

## Technical and Bibliographic Notes / Notes techniques et bibliographiques

The Institute has attempted to obtain the best original copy available for scanning. Features of this copy which may be bibliographically unique, which may alter any of the images in the reproduction, or which may significantly change the usual method of scanning are checked below.

L'Institut a numérisé le meilleur exemplaire qu'il lui a été possible de se procurer. Les détails de cet exemplaire qui sont peut-être uniques du point de vue bibliographique, qui peuvent modifier une image reproduite, ou qui peuvent exiger une modification dans la méthode normale de numérisation sont indiqués ci-dessous.

- Coloured covers /  
Couverture de couleur
- Covers damaged /  
Couverture endommagée
- Covers restored and/or laminated /  
Couverture restaurée et/ou pelliculée
- Cover title missing /  
Le titre de couverture manque
- Coloured maps /  
Cartes géographiques en couleur
- Coloured ink (i.e. other than blue or black) /  
Encre de couleur (i.e. autre que bleue ou noire)
- Coloured plates and/or illustrations /  
Planches et/ou illustrations en couleur
- Bound with other material /  
Relié avec d'autres documents
- Only edition available /  
Seule édition disponible
- Tight binding may cause shadows or distortion  
along interior margin / La reliure serrée peut  
causer de l'ombre ou de la distorsion le long de la  
marge intérieure.
- Additional comments /  
Commentaires supplémentaires:

Continuous pagination.

- Coloured pages / Pages de couleur
- Pages damaged / Pages endommagées
- Pages restored and/or laminated /  
Pages restaurées et/ou pelliculées
- Pages discoloured, stained or foxed/  
Pages décolorées, tachetées ou piquées
- Pages detached / Pages détachées
- Showthrough / Transparence
- Quality of print varies /  
Qualité inégale de l'impression
- Includes supplementary materials /  
Comprend du matériel supplémentaire
- Blank leaves added during restorations may  
appear within the text. Whenever possible, these  
have been omitted from scanning / Il se peut que  
certaines pages blanches ajoutées lors d'une  
restauration apparaissent dans le texte, mais,  
lorsque cela était possible, ces pages n'ont pas  
été numérisées.

# The Canada Medical Record

VOL. XVIII.

MONTREAL, FEBRUARY, 1890.

No. 5.

## CONTENTS.

<b>ORIGINAL COMMUNICATIONS.</b>		Hypodermic Injections of Corrosive Sublimate and Carbolic Acid in Erysipelas..... 107	The Administration of Chloroform by Gaslight..... 111
Report of Nine Cases of Hysterectomy for Uterine Fibroids—New Method of Treating Pedicle..... 97		Very Hot Compresses in Surgical Practice..... 108	The Art of Bating..... 112
<b>SOCIETY PROCEEDINGS.</b>		Does the Practice of Medicine Harden the Heart of the Physician..... 108	Prognosis of Bright's Disease..... 112
Medico-Chirurgical Society of Montreal, Meeting Dec. 21..... 99		Chlorosis..... 108	Albuminuria in Relation to Life Assurance..... 113
Medico-Chirurgical Society of Montreal, Meeting Feb. 7..... 102		Another Local Anæsthetic..... 108	Treatment of Bleorrhagia in France..... 112
<b>PROGRESS OF SCIENCE.</b>		A Gargle in Quinsy..... 109	X. International Medical Congress, Berlin, 1890..... 114
Instantaneous Remedy for Lumbago..... 107		The Action of Oil of Turpentine in Idiopathic Croup..... 109	Class-Room Notes..... 116
A New Journal..... 107		The Density of the Blood in Renal Disease..... 109	
To Restore the Polish of Instruments..... 107		Seborrhœa..... 109	<b>EDITORIALS.</b>
Quinine in Influenza..... 107		Treatment of the Nasal Mucous Membrane in Whooping Cough..... 110	Society Proceedings..... 118
		Is the Bath Wholesome?..... 110	Co-Education..... 118
		Local Application of Chloroform in Epididymitis..... 110	Book Notices..... 120
		Obstetrical Dant's..... 111	Personal..... 120

## Original Communications.

### REPORT OF NINE CASES OF HYSTERECTOMY FOR UTERINE FIBROIDS.

NEW METHOD OF TREATING PEDICLE. BY E. H. TRENHOLME, M. D.

Case 1.—Miss B., Brantford, Ont., aged 33. Fibro-cyst of uterus; a large amount of pus escaped by vagina a month before operation, which was made 12th June, 1874. Tumor was 16 lbs., and removed with body of uterus; stump was clamped and secured by pins and ligatures. There were many points of hemorrhage in the abdominal cavity, and about 50 hemp ligatures were needed to prevent bleeding. Patient made a slow but good recovery, and returned to her home at the end of the week; health completely restored, and continues well up to present time (15 years).

Case 2.—Mrs. C., Montreal, aged 55. Tumor filled pelvic cavity and prevented action of bowels and bladder; weight of tumor and uterus, 4 lbs. Removed it 17th November, 1877, by ecraseur ligated and dropped pedicle back. Death from shock at 68th hour.

Case 3.—Miss K., aged 37. One large and two smaller uterine fibroids removed on March 19, 1883; ligated and returned pedicle. Did well for some days, but death followed from exhaustion on 5th day due to uncontrollable vomiting.

Case 4.—Mrs. L., Levis, aged 42; 24th September, 1885. Tumor, 5 lbs. Had removed

ovaries and tubes for menorrhagia and hemorrhagia in January, 1876, which gave perfect relief up to spring of 1885, when, through over exertion, bleeding returned and uterus began to grow rapidly and was removed by the V incision and pedicle returned. Recovery was so far assured that, owing to some controversy with nurses, &c., she left the hospital and returned to Levis on 21st day after operation. Health perfect up to present time (15 years).

Case 5.—Mrs. L., Ont., aged 33. Large fibroid on the left side, smaller ones on right partly packed in the pelvis, 8th February, 1886. Removed 15 lb tumor by V incision; returned pedicle. Hemorrhage and death from shock seven hours afterwards.

Case 6.—July 12, 1886, Miss E. A. Large fibroid, weight not noted; split open tumor with long amputating knife; enucleated fibroids and formed walls of uterus into flap, which were brought together and secured by a clamp. Death from shock in 37 hours.

Case 7.—Mrs. G., Buffalo, U.S., aged 42. Size of tumor not noted. Divided tumor, as in last case, enucleated it, and formed a pedicle of the flaps of the sutured walls; secured pedicle outside by clamp. Patient did fairly well for 11 days, but died on 12th day from exhaustion.

Case 8.—Mrs. G. T., West Wickham, Que., 28 years; tumor 14 lbs. Operation, 2nd March, 1889. Used hemp for the snare, and after removal of fibroid and uterus at inner os, left the snare in situ. Hemorrhage from stump three hours

later was controlled by a slight increase of the constricting force. Ecraseur was removed on fifth day, but ligature around the pedicle not disturbed. Recovery good and returned home on 28th April. Recovery perfect; able to work, &c.

Case 9.—Miss V. B., 28 years, Ont. Fibrocyst. 11 lbs. Operation 23rd October, 1889. The hempen snare was used as in the last case and left for five days in like manner; a drainage tube was used for 50 hours on account of some bleeding points where the anterior surface of the tumor was adherent to the walls of the abdomen. Uterus was enclosed in the ligature above inner os, and separated by knife about centre of body. Recovery rapid and perfect. Left for her friends in the city on 20th day, walking down stairs and out to the carriage. After some weeks spent here she returned to her home in Ontario, and has been well since.

These nine cases are all my operations for fibroid and fibrocystic growths of the uterus. The large percentage of mortality is to me a cause of regret, as I believe the greater number, if not all, could have been saved by my present method of operation. Of the various methods employed for securing the pedicle in hysterectomies, I am thoroughly convinced that securing pedicle outside is the best. This conclusion may have some exceptions, but I have not met with a case that I would now treat otherwise. How to secure the pedicle has been the cause of much anxious thought, not only to myself, but to many others, and I think I have reached a mode of operating that, so far as I know, excels any yet known. My departure from that generally pursued in securing pedicle outside begins with the constricting agent, which, in my opinion, should not be of wire of any kind, but rather of hemp or silk, of a good large size and slightly twisted, merely enough to afford the required strength, which need not be very great, as the object sought should be merely constricting force to control hemorrhage—never to bruise or break the tissue or cause much pressure upon them or the nerves. Should hemorrhage occur, use just enough force to control it. This snare is placed along the side of abdomen and secured there by a strip of plaster, is easy of access, and need not be disturbed for five days, by which time it can be removed with safety, as the pedicle is then securely

adherent in the wound and cannot slip back. After removal of the instrument do not disturb the ligature around the stump, but leave it to act as a means of drainage for the escape of the pus which must necessarily occur from the dissolving tissue. This will save extravasation of pus into the walls of the abdomen and cellular tissue, which extravasation is frequently the cause of much after trouble. Further, this mode of securing the pedicle offers the constricted part of the neck (*i. e.*, the smallest diameter) to the fresh wound, which clamps the hour-glass constriction, whereby it is held quiet, and quickly unites with the tissues with which it is in opposition, and the deeper tissues are most favorably placed by quiet contact for rapid union. Thus all fear of retraction of the pedicle is removed, and union takes place from the depths of the wound upward, with all its consequent safety. Nor is this all; there is almost no shock—at least nothing to give anxiety, so far as my experience goes. There are no nerves lacerated or pressed upon, with their consequent pain and suffering, as must necessarily occur when pins and wire are used. The gentle pressure of the cord causing a slow death of the tissues deprived of blood, which thus slough away with little or no pain. In a word, this mode of operating is followed by results such as will please those who try it, and has yielded to me the greatest satisfaction.

Before closing, I would remark that previous to my first case in 1876, the late lamented Dr. Marion Sims reported 11 cases in the United States, with but one recovery; my own case being the twelfth, making but two saved out of the dozen operated upon. I would also say that I think Case 2 was sacrificed to the prejudice of my assistants, who dissuaded me from making the V shaped incision for removal of the uterus, an operation which I went prepared to perform. Cases 3 and 5 would most likely have been saved had I clamped the stump outside, while Case 7 was sacrificed to quarrels in the hospital, after a twelve days struggle for her life. Still another case was killed by a severe scald followed by suppuration all over the abdomen, caused by the injudicious application of a large hot sponge wrung out of boiling water saturated with a strong solution of carbolic acid. These cases have thus been most instructive, and here-

after the lessons taught will not be lost on myself or others.

## Society Proceedings.

### MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

*Regular Meeting, January 24, 1890.*

DR. ARMSTRONG, PRESIDENT, IN THE CHAIR.

Present:—Drs. Birkett, Trenholme, Schmidt, Rattan, Foley, Jas. Stewart, Allan, Jack, W. Gardner, K. Cameron, Alex. Gardner, Reed, McGannon, F. W. Campbell, Springle, and Laphorn Smith.

After balloting for, and election of, Dr. Shanks as a member, the following pathological specimens were exhibited:

1st. Dr. W. Gardner showed a sub-mucous myoma of the uterus which he had removed on the 19th September last. The patient had been treated for years by all the palliative methods, and at last went under a three month's course of Apostoli's treatment, without stopping the bleeding. The speaker decided to remove the appendages, but on opening the abdomen he found that this was impossible, so he removed the uterus with them.

2nd. A case of soft myoma containing lymph spaces, which had given such a soft and elastic sensation to the touch that the diagnosis was very doubtful. The operation was done four weeks ago, and on opening the abdomen it was found to be a fibro-cystic tumor of the uterus, at least judging from the grown appearance.

While the first patient was under electrical treatment she had an attack of severe pain and rise of temperature, which had given him far more anxiety than did the operation for removal. The second case had not been treated by electricity, but the recovery from the operation was complicated with phthisis, which had alarmed him somewhat, although now she was practically better. In neither case were there any adhesions. In both cases he had used Tait's pins and Koeberle's *serre-neud*.

