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THE CANADA LANCET.

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Original Communications.

FRACTURES OF THE THIGH.*

BY A. B. ATHERTON, M.D., TORONTO.

Fractures of the femur are naturally divided into those of the neck, shaft and lower end.

Those of the neck are sub-divided into intra-capsular and extra-capsular fractures, according as they take place within or outside the capsular ligament of the hip-joint. Many fractures in this locality, however, partake more or less of both characters.

Intra-capsular fracture generally occurs in persons over fifty years of age, and is much more frequent in females than males. The thinning of the osseous tissue, the increased deposit of fat in the cancellar tissue and the more horizontal position which the neck of the bone assumes in old age all assist in making fractures of the neck more common in the later periods of life.

The trochanter major is occasionally separated from the rest of the bone, either as an independent lesion or in conjunction with fracture of the neck.

When the fracture is an impacted one crepitus is of course absent, while all the other symptoms are present in a less marked degree than in cases of complete fracture. In such fractures it will not always be an easy matter to recognise them from a severe contusion of the hip, for it is not justifiable to exercise any violent force in order to get crepitus, lest the impacted fragments be separated and thereby the treatment and result be rendered less successful. All cases of doubt should therefore be handled with care from the first.

I may here remark that I think the best way of getting at the true length of a limb is by measuring from the anterior superior spinous pro-

cess of the ilium to the tip of the inner malleolus. Some prefer to start from the umbilicus, but it seems to me that this point would be more apt to vary somewhat with change of position, and be therefore not so reliable for purposes of measurement.

Some considerable discussion has at different times taken place as to the cause of the very general occurrence of eversion in fractures of the neck of the femur. In cases of complete fracture it is probable that the foot and leg falls outwards by their own weight, just as they naturally do when one is lying on his back while the muscles are relaxed, as in sleep. It has been thought also that the glutei muscles are influential in producing this effect. Bigelow has demonstrated that the cortical bony tissue is more strongly developed on the anterior side of the neck than on the posterior, and he contends that this is the reason why in impacted fractures the latter part yields more than the former and consequently gives rise to more or less eversion of the leg. On examination of the bone we also observe that the posterior part of the neck is hollowed out more than the anterior, which is especially marked at its upper part where the first force of a blow upon the trochanter major would be felt. This we think would tend to the more ready yielding of the posterior side of the neck, even though the tissue were of the same density throughout.

The accidents most likely to be mistaken for fracture of the neck of the thigh bone are (1) some fractures of the pelvis; (2) dislocations of the bone; and (3) severe contusions of the hip. It is not always easy to diagnose between fractures of the neck and those of the acetabulum, but as the treatment would be the same it is not so important to make the distinction. Recent dislocation is usually known by the greater fixation of the head of the bone. When, in cases of impacted fracture, there is much swelling of the soft parts, especially if the patient be a fat subject, it will often tax our powers of diagnosis to the utmost to decide as to the existence of the fracture. As before stated, however, we must when in doubt give the patient the benefit of that doubt and treat the case as one of fracture. There are two methods of assisting us in the diagnosis of fractures of the neck of the femur which are often found serviceable. One is the observation of Nélaton, that the

*Read before the Ont. Medical Association, June, 1886.

top of the trochanter in the natural condition of the parts always lies in the line drawn from the anterior superior spine of the ilium to the most prominent part of the tuber ischii. The second is Bryant's test, which consists in letting fall a vertical line from each anterior superior spinous process to the mattress, and comparing the distances from each trochanter to the nearest point on these lines. On the side of fracture the distance will be found to be less than on the uninjured side.

Still another measurement is mentioned in Holmes' Surgery, called the transverse; which is obtained by taking the distances from the median line of the body to the vertical antero-posterior line at right angles to the former drawn through the top of each trochanter. On the side of fracture the distance will be found to be diminished on account of the inward displacement of the bone due to the impaction.

Fractures of the shaft of the bone are caused both by direct and indirect violence, and are most frequent in the middle third. They occur at all ages, and are occasionally due to muscular action alone, especially in persons whose bones are weakened by scrofula or other cachexia, or in cases which are effected by a latent form of osteitis. I have myself seen a fracture in a female of about forty-five years of age caused by simply turning in bed. Rheumatic pains had preceded the event for some weeks. In another case I saw a surgeon of eminence produce fracture of the femur in a child while examining, with the exercise of but little force, the condition of the limb in long standing hip disease.

We are inclined to think that as to the direction of the fracture it would generally be outwards and forwards for two reasons, viz.: 1st, the facing inwards of the head of the bone; 2nd, the fact that the posterior side of the shaft is usually considerably concave. In all cases where the shaft is broken by a fall from a height upon the feet it will be readily seen that the force of the fall would be transmitted in a direct line from the condyles to the acetabulum, and would therefore cause the shaft to bend in an outward direction. This effect would, however, be probably somewhat modified by the posterior concavity of the bone so as to produce more or less projection of the broken ends forwards. Again in cases of fracture caused by a force acting directly upon the bone, the latter not

being a fixed part would be apt to rotate a little so as to bring the fracturing force somewhat towards its concave side, and thus a more or less anterior direction would be given to the displacement.

Usually there will be no difficulty in diagnosing fractures of the lower end of the femur. In all, except fracture of one condyle, there will be shortening of the limb. Crepitus will also be present, except in the rare cases of impaction. When there is a T fracture of the condyles, we may expect to find widening of the end of the bone; also in all forms of fracture into the joint there will be much swelling of the knee.

In fracture of the lower end of the shaft just above the condyles the upper fragment is generally displaced anteriorly with perhaps a slight variation to either side. The lower fragment is rotated backward by the action of the popliteus muscle.

Having thus briefly considered a few points in connection with the various fractures of the thigh, let us now direct our attention to their prognosis and treatment.

In complete fracture of the neck within the capsule, bony union is very rarely attained, and there will result a considerable amount of shortening, varying from one to two inches. Furthermore, more or less lameness and disability will persist to the end of life. Sometimes even death will ensue after a variable time in these cases, because of the confinement and consequent bed-sores arising in the old people, who are generally the subjects of this form of fracture. Many of these patients will not submit to the application of the usual kinds of apparatus intended to keep the limb at rest or secure extension. In such we must often be content with simply flexing the leg and thigh and placing the limb quietly on its outer side upon a pillow, or if that position does not satisfy the sufferer we must try to find some more comfortable one. Thomas' splint for hip disease is recommended for some of these cases, by which means the patient can be allowed to move about on crutches instead of being confined to bed.

Impacted fractures of the neck, when carefully handled and treated with proper skill, may not get displaced from their original position and will then probably recover with but little shortening and a useful limb. In fractures of the shaft in adults there will result generally shortening of

from $\frac{1}{2}$ to $\frac{3}{4}$ of an inch, no matter what plan of treatment we adopt. Exceptions to this rule are sometimes met with in cases of severe shock where the muscles are more or less paralyzed for a time and therefore do not exert their usual contractive power. I have only once seen such an instance in a man who had in addition to fracture of one thigh, compound comminuted fracture of both patellæ, Colles' fracture of both radii, two fractures of the lower jaw, and a rather serious injury of the thorax. In the case of young children recovery usually takes place with little or no shortening. This is probably chiefly due to the comparatively thick periosteum preventing much displacement of the fragments. Also the weak muscular action may account in some measure for the favorable result.

Fractures of the lower end of the bone are generally rather serious, because of the very great tendency there is to ankylosis of the knee joint in these cases. As to treatment, there is now a pretty general consensus of opinion that Buck's method of extension by means of strips of adhesive plaster to the sides of the limb, and the attachment thereto of a weight and pulley, is the best method to employ in order to avoid an excessive amount of shortening. Counter-extension is best got by raising the foot of the bedstead. As to the accessory application of coaptation splints, and the use of a long outside one to prevent eversion of the leg, opinion seems to be more at variance. Some employ sand-bags in lieu of both these. It may do to pursue this plan in hospital practice where a house surgeon is on hand all the time to rectify any displacement of the limb or bags, but in ordinary private practice, especially in country districts, it will be found that both the coaptation splints and the long outside one will be necessary to insure continued rest of the fragments of bone and the avoidance of eversion. In fractures of the neck it is well to mould a broad splint of poro-plastic felt to the outer side of the hip, while the long wooden splint will also be required to prevent eversion.

In fracture of one condyle, as there is no shortening, there will be no need of any extension. The broken fragment must be brought into position as well as possible and maintained there by the use of a well-padded splint of poro-plastic felt or binder's board, and perhaps a long wooden splint

to either the outer or inner side to correct the lateral bowing of the knee, which is apt to occur. Gooch splints may be substituted for poro-plastic material or the binder's board in many cases for coaptation purposes with good results. Little or no extension will be required in the partial fractures of children, but with the above exceptions extension will always be necessary in fractures of the thigh.

There exists some difference of opinion in regard to the weight to be attached to the leg in order to counteract the muscular contraction. Some surgeons advise the use of as much as thirty or forty pounds for this purpose. As far as my observation goes, however, I think that so great a weight will often give rise to a good deal of pain and discomfort, while I believe it defeats its own end by causing more or less spasmodic action of the over-stretched muscles. In children, from $1\frac{1}{2}$ to 6 pounds, will generally be found sufficient, while in adults, 8 to 12 or 13 pounds will retain the limb at the greatest attainable length.

As to the coaptation splints, in the upper third of thigh the tendency of the upper fragment to outward and forward displacement must be met by a broadish splint, running well up over the hip-joint, also an inner one will be required to aid in pressing the lower fragment into line with the upper end of the bone. In the middle third three splints will usually suffice to retain the bone in position; one for the outer, another for the anterior, and the third for the inner side. The mattress, on which the patient should always be placed, will support the parts sufficiently posteriorly. In fractures of the lower end of the femur especial care should be taken to bring the fragments into good position, and then a plaster or poro-plastic felt splint, well padded, should be applied posteriorly from six or eight inches above the fracture to below the calf of the leg. This may be supplemented by other splints of similar material to the sides, if the case is one which seems to demand it. A slight amount of flexion is generally to be allowed to the knee, so as to aid in coaptation of the lower fragment, which is apt to be turned backwards by the action of the popliteus muscle. If in spite of flexion of the knee, the lower fragment still projects very much, the tendo-achilles may be divided, with good effect. McIntyre's splint is sometimes used in these fractures, but in that case one must sacri-

face more or less in the way of extension, as the latter cannot be carried out so well when the limb is laid on this splint.

Up to a few years ago, Liston's or Desault's splint was in pretty general use in Great Britain for fractures of the shaft and neck of the femur; but of late we think it has been, to a large extent, superseded by Buck's method. A piece of gutta percha moulded to the groin and afterwards padded with lint, may obviate to a considerable extent the irritation usually set up by Liston's perineal band, which is one of the drawbacks to his method.

Some years ago, Nathan Smith, of Baltimore, invented an anterior splint, consisting of two parallel wire bars running the whole length of the limb, and bent somewhat in the middle and at both ends in order to conform to the shape of the parts. This, after being secured to the front of the limb by bandaging, was slung by two hooks—one above and the other below the knee—to a pulley above the bed. From what little experience I have had with this apparatus, I have not formed a very favorable opinion of it, and would not employ it again.

