point. Five to seven milliamperes should be applied for ten minutes or longer at a time. Massage should be used only when the actually painful stage is past. Rubbing and kneading along the nerve should be practised. Nerve stretching should be practised by bending the stiffly extended leg over the abdomen. In obstinate cases, hot baths, packs, sprays, hot air douches, etc., frequently bring about a cure. Nerve stretching by the surgeon has proved of little value, and the same is true of iodides, bromides, arsenic, etc.—*Edinburgh Medical Journal*.

### Treatment of Tuberculosis of the Bladder.

W. Watson Cheyne (*British Medical Journal*) says that the treatment may be either medical or surgical. Unfortunately, by neither method can we with any certainty bring about a cure, but nevertheless much may be done to relieve the patient's distress. Medically, good hygiene, country or seaside air, etc., are of the first importance, and light exercise is also advisable. In acute cases relief may be obtained by warm saline baths, mustard to the hypogastric region, warm water injections into the rectum, etc. The food should be light and easily digestible, and consist essentially of large quantities of milk. Cod-liver

oil should be given in large doses, and benefit may also be obtained from the use of arsenic, creosote, opium, and belladonna for the pain, etc. These means are, however, often ineffectual, and local measures are frequently adopted, more especially washing out the bladder so as to get rid of the pus and mucus, and injecting various substances, such as weak cocaine or opium, to relieve the pain, or antiseptic substances with the view of trying to interfere with the growth of the bacteria. Warm boracic lotion, about from three to four per cent., is one of the most suitable fluids for washing out the bladder. Iodoform and glycerin is often injected into the bladder and left in, but the results are disappointing. Iodoform and vaselin, about six drachms of a 5 per cent. mixture, has been strongly advocated by some French surgeons. Injections of nitrate of silver, which are of use in other forms of cystitis, almost always do harm. The instillation of weak sublimate solution (1-in-1000 to 1-in-5000) has been employed, and is much praised by some. Cocaine and opium injected into the bladder are very transient in their effects, and must be very carefully used, as they are apt to be absorbed. Benzoic acid taken internally helps to keep the urine sweet. Pills of iodoform in half-grain to one-grain doses, tincture of buchu, triticum repens, etc., may be employed. Attempts have also been made to increase the capacity of the bladder by gradual distention with fluid. The operative interferences consist in opening the bladder and draining it, in attempting to remove the tuberculous ulcerations, or in applying antiseptic substances to them.—*Medical Age*.

#### **Mercurial Ointment in Erysipelas.**

Dematters (*Gazz. degli Ospedalli Clin.*) reports a series of eight cases of this affection treated by mercurial ointment either alone or diluted with vaselin. The writer says that his success was remarkable. He found it of great value not only in the more or less stationary cases, but in those where the disease had a tendency to spread in other parts; even in gangrenous erysipelas it controls the extension of the disease. The author says that in all probability the efficacy of this remedy is due to its bactericidal action.—*Medical Age*.

#### **Guaiaicol- and Creosote-carbonates.**

Dr. Fritz Holscher (*Pageblatt für den Kongress zur Bekämpfung der Tuberkulose*) reports upon the use of these remedies in both acute and chronic diseases of the respiratory passages. These are not merely symptom remedies, but they act directly upon the cause of the disease, in that by impregnating the body with creosote combinations they influence unfavorably

the conditions of life, of the causes of the disease, and later improve the symptoms by eliminating poisonous products of retrograde metamorphosis. The discoloration of the urine is not a symptom of poisoning, and should not alarm the patient. After large doses of creosote-carbonate free creosote is eliminated through the lungs. The marked observed results are: (1) Great increase of appetite; (2) rapid, often great increase of weight; (3) fever, night-sweats, and weakness disappear, even if they have persisted for a long time; (4) cough and expectoration diminish, and bacilli disappear from the sputum; (5) the physical signs disappear after six months, although longer treatment may be advantageous. Apical bacillary catarrh comes to an end in two or three months. In acute pulmonary disease (pneumonia, broncho-pneumonia, grippal pneumonia) it is cut short by timely exhibition of large doses of creosote-carbonate, as has been shown by Cassoude and Corgier. The characteristic crisis comes on in twenty-four hours, and auscultatory signs are not found. At present creosote-carbonate is less expensive than guaiacol. In view of the extensive use of these remedies, carefully conducted clinical research, with tabulated results, is important.—*Amer. Journal of the Medical Sciences.*

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## OBSTETRICS AND GYNECOLOGY.

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IN CHARGE OF ADAM H. WRIGHT, JAMES F. W. ROSS, ALBERT A. MACDONALD,  
H. C. SCADDING AND K. C. McILWRAITH.

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### Treatment of Dysmenorrhea by Belladonna.

Wm. Murray, M.D., F.R.C.P. ("Rough Notes on Remedies," 1899, p. 40).—Whether dysmenorrhea is due to spasm or to mechanical obstruction plus spasm, or plus neuralgia, or plus congestion, there is a large field for belladonna. A patient under its influence is not likely to suffer from spasm, so that the spasmodic element can be eliminated by a dose or two. If the pain still continues, other elements—mechanical or congestive—are present, as the neuralgic element is also, to a great extent, eliminated by the belladonna. The best method of using the drug is as a suppository of 1 or 2 gr. of the extract repeated every 2 or 4 hours. The suppository should be used as soon as the first sign of pain indicates the molimen. Every woman who suffers ought to have this remedy at hand—*The Medical Review.*

### A Case of Simultaneous Intra- and Extra-Uterine Pregnancy.

Mond (*Munch. med. Woch.*, September 12th, 1899) reports a case of intra- and extra-uterine pregnancy occurring simultan-

ously, and reviews the literature up to the present time upon the subject. Laparotomy was performed in the case of Mond's and revealed an intra-uterine pregnancy of two or three months with hematoma of the right Fallopian tube after a ruptured tubal pregnancy. The treatment instituted was successful and the pregnancy after full time terminated with the birth of a living child. Gutzweiler has collected eighteen cases from literature, and six cases have since been reported. The common termination of such cases is shown to be as follows: The extra-uterine sac ruptures and also the tube, causing either an internal hemorrhage or hematocele, thus interrupting the intra-uterine pregnancy and producing abortion or premature labor. Very rare cases are reported in which full term has been completed with a normal labor.—*Cleveland Hospital Bulletin*.