Dr. Laphorn Smith then exhibited a specimen of fibro-cystic tumor of the uterus, removed by Dr. Trenholme by abdominal hysterectomy. He gave the following history of the case:

### FIBRO-CYSTIC TUMOR OF UTERUS: OPERATION—RECOVERY.

Miss X., aet 27, single, was sent to me on the 17th July, '89, by Dr. Bogart, of Millbrook, Ont.

Family history good.

*Previous History*—At school from 5 till 17 years old. Began to menstruate at 16. Always profuse, lasting 5 days, but never painful. Always constipated. Never had a day's sickness till 4 years ago, when she had what seemed to be an attack of inflammation of the womb, for which she was attended by Dr. Turner, of Millbrook. After recovery from this she first noticed a tumor at bottom of abdomen in front. At the same time menstruation became painful. Her health failing as the tumor enlarged, she consulted Dr. McAlpine, of Lindsay, who thought she had an ovarian tumor. Some time later she consulted Dr. W. L. Smith, of Toronto, who diagnosed a fibroid. Dr. Temple, of Toronto, was then consulted, who suspended judgment pending an exploratory incision.

*Present Condition*—Haggard and anxious-looking. Per vaginam a solid tumor was felt continuous with the uterus and filling pelvic brim. Abdominal palpation revealed slight fluctuation in a tumor extending to umbilicus and occupying middle of abdomen. I thought it was cystic, but was not sure whether of the ovary or uterus. Consultation with Dr. Perrigo, who thought it fibroid of uterus.

*Treatment*.—Seventy applications in three months of the continuous galvanic current positive pole in uterus; average strength, 100 m. Result, rapid and marked improvement of general health, and measurement round tumor diminished exactly four inches in two months, while upper margin of tumor came down two inches. During third month there was no decrease in size. She was about to leave for home quite satisfied with her improved condition, when a period came on, which lasted 14 days. Towards the end of the period she suffered a sharp pain in right inguinal region, with a temperature of 101. I decided to reconsider the diagnosis, and had a consultation with Dr. Trenholme, who thought it was a cyst, possibly ovarian. We agreed to operate, which was done on 23rd Oct.

Remarks by Dr. Laphorn Smith with regard to the difficulty of diagnosis.

*Difficulty of Diagnosing*—It is exceedingly difficult to accurately diagnose fibro-cystic tumors of the uterus from cystic tumors of the ovary. At a recent meeting of the British Gynæcological Society no less experienced an operator than Dr. Bantock reported a case in which he said he had diagnosed fibroid of the uterus, and even after opening the uterus this view was confirmed by appearances; but on pressing it with the finger he found it fluctuating, and on tapping it he withdrew seven and a half ounces of fluid. On removal it turned out to be a fibro-cystic tumor of the ovary, having no connection with the uterus whatever. The patient was a cook, single, and 35 years of age. This case is exactly similar to the one which I reported at the meeting before last, which was successfully removed by Dr. Perrigo, and which we nearly all thought was a fibro-cystic tumor of the uterus. Dr. Werder, of Pittsburg, at a recent meeting of the Allegheny Medical Society, reported a case of fibro-cystic tumor of the uterus, which he had successfully removed, but which he was so sure was an ovarian cyst that he made no preparations for treating the uterine stump and had to improvise a clamp on the spot. "Several physicians of ability," he said, "who had examined the case before I did, had already made the same diagnosis."

Gusserow, in his book on Fibroids of the Uterus, says: "The diagnosis of these tumors has only been made in the most exceptional cases, and even then has been the result of accident rather than of correct appreciation of the symptoms. Fibro-cysts so closely resemble multilocular ovarian cysts, particularly in their fluctuation and in their location, that the frequency with which they have been mistaken for ovarian tumors is not astonishing."

Then as regards the operation, Dr. Laphorn Smith was exceedingly well pleased with the method adopted by Dr. Trenholme. He had seen Martin, of Berlin, operate several times with intra-peritoneal treatment of the stump, but he much preferred the extra-peritoneal treatment. This operation was very easy; the tumor presented in the abdominal incision, and on plunging Tait's trochar into it about 8 ounces of straw colored fluid escaped. The tumor and uterus were then dragged through the incision and the tubes and ovaries were removed in the usual way. A *serre nœud*

in which the wire was replaced by a dozen strands of shoemaker's thread soaked in pure carbolic acid was then thrown around the uterus as low down as possible, which was about the middle of the body, and gradually tightened. The tumor was then cut away about half an inch above the *serre nœud*, and the stump was sewed to the abdominal incision. A drainage tube was then introduced to the bottom of Douglas' cul de sac. No pins were used. The patient made a rapid recovery, the only contretemps being a severe hysterical attack, which occurred about three weeks after the operation, when she sat up too long and the stump seemed to have given away and sunk into the abdomen.

The A. C. E. mixture was used, and there was no nausea or vomiting afterwards.

The patient suffered a good deal from wind, which was relieved promptly by the use of salines and turpentine enemata, but no morphia was used. Three months after the operation she was doing well. An examination of the specimen revealed the cause of what was supposed to have been a prolonged menstrual period, but what was really due to the end of the platinum sound having perforated a small uterine vein. This was also the probable cause of the sharp attack of local peritonitis over a surface as large as a ten cent piece, resulting in a small band of adhesion between the tumor and the pelvic brim. This accident can be avoided by covering the tip of the sound with shellac.

Dr. Trenholme then read the paper of the evening entitled "Nine Cases of Abdominal Hysterectomy for Fibroids," which appears on another page.

Dr. Laphorn Smith congratulated Dr. Trenholme on his courage in reporting these nine cases with five deaths. He hoped that others would follow his example. We wanted more of the failures reported and fewer of the successes, so that the younger men might not be misled by the *couleur de rose* reports which we sometimes heard.

Dr. Gardner said the diagnosis between cystic myoma and ovarian cyst was sometimes extremely difficult. The more one knows about these cases the more likely is he to be in doubt. The best thing is to be prepared for anything. He congratulated Dr. Trenholme in abandoning the intra-peritoneal method which in Schroeder's hands had given a mortality of 30 per cent. He

objected to the word shock, which he thought should rather be called hemorrhage. The making of the pedicle was important, especially in tumors extending down to the cervix, in which cases the dragging of the stump on the rectum sometimes caused obstruction of the bowel. He preferred the wire to the hemp ligature. The constriction should be gradual. There was generally very little pain after these operations. He thought the pins were a source of security in case the patient should sneeze or cough or vomit; he leaves them in for ten or fifteen days until the pedicle has sloughed away. He cuts the wire at the end of the third day so as to prevent downward sloughing. In one of his cases, in which ether had been used, there was vomiting, which, he thought, was sometimes due rather to defective preparation in the way of dieting than to the anæsthetic. When there was violent vomiting he purged with calomel and soda. His own death rate was only one in ten, but he admitted that Dr. Trenholme was a pioneer in abdominal hysterectomy, and that since 1874, when Dr. Trenholme had operated on his first case, the death rate had been steadily coming down.

Dr. Trenholme, in closing the discussion, said that he did not think the pins were of any service. During the first five days, while the *serre nœud* was in situ, slipping back of the pedicle was an impossibility, and by that time the adhesions were strong enough to retain the pedicle without assistance. Even suturing the pedicle to the edges of the incision was useless, and though such had been his custom, here, after he did not intend to do so. The great advantage of the hempen ligature was due to its perfect security against "post operative" hemorrhage, the means it afforded for thorough drainage of the wound and prevention of pus burrowing into the adjacent tissues, and the absence of pain and shock.

Dr. Trenholme related a case (sent in from the country) where a Hodge pessary had been allowed to remain till it had completely passed through posterior wall of the vagina and lodged in Douglas' fossa. The patient felt no inconvenience from its presence, and being in good health, no operation was attempted.

Dr. J. Leslie Foley here said: As is well known, all the ologies which go to make

up the science of medicine are related. I would like to occupy the attention of the Society for a few moments on the relation of dermatology to gynecology and obstetrics. As this is an evening especially devoted to gynecology, and there are those present specially interested in the branch, I thought it not inopportune to broach the subject. We have angioneuroses, neuroses, disorder of glands, inflammations, pigmentary, hypertrophies, vascular dystrophies produced by uterine trouble. *At puberty*, as every one knows, young girls frequently suffer from acne. Many of you, no doubt, are familiar with an acne, not distinctly pustular, which appears just before the monthly period and to which Roché has given the name of *menstrual acne*. He has found arsenic in doses of  $\frac{1}{100}$  gr. beneficial. An eczema sometimes proceeds or accompanies the menstrual period, which might likewise be called *menstrual eczema*. Purpura (rare) has been found to follow menstrual derangements. Acute general eczema has been known to follow laceration of the cervix uteri, which proved rebellious to all treatment until the uterine lesion was remedied. *At the menopause* we have climateric eczema, occurring chiefly on scalp and ears; furunculosis, pruritus, acne rosacea. Pruritus occurs frequently during menstruation, and again during this period an existing acne is often worse. Intra-pelvic lesions involving the cutaneous nerves may probably account for a recurrent herpes of the genitals. In uterine and vaginal catarrh, vulvar pruritus is common and severe, and the acrid secretions often set up an eczema of the perineum and adjacent parts. Morphœa is sometimes due to uterine derangement. Hyperidrosis, bromidrosis, &c., may follow uterine or ovarian disease. Dermatalgia and hyperæsthesia may likewise follow uterine disease (hysteria). Neurotic tumefactions (œdema), erythema multiforme, erythema nodosa, urticaria particularly in the more persistent and recurrent forms often result from female sexual disturbances. Pigment hypertrophies follow uterine disease.

*During pregnancy* we have dermatitis gestationis. I well remember when a student at the Lying-in Hospital, then on St. Antoine street, a rare skin disease occurring in a pregnant woman, under the care of the late lamented Dr. Kennedy, which was a puzzle to all. With

clearer ideas of dermatology, I have no doubt it was a case of the above disease. Eczema may occur during pregnancy, preceding or accompanying it. We may have pruritus, chloasma, herpes, urticaria.

*During lactation.*—Eczema mammae. The list of dermatoses affected by the uterus in its pregnant and non-pregnant state is not inconsiderable. I would very much like to have the experience of members on this topic.

Dr. F. W. Campbell spoke in corroboration of Dr. Foley's assertions; he had seen a great many cases of acne with irregular menstruation.

Dr. Jack thought that too much stress was laid by Dr. Foley on the relation of skin diseases and diseases of women. He thought that both classes of disease were often due to disorder of the whole system.

*Regular Fortnightly Meeting, February 7, 1890.*

DR. ARMSTRONG, PRESIDENT, IN THE CHAIR.

Present: Drs. W. Gardner, J. J. Gardner Birkett, Richard McDonnell, Allan, W. Johnston, Spendlove, Kenneth Cameron, Reid, Perrigo, Shepherd, J. McDonald, Leslie Foley, Blackader, Brown, Schmidt, F. W. Campbell, C. G. Campbell, James Bell, Harry Bell, McConnell, Alloway, A. G. Stewart, A. W. Gardner, Williams and Laphorn Smith.

Dr Johnston exhibited the following pathological specimens:

1st. Aneurism of the aorta, commencing three inches above the aortic valves. The sac was large and filled with recent thrombus, the swelling was firmly adherent to the trachea down to its bifurcation, upon which it pressed sufficiently to obstruct the breathing. It also pressed on the left pneumogastric and recurrent laryngeal nerve, which appeared to be atrophied. There was stenosis of the left subclavian artery barely allowing a probe to pass.

Dr. Richard McDonnell gave the history of the case. Patient came from the House of Refuge to the hospital in October with a severe cough and trouble with his throat, for which he consulted Dr. Major, who immediately diagnosed aneurism of the aorta and sent him to me. Patient presented all the physical signs characteristic of the disease. There was contraction of the left pupil, the left pulse was obliterated, and there was a systolic *bruit* under

the clavicle with dullness extending over a space three inches by two inches wide. Breathing was difficult, and there was a brassy cough and well-marked tugging at the trachea, which were so distinct that the pulsation of the heart could be counted by merely placing a finger on the thyroid cartilage. A week ago symptoms of suffocation set in, and the day before his death he became cyanosed. In this extremity he was placed under the influence of chloroform; but this failing to give relief, was then bled, which operation, owing to its being the first of the kind which the speaker had performed was not very successful.