In some rare instances of fracture in the upper third of the thigh, where the short upper fragment tends, in spite of the ordinary coaptation splints, to project much anteriorly, the double inclined plane may be tried. By so doing, however, much extension cannot be got by the use of strips of adhesive plaster, as they can only be applied to the sides of the *thigh* below the seat of fracture.

In the case of young children, where the bandages, etc., are apt to become wet and soiled by the excretions, Bryant recommends vertical extension by attaching the foot and leg to a bar or hook above the bed, the weight of the body acting as the counter-extension. We think, however, that the use of a starch or plaster-of-Paris bandage, protected by a piece of rubber cloth or some kind of varnish, will answer sufficiently well in such cases.

In conclusion, let me emphasize the importance of the following practical points in the treatment by Buck's method:—

1. Always insist upon having a good, firm, even mattress under the patient, so as to prevent sagging of the hips or other parts of the body.
2. Remove the foot-board from the bedstead; so as to have no obstruction in the way of the down-

ward movement of the body, which is apt to take place more or less on account of the constant traction of the weight. For the same reason, the pulley should be placed at some little distance from the foot. These precautions are not so requisite, perhaps, in hospital or city practice; but they will be worthy of attention in the country, where the surgeon is often not able to visit the patient more frequently than once in a week or ten days.

3. The strips of plaster should be applied exactly along the central part of each side of the limb, their upper ends reaching up as far as the fracture, so as to relieve the strain upon the ligaments of the knee-joint.

4. Bandage the limb from the toes up.

5. Place a cushion of folded blanket, or other suitable material, between the heel and calf of leg, so as to avoid ulceration of the former part from pressure on the bed.

6. See that the position of the pulley be such as to ensure traction in the line of the limb or in a direction a little above that line, otherwise the friction of the member against the mattress will more or less counteract the weight extension.

7. When the long outside splint is used, be careful to pad well the part above the malleolus, so as to protect the latter from pressure.

8. Steady traction is to be maintained by the assistant, until everything is in readiness for the attachment of the weight extension.

OVARIAN-UTERINE OPERATIONS.*

BY E. H. TRENHOLME, M.D.,

Prof. of Gynæcology, Bishop's Medical College, Montreal.

In this brief paper it is my desire to refer to some of the details connected with operations for the removal of the uterus, or its appendages. It is not my intention to refer to the diagnosis of uterine ovarian disease, nor deal with the after-treatment, to any great extent.

With regard to the preparing of the patient for the operation, I would advise you not to resort to purgatives, especially avoid aloes and castor oil, both of which favor congestion of the hemorrhoidal vessels, and consequently renders the patient more liable to inflammatory action. The bowels should

* Read before the Can. Med. Association, Aug. 19, 1886.

be brought into gentle action by diet and mild laxatives; avoid emptying the bladder, especially in extirpation of the uterus, its presence being easily recognized when full and not so liable to be injured; the legs should be wrapped in cotton wool, especially in cold weather, and the temperature of the operating room not less than 85°. The cotton wool can be removed after reaction has been established. There should be ready for use, a couple of dozen of hot towels, which are to be applied, as need may arise, around the body and over the abdomen during the operation; the temperature of the exposed bowels and surface of the body can in this way be easily maintained. It also protects the patient from escaped fluid and blood. I prefer to stand on the right side of the table, which is placed diagonally to the window, so as to allow the light to fall directly upon the abdomen of the patient.

The instruments required for these operations need not be very numerous nor complicated; generally speaking, a scalpel, scissors, director, half a dozen Keberle's forceps, three or four sponges, silver wire, shoemakers' thread, and horse-hair, a needle-holder and needles will suffice. I would press the importance of having clean sponges, instruments and hands, and allow no explorations of the parts during the operation by other hands than your own. Not only must the sponges be clean, but they require to be carefully washed during the operation, in plain water, and then squeezed out of carbolyzed water before being handed back to the operator. This part of the work should be entrusted to a competent assistant; abundance of boiling water and water, that has been boiled only should be used. If this is attended to, it matters little whether or no carbolic acid is used. It is well, however, to have all instruments, at the time of operation, kept in a 1 to 20 solution of carbolic acid. For ligating the pedicle and all vessels, No. 20 shoemakers' white thread, single or double, well carbolyzed, is all that is needed. My reasons for preferring this ligature to all others are, that it is quite strong enough, even single, to secure all the vessels that should be enclosed in one ligature, that it affords a safe knot, is easily disintegrated and removed by absorption. This ligature should be soaked at least 24 hours in pure carbolic acid before using, and not allowed to come in contact with water, and for convenience it may be cut

into lengths of about 15 inches and allowed to stand in pure alcohol. For closing the abdominal wound there is nothing better than silver wire for the deep, and carbolyzed horse-hair for the superficial sutures. Great care should be taken when closing the wound, to have the divided structures carefully coapted, while at the same time avoiding the inclosure of any muscular tissue—as advised by Dr. Goodell. By attention to this last point we avoid suppuration in the track of the sutures, and save the patient a great deal of suffering. There can be no advantage from effecting union between the recti muscles. It cannot possibly strengthen the abdominal wall, and must interfere with the proper action of these muscles.

In removing the silver sutures cut the wire close to the skin, with the blades of the scissors lengthwise of the body. In this way, pain and injury of the tissues in the track of the wire are avoided. In all my operations I use horse-hair for the superficial sutures, and never, in any instance, has it slipped or caused the slightest irritation. As to the abdominal wound, there is much need for good judgment in selecting the best place and mode of making the incision. It is most important to confine the wound, as nearly as may be, to the median line midway between the umbilicus and the pubis. In no case should the incision be extended toward the pubis nearer than one and a half inches. The reason for this is that the lower parts of the abdominal wall are the most important for suspension of the bowels, and also because the ligamentous structures of that part, when once divided, are difficult to coapt and retain in juxtaposition till union takes place. A small incision of 1½ to 2½ inches is all that is needed in most cases of ovariectomy or removal of the uterine appendages, and when this wound is properly made, it unites perfectly and becomes almost obliterated after a few months. The abdominal incision should be made in the median line, so as to divide the sheath of the recti muscles without cutting a single muscular fibre, for the reasons already given. The division of the skin and adipose tissue should be made at one stroke of the scalpel; it is worse than mere waste of time to divide the structures upon a director layer by layer; it is a bungling way to operate, and leaves the edges of the wound in such a state as to interfere with primary union. Care is needed in entering the peritoneal cavity; but be

sure you are in the cavity before proceeding further with your operation; I have seen more than one operator attempt to enucleate the cyst before the cavity had been reached.

In ovariectomy or spaying, having reached the pedicle, it should be ligated in small segments, taking care to avoid wounding any vessel, and, when possible, ligating the larger vessels by themselves—use the linen thread, tie firmly and cut off short—you need not fear hemorrhage. Always divide the distal end of the pedicle with the scissors, and at least $\frac{1}{4}$ of an inch from the ligature. I need not refer to the importance of thoroughly cleansing the cavity, and introducing a drainage tube when necessary, or a piece of carbolized lint. It is not advisable to allow a drainage tube to remain longer than 36 hours.

We have already referred to the closure of the wound, and therefore speak of external supports. I advise the use of carbolized gauze to the wound, a pad of six or seven thicknesses, three inches wide, placed on the wound, and kept in place by two or three straps of rubber plaster, not more than ten inches long. I allow no other dressing, except in those cases where the tumor removed was of enormous size and the parieties flabby, when an abdominal bandage is applied for 24 or 36 hours. Bandages are of no use, they greatly inconvenience the patient, and interfere with the use of hot water fomentations, which are of great comfort and service in almost all cases for the relief of pain and arrest of threatened inflammatory action. Another point is, that I allow my patients to move in the bed, so as to secure the most comfortable position. If the vessels are properly secured there is no danger of hemorrhage, and the relief from a constrained position, long maintained, is of great value in securing nerve and muscular rest. I also believe such movement favors the restoration of the natural position of the bowels, which sometimes become deranged during the operation. Anyway, I have never seen any ill effects from such movements.

With regard to removal of uterine fibroids, I have been led to vary the operation a good deal. When the growth is large, I think it well to divide the mass in a vertical line, having, of course, constricted the pedicle to prevent bleeding, and then having enucleated the growths, I form the stump of the uterine tissue only, making the V incision,

referred to in a former paper upon this subject. This mode of forming the pedicle has been used by myself for some years; yet inasmuch as Auguste Martin has adopted the same procedure, I am unable to say which of us is entitled to priority. One great advantage in thus operating is that a pedicle can always be secured, and the vascular connection of the flaps with the pelvic circulation need not be completely cut off. By this procedure the roof of the pelvis is maintained for the support of the abdominal viscera. The quilting, or shoemakers' stitch, used by me to coapt the flaps, suffices to control all hemorrhage after the ligation of the uterine arteries. The advantage of this mode of dealing with the pedicle requires no special pointing out. Another thing to which I would refer, is the value of linseed tea enemata; they greatly facilitate the passage of flatus, and give much comfort to the patient, while they are valuable for the sustentation of the patient at a time when but little nourishment can be administered by the mouth. The value of hot water fomentations in threatened peritonitis and cellulitis, is worthy of more attention than is generally supposed to be necessary. To be useful, however, they must be efficiently applied, and here I would say, trust no one to do the work without you have seen that they can do it well.

As to medicinal treatment, I hold but little to it. Aconite in solution, in two or three drop doses every four hours, is of some value when the pulse is wiry and quick, and the skin hot and dry. For the distress arising from flatulence, I have found caraway tea frequently do good service. When possible, avoid using the catheter; allow the patient to pass her water voluntarily.

There are many points connected with uterine ovarian operations which I have not alluded to, but have briefly referred to some things that I deem to be original, and to others that, perhaps, are not generally known. My main object, however, has been to elicit a discussion, and if in this respect my hopes are realized, I shall be satisfied.

An interesting discussion followed upon the reading of the paper, a report of which will appear in the "Transactions of the Canada Medical Association."

THE London *Lancet* will be edited by Dr. Wakley, nephew of the late editor.

TRIGGER FINGER.

BY A. M'PHEDRAN, M.B., TORONTO,

Physician to the Hospital for Sick Children.

A. P., æt. 38, employed in a wholesale shoe establishment, in which he operated a machine requiring considerable pressure to be made by the fleshy part of the thumb of the left hand. His history is good, not rheumatic. During the early part of last summer he found there was some pain and stiffness in the movements of the thumb. This increased, and when I saw him a few weeks after the symptoms first appeared, the last phalanx was arrested in partial flexion, on increasing the effort the impediment suddenly gave way, and flexion was completed with a penknife-like "snap," accompanied by sharp pain. Exactly similar symptoms were produced by extension. The pain was referred to the anterior surface of the metacarpophalangeal articulation, and pressure over the long flexor tendon at this point caused sharp pain, but no nodule or other abnormality could be found. This condition was of much annoyance to him as besides interfering with his work, it was frequently being flexed by coming into contact with objects, and at night he was often wakened by the pain. He was advised to wear a leather splint to keep it in a state of extension; this was to be removed night and morning and friction and passive motion resorted to freely. With the exception of a little stiffness he recovered completely some time ago.