### **An Early Sign of Pregnancy.**

Braun-Fernwald (*Wien. klin. Woch.*, March 9th, 1899), while discussing the early signs of pregnancy, refers to the well-recognized fact of the change of consistency of the uterus. He has also observed a significant difference in the anterior-posterior diameter of the uterine body. This thickening is usually located upon one side. This enlargement corresponds to the position of the ovum. This also brings into tactile prominence a sort of central groove in the corpora. He explains this condition by calling attention to the rarity of the central attachment of the ovum and the early growth of which nearly always takes place in or near one or the other of the cornui. Observation has convinced him that this sign is more constant and confirmatory than any other one of the signs or symptoms of pregnancy described. He was able to confirm the greater majority of his diagnoses by subsequent observation of the cases. In cases of abortion in which the ovum has been expelled, he found the central groove of the lateral thickening absent. On the other hand, if the ovum was still attached, he found both signs to obtain. He looks upon this as a very certain and important diagnostic. He also believes that cases of extra-uterine gestation which present the ordinary signs of pregnancy, are discoverable by the absence of the central groove and the lateral thickening of the corpora uteri.—*Bulletin of the Cleveland General Hospital*.

### **Alleged Safety of Chloroform in Parturition.**

The common use of chloroform to assist in parturition has caused the erroneous assumption that women in childbirth enjoy an immunity from the toxic effects of the drug. Simpson's early dicta upon the safety of chloroform, although unhappily not confirmed by experience, have survived among

many when applied to obstetric cases. Kidd, who wrote some of the first papers upon the subject, collected reports of various deaths under chloroform which have occurred in women during childbirth, and, as we have more than once insisted, stated that chloroform has no selective action on persons, and is just as liable to kill during an obstetric as during any other operation. That deaths are comparatively infrequent is due to causes other than an assumed capricious departure from a physiological law. Women in childbirth are seldom brought completely under the influence of chloroform, they are not allowed to pass beyond the second degree of narcosis, in which no paralysis of the respiratory centres can occur. The patient has no fear of the chloroform, but readily takes it, and does her best to breathe freely in order to be rid of her pains. Her mind is set on anything rather than her possible extinction by the anesthetic; so she does not hold her breath nor struggle, as by so doing she would increase her labor pains and cause herself suffering. However, deaths do occur sometimes through feebleness of the heart and circulation, seldom, if ever, from vasomotor paralysis, and not often from respiratory paralysis. since, as we have pointed out, deep anesthesia is not desirable and is seldom obtained. In a recent death the medical attendant is reported to have stated that the fatality was due to respiratory paralysis, that is, to profound action of chloroform upon the medullary centres. The patient was a primipara, the wife of a miner, and was at her own request given chloroform, the labor being delayed; 2 drachms were, it is said, given, and respiration failed. We are not told how the anesthetic was exhibited, or what posture the woman was in while inhaling it. It is therefore impossible to draw any moral from the case beyond the very obvious one that chloroform is never without danger, especially when, as often happens, the medical attendant has, single-handed, to employ the anesthetic and deliver the patient.—*British Medical Journal*.

### Placenta Previa and the Tampon.

Heurotay (*Journal d'Accouchements*, Liège, November 19th, 1899) believes in the tampon, though Pinard has condemned it as inefficacious, and far inferior to hot injections, rupture of the membranes, or dilatation with the bag. He watched the fourteenth pregnancy of a woman, aged 38; the usual symptoms of placenta previa set in during the eighth month. He plugged the vagina firmly, removing it on the next day. A week later a severe hemorrhage occurred. The cervix admitted the tip of the fore-finger. The tampon was again applied; it was removed, and replaced on the two succeeding days. Then the plug was applied to the cervix as well as to

the vagina to hasten dilatation. Henrotay watched the patient through the night; the pains were weak and occurred at long intervals, the flooding moderate. In the morning he could reach the edge of the placenta, high above the left border of the os. When he felt certain that the head presented he ruptured the membranes widely. A fair amount of hemorrhage followed, but stopped directly the waters had ceased to flow. Massage of the uterus failed to stimulate its slow and weak contractions. Ergotine was therefore injected. Strong pains set in, and two hours later a healthy female child was born. The placenta was delivered a few minutes later; there was no flooding, and the uterus contracted firmly. One more injection of ergotine was given. The puerperium was normal and the child was reared. Henrotay insists on the tampon in placenta previa when the hemorrhage is not excessive and can be checked by plugging. But the plug must consist of sterilised iodoform gauze; then, as in his case, there need be no fever, no fear of sepsis. The old "kite tail" row of plugs along a piece of string should be discarded. Henrotay has removed many such plugs introduced into the uterus for hemorrhage after abortion; they were nearly always fetid. Iodoform gauze is easy to procure in these days. Henrotay did not think that the case was severe enough to require version, which would have greatly endangered the child. In short, when the bleeding is not very severe in placenta previa, plugging and careful watching is the best line of treatment in the interests of mother and child.—  
*British Medical Journal.*

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## LARYNGOLOGY AND RHINOLOGY.

IN CHARGE OF J. PRICE-BROWN.