Dr. Shepherd—You should have called in a surgeon.

Dr. McDonnell—Or a barber.

He was relieved, however, for a short time; but another attack came on, in which he died. The speaker wished to lay particular stress on the tugging of the trachea. If there were no tugging it might be taken for granted that the transverse arch of the aorta was not affected. Showed a tracing from the sphygmograph, in which, instead of the usual sharp systolic rise, there was merely a number of waves. The iodide of potash treatment seemed to have no effect. He also showed a photograph of another patient who died a few days before the last mentioned one, and the mental impression caused by his death hastened the death of the first mentioned case. It showed a long vertical swelling on the left side of the back in the direction of the spinal muscles, and which was seen to grow from nothing up to a length of 13 inches. At first the pulsation could not be noticed by the students until the speaker had placed some postage stamps upon it, when these could be seen to rise and fall. The patients finally died from exhaustion.

Dr. Johnston remarked that the loss of pulse in the left radial was due in this case to the closure of the left subclavian rather than to the reservoir action of the dilated sac.

Dr. Shepherd asked whether Dr. McDonnell considered the unilateral swelling was due to pressure on the great sympathetic.

Dr. Laphorn Smith thought the condition of the pupil was interesting, as we knew it was controlled through the lenticular ganglion from the third and sympathetic nerves, so that when

the sympathetic was paralyzed the third nerve was unopposed and the pupil contracted.

Dr. Johnston then showed a specimen of rupture in urethra. The patient had come to the hospital suffering from retention, and the house surgeon had tried in vain to pass a soft catheter, but shortly after there was an escape of urine through a false passage. The introduction of the instrument was promptly followed by a chill and fever, and the patient died within 24 hours. He thought that this was due to septic absorption, with which Dr. Bell agreed.

Dr. Hingston said he had a curious experience with this accident, for which he could not account; namely, that in two cases in which he had passed the lithotrite many times, yet the very same instrument, passed in the very same way, had at last caused chill, fever and death. The late Dr. Campbell had narrated a similar experience. The only explanation he could give was that patients had their good days and bad days, on the latter of which their urethras could not be touched with impunity.

Dr. Shepherd could not agree with the last speaker. He thought in all cases of urethral fever there must be solution of continuity, and absorption of septic material.

Dr. Bell was of the same opinion as Dr. Shepherd, for this accident never occurs after external urethrotomy in which there were a free escape for the urine, etc. While it was very common after internal urethrotomy.

Dr. Bell showed a specimen of stricture of the urethra removed from an old man who came to the hospital suffering from retention, there being dribbling overflow from the bladder. Internal urethrotomy was performed next day, his temperature at the time being 103. The following day it became subnormal, gradually rising again the day after. Vomiting came on, which could not be controlled, and there being complete suppression of urine the patient soon died. At the autopsy there was found just such a condition of things as we might expect, from the fact that he had had difficulty in passing water for seven years; namely, hypertrophy of the bladder and chronic pyelitis of the kidney.

Dr. Bell exhibited another specimen of diseased urinary organs removed from a very old man who had died from tubercular disease of

the lungs, but who had come to the hospital with an impacted intra-capsular fracture of the femur. There was tubercular disease of the urethra and a sloughing condition of the mucous membrane of the bladder very much resembling diphtheria.

Dr. Hingston exhibited a diseased femur which he had removed by amputation at the Hotel Dieu from a man who had formerly been a patient at the General Hospital, where he had spent two months last summer under the care of Dr. Fenwick, who had removed several sequestræ. The speaker had also removed several sequestræ, but at last, at the urgent solicitation of the patient, he had amputated. On making a vertical section of the shaft the cavity was seen to be in a state of ulceration or osteo myelitis.

Dr. Shepherd exhibited a vermiform appendix containing a concretion, which he had removed from a patient of Dr. Blackader's, a boy of twelve, who had been suddenly taken ill with symptoms of disease of the appendix. He had found no difficulty in reaching the stinking pus cavity, which he had evacuated and washed out, but unfortunately vomiting had come on during the operation, and the bowels were forced out and became infected, peritonitis rapidly developing and death following in three days.

Dr. Blackader gave the history: The boy was playing hockey on the Friday and was operated on on Monday. It was curious that this was the fourth case of death from appendicitis in that family, while the mother was one of the cases of chronic peritonitis which he had reported some years ago, and who had died under the anæsthetic when about to be operated on. He thought now that hers also was a case of appendicitis. We had treated the boy on the Friday by sulphate of magnesia, which caused three motions without relief. Drs. Ross and Shepherd were called in, who decided to operate on Sunday morning, with the result as stated.

Dr. Armstrong said he had had two cases somewhat similar, the latter being a man 32 years of age, who had suffered from the influenza during convalescence of which peritonitis set in. He had already had several attacks of peritonitis during the previous year and a half. He was treated with salines and enematas, but without causing any movement of the bowels for nine days, when he was operated on. An operation being decided upon, the abdomen was



opened and a stinking abscess was found, which was evacuated, washed out and drained, and the patient's life was saved. The walls of the abscess were formed by a knuckle of intestine, and the appendix had sloughed off. The latter contained a concretion which was found to have been formed about the nucleus of two raspberry seeds.

Dr. Wm. Gardner read a paper on "Abdominal Section in Tuberculosis of the Peritoneum and Uterine Appendages," based on a report of five cases presenting a variety of symptoms and physical signs.

In the first there were the symptoms and physical signs of a large collection of fluid in the abdomen, simulating ovarian cyst. The operation revealed tubercular peritonitis with a large encysted collection of sero-purulent fluid. Great temporary relief but speedy development of cough and expectoration. Death six weeks from operation. General tuberculosis of lungs, liver and kidneys, besides the peritoneum; general matting together of intestines and pelvic viscera.

Case 2 began with acute general peritonitis, which developed into a chronic condition, in which pain, constipation and vomiting, with a nodular tumor-like mass occupying both abdomen and pelvis, persisted. Operation revealed tubercular peritonitis, with dense adhesions of coils of intestine to each other. Decided temporary relief to all the symptoms, especially pain, vomiting and constipation. Death from exhaustion six weeks from operation.

Case 3.—Pelvic symptoms following confinement; repeated attacks of inflammation. At time of operation, three years after the confinement, complete invalidism from pelvic pains, profuse, prolonged and over frequent menstruation, and a variety of reflex symptoms, with the physical signs of chronic inflammation of uterus and appendages. Operation revealed double pyosalpinx and cystic disease of one ovary, with dense adhesions. Slow convalescence from operation; steady but slow improvement fourteen months after operation. The parts removed were thickly studded with miliary tubercle; none observed elsewhere.

Case 4.—An unmarried woman, aged 22, gave a history of marked pelvic and abdominal pain, with feeble digestion, weak circulation and

much impaired nutrition, dating from a distinct attack of inflammation three years previous. No evidence of fluid in belly. Fixation of uterus, tender, fixed retro-uterine masses. Operation revealed parietal adhesions of abdominal contents; general matting together of contents of abdomen and pelvis, with universal dissemination of miliary tubercle over everything to be seen and felt through the incision. Incision closed without further interference. Recovery from operation was slow but uneventful. Four months later patient had greatly improved in every way; able to walk and drive. Appetite, digestion and sleep, good.

Case 5.—A married lady, aged 26, the mother of two full term children. Had pelvic symptoms since birth of first. Had a miscarriage on 18th August, 1889, followed by pelvic inflammation, fever and general invalidism. Symptoms on admission: Pelvic pain, especially on left side extending to thigh; defecation painful; slight evening fever, perspirations, marked emaciation; menses at long intervals, but profuse and prolonged; abdomen not distended, but hard; uterus, retroverted, enlarged and fixed; cervix deeply lacerated and granular, to left of uterus and closely adherent, a rounded, smooth, very tender mass. Palliative treatment for six weeks, then abdominal section, which revealed conditions almost identical with the last. General adhesion of everything to be seen and felt; miliary tubercle thickly sprinkled everywhere. Incision closed without disturbing anything; recovery from operation. Patient still under observation, but much better in every way; general health and strength much improved; local condition also greatly bettered.

None of these cases had been fully diagnosed, but the condition had been stumbled upon by operation. The results have been various, as has been the experience of other operators. In some the disease had run its course with partial relief to symptoms. In others great relief and improvement of health had followed; it would be too much to say it had resulted from operation. The experience of others had shown that in some recovery was complete and permanent. The best evidence on this head was obtained from the cases simulating ovarian tumor, as in Sir Spencer Wells' case operated on in 1862, alive and well 19 years later. In those cases,

with diseases of the uterine appendages, the cases are not so old, as operations for the latter condition are comparatively modern. A number of these, however, are reported as comparatively well several years after operation. If the theory held by certain eminent Germans be true, that the parent of tubercle anywhere is some cheesy mass or degeneration, then we are furnished with a strong argument for removing early suppurating conditions in the pelvis, which may, in those predisposed, lead to the development of peritoneal tuberculosis.

The results of abdominal section in such conditions may justify the following conclusions:—

1. The hitherto accepted universally unfavorable prognosis of tubercular peritonitis must be revised as a result of what we have learned by abdominal section. Recovery has taken place in a goodly number of cases after operation, and probably also in some not so treated.

2. Cases 4, 5 and 6 afford some evidence in favor of the theory that a cheesy deposit, the result of suppuration, is the parent of tubercle wherever found.

3. In the cases alluded to the origin of the disease was probably in the inflammatory disease of the uterine appendages.

4. In certain strongly predisposed subjects the early removal of such possible focus of tubercle is urgently indicated.

5. Abdominal section in these, as in less serious conditions, has, with proper precautions, been shown to be a recoverable operation in such a large proportion of cases as to justify its performance to clear up a doubtful case.

6. In a certain number of cases the operation may, with some reason, be fairly claimed to have been beneficial.

*Discussion.*—Dr. Laphorn Smith said that Dr. Gardner was to be congratulated on reporting his failures as well as his success. Although the result had been so discouraging he believed that this treatment had a great future before it. When there was tubercular disease of the of the appendages, Winkel says the result of the operation is not promising; nevertheless, in the hands of American operators the removal of tubercular appendages had been followed by good results. The speaker thought that the operation was not justifiable if there were tubercular disease of the lungs, but in chronic

peritonitis, no matter whether due to tubercle or not, he was prepared to open the abdomen, break down adhesions and wash out. During the course of his reading he had seen at least a dozen cases reported in different countries in which marked improvement had followed this treatment. Dr. McDonnell had reported several cases of collections of fluid in the peritoneal cavity, which had been permanently cured by repeated tapping, and as laparotomy in proper hands was now no longer a more serious operation than tapping, while to the advantages of tapping could be added the beneficial effects of washing out, and even drainage. Another advantage to be derived from laparotomy was that adhesions could be broken down and then the intestines were set free to perform their functions. He was inclined to think that this was the secret of the mysterious but undoubted improvement following exploratory sections. A question that had arisen was with what shall we wash out? Unfortunately, the solutions which were sure to kill the tubercle bacilli were equally fatal to the patient, so that neither carbolic acid nor bichloride should be used. Since germicides have been abandoned the mortality from abdominal sections has fallen enormously, so that there were several "runs" of a hundred sections without a death on record. So that it was clear that an exploratory section was almost devoid of danger. An interesting point was the cause. The speaker believed that just as tubercular disease of the lungs was caused by breathing tubercular air, so tubercular disease of the peritoneum was due to eating tubercular food. The peritoneum was now known to be a vast lymph sac, through which much or most of the food passed on its way from the intestines into the thoracic duct, and he could see no reason why the bacilli could not pass from the intestine into the peritoneal cavity with the lymph. On the whole, he thought that this paper was important for the practitioner as well as the abdominal surgeon, as the latter would never get the cases unless they were suspected and sent to them by the general practitioner.