This affection is a rare one; the only description of it that I have seen is in the proceedings of the New York Neurological Society,* which came under my notice some time after I had seen this case. In this Dr. Geo. W. Jacoby records two cases, and refers to several published in Europe. He collected altogether 33 cases, two-thirds of which occurred in females. The thumb is affected oftener than any one of the fingers. Sometimes extension only is interfered with. The condition has to be distinguished from paralysis and spasm of muscles and from rupture of tendons, all of which may lead to sudden extension after flexion or *vice versa*. In almost all the cases recorded, as in all nodule very painful on pressure, was found adherent to the flexor tendon near the

metacarpo-phalangeal articulation, and to it are to be attributed all the phenomena. No such nodule could be found in the case given above, though it was carefully sought for. The etiology is uncertain; in the majority, as in this case, it is possibly traumatic. Rheumatism may be a cause in some. Possibly the cause may be in the articulation in some cases.

Since writing the above, five additional cases have been published in the Proceedings of the N. Y. Surgical Society, by Dr. Abbe (*Medical News*, Dec. 4), and a very interesting selection on the "Mechanism of Trigger Finger," by Dr. Steintal, of Heidelberg, is given in the *Annals of Surgery* for November.

Correspondence.

To the Editor of the CANADA LANCET.

SIR,—The ex-president of the College of Physicians and Surgeons of Ontario, on retiring, criticized severely the utility of the Council. A committee investigated the matter and found the charges groundless. Here the matter ended. This is unfortunate. The committee surely could not have been possessed of some of the facts of the case, or their finding would have been modified. They certainly had reason to congratulate themselves that now there is but one licensing body, but there is abundant evidence that the examinations of the Council are too easy and not sufficiently practical.

As to the first indictment, that a man should become a matriculant of the College, it is deemed sufficient that his literary education should not exceed that required for third class teachers' certificates, with Latin; the easiest examination in the High School course. Yet, easy as this appears to be, the Council accepts men whose marks in Latin would not entitle them to third class certificates. Moreover, some young men who had hard labor for years to pass this matriculation (?) have obtained a license in two years and six months, without any difficulty.

A large number of third year students wrote for the license at the last examination, and not one failed, *i.e.*, two and a half years after they registered their names as medical students, they received a license.

A practitioner licensed in April, '86, during his

*Philadelphia *Medical News*, June 10th, 1886.

30 months' pupilage, managed to teach in Provincial High Schools 13 months, spend some time in the civil service in Ottawa, and teach night school while in Toronto. Another licentiate of '86, who neither possessed nor had access to final books till after Jan. 1st, 1886, passed the final examination in April, with honors, in four or five subjects. Several men engaged in teaching school from 9 a.m. till 4 p.m., every day but Saturdays, who do not neglect their schools and accompanying night exercises, pass easily in three and a half years, *i.e.*, four sessions of six months each, which, from the very nature of things, they cannot possibly attend. It may be said that it is no concern of the Council, where a man obtains his information or how long it takes him to get it; but surely it should take average men longer than two and a half years to acquire information enough in medicine and surgery, to have permission to tamper with men's lives.

In the second place, the final examination is altogether unpractical. Candidates are not asked to diagnose cases in medicine or surgery. Skill in palpation, auscultation or percussion is not looked for. No operation on a cadaver or practical device in minor surgery is expected. Physical skill is ignored. Hospital work is useless to candidates at the Council's final, and hence is neglected.

If I dared to trespass further on your valuable space, I could give instances of blunders made in the hospital theatres and the dispensaries by some of our best men; and when such is the case, what would likely happen in the practice of those who neglect their opportunities for experience?

Yours, etc.,

G. R. CRUICKSHANK.

MEDICAL REGISTRATION IN ONTARIO.

To the Editor of THE CANADA LANCET.

SIR,—One of the important question, if not the most important, that will engage the attention of the Medical Council at its next meeting, will be that of registration of English practitioners. Hitherto the only requisite has been the payment of the registration fee. But now, it is proposed to change all that, and compel all applicants for registration to undergo the examinations of the Council.

It is instructive, in view of this proposed

change, to contrast the action of the profession in the United Kingdom, with the proposals of the Ontario Council. And in order to do this I may give a summary of the provisions of the recent Medical Act which comes into force next June, in so far as they affect colonial practitioners.

Under this Act, the right of registration in the old country, which Colonial Universities and qualifying boards have all along claimed as due to their standard of medical graduation, is granted on the following conditions:

(1) "That the applicant holds some medical diploma or diplomas granted to him in a British possession to which this act applies, and that he is by law entitled to practice medicine, surgery and midwifery in such British possession. Then, on application to the registrar of the General Council, and on payment of a fee not exceeding five pounds, he shall be entitled, *without examination* in the United Kingdom, to registration as a colonial practitioner.

(2) "That the diploma or diplomas was or were granted to him at a time when he was not domiciled in the United Kingdom, or in the course of a period of not less than five years, during the whole of which he resided out of the United Kingdom."

The condition "in a British possession to which this act applies" is defined in the Act, as being a colony where equal privileges are granted to English practitioners. In view of this concession on the part of the home authorities it is difficult to find a reason for the proposed action of the Ontario Council. It has been suggested that the principal reason for passing this regulation is the fact that many students of medicine, in the different parts of Canada, avoid the examinations of the Council by going to the old country; and on their return, claim registration in virtue of their British qualifications, with consequent loss of fees to the qualifying body here. But there are higher considerations than fees. Surely the "National Policy" has not extended to the practice of medicine. Are the ailments of the Canadian public to be "protected" as against the skill of an English practitioner, in favor of those who have paid the fees of the Medical Council? If so, when the public finds this out, short work will be made of the privileges of the College of Physicians and Surgeons of Ontario.

It certainly cannot be argued that the condi-

tions upon which licenses are granted in Great Britain render it necessary to hold examinations in Canada in order to protect the public against incompetent practitioners. It is true that it is said that some who failed to pass the examinations of the Council here, have gone to Edinburgh and obtained a license there. This may be perfectly true. On the same ground exactly it might be argued that the examinations of the Council here are too easy because many men, who have failed to pass the examinations of the Universities, have succeeded in passing before the Council. These things are simply the accidents of examinations and prove nothing. To those who know how much practical work is needed to obtain a license in Great Britain as compared with Ontario, the idea of holding further examinations here, on British licentiates, is a little absurd. If the reason for the proposed change be that when students go to the old country, the fees are lost to the Council without any real advantage to the student, owing to the shortness of the time he spends there; then a much more dignified way out of the difficulty would be to refuse registration to such students, unless they have spent one or more years in one of the medical schools of Great Britain, and have obtained a creditable diploma. To shut the door in the face of the English practitioner is rather a heroic remedy for the small evil of losing student's fees! If Canada possessed the advantages of the great medical schools of Edinburgh and London, and exacted a much higher standard of medical knowledge than obtains in Great Britain, then we would have some excuse for being exclusive. We possess neither the one nor the other, and now, that equal rights can be secured to the colonial practitioner, by making registration in England and the colonies reciprocal, it is neither dignified nor good policy to enact prohibitory laws.

Yours, etc.,

D. E. J.

Toronto, Dec. 5th, 1886.

RE DOVER'S POWDER.

To the Editor of the CANADA LANCET.

SIR,—I notice in the CANADA LANCET for Nov., an article from *The Asclepiad*, on Dover's Powders. I have in my library a work, entitled, "The Ancient Physician's Legacy to his Country," by Thos.

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Dover, M.B., 1733, in which, under the treatment of gout, he gives the following prescription:—"Take opium, one ounce; saltpetre and tartar vitriolated, each four ounces; *ipocacuana*, one ounce; *liquorish*, one ounce. Put the saltpetre and tartar into a red-hot mortar, stirring them with a spoon till they have done flaming. Then powder them very fine; after that, slice in your opium; grind these into a powder, and then mix the other powders with these. Dose: from forty to sixty, or seventy grains." Is not this the original Dover's Powder? Judging from his book, Thomas Dover, M.B., was an arrant humbug.

Yours truly,

WM. J. ALMON, M.D.

Halifax, N.S., Nov. 28, '86.

Reports of Societies.

CHATHAM MEDICAL AND SURGICAL SOCIETY.

The monthly meeting of this society was held November 3rd, Dr. J. P. Rutherford, president, in the chair.

Dr. Tye read a carefully prepared paper on The Differential Diagnosis of Hysteria from Diseases of the Brain. He narrated a couple of cases where, after a thorough examination by two or more medical men, hysteria was diagnosed in each case; and yet, within a few days, one patient died of an uncertain brain disease and the other of tubercular meningitis. He quoted Gowers to the effect that hysteria simulated nearly every organic brain disease. Dr. Grassett, of Montpelier University, France, in "Brain" for January, 1884, advances the theory that hysteria is a symptom of the tubercular diathesis, and that attacks of each may alternate, one with the other. The reader of the paper has noticed this in many cases, and his attention was drawn to it in the above journal. In grave and obscure cases we are justified in diagnosing the more serious malady; or, at least, in warning them that more serious symptoms may appear in the future. Hysterical pyrosis is generally fugitive, hence a continuous fever for some days, favors a lesion. The coma due to hysteria must be diagnosed by the age, sex, absence of fever, ease or difficulty in deglutition, and the former and present history of the patient. Rapid

and the Cheyne-Stokes form of respiration may occur in hysteria, and especially in first attacks; but are present only in the last stages of grave organic diseases. In hysterical hemiplegia, the upper and lower extremities are seldom affected alike, and the face is never involved. Where there is contracture in hysteria, it is more marked, less resisting, and more irregular than in cases of true paralysis.

The skin and tendon reflexes and the electrical reactions are preserved in hysteria. In the paralysis due to hysteria, the wasting is due to disease. Hemi-anesthesia, without loss of motion, is almost always hysterical. Gowers says, "In conclusion, it must never be forgotten that many organic diseases of the brain produce hysteria. In any case apparently hysterical, the slightest symptom of organic disease is of absolute diagnostic significance, and until the absence of any symptoms of that kind, no other symptoms nor former history should be allowed to bias the observer's mind." In a large number of cases, attention to this rule will dispel all difficulty.

December 3rd, Dr. J. P. Rutherford, president, in the chair.

Drs. McKeough and Hall reported cases, showing the necessity for, and the value of post-mortem examinations. Dr. McKeough's case was that of a young man, *æt.* 26, who had always been healthy, till about six months before death. The last few months of his life, he complained of malaise, and vague pains through the body. Some weeks before his death he was confined to his bed, with what seemed to be a mild attack of typhoid fever. While convalescing from this, he got up from a lounge to do some little thing, and, on returning to the couch, complained of pain over the heart, turned blue, and in a few minutes was dead. The heart was examined the day before death, and no enlargement or lesion was discovered. The urine contained no albumen, but deposited copiously of urates. On post-mortem examination, the pericardium was found filled with partially clotted blood, and a rupture existed in the anterior wall of the right ventricle. The cavity of the right ventricle was normal in size, but its walls were as thin and friable as blotting-paper. His death was so entirely unexpected, that a post-mortem was asked for.

Dr. Hall's case was that of a baker, *æt.* 52, of temperate habits and free from any syphilitic taint. He applied for advice about four weeks before his death, complaining of not feeling well, of constipation, and a slight cough. At this time he was dull, and very slow in comprehending questions. Pulse rapid, wiry and irregular; temp. 97.5° F. Pupils contracted, but even and responsive to light. He grew gradually weaker, and on rising to walk, would stagger and have to steady himself before starting. Sensation was impaired, and the skin and tendon reflexes lost. The grip of the hand was weak, but both were equally strong. Respirations 10-14 per minute. The temperature rose to normal two days before death. On post-mortem examination, general softening of the entire brain was found, together with an abscess cavity in the right occipital lobe, and an excessive quantity of ventricular fluid.