### Case of Nasal Hydrorrhea.

Urbano Melzi (*Jour. Lar., Rhin. and Otol.*, December, 1899) gives an interesting account of a case of this rare disease. The report is instructive, as from the careful chemical and bacteriological examinations made, it was evident that the discharge was not of cerebro-spinal fluid. Some of the cases reported being unilateral and presenting no physical condition indicative of etiology, have been believed to be of that nature. Hence the carefulness of examination in this case.

The patient was a lady aged 40. Otherwise healthy, she had suffered from a continuous discharge for six years of a clear limpid fluid from the left nostril. It produced no excoriation, was not coagulable, did not stiffen or discolor the handkerchief.

Operative treatment and the use of astringents had little or no effect in checking the flow. The only remedy that, for the time, would stop the discharge, was the application of solution of cocaine on a pledget of cotton. The writer believed it to be a true case of hydrorrhœa from the one nasal fossa, the cause being unknown.

#### **A Case of Anosmia from Head Injury.**

Tresilian (*Jour. Lar., Rhin. and Otol.*, December, 1899). The patient, a female, aged 22, had a fall from a trap, her head striking the ground. She was unconscious for several hours. Then she was dazed and had headache and pain down the neck for several days. There was also loss of sense of smell and taste. The latter returned in a few days, but not the former; while there was always the sensation of a nasty smell, like "bad hops." Taste was perfect after its return, but she could not recognize odors. In treatment neither medicines nor the use of the constant current had any effect. The condition was considered to be due to injury to the olfactory bulbs with laceration, and perhaps partial separation.

#### **Edema of the Nasal Mucous Membrane and Edematous Occlusion of the Nasal Passages.**

Gradle (*Laryngoscope*, July, 1899). Edema of the nasal mucous membrane differs from that of the skin in not pitting upon pressure. Infiltration in polypus is sometimes simulated by infiltration of the mucous membrane of the middle turbinated in the upper recesses of the nose. That the condition is not due to vascular turgescence, is proved by the fact that cocaine produces but little shrinkage. Gradle reports three cases. The mucous membrane in all cases was full, the soggy condition extending to the septum as well as the turbinateds and outer wall. The history of each case indicated indefinite duration. The treatment most productive of good results was the dilatation of the passages by the application of cocaine tampons. These were aided by subsequent insertion of pledgets of nitrate of silver solution and carbolized glycerine. Menthol sprays were also of service.

#### **Cases of Enlargement of the Nose.**

Four cases of this deformity are reported (*Jour. Lar., Rhin. and Otol.*, January, 1900), two by William Hill and two by St. Clair Thomson. They all occurred in young people, three between the ages of eight and fifteen years, and one at the age of twenty-four years. In all there was marked enlargement which had been coming on for various lengths of time. In two

of them there was tenderness over the upper nasal region. In three there was discharge of purulent or crusty matter; while in the one without discharge, there was deficiency of the olfactory sense. No satisfactory treatment is suggested for any of the cases.

#### **A Case of New Growth in the Left Maxillary Antrum in a Child of Thirteen Years.**

Tresilian (*Jour. Lar., Rhin. and Otol.*, December, 1899) says there was no history of symptoms, merely a gradual increase of size for three years. There was slight narrowing of left inferior meatus. The chief extension was externally with hardening of the surface and without thinning of the wall of the antrum. It was considered to be an exostosis of the superior maxilla near the malar bone; and that no treatment at the time was indicated.

#### **Hemorrhage Following Adenoid Operations.**

Martin (*Laryngoscope*, July, 1899). The author gives the history of three cases of severe hemorrhage following operation. In the first, a youth of sixteen, bleeding took place an hour and a half after operation. It was very severe. A plug was inserted after the patient fainted. This was retained 36 hours and then removed. There was no return. In the second, a lad of seven, bleeding commenced on the second and fourth days after operation. Plugging had to be resorted to. In the third, a girl of six, bleeding did not occur until the sixth day. It was not severe, but continued for three days. Then the child vomited half a pint of blood, and the hemorrhage stopped.

#### **Operation on the Pharyngeal Tonsil—Hemophilia, Death.**

Richard Sachs, of Hamburg (*Jour. Lar., Rhin. and Otol.*, February, 1900). A boy, aged 10, suffering from septal spur and enlargement of one of the inferior turbinates, as well as adenoids, was operated upon under chloroform for the latter. The pharyngeal tonsil was cut off in a single piece with a modified Gottstein's curette. The piece was as large as a walnut. Some time after bleeding had ceased, the father drove home with the child. Several hours later bleeding occurred again, and was very profuse through the nostrils. Tamponage through the nostrils and in the naso-pharynx were persistently tried, as well as internal medicines and transfusion of solution of sodium chlorate. But all in vain. The child complained of nothing but thirst and died on the fourth day. Investigation proved that the child was a hemophile, having previously had two very severe and persistent hemorrhages from very slight causes. His grandfather had also died from hemophilic hemorrhage.

### "Purpura Iodique" of the Buccal Mucosa.

G. Milian (*Presse Medicale*, September 30th, 1899) gives a history of the case. It occurred in a woman, aged 43, and resulted from taking iodide of potassium for six days at the rate of six grams per day. The symptoms were—acute burning sensation in the palate, exudation of a reddish, sanguinolent fluid, with no tendency to coagulate. ecchymosis and large submucous hemorrhage in the palate. That the symptoms were due to the iodide was proved by their concurrence with other symptoms of iodism, and that they appeared or disappeared as the iodide was administered or withheld.

### Ulcero-Membranous Angina with Fusiform Bacilli on a Tonsil Affected with Chronic Hypertrophy.

Basquier (*Jour. de Chir. et Ther. Infantile*, May, 1899). The author publishes the case of a youth of fourteen affected with angina. There was slight fever with ulcero-membranous angina of one tonsil. The exudation was thick and adherent, covering an anfractuons ulcer. Bacteriological examination confirmed the presence of micrococcus tetragenus, streptococci, spirillæ and fusiform bacilli.