Dr. Alloway also congratulated Dr. Gardner in reporting his failures. He had seen three of these cases during operation, and there was no mistaking them for anything else than tubercular peritonitis. He had often thought that

these cases were more common than we had any idea of, and that many cases of death after minor gynecological operations were due to lighting up an acute attack of the disease.

Dr. Bell protested against the idea that the mere opening and closing of the abdomen would do any good to cases of tubercular peritonitis. He thought that many cases were self-limited and would recover, at least for a time. Those who survived the operation probably went on as before, and thought themselves well off to have recovered from the operation.

If the tubercle could be removed, he would favor operation.

Dr. Hingston thought that the happy medium lay between the opinions of Dr. Laphthorn Smith, who advised laparotomy in every case, and of Dr. Bell, who did not approve of it at all. His views were to operate when there was any doubt, for the purpose of clearing it up. In many of the cases of recovery he thought it was a matter of *post hoc* rather than of *propter hoc*.

Dr. Armstrong said that as far as he knew his experience was limited to two cases of the kind, one of which he had diagnosed and sent to Dr. Gardner and the other he had operated on for disease of the appendages, but on opening the abdomen the peritoneum was found to contain tubercle, and the appendages were so adherent that it was not considered safe to remove them, so that he had simply irrigated with hot water and closed the wound, a good deal of water being left in. For several days she was greatly benefited, the diarrhoea, which had been constant, having stopped and the pain being gone. Two months after the operation she was walking about and had a good appetite, although there was a slight return of the diarrhoea. He thought that irrigation of the abdominal cavity might yet be found to be of use in these cases.

Dr. Laphthorn Smith wished to be distinctly understood to attribute any good effect for operative treatment to 1st, the breaking down of adhesions; 2nd, the removal of effused liquid; 3rd, the washing out of the cavity.

Dr. Gardner did not wish to be understood as an advocate for operative treatment of tubercular peritonitis; in fact, he had stumbled upon it in three cases, in which there were well marked pelvic symptoms, the other two having been diagnosed. He admitted that many cases of

tubercular peritonitis were self-limited or chronic, and until we know more about its life history we must be cautious about attributing too much to the operation.

Dr. J. Leslie Foley exhibited a specimen of trichorrhæxis nodosum under the microscope. The hair could be seen to be split up and burst into shreds by the growth of the spores in the central tube. Dr. Foley said it was of interest, because only five cases had so far been published.

Dr. McConnell reported a very severe case of pemphigus.

Dr. F. W. Campbell related an interesting case in practice of a patient who was starting on a snowshoe tramp, but not feeling very well he called at Dr. Campbell's office, when the latter was surprised to find all the symptoms of pneumonia, excepting rise of temperature and pulse rate, through all the stages of which the patient passed successfully. The disease had followed an attack of influenza. With regard to what had been said about tubercular peritonitis, he thought that while the prognosis was severe it was not necessarily fatal, many of the cases getting well of themselves.

#### WARNER'S ANTISEPTIC PASTILLES.

Following a suggestion recently made by Dr. C. Seiler in the *Medical Record*, Messrs. William R. Warner & Co., the well-known pill and compressed pastille manufacturers, of Philadelphia, are now placing on the market antiseptic pastilles for the treatment of certain nasal affections. These pastilles are not only powerfully antiseptic and comparatively innocuous, but also distinctly deodorant, as sodium bicarbonate, sodium baborate, sodium benzoate, sodium salicylate, menthol, and oil of wintergreen enter into their composition. One of the pastilles makes 2 oz. of a lotion or spray for the nostrils, and it is, according to Dr. Seiler, "sufficiently alkaline to dissolve the thickened secretion adhering to the nasal mucuous membrane, and as it is of proper density, it is bland and unirritating, leaving a pleasant feeling in the nose. As an antiseptic and deodoriser it is also are superior to Dobell's solution or any other non-irritating deodorizer and antiseptic. The pastilles are introduced here by Messrs. F. Newbery & Sons, of King Edward St., London, E.C.—*The Chemist and Druggist*.

[We have given them a personal trial and are much pleased with the result.—ED. RECORD.]

## Progress of Science.

### INSTANTANEOUS REMEDY FOR LUMBAGO.

Collodion, tincture of iodine, liquid ammonia, equal parts. To be applied widely over the parts with a camel's hair brush.—*Peoria Med. Monthly.*

### A NEW JOURNAL.

Dr. I. N. Love, of St. Louis, Mo., an experienced medical writer and editor, will, we understand, soon establish a new medical journal, *The Medical Mirror*. There are not too many good medical magazines in the country, and we have a right to expect, from the reputation and experience of its editor, that the *Mirror* will take the first rank, and become a leader in the Southwest.

### TO RESTORE THE POLISH OF INSTRUMENTS.

Some weeks ago the stopper of a bottle of corrosive sublimate which was carried in a satchel along with a lot of loose instruments, came out and the chemical was emptied into the bag. The fact was not noticed at the time and the next day the instruments were found covered with rust and in some instances quite badly eroded. How to get the instruments clean without sending them to an instrument maker was a question which I determined to settle by experiment. The instruments consisted of dressing forceps, scissors, needle holder, needles, several bistouries, scalpels, etc., the knives all having tortoise shell or ivory handles. Without going into the details of the experiments I will give you the method of procedure, which yielded perfectly satisfactory results. A saturated solution of chloride of tin in distilled water was made and with this a number of large test tubes were filled to a height sufficient to admit of the immersion of the blades of the knives, the forceps, etc. The instruments were inserted and left over night. The next morning they were found quite clean and of a mat silver whiteness. Rinsing in water, wiping and rubbing with a chamois completed the operation. Chloride of zinc solution gave pretty good, but not nearly so satisfactory results.—F. L. J.

### QUININE IN INFLUENZA.

In the Moscow bi-weekly *Medizinskoie Obozrenie*, Nos. 9 and 10, 1888, p. 946, Dr. Pombrok says that quinine represents an excellent

remedy for influenza (*grippe*) in children, the statement being based on upwards of a hundred cases of his own, treated by the drug. In recent cases (of one or two days standing) the alkaloid is said to invariably cut short the disease, the temperature returning to the standard in twelve or twenty-four hours, never later than thirty-six hours. Nasal catarrh, cough, lachrymation and aural shooting pain strikingly subside after a couple of doses, while malaise disappears not less rapidly to give place to the sense of well being. In such cases which come under treatment at later stages (a week or so after the first symptoms), quinine proves powerless to abort the course of influenza, but still produces quite a peculiar favorable influence on the patient's general state, fever, and even on nasal and bronchial catarrhs. As to the dose, one grain of hydrochlorate of quinine was given by Dr. Pombrok twice daily to an infant of eight months, or three grains twice a day to a child of eight years. On the whole, Dr. Pombrok's experience is fully in accord with that of Professor N. F. Filatoff, of Moscow, who has emphatically recommended the quinine treatment of *grippe* in children in 1883.

### HYPODERMIC INJECTIONS OF CORROSIVE SUBLIMATE AND CARBOLIC ACID IN ERYSIPELAS.

In the *Meditzinskoie Obozrenie*, Nos. 9 and 10, 1888, p. 948, Dr. M. Strizover, of Soroki, Bessarabia, highly recommends hypodermic injections of a solution of corrosive sublimate (one grain) and carbolic acid (ten grains in two ounces of distilled water) in erysipelas of all varieties. The method as it has been extensively practiced by him during the last two years, is briefly this: A Pravaz syringeful of the solution is injected under the skin at several points, one or two drops at each. This procedure is followed by rubbing into the parts the same fluid by means of a piece of cotton wool for several seconds, after which the parts are covered with a piece of gauze or linen soaked in the solution, then with a layer of wadding, and ultimately bandaged with a gauze roller. The dressing is changed in six or eight hours. As a rule, a single injection proves to be sufficient to cut short the morbid process and to rapidly bring about a complete recovery. To adduce a brilliant illustrative case: A weaver of twenty was admitted with intense erysipelas of the whole left lower limb, high fever (41° C.), delirium, etc. Late in the evening the injection was made. On the next morning early the temperature was found to be 38° C., redness, tenderness, swelling strikingly decreased, the patient feeling comfortable. On the third day the limb was normal.

## VERY HOT COMPRESSES IN SURGICAL PRACTICE.

Professor I. I. Nasiloff, writing in the *Vratch*, gives an account of several cases of inflammation of the lymphatic glands, which he treated with very marked success by means of very hot compresses. These compresses consisted of a four-fold piece of linen, rather larger than the surface over the affected glands. It was dipped into water at a temperature nearly or quite equal to 212° F., wrung out, and applied quickly over the glands, its own temperature being then from 140° to 165° F. These applications were made morning and evening, the compresses being allowed to remain on, covered over with cotton-wool, for about fifteen minutes. As may be supposed, the application produced somewhat severe pain, but this did not last long, though sometimes not only redness, but a blister was caused. The treatment was continued for about a fortnight. It was found that it very soon began to promote absorption; this action was always accompanied by a rise of temperature, depending apparently upon the size of the diseased glands, and upon the extent to which absorption was taking place. It was noticed that the earlier the treatment was adopted the more effective it showed itself. Professor Nasiloff believes that hot compresses are a valuable form of treatment, not only in strumous glands, but in rheumatic osteo-myelitis and in fungoid inflammation of the joints.—*Lancet*.

## DOES THE PRACTICE OF MEDICINE HARDEN THE HEART OF THE PHYSICIAN?

This question has so often been answered in the affirmative, that it gives one who is in the ranks gratification to read of such a marked refutation of the charge. as the one given, in the *Med. News*, by Dr. Forbes, of Philadelphia. Hard-heartedness is nothing more nor less than deep-rooted selfishness. Among physicians, as among every other class of men, persons are to be found who possess this quality in a high degree; but the practice of medicine is in no way calculated to develop it. A good physician is schooled to meet emergencies, and his deliberate manner, when all those around him are giving pronounced expression of their feelings, has often been mistaken for hardness of heart. Under such circumstances the doctor often has a stimulus that none of the others have—his knowledge of the course that is able to relieve the suffering and lighten the distress of those around him. He is the hero of such occasions, and the realization of his responsibility urges him to do his duty in controlling those around him.

Dr. Forbes states that during the Johns' own

disaster, more than one-fourth of the entire number of physicians of the place lost their lives in trying to rescue others; and many of those who survived were conspicuous in their efforts to render aid to other sufferers from the flood.—*St. Louis Weekly Med. Review*.

## CHLOROSIS.

Dr. Huchard, *Rev. de Clin. et Therap.*, points out that it is a mistake to push the ferruginous treatment in all cases of chlorosis. The total amount of iron in the body under ordinary circumstances is not more than a few grammes, and even in chlorosis all of it has not disappeared. Any surplus iron is more likely than not to give rise to gastro-intestinal irritation. He prefers to give the iron in the form of iron filings mixed with chalk, powdered coffee, or rhubarb, in the form of a powder. Vinegar, to which chlorotic patients are often extremely partial, is not to be absolutely forbidden; on the contrary, a draught containing hydrochloric acid, taken after each meal, is a powerful aid to digestion. The constipation should be overcome by means of podophyllin, and the uterine functions should be stimulated at the approach of the menstrual epoch by means of hot baths and an infusion of saffron internally. Massage and general gymnastics are also to be commended as adjuncts. In many cases when iron has failed, arsenical preparations, in conjunction with bitters, are successful, and the binocide of manganese has given good results when both iron and arsenic had been tried in vain. The binocide can be given in a powder with charcoal and powdered calumba root, or it may be given in the form of the lactate of manganese, made into pills with extract of cinchona. When iron is well borne he recommends the following formula: R ext. cinchonæ, ext. gentianæ, ext. rhei., āā, 5 grammes; ferrum tart., 5 grammes; ext. nucis vom., 50 centigrammes; ol. anisi, m v; glycerine, q.s. To be mixed and divided into 100 pills. Two to be taken before each meal.—*Lond. Med. Rec.*

## ANOTHER LOCAL ANÆSTHETIC.

Since the advent of cocaine, it has become quite the fashion to discover local anæsthetics. The latest is one which was introduced to the members of the Berlin Medical Society recently. Hayap is its name, and it seems to have considerable power. An aqueous solution distilled into the eye of an animal brought about complete anæsthesia which endured in various instances from ten to twenty-four hours.—*St. Louis Weekly Medical Review*.