The President reported two cases of poisoning, in a man and his wife, from eating head-cheese. The symptoms set in about three hours after partaking of it, and consisted of violent vomiting, followed by purging. The general opinion was that the meat had undergone some fermentative change, either before or after its manufacture.

Dr. Backus read a paper on Chronic Constipation, dealing with its causes, results, and treatment. All present joined in the discussion following it, and in the main agreed that more was to be hoped for from hygiene, diet, kneading of the abdomen, enemata, and regularity in going to stool, than from the continuous use of medicine.

MEDICO-CHIRURGICAL SOCIETY, MONTREAL.

Regular meeting held 3rd December, 1886. Dr. Cameron in the chair.

Dr. Stewart exhibited a patient with glandular enlargement or Hodgkins' disease; the blood was deteriorated, red corpuscles were about 1 to 20 of white. Treatment in many cases was successful. Billroth uses large doses of arsenic.

Dr. Bell said he had seen a number of these cases, and while some of them died in a few months, others lived for a long time; in some cases complete recovery has obtained.

Dr. Mills said recent investigation tended to

show that the red corpuscles were produced by the lymphatic glands; the case now spoken of tended to confirm this view.

Dr. A. L. Smith exhibited a case of psoriasis, where the ordinary treatment and chrysophanic acid failed to subdue it, but which rapidly yielded to anti-syphilitic treatment.

Dr. Shepherd exhibited a lad, about 18 years of age, who is the subject of leprosy; he is from Trinidad, where there is a great deal of leprosy, but none in his family. The disease first made its appearance about six years ago. There were well defined areas of anesthesia, especially on anterior aspect of both thighs. There were many tubercles, and the face and state of the fingers (especially) were markedly characteristic of the dread disease.

Dr. S. also showed specimens of cancer of the pylorus, and of a heart that extended three inches over the right side of the median line. The right auricle held $\frac{3}{4}$ xvij. and right ventricle $\frac{3}{4}$ x., while the left heart was but slightly dilated. The man was the subject of acute tuberculosis of the lungs and tubercular disease of kidneys. There was no valvular incompetency, and it was surmised that the enlargement was due to the lung trouble.

Dr. W. Gardner exhibited the ovaries of two patients, one aged 28, where one ovary was as large as a filbert and the other slightly enlarged. The other specimens were from a lady aged 38 years, the subject of pelvic distress and menorrhagia. Both ovaries were atrophied.

Dr. Trenholme was opposed to spaying in cases similar to the last mentioned, inasmuch as the patient was 38 years old, has lost much blood, and the functional activity of the ovaries had subsided. Patients who lose much blood at the menstrual periods, generally reach the climacteric period early. In a very similar case under his care, the patient ceased to menstruate before she was 40, had no more hemorrhages, and was now quite well.

Dr. Mills read a very interesting paper on the "Causation of heart-beat." It is not possible to give a very satisfactory summary of this paper. He regards intra-cardiac pressure as the chief factor of the cardiac action. Intra-cardiac nerve-cells are not essential to action of the heart, *e. g.*, in some of the lower grades of animal life. The heart's action is due to—1st. Inherent contrac-

tility of the muscular cell. 2nd. To intra-cardiac pressure. 3rd. To nutrition of the cells under control of the nerves. It has also been noted that the influence of the nerve force becomes more decided as the scale of organization attains a higher grade.

Dr. Shepherd gave a brief but interesting report of a case of suture of the ulnar nerve. It was dissected out from its cicatricial adhesions, the ends freshened and sutured together with most satisfactory results, sensation being restored in 24 hours and subsequently motion also.

Dr. Roddick related a case of suture of the sciatic nerve, some two years ago. The results in this case were also very satisfactory.

MICHIGAN STATE BOARD OF HEALTH.

A sanitary convention, under the auspices of the State Board of Health, was held Nov. 18 and 19. We give abstracts of a few of the papers.

Dr. J. P. Stoddard, of Muskegon, read a paper on "Injuries of Every-day Drug-taking." He said the habit of taking drugs and nostrums was beyond comprehension. It partly came from mothers dosing babies with soothing syrup, hive syrup, paregoric, worm lozenges, etc. Druggists and proprietary medicine companies distributed flaming bills, chromos and free samples of nostrums from house to house. The prevention was to educate the people in the injurious effects of drugs. There should be less medicine taken, and only on the advice of a physician after a careful diagnosis. A doctor was not capable of prescribing for himself when ill, much less the laity, who knew nothing of the action of drugs.

Dr. D. Inglis, of Detroit, read a paper entitled "Alcohol: What Effect has it as Food, Medicine, or Poison?" In closing his remarks on alcohol as a medicine, he said: I should like to produce the continually accumulating evidence of the positive harm caused by such indiscriminate use of all kinds of alcoholic drinks, bitters, and tonics. I should like, even more carefully, to define the conditions in which alcohol ought to be used than I have here done. I have only time to urge that we ought, in all cases to let alcoholic liquors be the last and not the first, remedy; that we ought to give alcohol in definite and known doses, and

only during such time as the drug is required, and to make it our business to see that its use is then suspended, just as we do in case of opium.

Dr. J. Avery, of Greenville, President, read a paper on the subject of "Pasteur and Protective Medicine." Dr. Avery told of Pasteur's parentage, his boyhood, his studies, and his first triumph as a chemist in discovering the left-handed polarizing tartaric acid. Pasteur, after this work, was made assistant professor of chemistry at Strasburg, where his first work was to prove the power of minute organisms to change or modify chemical affinity. He was then made dean of the faculty of science at Lille. Here he determined to devote a portion of his lectures to the study of fermentation. The prevailing theory of fermentation at this time, Pasteur could not accept. He experimented with milk, and discovered the lactic ferment. And soon after, in the same substance or some of its products, he found the butyric ferment. These two organisms he found to be entirely distinct. The lactic ferment required for its existence and multiplication, free oxygen or air; while the butyric ferment died when exposed to the atmosphere. Pasteur soon demonstrated that the special fermentation known as putrefaction is caused by a living organism belonging to the same class as the butyric ferment; and he also soon discovered the acetic acid ferment—the "*mycoderma aceti*." Pasteur's next work was to demonstrate that spontaneous generation was a myth; and he then discovered the germ which caused so much havoc among the silk worms of France and other countries. He demonstrated that the disease among the silk worms was contagious, and gave practical directions for its prevention which restored the silk industry to Europe. This work led him to the great work of his life,—the development of the theory of the parasitic origin of communicable diseases; and in this effort he took the disease known as anthrax or splenic fever, which was decimating the flocks of all Europe. He put a drop of splenic fever blood into sterilized yeast water; in a few hours it swarmed with myriads of bacteria. A drop of the first cultivation he put into a second flask containing the same kind of liquid, and the bacteria multiplied as before. This process he repeated 15 or 20 times, and by this means freed the initial drop of blood from any substance it might have carried with it. And

now, if a drop of this last cultivation is injected under the skin of a rabbit or a sheep, the animal dies with all the symptoms of idiopathic splenic fever." Pasteur had studied vaccination, and he now undertook to vaccinate for protection of animals against splenic fever. "Before the close of the year 1881, Pasteur had vaccinated 33,946 animals. In 1882, the number amounted to 399,102, including 47,000 oxen and 2,000 horses. In 1883, 100,000 were added to the list. In 1881, it was the common practice of farmers to vaccinate one-half of their herds and leave the other half unprotected. It was found at the close of the year, that the loss in the protected sheep was ten times less than in the unprotected, being 1 in 740 as against 1 in 78. In cows and oxen it was 14 times less. * * * "In pursuing his investigations of the splenic fever disease, Pasteur made some curious and interesting discoveries which are of practical value to sanitarians and all who are interested in preventing the spread of communicable diseases. * * * He found that an attenuated virus that could cause no harm to a guinea pig a year or a month or even a week old, would kill one just born. The weakened microbe could multiply itself in the blood of one so young; and a few drops of this pig's blood would kill one still older, and so on until the full virulence of the microbe was restored. * * * Exposed to the air, these germs become weakened or take on the form of spores, in which condition they will remain viable for years, and float in the air as minute particles of dust, until they find lodgment in the proper media for their development and multiplication. What is true of these germs, may also be true of the germs of diphtheria, scarlet fever, small-pox, typhoid fever, and other communicable diseases. In localities where these diseases have prevailed as epidemics, is it not quite possible their attenuated and viable germs are constantly floating in the air, ready to resume their active form whenever and wherever the conditions of climate, of poverty, of wretchedness, of filth, and of bad air, present themselves?" Dr. Avery closed his paper with a discussion of Pasteur's work in inoculating for hydrophobia.

Selected Articles.

RAPID DILATATION OF THE CERVIX FOR DYSMENORRHOEA AND STERILITY.

BY DR. GOODELL, PHILADELPHIA.

Our next patient is a woman, 28 years of age, who has been married some years and is sterile. Puberty occurred at the age of fourteen. She has always had dysmenorrhœa, the worst pain coming shortly before the flow begins. The flow is not very great and does not last longer than two days. We have here a case of stenosis or narrowing of the cervical canal. This is partly congenital and partly the result of ante flexion. The history of these cases is that when menstruation begins, the woman has pain. The womb gradually fills with blood, which cannot escape on account of the bend. As the fluid continues to accumulate in the uterus, the pain becomes excessive. The distention straightens the canal, and the blood escapes, when there is relief to the pain for a time. After the womb is empty, the cervix resumes its bent position, and the same process of filling and of emptying is again gone through with.

By far the best operation for the relief of this condition is forcible dilatation. Formerly, after its introduction by Dr. Marion Sims, to whom we owe pretty much all that we know in gynæcology (for he gave us the hints which have since been developed), what is termed the bloody operation was extensively employed. The loss of life following this operation was very great, and the death of a patient after an operation for the relief of a condition of this kind is a serious matter. Some years ago a lady came to me with severe dysmenorrhœa. She was an active and valuable member of society. When the menses came on she was compelled to go to bed and take large doses of opium, and for seven or ten days of each month she was unable to do anything. This condition preyed upon her constitution, and her health began to fail, and she was anxious to be cured. I performed the posterior incision. This was before we knew as much about septic diseases as we do now. In this case, septicæmia set in and the patient died on the ninth day. If the operation had not been performed, the lady might have lived indefinitely, so far as the dysmenorrhœa was concerned. This sad experience led me to give up the posterior incision. Then there began to appear in the journals reports of deaths following this operation. One physician stated that he knew of at least fifteen deaths following the posterior incision that had never been reported. After thoroughly considering the matter, it seemed to me that rapid dilatation would be a safer and better method.

I do not mean to say that I am the author of the operation. It had been suggested before this by Ellenger, of Germany, but the instrument which he employed was too weak to accomplish the desired object. The great advantage of his instrument was the parallel action of the blades. I modified his instrument somewhat, and made one with stronger blades which could not feather and which were roughened to prevent slipping. That there was much dissatisfaction with the old operation is shown by a little experience a few years ago. I read a paper before one of our societies on this subject, and mentioned the name of the instrument maker who made my dilator. There was at once a great demand for the instrument, and the manufacturer told me that he had to keep three men at work for over a year simply making these dilators. From the names of those who had sent for the instruments, I am satisfied that their results had not been satisfactory with the old plan of treatment. This is an operation which I can confidently recommend. I have now operated over two hundred and fifty times, and I have never had a serious result follow. In a few cases there has been a local peritonitis, but not of a severe character.