### Sarcoma of the Tonsillar Fossa Simulating Phlegmon of that Region.

Gaudier (*L'Echo Medical du Nord*, September 24th, 1899). Male, aged 35, had been sent to Gaudier with diagnosis of "phlegmon of left tonsil." Two exploratory incisions had been made, but no pus found. There was difficulty in deglutition and in opening the mouth, but no odynphagia, no enlarged glands and no fever. A large tumor was situated between the anterior and posterior pillars. The tonsil sat upon it like a cap. The tumor was elastic, but without fluctuation, and a slight wound produced profuse bleeding. At this time the symptoms had only been present eight days. Diagnosis of rapidly growing small-celled sarcoma was made, but no operation was attempted. A few days later patient could scarcely swallow. The tumor was then of the size of a large orange, and was removed. One month later patient died of pneumonia. Microscopical examination proved the diagnosis to be correct.

### Innocently Acquired Syphilitic Infection of the Throat.

Packard (*Jour. Eye, Ear and Throat*, October, 1899). This was a case of an unmarried professional nurse acquiring syphilis, in the form, first, of chancre of the mouth, and second, of ulceration of the tonsil, from kissing a patient whom she attended in confinement. It was subsequently discovered that the woman

she was attending had mucous patches of vulva, anus and also the mouth. The writer maintains that not infrequently innocent people have similarly contracted the disease.

#### **On the Function of the False Cords in Phonation.**

Donogany (*Monatschrift für Ohrenheilkunde*, January, 1900). Out of one thousand patients, only one hundred and fifty could hold the constrictors of the pharynx still enough to permit of examination. During normal phonation the false cords moved in 62 per cent. of the cases examined. The movement consisted of an approximation of the cords, which was greatest in the higher tones. At the moment of phonation they became rounder, thicker and firmer, the approximation being closest in the middle, where a little swelling forms. Sometimes the anterior ends approach most closely, leaving a triangular interval behind. On two occasions the false cords receded from each other during the production of high notes. The movements are most marked when short notes are sounded in rapid succession. The movement begins at the moment when the glottis is closed, and lasts till it is opened again, and is independent of the height of the note. The false cords may touch only at one point, or, when assuming the functions of the true cords, along the whole length, producing a rough, unmodulated voice.

#### **Repeated Intubation for Persistent Laryngeal Stenosis.**

Joseph A. Kenefick (*Laryngoscope*, February 19th). This was a report of the case of a colored child, aged two and a half years, intubated for laryngeal diphtheria six months previously. It had been found that on removing the tube at any time dyspnea would return. The consequence was that during six months the child had been intubated forty times, and still retained the power of articulation when the tube was out.

#### **Two Hundred Consecutive Cases of Diphtheria Treated with Anti-Diphtheritic Serum.**

A. J. Tonkin (*Lancet*, October, 1899). This is a study of a series of interesting tables showing the mortality, according to situation of membrane, age, sex, and day of illness when antitoxin was administered; also, tables showing amount of albumen, frequency of mortality after tracheotomy, etc. As the result of these investigations, he looks upon the following conclusions from the use of antitoxin as being established: 1. The general mortality rate is reduced when treated during the first three days to 3 per cent.; in all other cases to 12 per cent. 2. Laryngeal cases treated early are markedly affected for the better, the death rate being considerably reduced. 3. Tracheo-

tomy mortality is very much lessened. 4. There is less need for tracheotomy if treatment be begun early. 5. All ages and both sexes are alike. 6. Chances of nephritis are lessened. 7. When treatment is begun early, albuminuria may not appear, will be less severe and will disappear sooner. 8. Paralysis lessened in cases treated on first and second days, also reduced mortality from this cause. 9. Less extension of disease downward after use of antitoxin. 10. The only disadvantage noted was discomfort from urticarial rashes and pains in a certain percentage of cases.

## Book Reviews.

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*The Medical Digest, or Busy Practitioner's Vade-Mecum.* Appendix, years 1891 to March, 1899. By RICHARD NEALE, M.D. London: John Bale, Sons, and Danielson. Price, 15s. 6d.

Most medical men are familiar with "Neale's Medical Digest." By the aid of "The Digest" and "The Appendix," a subject can be studied in a very thorough manner. This presupposes access to the journals referred to. With a good library and "The Digest," work becomes easy and a pleasure.

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*Therapeutic Electricity and Practical Muscle Testing.* By W. S. HEDLEY, M.D., M.R.C.S. Eng. In charge of the Electro-therapeutic Department of the London Hospital. London: J. A. Churchill, 7 Great Marlborough Street. 1899: Price, 8s. 6d.

After having read or examined many books upon the subject of electricity, this work may be pronounced one of the very best because it is alike scientific and practical, while it is not too large.

The first section of the work is devoted to a careful study of the subject, Electricity; the second section deals with the appliances required and the human body as influenced by electric currents; and the third section treats of the application of electricity to the treatment of diseases. If any physician purposes making use of electro-therapeutics, a work such as Dr. Hedley's is a necessity. It makes clear what instruments he should procure, and then explains fully how they should be employed. The book is well printed, and the paper is of the best, richly illustrated and substantially bound. It can be confidently recommended as in every way up-to-date.

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*Letter-, Word-, and Mind-Blindness.* By JAMES HINSHELWOOD, M.A., M.D., F.F.P.S., Surgeon to the Glasgow Eye Infirmary. London: H. K. Lewis, 136 Gower St. 1900.

We have here, in the short space of eighty-eight pages, a most erudite study of the whole subject of visual memory, letter-, word- and mind- blindness, peculiar forms of word-blindness, partial word-blindness with dyslexia, word- without letter-blindness, and letter- without word- blindness. The little volume works out the proof that the visual act is the combined result of the harmonious activity of the eye and the brain.