## A GARGLE IN QUINSY.

Dr. W. M. Beck, of Kensington, Kansas, writes: "I notice that Sajous recommends guaiac as a gargle for early stages of quinsy. Chloral hydrate has been far more efficient in my hands; in fact, nearer a specific than anything recommended in the text-books. Three or four grains to the ounce of glycerine may be used as a gargle. I mention this because no mention is made by Ringer or other therapeutists on this fact. Its efficiency and *modus operandi* are at once apparent when we consider that it is locally antiseptic, astringent and sedative."—*Medical Record*.

## THE ACTION OF OIL OF TURPENTINE IN IDIOPATHIC CROUP.

Lewentaner (*Centralbl. f. klin. Med.*) formerly reported his success with oil of turpentine in the treatment of croup, but there might possibly be a question raised about the correctness of his diagnosis, since no membrane was found expectorated. He now reports two other cases, both of them in *extremis* when the treatment was commenced, and both of which were saved, apparently by the use of turpentine.

The first case was a child of two years, who had exhibited signs of stenosis for several days, and who had reached about the seventh day of the disease. When first seen by the author the asphyxia was extreme, the cough entirely aphonic, the face pale and livid, and the pulse scarcely perceptible. No membrane had been expectorated. A teaspoonful of oil of turpentine was administered, and ice compresses put around the throat. The child slept more quietly during the night, received another dose of turpentine on the next morning, and during the day expectorated a portion of membrane of considerable size. Under continued administration of turpentine in smaller doses, improvement steadily progressed.

The second case was that of a child of four years, who had been attacked with symptoms of stenosis, and was in the eighth day of his illness when seen by the author. He then exhibited extreme dyspnoea, with pale skin, and filiform and scarcely perceptible pulse. There had been no membrane expectorated. A teaspoonful of oil of turpentine was given, and the continuous atomization of a mixture containing turpentine prescribed. Very soon after the ingestion of the drug there was a violent paroxysm of coughing, and a large piece of membrane three to four inches long was expectorated. As it, however, continued to form, the treatment was persisted in, a teaspoonful of the medicine being given twice a day. Membrane was coughed up in abundance, and in a few days the child was well. The author is fully convinced that turpentine has a specific action on the disease.—*Am. Jour. of Med. Science*.

## THE DENSITY OF THE BLOOD IN RENAL DISEASE.

Dr. Lloyd Jones, of St. Bartholomew's Hospital, who has devised a simple clinical method of estimating the specific gravity of the blood (*Journal of Physiology*, vol. viii.), contributes to the current issue of the *Practitioner* the results of some of his investigations in this direction. By comparison with several hæmocytometric numerations, he shows that, as might be expected, the specific gravity varies in proportion to the relative amount of corpuscles and plasma; and this being so, it suggests that in renal disease changes in the specific gravity would be prone to occur. He therefore made a number of observations on the blood of cases of acute nephritis, chronic parenchymatous nephritis, and chronic interstitial nephritis. In the first the specific gravity was variable, being either normal or below the normal; in the second it was diminished in every case but one. But as regards chronic interstitial nephritis, he found that in the cases accompanied by gout the rule was for the specific gravity to be below the normal (average about 1051) whilst in those in which gout did not occur it was above the normal (average about 1058). Among these latter, however, the interesting fact was shown that in those dying from cerebral hemorrhage the specific gravity was highest (average about 1060), and that the presence of such a condition in a case of chronic interstitial nephritis is an index of the liability of the patient to cerebral hemorrhage. Dr. Lloyd Jones argues that the tense pulse of acute renal disease is attributable to a non-excretion of water, causing an increase in the volume of blood, and further suggests that such an increase may occur in the early stages of granular kidney, and contribute to the cardiac hypertrophy and vascular changes, which in the latter stages suffice *per se* to explain the heightening of the blood-pressure.—*Lancet*.

## SEBORRHOEA.

In his Atlas of Venereal and Skin Diseases, Dr. P. A. Morrow recommends the following treatment for seborrhœa of the scalp: First loosen all crusts; then shampoo with spiritus saponis kalinus and warm water and dry. After this apply the following ointment:

R. Acidi tannici,	ʒi.
Glycerini puri,	ʒi.
Petrolati,	ʒii.
Ung. Aquæ Rosæ,	ʒj.

M.—Ft. ung.

To prevent the re-formation of crusts apply:

R. Sulfuris loti,	ʒi.
Adipis,	ʒi.

M.

## TREATMENT OF THE NASAL MUCOUS MEMBRANE IN WHOOPING-COUGH.

Several physicians, believing that the paroxysms of whooping-cough are to a greater or less extent due to reflexes from the nasal mucous membrane, have directed their attention to it with regard to the treatment of the disease. Dr. Beltz, who has conducted a large number of observations on the treatment of whooping-cough in the Griefswald polyclinic, speaks especially highly of a plan first practised by Michael, which consists of employing nasal insufflations of a mixture of powdered nitrate of silver with magnesia in the proportion of 1 in 10. These insufflations are given at first once a day, and subsequently in two or three days, according to the frequency and severity of the attacks. He finds that the attacks are very decidedly lessened even after the first insufflation, and has come to the conclusion that this affords a more satisfactory method of treating whooping-cough than any other plan with which he is acquainted.—*Lancet*.

## IS THE BATH WHOLESOME?

Nothing in human affairs has a reputation so fixed that it may not be called in question by some one in a moment of originality. This has happened repeatedly in the case of the daily bath. Some critics, for example, suggest that the bather, in consequence of his very cleanliness, lives too fast, is functionally too active, and that delayed and more gradual excretion would better accord with health. Others appear to think that by daily ablution the skin loses a part, or all, of the protection against weather, derived from its own effete products. Yet the bath not only continues to hold its own, but its popularity increases year by year. As regards amenity, both personal and relative, to one's neighbors, there can be no doubt that this is usually much assisted by a habit of regular bathing. Other advantages are not lacking. Among these are, when cold water is used, the invigorating exercise of the nervous and circulating systems, the resistance to weather changes, and the tonicity of skin engendered by immersion. Further, it is undeniable that the non-removal of effete matters from the body imposes a most unwholesome check upon waste excretion in deeper tissues. It is said that some savage races maintain a robust life in spite of personal uncleanliness; but these tribes, it must be remembered, are exceptionally favored in regard to fresh air and exercise. It is probable, also, that even they do not thrive as they should, and would, under purer conditions. For civilized men of sedentary habits, the advantage of possessing a clean and freely active skin is a virtual necessity of healthy existence.—*Lancet*.

## LOCAL APPLICATION OF CHLOROFORM IN EPIDIDYMITIS.

Dr. Theodore Clemens, of Frankfort, in an interesting paper communicated to the *Allgemeine Medicinische Central Zeitung*, describes the great benefit he has obtained in cases of epididymitis, both specific and non-specific, by means of chloroform locally applied. He regards as most unsatisfactory the treatment of the affection by other methods as compared with his own, which he has employed now for a great many years. It consists in laying some cotton wool saturated with chloroform and spirit at the bottom of a large glass vessel, into which the genitals are then put and packed round with dry cotton wool, the buttocks and thighs forming a cover, this application being continued for from fifteen to twenty-five minutes, and repeated two or three times a day. Pathologically, he considers venous congestion of the epididymis and the cord through retention of the semen a predisposing cause of the disease. He also considers epididymitis as very likely to occur when gonorrhoea has been contracted in excessive venery. He mentions a case of treatment by chloroform thirty-six years ago, not of epididymitis, but of periodical "heat" occurring in the human subject. The man used to suffer periodically from a form of orchitis, during which the testes felt hot and swollen, and the plexus pampiniformis was full and turgescient like a varicocele. He was ordered the local application of chloroform three times a day, from fifteen to twenty-five minutes each time, but the first time he bore the chloroform for nearly thirty-five minutes, after which the pain of the severe attack completely ceased and the swelling considerably decreased. This treatment lasted three days, during which time he was able to walk about, the cotton wool which had been used for the chloroform being put into the suspensory bandage and the testes covered with it. After that both the swelling and sensibility disappeared. Another case is mentioned, where epididymitis had been caused by the continuous pressure of a rudder handle on the hypogastrium, in which similar treatment proved entirely successful. Again, a class of case that is usually very difficult to treat—viz., that of gonorrhoeal orchitis—seems to have proved fairly tractable when managed with the help of chloroform: Here one of the first signs of improvement was frequently the re-establishment of an old discharge, which was soon cured simultaneously with the epididymitis.—*Lancet*.

In the treatment of fetid bronchitis, Prof. Da Costa recommends full support, cod-liver oil and carbolic acid, both by inhalation and internally.

It is stated that one grain of pilocarpine in a half ounce of vaseline applied to the scalp will prevent baldness.

## OBSTETRICAL DON'TS.

1. Don't begin the administration of an anæsthetic early in labor; it predisposes to post-partum hæmorrhage.
  2. Don't use an anæsthetic against the will of the patient or friends.
  3. Don't object to the moderate use of an anæsthetic during the latter stage of labor, as it is almost wholly without danger.
  4. Don't put the woman entirely under the influence of the anæsthetic, unless you intend some operation.
  5. Don't immediately cut and tie the umbilical cord; the child may lose a good deal of blood by so doing.
  6. Don't make a strenuous effort to take the placenta away at once, not until the uterus has begun to contract.
  7. Don't make forcible traction of the umbilical cord.
  8. Don't permit the placenta to remain more than an hour.
  9. Don't withdraw the hand from the uterus in taking away the placenta until the walls have begun to contract.
  10. Don't forget to examine the perineum after labor.
  11. Don't neglect to keep the hand on the fundus uteri for several minutes after delivery, and press down.
  12. Don't permit the woman to be left alone for the first hour at least. Danger of post-partum hæmorrhage.
  13. Don't leave without giving instructions to apply the child to the breast an hour or two after labor.
  14. Don't refuse to place a binder upon a woman; a bandage when properly applied is a benefit.
  15. Don't let the nurse tend to the child until the mother has been cared for.
  16. Don't permit the nurse to wash the baby until it has been smeared with oil of some kind.
  17. Don't put undue pressure on the child's head to mould it into symmetrical shape, when it has been flattened somewhat from the labor, as it will return generally to nearly its natural shape.
  18. Don't allow the nurse to press out the secretion of the breasts for a new-born infant.
- Med. Advance.*

## THE ADMINISTRATION OF CHLOROFORM BY GAS-LIGHT.

As is well known, it has been the practice to avoid the use of ether for anæsthetic work if artificial light is needed, whenever there is fear lest the ether vapor mixed with air be heated sufficiently to explode. The heavier vapor of chloroform, in addition to not being liable to form an explosive mixture with common air, is far less inflammable, and so has been hitherto regarded as a safe anæsthetic in such cases, at least as far as fires are concerned. Recent researches undertaken by Dr. Iterson, however, seem to show that chloroform vapor, when allowed to mix with the products of combustion of ordinary coal gas, undergoes decomposition and liberates gases of a most irritating nature. Dr. Iterson believes death has been brought about in one case at least by inhaling these noxious vapors, and recounts other instances in which alarming symptoms have supervened. One patient, although apparently but little affected while inhaling the chloroform, became painfully dyspnoic afterwards, gasping and evincing the usual symptoms of asphyxia due to irritant vapors. These alarming effects passed off when the windows were thrown open and the fumes of coal-gas combustion and chloroform were permitted to escape. It is well known that samples of chloroform which have been kept exposed to diffused light will after a while become contaminated with substances which possess most irritating properties; but until Dr. Iterson's warning arrived, we were not aware that chloroform vapor would, when diffused in the air of a room or operating theatre, be decomposed in passing over a jet of ignited coal-gas. We know that, heated to redness, chloroform splits up into hydro-chloric acid, chlorine and other products, including the trichloride of carbon; and both Soubeiran and Liebig have pointed out that, although chloroform vapor cannot be ignited in the air, it will, if passed over a spirit lamp flame, burn, and liberate irritating vapors. The question as to the gases most probably formed, if the coal-gas is capable of uniting with the products of chloroform decomposition, is too wide a one for us to enter upon; nor do we think we need go further than to say that, if Dr. Iterson's facts are to be taken without reservation, the irritant bodies which exercised so deleterious an influence were, in all likelihood, the products of the ordinary decomposition of chloroform—namely, free chlorine, hydrochloric acid, and possibly other chlorides and ammoniacal compounds.—*Lancet.*

The following is Buckley's anti-pruritic ointment: Gum camphor, chloral hydratis, of each one drachm. Mix and rub together until a liquid results, then add one ounce of ointment of rose water.