I used to do this operation without antiseptic precautions. I now, however, always use antiseptics. The other day I was called upon to perform the operation rather unexpectedly, and there was no carbolic acid or bichloride at hand. I sent for some vinegar, and employed this as I would any other antiseptic, for it is an excellent antiseptic. I wash the vagina by injecting a 1-2000 solution of the bichloride of mercury. Before beginning the operation I introduce a suppository containing one grain of the aqueous extract of opium, and by the time that the effect of the ether has passed off, the opiate will be beginning to act. I now introduce the speculum and bring the os into view. I catch the cervix with a strong tenaculum and introduce the slender dilator, and dilate to an extent sufficient to permit the entrance of the larger instrument. The stronger dilator is now passed and its blades slowly separated. I shall, if possible dilate to the extent of one and one-fourth inches. It is rare that I do not dilate more than one inch. You may ask: "Is there not danger of tearing the cervix in this operation?" There is some danger of tearing the cervix a little, and I have done this occasionally, but not very frequently. In the bloody operation, the whole thickness of the cervix was cut through posteriorly. Here a little lateral tear is all that takes place, and I have never seen it of sufficient extent to require a suture.

I have now slowly dilated the cervix to the desired extent, but there has been no tearing. I shall next syringe the vagina again with the bichloride solution, and pass some of it into the dilated

canal. To-morrow we shall begin and use injections, twice a day, of a 1-4000 solution. The suppositories will be repeated every two hours, as long as there is any soreness. Two or three are usually all that are needed. The patient will be kept in bed as long as any soreness remains. Eight and forty hours in bed is, as a rule enough. She will be advised to do no laborious work for a week, in order to avoid all danger of peritonitis. Treating patients in this way, I have had no serious trouble. The most troublesome case that I have had was in the wife of a physician. She had a uterine fibroid, and when the uterus is the seat of a fibroid tumor, it is particularly vulnerable. She also suffered severely from dysmenorrhœa, for which I thoroughly dilated the canal. This was followed by very severe uterine colic. Under the use of large doses of *asafoetida*, this was overcome. By large doses, I mean nine grains three times a day, three three-grain pills being given three times a day. This is a harmless remedy, and it certainly has, when given in large dose, a beneficial effect over nervous symptoms. It is of service in hysterical girls. If there are convulsions, overcome these with an emetic, and then saturate the system with *asafoetida*. The remedy cannot be given in an extemporaneous preparation on account of its taste, but should be given in sugar coated pills.

What is to prevent the cervical canal from shrinking and returning to its former condition, with a return of the dysmenorrhœa? The reason is, that the muscular fibres have been overstretched, and they will never return to their original condition, just as a rubber band which has been overstretched never returns to its former shortness.

—*Polyclinic.*

SUBCUTANEOUS INJECTIONS OF MERCURY IN SYPHILIS.

MR. J. ASHLEY BLOXAM (*Lancet*, August 21, 1886) recently delivered a lecture on the excellent results which he had obtained at the Lock Hospital and elsewhere in the treatment of syphilis by intra-muscular injections of a solution of the perchloride of mercury. The solution for injection contains six grains of the perchloride to the ounce of distilled water, and should be made fresh for each *séance*. Since he had adopted this method, now a period of some eighteen months, upwards of fifteen hundred cases had been treated with the best results. The sore generally begins to heal very promptly after one or two injections, the secondary symptoms are markedly modified, and after a course of treatment extending over a year, more or less, the patient is enabled to discontinue his attendance. Towards the latter end of the course of treatment the injections may be given less frequently, and, as a general rule, not more

than from eight to twelve grains of the perchloride are injected in all. It is undesirable to repeat the injections oftener than once a week, as otherwise salivation might be induced, and the quantity injected each time (one-third of a grain) is found to be quite sufficient until the next time. There are several advantages attending this method of exhibiting mercury. In the first instance, it is only necessary to see the patient once a week, when sufficient mercury is injected to last until the following week; secondly, salivation is not produced, as when the patient continued to take mercury for a whole week away from the supervision of his medical attendant; thirdly, the gastric derangements which are so apt to follow the administration of mercury by the mouth are by this means avoided; lastly, the ease and certainty of the administration, which enable the surgeon to do his own dispensing with a minimum of trouble. A little quinine is generally given during the course as a tonic, but no other form of mercury is administered.

The injection itself is a very simple operation, but certain rules have nevertheless to be observed in order to obviate any inconvenience which might otherwise result. An ordinary glass hypodermic syringe is used with a fine needle (the needle is apt to become very brittle from the action of the mercury on the steel, and requires to be replaced from time to time), containing twenty drops of the solution, equivalent to one-third of a grain of the perchloride. After filling the syringe, the needle is freed from adhering solutions by washing in order to avoid irritation in its track, and is then plunged deliberately into the muscular tissue of the buttock, selecting for this purpose the spot corresponding to the muscular mass of the *glutei* into the substance of which the injection is made. If this precaution be observed, no discomfort or abscess formation follows, the only solitary case in which this has occurred being attributable to the injection having been made into the areolar tissue over the trochanter. The pain of the injection is but slight and soon passes off. It is desirable that the patient should not take active exercise immediately after the injection, as it has been noticed that blood may be effused at the point of injection, giving rise to the sensation of a severe bruise of the part, which lasts for several days. The same effect has followed the puncture of a large vessel, but in any case the result is only transient, and disappears after the lapse of a few days. If for any reason the buttock be objected to as the site of the operation, the injection may be made into the trapezius muscle at a point two inches above the superior angle of the scapula, but the injection into the buttock is attended with less inconvenience.

Mr. Bloxam mentioned that his own opinions were strongly in favor of syphilis being bacillar in

origin, thus accounting for the specific action of mercury in the treatment of the disease. In support of this view, he alluded to the remarkable researches of Messrs. Eve and Lingard, whom he had furnished with blood and chancrous tissue from patients at the Lock Hospital, the subjects of syphilis.—*Therap. Gazette.*

DIAGNOSIS OF SCROTAL TUMORS.

In sarcocele of the testicle the tumor is usually hard and resistant, heavy, often nodular and irregular; painful; grows slowly; dull or flat on percussion. The inguinal canal is empty; no impulse on coughing; bowels unaffected; irreducible; no auscultatory sounds. Simple sarcocele is chronic orchitis. Both the epididymis and body of the gland are affected. The cord is usually thickened. Abscess of the organ may occur. It is caused usually by an injury, followed by inflammatory deposits.

Tubercular sarcocele is met with most frequently in early manhood, and may occur in any constitution; in the strong and robust as well as the weak and cachectic; and although often associated with tubercularization of other organs, it is common enough to find the tuberculous nidus in the epididymis, not as a sequence of gonorrhœal inflammation or some slight injury followed by inflammatory infiltration—as was formerly believed—but as a coincident. The progress is slow and insidious. The gland at first moderately enlarges with little or no pain, the hypertrophy being especially marked in the globus major. Presently the outline of the tumor becomes craggy or nodulated, and circles around the testicle from behind forwards in the form of a crescent. After several months, the adventitious tissue exceeds in size the testicle proper, and then it begins to soften at points and one or more abscesses burst and discharge a thin shreddy pus. The vas deferens is greatly enlarged.

In syphilitic sarcocele or gummata, the history of the patient guides us in the diagnosis. Also, we find that the body of the gland is usually the seat of the infiltration which takes place in the connective tissue between the tubuli seminiferi, the epididymis undergoing little if any enlargement. The cord and vas deferens are unaffected. There is little or no tenderness, and the peculiar sensation elicited by squeezing a healthy testicle is absent. The tunica albuginea is very greatly thickened. Hydrocele is a frequent complication and tapping is often required to establish a diagnosis.

Cystic tumors of the testis closely resemble hydrocele, and differ chiefly in being opaque instead of translucent. Aspiration should be practised before pronouncing positively upon their character.

Cancer of the testicle primarily invades the

body of the gland, and almost invariably assumes the encephaloid form. Most observers doubt the existence of other varieties of malignant disease in this organ. The development of the disease is rapid. The patient has a sensation of weight, pain and dragging in the testis, the scrotum becomes distended, reddish or purplish, and the superficial veins are seen to be enlarged. The skin adheres to the gland, ulceration occurs, fungus protrudes, the inguinal glands are secondarily involved, and the patient by this time presents the characteristic cancerous cachexy.—Dr. Steele, *Jour. Am. Med. Ass'n.*

CLASS-ROOM NOTES.

In subacute *pelvic peritonitis*, Prof. Parvin directed rest, iodide of potassium, blister to abdomen and persistent injections of hot water, if, after trial, they are found to be doing good.

Cocaine, in doses of gr. $\frac{1}{4}$ ter die, succeeded in controlling the *vomiting* of carcinoma of stomach after all other means had failed, in a case shown the class at Pennsylvania Hospital, by Dr. Meigs, recently.

"Never give opium or quinine to a person who has slight *aphasic symptoms*; it will tend to develop the disease."—Da Costa.

Injections of one per cent. solution of resorcin in *cystitis* have been found, by Prof. Bartholow, to be very beneficial, especially in those cases due to obstruction at the neck of the bladder by an enlarged prostate.

Besides the usual directions given as to diet, Prof. Da Costa prescribed the following, in *gastric ulcer* :—

R—Argenti oxidi gr. $\frac{1}{4}$
 Ext. belladonnæ gr. $\frac{1}{4}$
 Ft. Pilula. Sig.—Ter die.

In dressing a *fractured olecranon*, Prof. Brinton, instead of placing the arm in complete extension, as commonly taught, found that, by allowing a slight degree of flexion, you render the patient much more comfortable, give him greater ease, and do not materially interfere with the result desired.

A case of *purpura*, the patient a child about three years old, Prof. Da Costa treated as follows :

R—Ext. ergotæ fluid gtt. x.
 Elixir simplicis,
 Aquæ āā q.s.—M.
 Sig.—Ter die.

Dr. Neff, at a recent clinic, formulated the following comparatively simple treatment for *acute pleurisy*. Strap the affected side of the chest firmly with adhesive strips, having previously used dry cups over the part: thus you procure rest. Give

pulvis ipecac. et opii, in gr. iv doses, every four hours, for quiet and sleep; if more opiate be required, use morphine hypodermically.

Dr. Rex, in a case of *chronic bronchitis*, prescribed, at Jefferson Medical College Hospital, the following:—

R—Ammon. chlorid. grs. x.
 Vini ipecac. gtt. v.
 Tinct. hyoscyam. gtt. x.
 Syrup senegæ ℥ xl.
 Mist. glycyr. comp., q.s. ad f ʒ ij.—M.
 Sig.—To be taken at first every two hours, but afterward reduce to three times daily.

—*Coll. and Clin. Rec.*

A CANNULA FOR TAPPING.

BY JOHN S. MILLER, M.D., PHILADELPHIA, PA.

The frequent occlusion of the cannula by intestine or omentum, in the operation of tapping, has suggested the device shown in the accompanying cut. The stoppage generally occurs when about a pint of fluid has been withdrawn, and various manœuvres are resorted to—such as the endeavor to float away the obstruction by changing the patient's position, or the dangerous one of introducing a probe through the cannula—and generally without success.