Another point to which the author devotes much attention is that visual impressions are arranged in groups, and this explains why the memory for letters may be lost, while that for words is retained, or that the memory for words may be lost while that for letters and other objects is intact. The author remarks that the visual perceptive centres are situated in the neighborhood of the cuneus and calcarine fissures. These centres enable us to determine the position of an object in the visual field. The visual memory centre is in the supra-marginal and angular gyri. Derangements of this centre cause mind-blindness. The objects are seen but they convey no information to the person, as they are not recognized by him. The little book is a very interesting monograph upon this subject.

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*Mentally Deficient Children: Their Treatment and Training.*

By G. E. SHUTTLEWORTH, B.A., M.D., etc. Second edition. London: H. K. Lewis. 1900.

It is perhaps a matter for regret that medical men generally do not take more interest in this subject. While there are a goodly number of children that are feeble-minded, in the sense of imbecile or idiotic, there are a still larger number that present a certain amount of mental deficiency in some direction, falling within the limits of the above, and yet disqualifying them from profiting by the ordinary course of education.

His classification of pathological grounds is very interesting.

1. There are the cases of congenital mental deficiency: microcephalus, congenital hydrocephalus, mongol or kalmuc type, scofulous cases, birth-palsies with athetosis, congenital cretinism, primarily neurotic.

2. The non-congenital cases—(a) developmental cases: The eclamptic, as from convulsions during teething, etc., epileptic cases, inherited syphilitic cases; (b) accidental or acquired: Traumatic, post-febrile, emotional, as shock and fright, toxic influences on the brain.

The treatment is discussed under general, medical and surgical. In the treatment of sporadic cretins he speaks highly of the value of thyroid extract. The author condemns the practice of craniectomy. He concludes that the removal of strips of bone does no good, and that in the light of results, the operation should be abandoned.

He speaks highly of the value of proper educational, industrial and moral training. On the whole, he takes a very hopeful view of the improvement that may be effected in many of these cases along the lines of a true physiological education. He has little sympathy with saying, "once an idiot, always an idiot." We strongly commend the book.

*Diseases of the Nose and Throat.* By J. PRICE-BROWN, M.B., L.R.C.P.E., Fellow of the American Laryngological Society; Laryngologist to Toronto Western Hospital; Laryngologist to the Protestant Orphans' Home, etc. Illustrated with 159 engravings, 6 full-page color-plates, and 9 color-cuts in the text, many of them original. Philadelphia and London: The F. A. Davis Company, Publishers. 1900.

Within a very recent period there have appeared a number of new works on this subject, besides new editions from well-known authors. But the work before us is welcome to the list because of its excellent features. The work consists of 471 octavo pages. This would seem a large work, but the difficulty is not in writing this number of pages, but rather in reducing that vast amount of material into the above space. This task the author has accomplished in a most satisfactory manner. Thus, while the book is large, it is not too large, and it is full and complete without being padded out.

Another feature of many special and general works is that the space allotted to the several diseases is not balanced, one disease receiving too lengthy attention while another receives too little. This mistake has been here carefully avoided. The various diseases of the nose, throat, and larynx have a due measure of space given them. In this way the reader is spared an over discussion of one condition to be annoyed by the scant consideration of another. The author will certainly merit the thanks of the readers for the care that has been displayed in this particular.

Another very pleasing feature of the work is that it is written in readable and enjoyable English. Altogether too often medical works may be good in matter, but so bad in the form of language employed that it is drudgery to read a chapter on any disease. The style in the present work is clear, direct, condensed and expressive. There is not an ambiguous sentence in the book.

The first section of the work is devoted to the nasal passages, and occupies 181 pages; the chapters on the diseases of the pharynx take up 143 pages, and those on the larynx the remainder of the book, 147 pages. It will thus be seen that there are three convenient-sized monographs in one volume.

There is an independency of thought throughout the work that is refreshing. It is never very pleasant to read a mere compilation, and often far from instructive. But this work is no mere compilation. While the author has availed himself to the fullest extent of all that is good in the treatises, he has followed none in any slavish manner. He has maintained throughout his individuality. He has something to say, and says it in his own way, giving the reader the full benefit of the

literature upon the subject, toned down and blended together by his own experience and in his own language. It is, therefore, as thoroughly original as it is possible for a scientific work to be.

A careful examination of the contents makes it clear that nothing has been omitted. It will thus prove of value alike to the specialist who desires to know the views of another specialist, and to the general practitioner who wishes to consult such views in all matters of doubt. The work should, in this way, find a large field. A careful perusal of the pages enables the reviewer to state that while nothing has been omitted, the discussion of the many diseases is reliable and up-to-date.

The illustrations, 159 in all, have been chosen with judgment. They give an excellent notion of the instruments required and the diseased conditions to be treated. They have been well executed, both plain and colored, and reflect much credit upon the publishers. The perspective matter, too often ignored in illustrating medical works, is very good indeed, and gives to the illustrations a reality and an instructiveness that are quite agreeable.

From the standpoint of the general practitioner the work presents several attractive features. In the first place the anatomy of the parts concerned are clearly and briefly given. This is a great advantage where there may be no other work of reference giving this needed information. In the second place, diagnosis and symptomatology are gone into with much care, so that few errors need be made if due attention is given to what is said; and in the next place, treatment is full and explicit. This is the great aim of the work, and it is well realized. Throughout the work there are a great many formulæ and helpful suggestions on matters of therapeutics. We are glad to notice that the work has so large an element of the practical in it.

It would be impossible to examine the work in detail. Let it suffice for the present purpose to refer to one disease, pharyngeal mycosis. The author adopts the parasitic nature of the disease. There is a colored illustration to aid the diagnosis. The treatment recommended is the galvano-cautery needle to each fungoid deposit and the use of antiseptic sprays, the favorite being a 10 per cent. watery solution of izar.