In a case of inflammation of the patellar bursa, with accumulation of fluid, Prof. Gross tapped the sac by a trocar, removed the fluid and injected twenty drops of pure carbolic acid.



## THE ART OF EATING.

There is little if any doubt that cooking has been employed by man in the preparation of food from the remotest ages. It is probable also that empirical ideas of what conduces to comfort in diet early formed the basis of a gastronomic art not without some relation to physiological truth. It has been reserved for later times, however, and for civilized man, to discover and formulate a regular method of dining. By a process of natural selection, the work of elaborating this system has in great measure passed into the hands of our French neighbors, who have thus been able to develop an art characteristically their own. Our simpler national customs relating to the table have, in common with those of most other peoples, attracted less attention, though it is not likely that they will ever disappear. It is needless here, however, to discuss in detail each local peculiarity. We should rather aim at understanding those common principles which underlie all rightly constituted systems, and give to each its value as an aid to wholesome nutrition. The time of eating is a matter of no small consequence. This is to some extent subject to individual convenience, but we may take it that as a general rule not less than five hours should separate one meal from another. The short interval of rest usual after meals will commend itself as being in strict accordance with physiological necessity. The quantity and quality of food taken also require careful attention, and these again must be regulated by reference to the work to be done by a given person. Some difference of opinion has always existed as to the proper daily allowance of meat. We shall probably do justice to the digestive powers of most persons, however, by advising that only one substantial meat meal be taken daily. More than this would tend, if continued, to overload the tissues with digestive products, and less would hardly suffice for full nutrition. Drink, if alcoholic, should be sparingly taken, or not used at all. Cookery has in these days been elaborated almost to excess. Variety and delicacy are carried to an extreme, and we should probably gain rather than lose if plainness combined with care were adopted as our rule of practice in such matters.—*Lancet*.

## PROGNOSIS OF BRIGHT'S DISEASE.

The progress of any extensive organic disease of the kidneys is grave, and especially so if both kidneys are involved. If graver symptoms subside, if there is a steady diminution in albumen and other abnormal ingredients of the urine, and the latter tends to a gradual restoration to its normal composition, the prognosis is more favorable. Even when albumen and casts persist for some time the case may recover;

much will depend upon the quantity of albumen and upon the character of the casts. If the urine grows more scanty, if it contains large quantities of albumen, casts and blood, the immediate prognosis is more grave. The chief signs of proximate danger are the supervention of uremic symptoms, edema of the glottis or or lungs, abundant pleuritic or pericardial effusion, severe erysipelas afflicting dropsical parts, and the development of acute inflammatory complications.

In cases of *acute parenchymatous nephritis* the prognosis varies. *Idiopathic cases* in which cerebral symptoms and dropsy are present, or cerebral symptoms alone, usually end fatally. The prognosis of cases characterized by dropsy and anemia is more favorable, although the albumen and casts may persist for a long time. In cases secondary to another disease, severe attacks may aggravate the primary disease or may be prolonged after it. In *chronic parenchymatous nephritis* the prognosis is not so bad as in *chronic diffuse nephritis*, as some cases recover without further indications of kidney disease. In the milder cases of diffuse nephritis the prognosis in the majority of idiopathic cases is good, recovery taking place in two or three weeks or months. Severer cases terminate fatally at the end of a few days, with cerebral symptoms, or all the symptoms continue, the patient dies at the end of several months, or they pass into the symptoms of *chronic diffuse nephritis* or some complicating inflammation causes death. In the acute diffuse nephritis following scarlatina, the prognosis in mild cases is good. Severe ones may terminate early, with cerebral symptoms, or at the end of a few weeks. Recovery may take place after cerebral symptoms. In every case of chronic diffuse nephritis the (1) natural course of the morbid changes in the kidney tissues is to become more marked and to involve more and more the kidneys; (2) the effect upon the general health of the patient is not in any exact relation to the extent of the kidney lesion. These two facts render the prognosis of chronic diffuse nephritis very uncertain. The disease is a serious one and terminates regularly in destroying life, but its duration and the way it will cause death are difficult to foretell.

Nephritis, acute and chronic, occurring during pregnancy, gives a serious prognosis. If the albumen is marked and persists, we have threatened abortion, eclampsia, premature labor and post-partum hemorrhage. At the end of pregnancy the renal disorders reach their climax. The prognosis in any form of nephritis is, for the mother, sufficiently grave; for the fetus it is still more so. If it has escaped premature expulsion from the uterus, in a large proportion of cases it succumbs during parturition to the influence of the excrementitious products retained within the maternal blood.—*So. Cal. Pract.*

## ALBUMINURIA IN RELATION TO LIFE ASSURANCE.

Since the examination of the urine has become a routine measure on the part of medical men, and especially of those engaged in the inspection of candidates for life assurances, a doubt has been gradually growing up as to the veritable significance in certain cases of the presence of albumen in the urine. We do not of course allude to those cases in which albuminuria is merely symptomatic of renal disease, since its pathological significance does not then admit of any discussion, but rather to those cases in which albumen is present only in small quantities, and is unassociated with any other sign of Bright's disease. There is a further class of cases in which albumen is only to be found at certain periods of the day, recurring at fixed intervals. To this category Dr. Pavy has given the name of "cyclic albuminuria." It has been ascertained beyond the reach of doubt that under certain circumstances, albumen may be present in the urine without involving any other obvious departure from the normal standard of health. Violent exercise, the ingestion of certain foods, and exposure to cold are all known to cause albumen to appear in the urine, varying in amount and duration. Seeing in these cases the effect usually passes off with the removal of the exciting cause, it is evident that the physician would not be justified in taking an unfavorable view with respect to the future of such individuals solely on the strength of the existence at a given moment of albumen in the urine. An important and interesting discussion on this subject was inaugurated at Leeds last week by Dr. Pavy, whose experience of this class of cases is very extensive. Placing on one side the cases in which albuminuria is only one of a group of morbid symptoms, we gather that Dr. Pavy does not regard the discovery of traces of albumen in the urine as a *prima facie* reason for refusing permission to assure, provided always that no other sign of renal disease be present. When the quantity of albumen present is greater and is persistent, the outlook is somewhat graver, although even then, if after a sufficiently long period of observation no further symptoms were developed, he would be disposed to take a more favorable view of the future than would at present be allowed by the majority of those engaged in life assurance work. There is at any rate serious reason for believing that cases do occur in which albumen may be persistently present in comparatively large quantities without entailing any tangible disability. He raises the question, therefore, whether such cases might not be admitted to assurance on the payment of an extra premium to cover the additional element of uncertainty. Even if we admit, that such cases do exist, we are confronted by the difficulty that in the present state of our

knowledge no means are available, short of prolonged observation, to enable us to distinguish between the cases in which the albuminuria is, so to speak, merely functional, and those in which it is the precursor of the characteristic symptoms of Bright's disease. We now come to the consideration of those very curious and interesting cases of "cyclic albuminuria." These cases form a perfectly distinct and easily recognizable group, and they often go on for years without the supervention of any further symptom. They present this interesting peculiarity, that whereas the albumen found in the urine in other forms of albuminuria is not precipitated by organic acids, it being in the form of serum albumen, the addition of an organic acid to a specimen of urine in a case of "cyclic albuminuria" is almost invariably followed by a precipitate, showing that other varieties of albumen are present. So generally is this the case that it has been suggested as a means of differentiating the cases of albuminuria belonging to this class. An extended experience of these cases has led Dr. Pavy to the conclusion that although some uncertainty must always exist in respect of the future of individuals the subjects of this variety of albuminuria, a favorable view may in a certain proportion of the cases be taken. As will be seen, Dr. Pavy's contribution to our knowledge of this obscure subject is rather suggestive than absolute. He has, however, done good service in inspiring a doubt in the minds of medical men as to the precise significance of the presence of albumen, and now that attention has been called to this point we may hope to be further edified as to the means of distinguishing between cases in which albuminuria must be held to constitute an absolute bar to life assurance, and those in which it may be taken merely to indicate the necessity for closer examination, and possibly the imposition of higher premiums.

In the discussion that followed, although several of the speakers were prepared to admit the existence of the so-called "functional" albuminuria, they were almost unanimous in adhering to the maxim that the presence of even a trace of albumen in the urine must be held to justify rejection, or, at any rate, the postponement of any decision on the subject. —*Med. Press.*

## TREATMENT OF BLENNORRHAGIA IN FRANCE.

By J. L. Julien, Surgeon to Saint Lazaire.

In the present state of medical science it seems to me impossible to formulate the one best treatment for blennorrhagia. Of the older agents in use for local application in this dis-

ease, nitrate of silver still holds a place; but, though a microbide of the first water, it is not adapted, by reason of its causticity, to general use. Sulphate of zinc, tannin and lime-water are also old-time remedies of utility. They are, however, much inferior to the newer remedies, bichloride of mercury, salicylate of mercury, resorcine, creoline and pyridine.

What is the best mode of treatment for an acute blennorrhagia? If it is absolutely at its beginning, the abortive treatment is to-day what it always has been: an injection of nitrate of silver, 12 grains to the ounce. To obtain a radical result a concentrated solution is necessary. Diday has reported recently a complete cure following the one injection of a 10 per cent. solution.

When dealing with a later stage, when the discharge is fully established, one of the following injections may be prescribed:

- R.—Liq. calcis..... ʒi ss  
Aq. dest..... ʒv.
- R.—Hydrarg. chlor. cor..... ʒgr. ss.  
Aq. dest..... ʒv.
- R.—Hydrarg. salicylat..... gr. i.  
Sodii. bicarb..... ʒgr. xv.  
Aq. dest. q.s. ad..... ʒv.
- R.—Resorcini..... ʒgr. xlv.  
Aq. dest..... ʒv.
- R.—Creolini..... ʒgr. xxii.  
Aq. dest..... ʒv.
- R.—Pyridini..... ʒgr. viiss.  
Aq. dest..... ʒv.

Injections ought to be at short intervals, every two hours if possible, and after each micturition. The best effects are obtained when the injected solutions are used at a temperature of about 140° F. Pyridine, of all the medicaments mentioned, is the one which has given me the best results. But whatever be the agent employed, it is exceptional to effect a cure by its continuous use, as generally, at the end of a few days it seems to be losing its effect, and a new agent has to be substituted.

When the pain has disappeared, and the discharge has about subsided, then it is that we get the greatest success from the use of the balsamics, of which a mixture, containing two parts of cubebs to one of copaiba, with a little peppermint, is as good as any.

Such is the general plan of treatment, and in dealing with an attentive patient and one who is not predisposed by his antecedents or his constitution to prolonged suppuration, a cure ought to result in fifteen days, and sometimes less. If the desired end is slow in showing itself, it is by varying the preparations, and by rendering their action more durable, and especially by the use of suspended powders, that a

cure is brought about. The following are some of the formulæ which succeed best in this class of cases:

- R.—Bismuthi subnit..... gr. lxxv. to gr. ci.  
Aq. dest..... ʒv.
- R.—Bismuthi salicyl. .... gr. lxxv. to gr. ci.  
Vasellini liquidi..... ʒv.
- R.—Quin. sulph ..... gr. xv.  
Bismuthi subnit..... gr. lxxv.  
Acaciæ ..... gr. ci  
Glycerini ..... ʒv.  
Aq. rose..... ʒiv.
- R.—Bismuthi salicylat... gr. lxxv.  
Resorcini..... gr. xlv.  
Iodol ..... ʒgr. xvss.  
Vasellini liquidi..... ʒv.