The device to which reference has been made is a smaller and longer cannula, introduced into that already in position, in case there is a cessation of flow. It is blunt, and provided with two long fenestra. In the latter there are springs, which expand and push away the obstruction on emerging from the original cannula, and which are so solidly soldered as to offer no danger of breaking off in the abdominal cavity.

In reply to the query whether or not the gut can become incarcerated and wounded in the springs, it may be stated that in several operations no such accident has occurred, nor were efforts successful to bring such about upon the *recent* cadaver.

The instrument can be used with any trocar and cannula above calibre 16, French.—*Med. Rec.*

THE INVENTOR OF SACCHARINE.—A representative of the *American Analyst* called upon Dr. Con-

stantine Fahlberg, the inventor or discoverer of saccharine, the new coal tar sugar, and had a long talk with him about his new discovery.

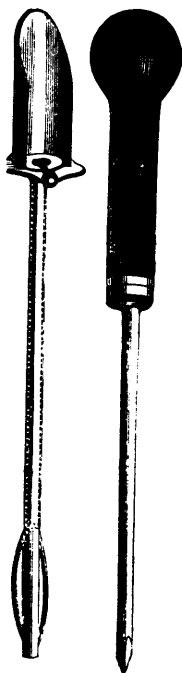
"How did I discover saccharine?" he said. "Well, it was partly by accident and partly by study. I had worked a long time upon the compound radicals and substitution products of coal tar, and had made a number of scientific discoveries that are, so far as I know, of no commercial value. One evening I was so interested in my laboratory that I forgot about supper until quite late, and then rushed off for a meal without stopping to wash my hands. I sat down broke a piece of bread, and put it to my lips. It tasted unspeakably sweet. I did not ask why it was so, probably because I thought it was some cake or sweetmeat. I rinsed my mouth with water and dried my mustache with my napkin, when, to my surprise, the napkin tasted sweeter than the bread. Then I was puzzled. I again raised my goblet, and, as fortune would have it, applied my mouth where my fingers had touched it before. The water seemed syrup. It flashed upon me that I was the cause of the singular universal sweetness, and I accordingly tasted the end of my thumb, and found that it surpassed any confectionary I had ever eaten. I saw the whole thing at a glance. I had discovered or made some coal tar substance which out-sugared sugar. I dropped my dinner and ran back to the labortory. There, in my excitement, I tasted the contents of every beaker and evaporating dish on the table. Luckily for me none contained any corrosive or poisonous liquid.

"One of them contained an impure solution of saccharine. On this I worked then for weeks and months until I had determined its chemical composition, its characteristics and reactions, and the best modes of making it scientifically and commercially.

"When I first published my researches, some people laughed as if it were a scientific joke, others, of a more sceptical turn, doubted the discovery and the discoverer, and still others proclaimed the work as being of no practical value.

"When the public first saw saccharine, however, everything changed. The entire press, European and American, described me and my sugar in a way that may have been edifying, but was simply amusing to me. And then came letters. My mail has run as high as sixty a day. People wanting samples of saccharine, my autograph, or my opinions on chemical problems, desiring to become my partner, to buy my discovery, to be my agent, to enter my laboratory, and the like.'

TREATMENT OF PAINFUL FISSURE OF THE ANUS.—J. T., a coachman, aged 56, had, for eighteen months, suffered such agonizing pain during defecation, that an enforced habit of constipation was established. From time to time he relieved



his bowels by enemata, first taking a large dose of laudanum to alleviate his sufferings. On examination with a speculum, I found a fissure, nearly an inch in length, with irregular edges and an indurated base. The sphincter was much hypertrophied, and contracted powerfully and spasmodically during the examination. I ordered a full dose of castor oil, with some rhubarb for its secondary astringent action, forbidding the customary laudanum. When this had operated, I had the bowel well washed out with an enema containing Condy's fluid. This done, I passed the speculum, and painted the fissure with a solution of chloride of zinc (twenty grains to one ounce); then introduced a piece of lint, smeared with boric ointment, the contraction of the sphincter keeping it in contact with the sore. The bowels were kept in check by pilula plumbi et opii. Liquid food only was allowed. The subsequent treatment consisted in the use of a powder (powdered boric acid, half a drachm; violet powder, one ounce), which was sprinkled freely on lint, and introduced into the anus to dry up any discharge, and the continued use of the boric ointment. By these means the fissure was entirely healed in six days, and there has been no return of the symptoms.

I have always found one application of chloride of zinc enough; it usually causes some smarting and uneasiness, but nothing more effectively purifies the ulcer or stimulates the reparative process. The introduction of cocaine robs the operative procedure of one drawback—the necessity of taking an anæsthetic; yet I may recommend a trial of this treatment, at least in the case of those who have an innate horror of anything approaching "cutting."—*Dr. Macgregor in Brit. Med. Jour.*

STIMULANTS AS RETARDING DIGESTION.—The extended consumption of one or the other of this class of substances points to the existence of some beneficial effect to be derived therefrom, although what this consists in it has been difficult to say, judging otherwise than subjectively. Sir William Roberts, of Manchester, has lately suggested an ingenious hypothesis, which offers a plausible explanation of their use. Man, in a state of nature, would derive his sustenance presumably from materials which, from their being raw, or at any rate imperfectly cooked, would be necessarily but slowly digested and assimilated. With civilized communities, on the contrary, everything is done with the view of facilitating digestion, by the removal of indigestible parts of the food, or by submitting them to processes which favor the action of the juices with which they are to be brought into contact. Under these circumstances, it is quite possible that digestion and assimilation may proceed at a speed not only unnecessary, but even disturbing, to the equilibrium of the organism, and provocative of waste. The employment of

alcohol, tea, coffee, etc., would tend to correct this undesirable acceleration of the assimilative processes; for Sir W. Roberts has proved, by a series of carefully conducted experiments, that their effect is powerfully to retard the action of the various digestive ferments on the foods; and it may be that the instinctive sense of the benefit thereby derived lies at the root of the yearning of all civilized nations for such substances. Again, some condiment, such as common salt, is added to restore sapidity to articles from which the salts have been removed in the process of cooking; and, taken in excess, it only throws extra work on the organs of excretion.—*Brit. Med. Jour.*

CROUPOUS TONSILLITIS VS. DIPHTHERIA.—In order to present more forcibly the points of contrast between this disease and true diphtheria, I have arranged them in the following form:

Croupous Tonsillitis.—1. Invasion abrupt. 2. Most marked general disturbance during the first two days; no tendency to asthenia. 3. Starts with a temperature of from 103° to 104.5° 4. Pulse full and rapid. 5. Membrane of yellowish color; edges sharply defined; limited to tonsils; does not bleed when detached; superficial; not very adherent; no tendency to reform after removal; appears early; does not spread. 6. Albuminuria rarely if ever present. 7. Reaches its height by the second day; by the fourth, the patient is generally convalescing. 8. Paralysis never follows as a sequela. 9. It is doubtful if it is ever contagious.

Diphtheria.—1. Much more often it is insidious. 2. Generally not much general disturbance before the third day, but after that marked tendency to asthenia. 3. Rarely high in the beginning, 100° to 101°, gradually rising till the fourth or fifth day. 4. When pulse rapid, it is feeble. 5. Color gray, sometimes greenish; shades off gradually; on uvula, soft palate, and pharynx, as well as the tonsils; bleeds readily, even without being detached; infiltrates the deeper tissues; adherent; strong tendency to reform after removal; may not be seen the first or even second day; spreads steadily. 6. Albuminuria rarely absent. 7. Most commonly does not reach its height before the fourth day. 8. Paralytic sequelæ quite common. 9. Frequently spreads by contagion.—*Dr. Holt, in New Jersey Med. Jour.*

THE USE OF ICE-WATER ENEMATA IN THE TREATMENT OF DIARRHŒA.—This means of treatment has frequently been adopted in cases of collapse occurring during the diarrhœa of young children at the Birmingham General Hospital. In cases outside of hospital practice, I have found this method not generally known. Being convinced of its utility, I am tempted to record my experience. Ice should be dissolved in water, and from two

to three ounces injected. The immediate effect is commonly a quiet sleep and improvement in the collapsed condition. Subsequently the effect upon the diarrhoea is also good, and it will rarely be found necessary to repeat the enema. Internal treatment may often have to be continued, but I have no doubt that the life of many a collapsed child has been saved in this way. No reference is to be found in Ringer's Therapeutics to this method of treatment, but doubtless it is known to many of the older practitioners, though its disuse has led to its being unknown to the younger members of the profession. It appears probable that it acts by an astringent effect on the loaded vessels of the intestines, and so at the same time warming the exterior of the body, and diminishing the materials for the intestinal flux.

It has sometimes been found expedient to give a few drops of brandy about the time of injection; but in my experience, no depression or bad effects have resulted.—*Brit. Med. Jour.*

MILK BOILED AND UNBOILED.—Dr. M. Reichmann, in *Deutsche Medical Zeitung*, draws the following conclusions from a number of elaborate experiments as to the digestibility of milk in the human stomach:

1. Boiled milk leaves the healthy stomach more rapidly than an equal quantity of unboiled milk.
2. The digestion of boiled milk is more rapidly accomplished than that of unboiled milk.
3. The coagulation of unboiled milk in the stomach is complete in five minutes.
4. The coagulation is not caused by the acid of the gastric juice, but by the influence of a special ferment (milk-curdling ferment).
5. The acidity of the gastric juice is at first due almost solely to lactic acid, and, later in the process of digestion, to the presence of hydrochloric acid.
6. Hydrochloric acid first appears in perceptible amount forty-five minutes after the ingestion of half a pint of milk.
7. For the first hour and a quarter after the ingestion of milk, the acidity gradually increases, and then decreases until the milk has entirely left the stomach.
8. The curds in case of digestion of boiled milk are much softer than in the case of uncooked milk.

HEADACHES IN DIAGNOSIS.—1. When pain is located between the ears at the occiput, below the lambdoidal suture. The gastrodigestive apparatus, the automatic centres of life, and the sexual organs will be the seat of disturbance. 2. When pain is located in the region of the parietal bone, from the coronal to the lambdoidal suture, and from the squamous suture to the superior outline of the parietal eminence. The duodenum and small intestines will be the seats of disturbance. 3. When pain is located in the forehead, from the coronal suture to the superciliary ridges below, and within the temporal ridges on either side.