The publishers have spared no efforts to make the book attractive. The paper, type, illustrations and binding are all that could be desired.

We heartily congratulate our Toronto confrère on the result of his labors, and bespeak for the work a large sale among appreciative readers. It is not going too far to state that from every standpoint the work can be cordially recommended

J. F.

*Lea's Series of Pocket Text-Books.—Histology and Pathology.*  
By JOHN B. NICHOLS, M.D., Demonstrator of Histology, Medical Department Columbian University; and F. P. VALE, M.D., Assistant in Pathology, Medical Department University of Georgetown, Washington, D.C. In one handsome 12mo volume of 452 pages, with 213 illustrations. Cloth, \$1.75 net. Flexible red leather, \$2.25 net. Philadelphia and New York: Lea Brothers & Co.

This is an excellent piece of book-making so far as the publishers are concerned. We should not care to recommend the work as the sole text-book in two subjects so important. The portion devoted to Histology properly precedes that given to Pathology, and if accompanied by a full course in the laboratory might be held to be quite adequate. But 62 pages, not large, with much space occupied by cuts and diagrams, is not enough for General Pathology; while Special Pathology has only 132 pages, including cuts. The standard of medical education here calls for a more extended course of reading than can be got from this work, which is an objection that the reviewer has always urged against "pocket" text-books in general.

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*Saunders' Question Compend, No. 11. Essentials of Diseases of the Skin, including the Syphilodermata, arranged in the form of Question and Answer, prepared especially for students of medicine.* By HENRY W. STELWAGON, M.D., Ph.D., Clinical Professor of Dermatology in the Jefferson Medical College; Physician to the Department for Skin Diseases, Howard Hospital; Dermatologist to the Philadelphia Hospital, etc. Fourth edition thoroughly revised and illustrated. Philadelphia: W. B. Saunders, 925 Walnut St. 1899. Toronto: J. A. Carveth & Co.

This little book has been already approved of by students of medicine. The fact that this is the fourth edition is ample proof of the demand for such a work among students. Since the issue of the first edition much labor has been spent in careful scrutiny and revision. The system of "Question and Answer" has its advantages in the fact that it serves to impress the salient and diagnostic points upon the reader's memory. In treatment a great deal of attention has been paid to prescription writing, which is valuable to the student.

## Selections.

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### Typhoid Fever as a Systemic Disease of Manifold Manifestations.

It has become so common to regard typhoid fever as a local affection the lesions of which are situated in the lower part of the small and the beginning of the large intestine, that the essentially systemic character of the disease has been more or less lost sight of. Of course, it is clearly understood that the absorption of toxins from the typhoid ulcers in the bowel gives rise to very prominent constitutional symptoms, while the occurrence of spots on the skin shows a cutaneous attempt at one stage of the disease at least to eliminate certain toxic substances, biological or chemical in nature, from the circulation.

Most of the pharmaceutic schemes of treatment planned for typhoid fever, however, are limited to the use of drugs that act upon the intestinal tract. Intestinal antiseptics has been a favorite catchword of the ambitious therapist in many diseases beside typhoid. Though each new attempt to create this condition has proved as ineffectual as the last, further therapeutic claims in this line gain a ready hearing if they but seem to be bolstered up by a pretended successful clinical experience. Of late years, however, we have come more and more to the realization that typhoid fever is as characteristically a constitutional disease as measles or scarlet fever. The main lesions in both of the latter diseases are situated in the upper air passages, but we by no means consider that the angina of scarlatina or the severe coryza in measles constitutes the essence of either disease or furnishes the only indications for treatment. Prof. Chiari's work at Prague has shown that typhoid not infrequently limits itself to the bile passages, and this notwithstanding all that we have recently learned about the bactericidal power of bile. Osler's work in this country, besides confirming Chiari's observations as to typhoid localization in the bile passages, has served to show that, exceptionally at least, the lesions of typhoid fever are limited to other localizations—the spleen, for example. Certain French clinicians claim to have observed typhoid fever of the meninges, or a febrile disease in which the only possible cause discoverable was the presence of Eberth's or Jaffky's bacillus on these membranes.

Even where the lesions of typhoid fever are limited to the digestive tract we are gradually being brought to realize that

they need not necessarily be localized within the immediate neighborhood of the cecum, but under special conditions of poorly resistive vitality typhoid ulcers may occur in other parts of the gastro-intestinal tract. A striking illustration of this is afforded by one of the plates in Prof. Hare's new book on "The Medical Complications of Typhoid or Enteric Fever."\* The illustration reproduces a set of typhoid ulcers that had developed in the stomach of a young girl who succumbed during the third week of her attack. Four well defined ulcers were noted in the pyloric region, one of which presented a loosely adherent slough. It appears that under certain circumstances not well understood as yet, a diseased condition of the solitary glands of the gastric mucosa may give rise to a form of perforating ulcer of the stomach which closely resembles the idiopathic ulcer of typhoid fever, as that lesion is usually observed in the ileo-colic region of the intestine. It is interesting to note that in this case there was no hematemesis to arouse suspicion of ulcers of the stomach.

The great diversity of typhoid complications has by no means received the general attention the importance of the subject deserves, and we venture to predict that by their own diligent study many dark places in both diagnosis and treatment will be made plain. In this direction Dr. Hare, with characteristic energy, has taken a long step.

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#### Persons who should not take Alcohol.