These injections ought not to be so frequently repeated as those before given; before retiring and after rising is often enough.

Two preparations of the older pharmacopœia are well worthy of praise. They are:

- R.—Zinci sulph.....  
Cupri sulph.....  
Feri sulph..... aa gr. i. to gr. iii.  
Aq. dest..... ʒi
- R.—Acid. cit ..... gr. xiii.  
Acid. salicyl..... gr. ss.  
Aq. dest..... ʒv

The balsamics may be varied in the same way, using copaiba, cubebs, sandal wood oil, kava-kava, etc.

In many cases all these agents are insufficient to essentially modify the conditions of the bulbar and retro-bulbar regions, the ultimate retreat of the gonococcus. Here we have to fall back on anterior or deep injections of a three per cent. solution of nitrate of silver.—*Le Bulletin Medical*.—*Pittsburg Medical Review*.

## X. INTERNATIONAL MEDICAL CONGRESS, BERLIN, 1890.

### REGULATIONS AND PROGRAMME.

I. The Tenth International Medical Congress will be opened in Berlin on Monday, August 4th, 1890, and will be closed on Saturday, August 9th.

II. The congress shall consist of legally qualified medical men who have inscribed themselves as members, and have paid for their card of membership. Other men of science who interest themselves in the work of the Congress may be admitted as extraordinary members.

Those who take part in the congress shall pay a subscription of 20 marks (one pound sterling or \$5) on being enrolled as members. For this sum they shall receive a copy of the transactions as soon as they appear. The enrolment shall

take place at the beginning of the congress. Gentlemen may, however, be enrolled as members by sending the amount of the subscription to the treasurer (\*) with their name, professional status and residence appended.

III. The object of the congress is an exclusively scientific one.

IV. The work of the congress will be discharged by eighteen different sections. The members shall declare, upon enrolment, to which section or sections they intend more particularly to attach themselves.

V. The committee of organization shall, at the opening sitting of the congress, suggest the election of a definite committee (or bureau) which shall consist of a president, three vice-presidents, and of a number—as yet undetermined—of honorary presidents and secretaries.

At the first meeting of each section a president and certain number of hon. presidents shall be elected; these latter shall conduct the business of the sections in turn with the presidents.

On account of the different languages employed, a suitable number of secretaries shall be chosen from among the foreign members. The duties of the foreign secretaries shall be confined to the sittings of the congress.

After the termination of the congress the editing of the transactions shall be carried out by a committee specially appointed for this purpose.

VI. The congress will assemble daily, either for a general meeting or for the labours of the different sections.

The general meetings will be held between 11 and 2 o'clock. Three such meetings will take place.

The time for the sittings of the various sections will be fixed by the special committee of each section, it being understood, however, that no such sittings are to take place during the hours allotted to the general meetings.

Joint sittings of two or more sections may be held, provided that the bureau of the congress can offer suitable rooms for such sittings.

VII. The general meetings shall be devoted to

(a) Transactions connected with the work and general management of the congress.

(b) Speeches and communications of general interest.

VIII. Addresses in the general sittings, as well as in any extraordinary meetings which may be determined upon, can only be given by those who have been specially requested by the committee of organization.

Proposals relative to the future management of the congress must be announced to the com-

mittee of organization before July 1st, 1890. The committee shall decide whether these proposals are suitable to be introduced for discussion.

IX. In the sittings of the sections, questions and problems will be discussed, which have been agreed upon by the special committee of organization. The communications of those appointed by the committee to report on a subject, shall form the basis of discussion. As far as time allows, other communications or proposals proceeding from members and sanctioned by the committee of organization may also be introduced for discussion. The bureau of each section decides as to the acceptance of such offered communications, and as to the order in which they shall come before the meeting, always provided that this point has not been already determined in the sitting itself by a decree of the section.

Scientific questions shall not be put to the vote.

X. Introductory addresses in the sections must as a rule not exceed *twenty minutes in length*. In the discussions no more than *ten minutes* are allowed to each speaker.

XI. All addresses and papers in the general and sectional meetings must be handed over to the secretaries, in writing, before the end of the sitting. The editorial committee shall decide whether—and to what extent—these written contributions shall be included in the printed transactions of the congress. The members who have taken part in the discussions, will be requested to hand over to the secretaries, before the end of the day, in writing, the substance of their remarks.

XII. The official languages of all the sittings shall be German, English and French. The regulations, the programme and the agenda for the day will be printed in all three languages.

It will, however, be allowable to make use of other languages than the above for brief remarks, always provided that one of the members present is ready to translate the gist of such remarks into one of the official languages.

XIII. The acting president shall conduct the business of each meeting according to the parliamentary rules generally accepted in deliberative assemblies.

XIV. Medical students and other persons, ladies and gentlemen, who are not physicians, but who take a special interest in the work of a particular sitting, may be invited by the president or be allowed to attend the sitting by special permission.

XV. Communications or enquiries regarding the business of separate sections, must be addressed to the managing members thereof. All other communications and enquiries must be directed to the General Secretary, Dr. Lassar, Berlin NW., 19 Karlstrasse,

(\*) Treasurer's Address: Dr. M. Bartels, Berlin SW., Leipzigerstrasse 75. Please to enclose a visiting card.

## CLASS-ROOM NOTES.

(From the College and Clinical Record.)

In a case of post-hemiplegic chorea, Prof. Bartholow directed five drops of the fluid extract gelseminum ter die.

Prof. Da Costa regards the examination of Bacilli of tubercle of the highest diagnostic value in the recognition of phthisis.

The long continued use of hot water as a drink is injurious, bringing about atrophy of the gastric glands. (Prof. Bartholow.)

For the constipation concomitant with gastric cancer, Prof. Da Costa advises rectal injections of ℥j of glycerine.

In the treatment of the laryngeal complications of phthisis, Prof. Da Costa advises the insufflation of iodoform or application of cocaine.

In the case of a man with aneurism of the thoracic aorta, Prof. Bartholow directed low diet, ergot daily, and iodide of sodium ℥j ter die.

In cases of bronchitis in children, tending to spread downward and become capillary, Prof. Da Costa recommends the administration of iodide of potassium.

In the case of an old lady at the clinic suffering with prolapsus uteri Prof. Parvin did an anterior and posterior colporrhaphy, and restored the perineum by Tait's operation.

In the treatment of ovarian neuralgia Prof. Bartholow recommends the tincture of gelsemium, given in 5-drop doses t.d., and gradually increased till double vision results.

In the treatment of fibroids of the uterus by ergot, where the stomach rebels, give the remedy hypodermatically; it may be continued for months in this manner. Prof. Parvin.

In fractures of the radius above the insertion of the pronator radii teres, Prof. Brinton directs the hand to be in extreme supination, and the application of an anterior angular splint.

In the treatment of yellow fever Professor Da Costa advocates laxatives throughout, calomel followed by salines at first, and the salines kept up; giving preference to the sulphate of sodium.

In cases of temporarily irreducible hernia (non-strangulated), Prof. Brinton advocates the application of ice bags, using at least three layers of flannel over the surface, and only keeping the cold applied one-half hour at a time.

Prof. Bartholow directed in the case of a man with ascites, the patient being already too weak for any of the more active remedies, that the abdominal muscles be faradized with a rapidly interrupted current daily.

When ordinary remedial measures fail to arrest hemorrhage from the lungs in a reasonable time, Prof. Da Costa recommends sulphate of copper in  $\frac{1}{2}$ ,  $\frac{1}{4}$ ,  $\frac{1}{8}$  gr. doses, or tinct. matico, fʒ ss every four hours.

In the treatment of tertiary syphilis, Prof. Gross advises the following:

R. Potassii iodidi, gr. x.  
Hydrarg. chlor. corrosiv, gr. 1-12 M.  
Sig.—Three times a day.

For after pains of labor, Prof. Parvin advises, if treatment be necessary, the following:

R. Opii pulv., gr. ss.  
Camphoræ, gr. j. M.  
Ft. pil. j.

Sig.—Every hour till relieved.

In the administration of cod-liver oil Prof. Da Costa recommends the following modes: either floating the oil in its purity on ice water, or taken in carbonated water made agreeable by the addition of a little syrup.

When using the alkaline treatment for acute rheumatism, during which anæmia or relapses are liable to occur, give quinine from the middle of the attack and during convalescence to obviate these conditions. (Prof. Da Costa.)

In erysipelas in strong, robust subjects, Prof. Da Costa advocates the use of pilocarpine or jaborandi, 1-6 gr. of hydrochlorate of pilocarpine hypodermically; repeated again in four hours, provided pronounced diaphoresis has not occurred.

Prof. Bartholow ordered for a case of posterior spinal sclerosis, the use of the rubbing wet pack, *i. e.*, rubbing with a sheet dipped in water about the temperature of the body, and in addition the internal administration of bichloride of mercury.

In cases of chancroid which are excessively painful, Prof. Gross directed the following wash:—

R. Chloral hydrat., gr. viij.  
Aquæ destillat., fʒj. M.  
Sig.—Apply on cotton.

For a man at the clinic, with hyperæsthesia of the stomach, Prof. Da Costa directed a milk diet exclusively; ℥ij sodii phosphas in the morning, and the following ter die:—

R. Acidi arseniosi, gr. 1-40  
Ext. cannabis Indicæ, gr.  $\frac{1}{8}$  M.

For jaundice of three years' duration, with evidence of specific disease, Prof. Bartholow directed:

R. Hydrarg. iodidi viridis.  
Extract. belladonnæ, āā gr. iij. M.  
Fiat pil. xxx.  
Sig.—One t. d.

For the irritative fever of phthisis pulmonalis, when treatment is absolutely necessary, Prof. Da Costa recommends :

R. Antipyrin, gr. ij.  
Quininae sulph., gr. j. M.  
Ft. j. in capsul.  
Sig.—One every few hours.

As local treatment of the joints in acute rheumatism, among other means, Prof. Da Costa advises the following :

R. Potassi nitratis, ʒj.  
Morph. sulph., gr. ij.  
Aq. destil., Oj. M.  
Sig.—Keep the joint saturated.

For a case of phthisis at the clinic, Prof. Da Costa directed ol. morrhuae ʒiv t.d.; inhalations of terebene ʒj to Oj boiling water and the following prescriptions :

R. Liquor potassii arsenitis, ʒiij.  
Tinct. nucis vomicae, gtt. v  
Tinct. cinchonae comp., ʒj. M.  
Sig.—Ter die.

In the case of a child with tubercular disease of the knee joint, after breaking up the existing adhesions and placing the part on a splint, Prof. Gross directed rest, extension, and the following :

R. Iodoformi, p. j.  
Unguent. simpl., p. x. M.  
Sig.—Rub well in twice daily.

In the treatment of a chronic ulcer, free the bound-down edges, paint the surrounding tissue with equal parts of alcohol and iodine, touch the surface thoroughly with solid nitrate of silver, put the patient to bed, and wrap the limb up in a solution of lead water and laudanum. Prof. Gross.

For a case of obstinate sciatica rheumatism, at the clinic, Prof. Da Costa ordered the following, to be taken ter die :—

R. Sodii salicylat, gr. xv.  
Tinct. acconiti, gtt. j. M.

and also directed that in case this failed injections of osmic acid should be used.

Where labor is delayed in the second stage by uterine inertia, the foetal head having escaped from the os uteri, Prof. Parvin advises the following :—

R. Extract. ergotae fluid, gtt. x  
Tinct. cinnamomi, ʒj. M.

Sig.—Every fifteen minutes until 4 or 5 doses are taken.

For a case of leucocythemia, at the clinic, in which the white corpuscles were 1 to 60 red, Prof. Da Costa ordered of arsenite of sodium ʒ40 gr. t.d., and

R. Iodi, ʒj  
Ol. bergamot., ʒj  
Lanolin, ʒj. M.  
Sig.—Rub in over the spleen.

In the treatment of mucuous patches in the mouth in secondary syphilis, Prof. Gross advises first :—Dry with absorbent cotton and apply a four per cent. solution of cocaine; then apply the following with camel's-hair pencil :—

R. Hydrargri nitratis (acid), p. j.  
Aqua destillat., p. xij. M.

Sig.—Apply daily once, and between applications may use the following :

R. Acid. pyroligneosi, ʒj.  
Aqua destillat., ʒviiij. M.

Sig.—Use as a mouth wash.