The large intestines will be the seat of disturbance. 4. When pain is located below the superciliary ridges including upper eyelids, to the external angular processes on either side. The nasal passages and buccal cavity will be the seats of disturbance. 5. When pain is located in the temporal fossa, from the squamous suture to the zygoma below, and from the temporal ridge to the mastoid process. The brain and its meninges will be the seats of disturbance. 6. When pain is located at the vertex, from the coronal suture and two inches posterior to it in the median line, and two inches on either side of that extent. In the female, the uterus; and in the male, the bladder, will be the seat of disturbance.—*Medical World.*

ARSENIC IN THE TREATMENT OF ARTHRITIS DEFORMANS.—Two cases of anhrthritis deformans in which the symptoms were remarkably controlled during the exhibition of Fowler's Solution are described by Dr. Karl von Ruck. Both occurred in female subjects, the disease being in the one case strongly marked, in the other case attended by but moderate deformities of the fingers. Four minims of Liquor Arsenicalis were given after each meal; and the treatment was persevered in for months, with visible benefit. The writer calls attention to the etiological factor in anhrthritis deformans, especially in some cases, which supports the theory of a central cause situated in the nervous system. The development of the disease after nursing a dear relative until the fatal termination of a tedious illness, with the attendant anxiety and grief, the symmetrical development and progress of the disease, and the trophic disturbances, all point, in his opinion, in this direction. He believes this theory to be further confirmed by the results obtained from arsenic, which, he holds, always produces its therapeutic effects by its action upon the nerves and nerve centres.—*Therap. Gaz.*

A SOLVENT FOR SORDES.—Dr. A. D. MacGregor speaks highly of boric acid as a topical application in the unhealthy condition in which we frequently find the mouth, tongue, and teeth in severe cases of typhoid fever. He says, in the *British Medical Journal*: The mouth is hot; the lips dry, cracked, and glued to the sordes-covered teeth by inspissated mucus and saliva; the tongue dry, or even glazed or hard, brown or black, crusted with a fetid fur. Under these circumstances a pigment containing boric acid (30 grains), chlorate of potassium (20 grains), lemon-juice (5 fluidrachms), and glycerine (three fluidrachms), yields very comforting results. When the teeth are well rubbed with this, the sordes quickly and easily become detached; little harm will follow from the acid present. The boric acid attacks the masses of bacilli and bacteria, the chlorate of potassium cools and soothes the mucus membrane, the glycerine

and lemon-juice moisten the parts and aid the salivary secretion.—*Med. Rec.*

THE UTERINE APPENDAGES AGAIN.—The following appeared in *The Med. Press and Circular*: "A certain operator proposed to remove the "uterine appendages" from a patient under his care, and he asked a gentleman present if he would like to examine the patient, saying she had been suffering for years with an acute pain, that life was a burden, etc. The gentleman, struck by the full, round, rosy cheeks and red lips of the woman, first asked her how she slept at night. 'Oh, very well, thank you,' was the reply. 'You have no pain at night, then?' was the next question. 'Oh, no,' she answered. 'Have you pain all day long?' continued the questioner. 'Not all the day through,' she replied. 'Have you pain every day?' he went on. 'No, not every day,' was the answer. 'How often does the pain come on, then?' the gentleman continued. 'Oh, three or four days a month,' was the innocent reply, much to the amazement of the questioner. The would-be operator was heard to mutter something about 'getting any answer you like,' but it will be satisfactory to learn that the patient saved her ovaries on that occasion, at least.

URINE IN CHILDREN'S DISEASES.—Dr. Alexandra J. Eckert (*Vratch; Lond. Med. Rec.* Oct.), of St. Petersburg, states that she has made 1,500 analyses of urine in 104 children suffering from various diseases. Her conclusions are as follows: 1. All affections considerably disturbing nutrition of the child's system, and running their course in association with a high febrile state, give rise to albuminuria in an overwhelming majority of cases. 2. The characteristics of albuminuria are usually dependent upon the intensity of the morbid process, and the duration of the febrile period. 3. As a rule albumen rapidly disappears after abatement or cessation of fever. 4. Non-febrile affections, as well as those accompanied only by slight fleeting febrile movements, seldom give rise to albuminuria of any considerable degree; and when they cause albuminuria, it occurs only as a phenomenon of very short duration.

A REMARKABLE MOTHER.—A Boston physician was called out of a sound slumber the other night to answer the telephone. "Hello! what is it?" he asked, little pleased at the idea of leaving his comfortable bed. "Baby is crying, doctor, what shall I do?" came across the wire. "Oh! perhaps it's a pin," suggested the doctor, recognizing the voice of a young mother, one of his patients. "No," was the reply, "I'm sure it can't be that." "Perhaps he has the colic," returned the doctor, with well-simulated solicitude. "No, I don't

think so," replied the anxious mother, "he doesn't act that way." "Well, then, perhaps he is hungry," said the doctor, as a last resort. "Oh! I'll see," came across the wire; and then all was still. The doctor went back to bed and was soon asleep again. About half an hour afterwards he was again awakened by the violent ringing of the telephone bell. Jumping out of bed and placing the receiver to his ear, he was cheered by the following message: "You are right, doctor; baby was hungry."—*Chicago Living Church.*

HYDRASTIS CANADENSIS IN THE TREATMENT OF UTERINE CONGESTIONS, MENORRHAGIA, AND METRORRHAGIA.—J. Chéron (*La France Médicale*) writes enthusiastically with regard to the use of hydrastis in uterine disorders accompanied by congestions or hemorrhages. The dose is usually from fifteen to twenty drops of the tincture, given three or four times a day. A good formula is the following:

R—Tincturæ hydrastis,	iv. grs.
Elixir,	xx. grs.
Syrup,	xxx. grs.
Aquæ destillatæ,	cxx. grs. M.

To be taken in eight doses in the course of two days. Or berberine phosphate or hydrastin hydrochlorate may be given in doses of two centigrammes; four pills a day, one at each time. Hydrastin may be given in ten-centigramme doses, in pill, several times daily. This medicament, so very useful in the cases just mentioned, is also a remarkable modifier of atonic dyspepsias and catarrh of the stomach, which is not to be despised when we contrast this action with that which is exerted upon the alimentary canal by the ergot of rye.

SUBNITRATE OF BISMUTH AS A DRESSING.—1. Subnitrate of bismuth possesses antiseptic properties at least equal to those of iodoform. 2. No poisonous effects are to be apprehended as in the employment of iodoform. 3. The subnitrate of bismuth being a chemically indifferent substance, does not irritate the wounds; secretion is diminished. 4. Its action is very prolonged, though not vigorous, so that the dressings do not require to be frequently changed, and rest is insured for the wounds. 5. There is no action at a distance, nor does any specific effect attach to it. 6. It does not afford protection against erysipelas and other wound diseases, at least no more than iodoform. 7. It is no disinfectant, but as an antiseptic it keeps the wounds pure. 8. All wounds capable of healing by first intention can do so when dressed with bismuth. 9. It also represents an excellent material for forming scabs under which epidermis can grow over the wound. Its use on granulating wounds has not, however, been sufficiently studied as yet.—*Annals of Surgery.*

DIPHTHERIA OF THE VAGINA.—Surgeon Jas. B. Clibborn, R.N. — Mrs. T., when attending her child, who was suffering from diphtheria, was scratched by him on her right wrist. Some days after a few isolated, inflamed vesicles appeared on the wrist, which implicated the glands at the bend of the elbow and axilla. There was no pyrexia, and the throat was not affected. The wrist soon healed under treatment, and the inflammation in the glands subsided, when a fresh crop of vesicles appeared around the nipples of both breasts; there was still no rise in temperature, and the patient complained of little inconvenience beyond weakness and general malaise. The latter crop of vesicles went away as rapidly as those on the wrist, but the patient complained of weakness, daily increasing; she also stated that there was a fetid discharge from the vagina. On making a vaginal examination the mucous membrane was found to be greatly inflamed, discharging pus and covered in parts with well-developed shreds of false membrane. The constitutional symptoms now rapidly developed, asthenia increased, and the patient suffered at times from delirium and delusions, and had one well-marked epileptiform convulsion. The urine contained a small quantity of albumen. The highest temperature taken only indicated 99.4°; the throat at no time presenting an inflamed appearance. The inflammation in the vagina daily increased, large shreds of false membrane, almost forming complete casts of the vagina, were discharged; asthenia was great; the pulse small and compressible; the pupils were frequently irregular, and responded feebly to light. About this period of the disease the patient (who was five months pregnant) was attacked with well marked labor pains, occurring at regular intervals. As it was considered that, should a miscarriage take place, the disease would extend to the uterus, with a probably fatal issue, very large doses of opium were given with a view of stopping the uterine contractions, which had the desired result after the patient had taken about five grains. Under treatment the discharge from the vagina became less and the development of false membrane decreased till about 10 days after its first appearance, when it had entirely disappeared. Convalescence rapidly took place, and she was subsequently delivered, of a living child with no bad results. *Treatment.*—Carbolic acid combined with quinine was given internally every three hours (each dose containing one minim carbolic acid, 10 minims glycerine, and one drachm tincture of quinine, in an ounce of water), the urine being carefully watched during its administration. Iodoform was applied locally with vaseline (a drachm to the ounce). When the vagina became affected, it was frequently washed out with a solution of permanganate of potash. Strips of lint soaked in iodoform and vaseline were introduced into the vagina and changed every

few hours. Stimulants and strong liquid food were given in large quantities when the asthenia was great.—*Lancet*,

SORE NIPPLES.—Dr. Wilson, of Glasgow, recommends the following for sore nipples:

R Plumb. nitrat. gr-x.xx.
Glycerini ʒj.

M. Apply after suckling, the nipples being washed before the child is again put to the breast.

Dr. Playfair recommends:

R Sulphurous acid ½ oz.
Glycerin of tannin ½ oz.
Water 1 oz.

M. Apply after suckling.

Dr. Barnes recommends:

R Liquor plumbi 1 dr.
Prepared calamine powder 1 dr.
Glycerini 1 dr.
M. Vaseline 7 dr.

Qr. Comp. Med. Sci.

SOLIDIFIED LINIMENTS.—Any one who has had to apply a liquid liniment to the chest, or any other part of the body in an upright position, will have experienced the difficulty in keeping the liniment in the palm of the hand until it is fairly brought in contact with the affected part. It is a matter of surprise that in the last edition of the Pharmacopœia liniments are retained in their liquid form. There is no difficulty in solidifying most liniments by the addition of some gelatinizing material, so as to enable them to be smeared over the affected part with some approach to definiteness of quantity and to the great convenience of the patient. Solidified liniments are not only more convenient of application, but are far more easy of transport.—*Lancet*.

REMOVAL OF SUPERFLUOUS HAIRS BY ELECTROLYSIS.—Mr. Startin gives (*Lancet*) the following as his method in the above operation—The application of the needle electrode cannot be made without more or less pain varying much in different patients, no matter how the sponge electrode is applied. I then, after a prick or two of the needle electrode, brush over the part a 5 per cent. solution of hydrochlorate of cocaine, with good result, almost invariably deadening the pain. In one or two instances I have had an anæsthetic administered, but I find this is seldom necessary, as the pain is slight. The operation can now be proceeded with. The negative needle electrode is plunged into the root of the hair for about one-sixteenth of an inch, and the positive electrode sponge is applied in the immediate neighbourhood. The needle should be kept in for about the space of five seconds, then the sponge electrode should

be removed and afterwards the needle electrode. To know that the operation is effectual the needle should produce slight frothing of the tissues. The hair destroyed can now be easily epilated with an ordinary pair of dressing forceps, and it should come out without the slightest adhesion. This operation applies more especially to hairs that are noticeable to the naked eye. Fine downy hairs can always be destroyed by the application of a properly made depilatory. A slight inflammation of temporary character occurs for an hour or two after the operation in the destroyed follicle; this can be controlled by the use of a soothing lotion. The operation, if carefully done with a battery in good working order, is invariably successful, especially if the hairs are few and of good size—from a quarter to half an inch long. If many hairs have to be removed, then several sittings will be required at intervals of about ten days. A hundred hairs can be removed at a sitting.