According to Dr. Clouster (*The Practitioner*), the use of alcohol should be forbidden to all persons :

1. Who have any family history of drunkenness, insanity or nervous disease.
2. Who have used alcohol to excess in childhood or youth.
3. Who are nervous, irritable, or badly nourished.
4. Who suffer from injuries to the head, gross diseases of the brain, and sunstroke.
5. Who suffer from great bodily weakness, particularly during convalescence from exhausting diseases.
6. Who are engaged in exciting or exhausting employments in bad air and surroundings in workshops and mines.
7. Who are solitary and lonely and require amusement.
8. Who have little self-control, either hereditary or acquired.
9. Who suffer from brain weakness, the result of degeneration.—*Cinn. Lan.-Clin.*

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\*"The Medical Complications, Accidents and Sequelæ of Typhoid or Enteric Fever." By H. A. Hare, M.D. With a special chapter on the Mental Disturbances following Typhoid Fever, by F. X. Dercum, M.D. Lea Brothers & Co., Philadelphia and New York. 1899.

# Miscellaneous.

## HEROIN IN COUGH.

BY CHAS. HERWIRSCH, Ph.M., M.D.

Instructor in Clinical Medicine in the Philadelphia Polyclinic; Laryngologist to the Rush Hospital for Consumptives in Philadelphia Visiting Physician to the Nazarene Home for the Aged.

Among the newer drugs which have within a year appeared on the market, and to which the attention of physicians has been called, Heroin appears to be one of the best. Dreser and Floret published their experiments with this new derivative of morphine in the *Therapeutische Monatshefte* for September, 1898, in which they stated that Heroin not only very much modifies and quiets the cough, but also that the frequency of respiration was lessened and the inspirations prolonged. The same authors state that Heroin has a more sedative effect upon respiration than morphine, and is ten times more powerful than codeine.

Leo (*Brit. Med. Jour.*, April 20th, 1899) also discusses the value of Heroin. He states that the drug has a particular action on the respiratory centres, lessening the frequency but increasing the depth of breathing. He says that its narcotic action is much less than morphine; and thus in sciatica, neuralgia, cardialgia, including the pain due to gastric nerve and muscular rheumatism, Heroin did not relieve the pain, or did so only momentarily. Leo found the action of this drug exceptionally satisfactory in the various forms of dyspnea; it increases the duration of inspiration and the amount of air taken in. He cites a number of cases, among them two cases of uremic dyspnea, some of emphysema, chronic bronchitis, and asthma, and says that in all but three cases out of thirty the results were good. He also says that Heroin can be used with confidence, and will be permanently found to be a valuable remedy, in diseases accompanied by dyspnea.

During the last ten months I have used Heroin in more than thirty cases, mostly with good results. In acute bronchitis I used it in adults as well as children with much satisfaction. In chronic bronchitis and in phthisis the drug has in most cases given good results, and failed in only three.

Miss W. H., aged 13, contracted a heavy cold in December, 1898. After administering the usual remedies, the patient had still, after three weeks, a distressing cough with tenacious expectoration. I ordered Heroin, 1-24th grain, three times a day. After forty-eight hours the patient reported the cough decidedly better, and the expectoration much lessened. After a week's treatment the cough had disappeared.

M. B., a boy nine years of age, was left with a severe bronchitis after an attack of measles in December, 1898. He was given Heroin in 1-24th grain doses three times a day, with the same happy results.

Mrs. H. H., aged 43, had an attack of acute bronchitis in January, 1899. After employing hyoseyamus and codeine without very good results, Heroin in 1-12th grain doses was given three times a day; this eased the cough, the patient could sleep, and in a week she had recovered.

Mr. F. A. G., aged 31, had an acute bronchitis and laryngitis in January, 1899. He was a business man and used his voice constantly. I ordered local applications to his throat, with inhalations, and gave him Heroin in 1-12th grain doses, four times a day. He reported from day to day as getting better, only complaining of a drowsy feeling. After three days the Heroin was cut down to three doses a day, when the drowsiness ceased, and after ten days the patient reported himself free from cough. I myself contracted an acute bronchitis in February, 1899, and Heroin in 1-12th grain doses relieved the cough promptly.

F. B., aged 19, suffering with phthisis pulmonalis, with a cavity in the left upper chest and much dyspnea. He is frequently troubled with a dry cough. He had formerly taken morphine in one-eighth grain doses, or codeine in half-grain doses, four times a day. Heroin is now given in 1-12th grain doses three times a day; after a few doses it relieved the cough and subdued his dyspnea.

A. P., aged 27. Phthisis pulmonalis, cavity in upper lobe of right lung. He has been in different sanatoria, and has taken for a year serum injections. Two months ago he came to me, complaining of a cough lasting the previous five weeks day and night, much dyspnea, vomiting after taking food, and an afternoon temperature of 103°. At first I gave this patient codeine  $\frac{1}{2}$  grain and acid hydrocyan. dilut. 1½ minims in a vehicle every three hours, with local treatment to his throat; this relieved him for three days, when he again began to cough constantly. I now ordered Heroin in 1-12th grain doses every four hours, which promptly relieved the cough and dyspnea, and made him drowsy. After several days the above dose was given every six hours, and he now takes that dose every eight hours, and except for a cough in the morning is very comfortable during the day. Other appropriate treatment was instituted, and on the 7th of August, when I last saw the patient, his temperature in the afternoon was 99.4°, respiration 28, pulse 92 per minute; he had gained four pounds in two months. He coughs very little and reports feeling well and enjoying his meals. He has not vomited for six weeks; bowels are normal.

At the Rush Hospital I am using Heroin on a number of

patients mornings and evenings in 1-12th grain doses for the cough, and among ten patients in only one, after six weeks' use of that dose, had this dose to be increased.

Early in my experience I gave to a patient, Mrs. F. P., aged 35, suffering from phthisis, Heroin in doses of 1-12th grain every four hours. but although the cough was relieved I had to discontinue the drug, as it produced sleep, the patient not being able to keep awake at any time, even after the dose was diminished.