In the treatment of chronic alcoholism, Prof. Bartholow says : For the disorders of digestion, morning vomiting, loss of appetite, accompanied by wakefulness and nervousness, the appropriate remedies are abstinence, careful alimentation, and such tonics as quinine, nux vomica, and the administration of bromide of potassium to procure quiet sleep. In the more chronic cases, where degenerative changes may be expected to have taken place, arsenic in small doses, hypophosphites and cod liver oil are recommended, and should be given for several months. Chloride of gold and sodium or corrosive sublimate will retard changes taking place in the connective tissue, if given early enough.

When hospital gangrene occurs, isolate the patient at once. Remove the slough by roughly rubbing with sponge (immediately burning the sponge used), cleanse with warm water, dry the wound and cauterize thoroughly with chloride of zinc (with just sufficient water to convert it into an oily liquid) by means of absorbent cotton; allow cauterant to remain on ten minutes; remove and apply antiseptic dressings. An anæsthetic should be administered during treatment; good nourishing diet and opium to relieve pain subsequently. (Prof. Gross.)

Aseptic catgut ligatures, chromicized for use on the larger arteries, may be prepared as follows : Take 200 grains catgut; remove fatty matter by immersion in ether for twenty-four hours; wrap when dry on spools and immerse forty-eight hours in following solution :

R. Acid. chromic, gr. j  
Acid. carbohc, gr. cc.  
Spirit. vini rectificat, ʒij.  
Aqua destillat, ʒviiij. M.

Remove the catgut under antiseptic precautions; dry, wrap up in any aseptic impermeable material, and before using place for a short time in ordinary 1 to 1,000 corrosive solution to which one-fifth its weight of alcohol has been added; these ligatures cut through in about seven days. (Prof. Gross.)

---

**THE CANADA MEDICAL RECORD,**

PUBLISHED MONTHLY.

---

*Subscription Price, \$2.00 per annum in advance. Single Copies, 20 cts.*

---

EDITORS:

A. LAPHORNSMITH, B.A., M.D., M.R.C.S., Eng., F.O.S., London

F. WAYLAND CAMPBELL, M.A., M.D., L.R.C.P., London.

ASSISTANT EDITOR:

ROLLO CAMPBELL, C.M., M.D.

---

Make all Cheques or P.O. Money Orders for subscription or advertising payable to THE HERALD COMPANY, No. 5 Beaver Hall Hill, Montreal, to whom all business communications should be addressed.

All letters on professional subjects, books for review and exchanges should be addressed to the Editor, P.O. Drawer 1923 Montreal.

Writers of original communications desiring reprints can have them at a trifling cost, by notifying THE HERALD Co. immediately on the acceptance of their article by the Editor.

---

MONTREAL, FEBRUARY, 1889.

---

SOCIETY PROCEEDINGS.

We call the attention of our readers to the full report of the two last meetings of the Medico-Chirurgical Society. We have spared no pains in making this department a special feature of the RECORD, and we are glad to know that our efforts are being appreciated. We are obliged to condense a little owing to the pressure on our space, but we aim at being fair and impartial, so that every member who attends the meetings and speaks will be duly noticed in our reports.

---

CO-EDUCATION.

A good deal of agitation has been going on lately among the highly educated and ambitious females of this city, with a view to the provision for them of the means of

obtaining a thorough medical education on equal terms with their brothers. So far they have been laboring under the inconvenience and expense of sojourning during four long years far from their mother's protecting eye, in the city of Kingston, where the Women's Medical College is located, which is the only institution of the kind in Canada to which women are admitted. From certain items, however, which have lately appeared in the daily press, it would seem that even this avenue to the realms of fame and fortune was about to be closed to them. One would think that their male fellow-students would welcome them with open arms to any of the existing colleges, but so far this has not been the case. Even in some quarters they seem to have been given the cold shoulder. It is the object of this article to make a special plea for the admission of the *girls* on equal terms with their brothers. Why should they not be? A girl of 17 is generally quite as intelligent and well educated as a boy of that age; indeed, much oftener, more so. So that the objection that the sprinkling of girls would keep the class back does not hold good. As far as behavior is concerned and the sense of discipline, we think that everyone will admit that it is far easier to maintain order among a class of girls than among the same number of boys. So there is nothing to be feared—but rather, we think, a great deal would be gained by the example of the young lady element. A hard-working and conscientious professor sometimes experiences the most acute annoyance from the sometimes rough and noisy frolicking of young men; if the eyes of a dozen or so of refined ladies were upon them perhaps they would be charmed into silence and sense. Just as a few turbulent spirits are capable of creating anarchy, so, we think, a few earnest, gentle girls would have a powerful influence in maintaining order. Another great advantage would be the incentive to work due to competition. When a girl makes up her mind to study medicine she

is in earnest about it ; from the very beginning she is a worker. On the contrary, her brother is so confident of his ability to master our most difficult science and art in three years that he very often devotes the first of the four years of study required by law to seeing life and pursuing other pleasures more or less harmful to himself or the property of the citizens. But the medical student is an honest fellow, and he frankly admits, when the perspiration is pouring down his back, towards the end of his fourth year, that he would have spent his first year very differently if he had to spend it over again. The example of the hard-working girl students would surely benefit him in this respect. So far as we can learn, the objection to the admission of female students has come principally from male students ; three explanations for this may be given :—

1st. He may object to her studying medicine at all, but this will not prevent her from studying, for if she cannot get her education here she will go elsewhere for it. We quite agree with the students that it would be far better for women to devote their energies to that which they are so much better suited. In bearing and nursing children men can never take their place—at least not with any degree of success—while it seems clearly to have been the Creator's intention that she should be a wife and mother, and if she does those duties well she will find her hands and arms full. We cannot view with any satisfaction the tendency of the women of this age to shirk their manifest and divine destiny ; but, in spite of all this and the many physical disabilities under which the female doctor must labor, there will be female doctors. As long as women labor under the delusion that it is an easy way to earn a living, it would be unjust and ungenerous for us to throw any obstacles in their path. We may as well welcome them to our ranks, and let the fittest survive in the struggle.

2nd. He may object to the restraining influence which their presence in a class might have upon him ; but this, we have already shown, would be for his own good. In fact, it is just what he most requires, any little coarseness in his jokes and stories would soon be replaced by delicate refinement. Polish in manners is an asset of no small value to the practising physician. Surely the presence of educated ladies in the class could not fail to have a refining influence.

3rd. The male students might object that the presence of ladies in the class or at the bedside might cause the professor an awkward feeling of constraint. In fact, that when he came to discuss the etiology and treatment of diseases of the sexual organs he would not dare to call a spade a spade, and that the male students would thereby be the losers. In proof of this we may refer to an incident which occurred some years ago when the experiment of co-education was first tried in a western college, when the girl students left the physiology class in a body because the professor indulged in an unnecessary double *entendre*. For our part this objection could have no weight with us, for we tell the students nothing but what is necessary for every doctor, male or female, to know, and what would be very useful for every girl to understand. The objection of indelicacy to co-education seems to us absurd when we consider the relation of the male accoucheur and gynecologist to his female patients. We never refuse such patients because it would be indelicate to ask them questions and give advice. Why then object to the relation of male teacher to the female student ? The presence of a few female students, and many female nurses at the Women's Hospital has never prevented us from speaking plainly, although decently on the most delicate subjects. It being evident that women doctors must be educated somewhere and that there is no valid objection to their being co-educated with men, what college will open freely its



doors to them? There is no college more able to meet these requirements than Bishop's College.

1st. Because, although the staff is complete and the school well equipped, the number of students is comparatively small, so that 20 or 30 female students would find the college almost as much their own as the men's.

2nd. Because it has special facilities enjoyed by no other school in Canada for the teaching of midwifery and diseases of women. We therefore venture to throw out the suggestion that instead of establishing a new and necessarily very costly separate school, the women should invade the school of Bishop's College, which has been in working order for 19 years, and the graduates of which, established in every part of the world, have proved by the extraordinary success which they have attained that the education they have received has been unusually practical.

### BOOK NOTICES.

A COMPEND OF HUMAN PHYSIOLOGY. Especially adapted for the use of medical students. By Albert P. Brubaker, A.M., M.D. Fifth edition, revised and enlarged, with new illustrations and table of physiological contents. Philadelphia: P. Blakiston, Son & Co., 1012 Walnut street. Price \$1.00.

The popularity of this little work is amply shown by the fact that it has run through five editions. The print is fine, so that as much information is contained in it as will generally be found in larger and more expensive works. It commends itself to the physician because it is small enough to go into his pocket, so that he might spend to advantage in refreshing his knowledge many a waiting hour which might otherwise be lost.

THE DISORDERS OF MENSTRUATION. By Edward W. Jenks, M.D. 12mo. pp. 120. Detroit: Geo. S. Davis, 1888.

This is one of "The Physicians' Leisure Library," a series of short, practical treatises addressed to practitioners. In the present volume Dr. Jenks has given a fair *résumé* of the modern treatment of menstruation. The limits of his book forbade discussions of doubtful points, and the introduction of a thorough survey of the pathology of the affections described. Nor can the book claim original methods of treatment. The practice of the average American gynecologist is, however, fairly described; formulæ and illustrations sufficient to bring clearly before the mind the instruments and drugs used are inserted; and the

book may be read in the scattered moments of a physician's leisure with profit and interest.

WOOD'S MEDICAL AND SURGICAL MONOGRAPHS. Neuralgia; its etiology, diagnosis and treatment. By W. R. Gower, M. D., F. R. C. S. The Prognosis of Diseases of the Heart. By Prof. E. Leyden, Berlin. The Sputum; a contribution to clinical diagnosis and practical examination for Tubercle Bacilli. By Peter Kaatzer, M. D. Hypnotism; its significance and management briefly presented. By Dr. August Forel. The forms of nasal obstruction in relation to Throat and Ear Diseases. By Treville Macdonald, M. D. William Wood & Company, publishers, 56, 58 Lafayette Place, New York. Volume 5, No. 1. January, 1890.

The careful perusal of this volume convinces us more than ever of the good value which the publishers are giving for ten dollars a year. Dr. Gower's article alone is worth the price of the whole book, while Prof. Leyden's article, coming as it does from the pen of one of the most experienced and reliable writers in Germany, is simply invaluable. In the light of the recent discovery of the infectiousness instead of the inheritability of tubercular disease, the article of Dr. Kaatzer (the practical examination of the sputum) will prove of great service to the general practitioner in recognizing the disease in time to isolate the patient before the whole family is infected, as has so often been the case heretofore.

A HANDBOOK OF DISEASES OF WOMEN, INCLUDING DISEASES OF THE BLADDER AND URETHRA. By Dr. F. Winckel. Authorized Translation, edited by Theophilus Parvin, M.D. Second edition, revised and enlarged, with one hundred and fifty illustrations. Philadelphia: P. Blakiston, Son & Co., 1012 Walnut street. Price, \$3.00

Of this work we cannot speak too highly. The author has attained the highest rank among the writers of his own country, while at the same time he is recognized as a most reliable authority throughout the world. The American editor is also one of the most reliable of the conservative school of gynecologists. Thoroughness is the main characteristic of both author and editor; the whole subject is fully but concisely gone over.

Although we would recommend the possessor of a single work on Gynecology to have first an American one, we would as strongly recommend Winckel's book as one of the best of foreign ones. The publishers are deserving of the thanks both of practitioners and students for fixing the price at a sum within the means of all. The expense of buying ten dollar volumes presses heavily on the resources of many studious young men, and often debars them from obtaining what they so much need. This reducing of the extravagant prices maintained by some publishers and authors is a step in the right direction.

### PERSONAL.

Dr. Frank Ferguson, Pathologist, to the New York Hospital, has been elected Professor of Pathology in the New York Post-Graduate Medical School and Hospital.