David E., aged 28, suffering from phthisis, with extensive cavity in left chest, was given Heroin in 1-12th grain doses for his cough. The drug had no influence on his cough, but constipated him to such an extent that it had to be discontinued.

F. L., male, aged 47, suffering from phthisis pulmonalis, last stage, was given Heroin as an experiment. The patient was very comfortable with morphine in one-eighth grain doses three times a day; this was omitted and Heroin in 1-12th grain doses given, which was later increased to four doses a day, and again a few days later to one-sixth grain doses three times a day, but without having any influence on the cough, and I had to return to morphine again.

I have in all treated thirty-five cases with Heroin, but space prohibits the giving of more histories.

From the foregoing cases the following can be deduced: Heroin in doses from one-twelfth to one-sixth grain three times a day is a valuable addition to our materia medica in acute as well as chronic bronchitis, and the cough accompanying phthisis. The drug acts well in most cases, and except in the three cases mentioned, where it did not give any benefit and had to be discontinued, the results were always satisfactory. The number of respirations of the patients taking the drug was diminished, as the charts in the hospital, and of some of the cases in private practice when such could be kept, prove, the drug after being taken in some cases for three months, except in one case, had not to be increased, and no drug habit was established. Except in one case Heroin had no tendency to constipate like morphine, and in only one case did drowsiness follow its administration. No headache or disorders of the stomach resulted from the use of Heroin, as is often the case with morphine. The dose is much smaller than either morphine or codeine, and very much cheaper than the latter drug, a great advantage if a drug has to be used for a long time, as in phthisis. Of late hydrochloride of Heroin, soluble in water, has come into the market, which is adapted for hypodermic use, and as Eulenburg in the *Deutsche medicinische Wochenschrift* of March 23rd, 1899, reports, the same so used acts more rapidly than when given by the mouth.

—*Clinical Excerpts.*

**Boer and Briton.**

That strange element in human nature which makes some people rejoice in the dangers and difficulties which beset others, has been exhibiting itself lately in Paris, Berlin, St. Petersburg, etc., over the temporary set-back experienced by the English in their conflict with the Boers. Americans do not sympathize in these rejoicings, knowing well that England's cause, in the highest and broadest sense, is our cause, and that if disaster or defeat threatened us, we, in our turn, would be held up to scorn and derision.

The early triumphs of the Boers have no special significance as regards the outcome of this struggle. A stream does not rise higher than its source, and the Boers are a century or more behind the English in natural development and powers.

The Boers are unreasonable, blindly selfish and tyrannous in their exactions and policy. The American people would never submit to the kind of government the enlightened Outlander is expected to content himself with. The latter has no representation in the law-making body of the Transvaal. While the Outlanders represent three fifths of the population, and pay nine-tenths of the taxes, yet they have not a word to say as to how this money shall be spent. Poor and feeble as were the American Colonies in 1776, they would not stand such tyranny as this.

The Outlanders have no constitutional guarantee for life, liberty and property, the courts being subject to coercion by the Boer Government, and the Constitution to whimsical and capricious changes on a simple motion of the legislative body. The other demands of the Outlanders for the wiping out of monopolies, the putting of English and Dutch languages on an equality in the courts, better civil service, freedom of press and religious opinion, suitable schools and a more liberal trade policy, are all in the line of civilization, and merit the hearty endorsement of enlightened men everywhere.

The attitude of the Irish, in this difference between Boer and Briton, is characteristic. Their sense of belligerence overpowers their logic. Although the Boer policy is decidedly antagonistic to the interests of the Irish in the Transvaal, prohibiting them from voting, yet the Irish everywhere are loud in their sympathies and hopes for Boer victory.

There can be but one termination to this war. The English have right and justice on their side. Their demands are all in the interests of a higher civilization. The Boers want to use arbitrary power to dam back progress when it conflicts with natural propensities and inclinations, regardless of the great principle fundamental to all human societies—the greatest good to the greatest number.

While the English were, to a certain extent, unprepared for war, and have suffered, seemingly from a want of knowledge as to the lay of the land, the nature and methods of the Boers, and a lack of strategic ability in their commanders, due to the fact that the army is largely officered by younger members of the nobility, instead of field veterans, yet she will rise to the occasion, learn by her mistakes, and turn her defeats into victories.

The significance of this war is great to Americans as well as English. It means Anglo-Saxon supremacy the world over, with its wondrous material civilization and great moral power. Without England, the United States would have to fight the battle of civilization single-handed against the world. Together, we are invincible. Therefore, her cause and her success are ours. Our sympathies and hopes follow her, and will rejoice with her in the final triumph of Saxon liberty and justice over the short-sighted, wrong-headed, though strong and brave, opposition of the Boers.—Editorial, *Medical Brief*, March, 1900.

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#### Gonorrhœa a Cure for Inebriety.

A correspondent writes: One of the best cures I am acquainted with for habitual excessive indulgence in alcoholic beverages is the gonococcus. This is not a serum treatment because, for the purpose in view, the effects of the organism must wreak themselves on the urethra. I have, over and over again, failed to induce patients with this particular weakness to control their appetite for alcohol. Promises of reform were made only to be broken. Then it has happened that they contracted gonorrhœa, and forthwith without any pressure, for three long months at least, they have foregone their tipples, and have recovered the strength of will which they had lost. I could point to a number of cases in which the drunkard's progress has been summarily arrested by an intercurrent attack of gonorrhœa with the most satisfactory results in respect of his after life. It is open to question whether, in refractory cases, this treatment might not offer an alternative to seclusion in a home for inebriates.—*Medical Press and Circular*.

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George Meredith's novels and poems are written in a small study, built by itself in his garden on the slope of a hill, at the foot of which stands his house, just off the main road beyond Burford Bridge in the beautiful district of Boxhill in England. His unmarried daughter lives with him. His son is associated with a prominent publishing house in London.—March *Ladies Home Journal*.