RHURARB FOR THREAD-WORMS IN CHILDREN.—

A practical note on this subject is made in *The Practitioner*, by Sidney Martin, M.D., M.R.C.P., London. All physicians recognize that the complete cure of thread-worms in children is often very difficult. While the ordinary methods used, such as rectal injections of salt and water, infusion of quassia, and other remedies, do good for a time, yet they often fail to relieve the attendant symptom of "worms"—symptoms usually very irregular, and in some cases severe, in character. In many cases, though the irritation about the anus is relieved by injections, the irregularity of the bowels, and the disturbance of sleep, remain the same. This is probably due to the fact that the habitat of the worms is higher up in the large intestine, where no remedy introduced by the rectum can reach them. In many cases Dr. Martin has found that rhubarb in small doses brings away large numbers of worms, and at the same time regulates the bowels; so that the use of injections may, in most cases, be dispensed with. The formula which he has found, most useful is as follows, varying slightly with the age of the child:

R. Tincturæ rhei m iij
Magnesii carbonatis gr. iij
Tincturæ zingiberis m j
Aquam ad ʒ j—Misce.

This is to be taken twice or three times daily, according to the effect on the bowels. Whether the rhubarb acts as a vermicide, or simply by "moving the worms on," he is unable to say.—*Virginia Med. Monthly*.

ARSENIC IN HÆMORRHAGIC MALARIAL FEVER.—

In the October number of the *Alabama Medical and Surgical Journal*—Dr. Benj. H. Riggs, of Selma, Ala., states that in his town there have recently been "quite a number" of cases of

hæmorrhagic malarial fever, and nearly all recovered. He refers to three cases which came under his observation—all white—which recovered *without any quinine whatever*; the main reliance was *arsenious acid*. He believes that arsenic arrests this blood-destroying process better than any other agent we have. In all of his cases, the hæmorrhage disappeared within twelve hours after beginning with arsenious acid, but the fever continued for some days in two of the cases, who were treated with an alkaline fever mixture and morphine hypodermically. The following is the formula he usually prescribes:

R. Acid arseniosi gr. ʒ.
Piperinæ gr. ij.
Pulv. Doveri gr. x.
Extract. hyoscyami gr. v.

Mix. Make five capsules.—Sig. One every three hours, according to age and other circumstances.

Of course, be careful to prevent arsenical poisoning.

THE ADMINISTRATION OF COD-LIVER OIL.—

Dr. W. Washburn, of New York City, writes that he has long been in the habit of administering cod-liver oil in milk to both infants and adults. Milk is taken in the mouth and held there, and the spoon is first dipped in milk and then the oil is poured into it. Just as the oil is taken into the mouth the milk should be swallowed, and then another sip of milk taken. Children, if interrupted in nursing, readily swallow a teaspoonful of oil, and then proceed with nursing as if nothing had happened. The oily nature of the milk seems completely to shield the mucous membrane of the mouth and throat from contact with the cod-liver oil.—*Medical Record*.

A NEW DISINFECTING COMPOUND

for purifying the atmosphere of the sick-room has just been presented to the Berlin Medical Society. Oils of rosemary, lavender, and thyme, in the proportion of 10, 2½, and 2½ parts respectively, are mixed with nitric acid in the proportion of 30 to 1½. The bottle should be shaken before using, and a sponge saturated with the compound and left to diffuse by evaporation. Simple as it is, the vapor of this compound is said to possess extraordinary properties in controlling the odors and effluvia of offensive and infectious disorders.—*Med. News*.

THE St. Louis Medical and Surgical Journal

says that for bruises there is nothing to compare with the tincture or a strong infusion of *capricum annuum* mixed with an equal bulk of mucilage of gum arabic, and with the addition of a few drops of glycerine. This should be painted all over the bruised surface with a camel's hair pencil and allowed to dry on, a second or third coating being

applied as soon as the first is dry. If done immediately after the injury is inflicted this treatment will almost invariably prevent the blackening of the bruised tissue. The same remedy has no equal in rheumatic, sore or stiff neck.

CAUSATION OF PNEUMONIA.—Henry B. Baker, M.D., at a meeting of the Michigan State Board of Health, gives the result of his observations in regard to the causation of pneumonia. He finds that the percentage of cases gradually increases as the temperature lowers, this he attributes, not so much to the lower temperature, as to the fact that air at low temperatures contains less moisture. Thus a cubic foot of air saturated with the vapor of water at 0° F. contains half a Troy gr., at 70° eight, and at 98°, 18.69 gr. Dry air would thus constantly take up an extra amount of moisture from the lungs, and an increased quantity of fluids must pass from the blood into the air-cells and air-passages in order to keep them in the normal moist condition, and as these fluids contain salts, such as chloride of sodium, which would not pass off with the expired air, it follows that the chloride of sodium will remain in the lungs and may prove a source of irritation. The writer points out that chloride of sodium disappears from the urine during pneumonia, and has been found by Beale in his analyses of the lungs and sputa of pneumonic patients. He thinks the exudation of the albuminous constituents of the blood-serum is favored by the presence of chloride of sodium on the principle of exosmosis; since, if a mixed solution of albumen and salt be placed in a dialyzing apparatus, the salt alone at first passes out leaving the albumen; but after the exterior liquid has become perceptibly saline, the albumen also begins to pass in appreciable quantity.

THE INFLUENCE OF FOREBODINGS IN DISEASE.—In the *Asclepiad*, January, 1886, Dr. B. W. Richardson, states that there are two kinds of forebodings—the fanciful and serious. False forebodings are presented by the persons fanciful and flighty natures, who are really found of contemplating risks, and who suggest anxiety one minute, and laugh at them a few minutes afterwards. These forebodings have no serious importance. True or serious forebodings emanate from persons who are firm and thoughtful, who as a rule keep to themselves what is on their minds until something like a crisis has been reached, when they come to a conclusion to which they adhere, by which they are much influenced. These forebodings are a critical disease and are bad, they have a direct effect on the physical powers; the heart's action is impaired, the digestion becomes affected, and there is a want of tone very much opposed to the restorative efforts. A wise plan is to take as little notice of these forebodings as possible, but to ridicule them is bad.

OTORRHOEA.—Dr. Brunetti of Venice, gives the case of a physician, aged forty years, who had suffered for thirty-five years from offensive otorrhœa. Tympanum was absent on both sides. The ossicles were present on both sides; on the left they were incompletely ankylosed. The auditory passage and middle ear were cleansed and iodoform and spirits vini recti employed; in two days the stench disappeared. For eleven days five-tenths per cent. solution sulphate zinc was used, then the iodoform again. In a month the vegetations in the tympanic cavity had disappeared; and patient was discharged with his hearing much improved.—*Med. Press.*

IODOL IN EAR DISEASES.—Dr. Stretter, who has used iodol, the new inodorous substitute for iodoform, in a large number of cases of ear disease, finds that in acute purulent inflammatory affections iodol applications rapidly produce marked benefit, but that in chronic inflammations of the middle ear it is generally quite useless, or at best no better than other more common methods of treatment.—*Lancet.*

PROF. ANTONIO CECI, of Genoa, has recently extirpated the spleen successfully. The patient was a servant girl, seventeen years of age. The spleen was enlarged to such an extent that it constituted one-fifteenth the entire weight of the body. This is the seventh splenectomy performed in Italy, and is the second successful case.—*Med. Herald.*

TREATMENT OF OZENA.—Dr. Malacrida, after cleansing the nostrils with a solution of chloride of sodium and drying the mucous membrane with pledgets of absorbent cotton, introduces a bit of cotton moistened with a few drops of the essential oil of turpentine. In a number of cases in which this method was employed, the disagreeable odor was almost immediately destroyed, and a permanent cure was obtained in less than a month.—*Med. Herald.*

CHARCOAL AND CAMPHOR IN CHRONIC ULCER.—A mixture of equal parts of camphor and animal charcoal is recommended by Barbocci as an application to prevent the offensive odor and remove the pain of old excavated ulcers. The camphor acts as a disinfectant, and the charcoal absorbs and destroys the offensive odors.—*British Medical Journal.*

SIR THOMAS WATSON AND SIR JAMES PAGET.—At the recent banquet of the British Medical Benevolent Fund, Dr. Broadbent, in proposing the health of the Chairman, Sir James Paget, applied to him the words Sir James himself had used of Sir Thomas Watson: "His knowledge was so vast, his goodness so great, and his example so elevating, that we all wished he might spend part of his immortality on earth."

PSOAS ABSCESS ; WHEN AND HOW TO OPEN IT.

—At a recent meeting of the British Medical Association, Mr. Edmund Owen read a paper on the above subject. Mr. Owen said there was no disease the treatment of which had derived a greater impetus from the introduction of antiseptics than psoas abscess. By antiseptics he did not mean the use of the spray. The spray was now cooling down in more senses than one, and the surgeon did not now have to look through a cloud of carbolic vapor at his patient. By the use of antiseptics, he meant antiseptics as used by the great masters in surgery, whether by Tait, Gamgee, Savory, or Lister. Twenty years ago every surgeon preferred to leave a psoas abscess alone, so long as it remained unopened. Stanley, writing forty years ago, said a psoas abscess might disappear. Could it? Mr. Owen said that in an extensive out-patient experience, extending over years, he had only seen one case in which, after a fusiform tumor had been detected ascending along the iliac fossa, he had seen it disappear. Aspiration was useless, for it refilled. When evacuation of the abscess was performed, it should be done thoroughly, and no useless temporizing measures made use of. During delay the pus would be burrowing out for itself an extensive ramifying cavity. A free anterior and posterior opening should be made, and the wound thoroughly drained. The sac should be washed out with a warm antiseptic lotion, and a drainage tube the size of a cedar pencil passed through. The wound should be covered with sublimate gauze, then some oakum placed over it and the dressings changed as seldom as possible. He had employed as the antiseptic lotion a warm solution of corrosive sublimate (1 in 1,000). He should, however, in future, discard the use of the sublimate, as he had had a case which died in four hours with black urine, due, he believed, to the absorption of the sublimate. Mr. Owen, in concluding, summed up his conclusions as follows :

1. Spontaneous absorption of psoas abscess is impracticable. Sooner or later it must be evacuated, either by nature or art, and the advantage is on the side of art.
2. The sac should be opened both in front and at the back, and irrigated. For a small abscess a single opening at the back might suffice.
3. Antiseptics should be employed.
4. The operator should bear in mind that pus might collect on the opposite side after evacuation of the abscess. If any rise of temperature take place, a second abscess should be suspected, and, if found, evacuated at once. Bilateral abscesses should be attacked simultaneously, as their cavities frequently communicate. In reply to a query from a member as to the source of his method, Mr. Owen replied that it was neither English, French, Scotch, nor Italian, but Welsh, thereby signifying

that the idea was his own, and that he had not borrowed it from any one.—*Medical Record.*

NIGHT PALSY.—Dr. W. E. Stevenson ("Practitioner"), contributes a short article on a special form of numbness of the extremities occurring, for the most part, during the night, and to which Weir Mitchell has given the name of night palsy. Dr. Ormerod's description is quoted as follows : "The symptoms are remarkably definite in character. They occur in women, usually about the climacteric period, and begin in the night. On waking, the patient has a feeling in the hands and arms (commonly on both sides) of numbness, deadness, pins-and-needles ; sometimes there is actual pain, severe enough to wake her. There is also loss of power, the hands and arms become useless, and she cannot hold things. This may so far predominate that the patient comes to be treated for a supposed paralysis. Sometimes also the patients say that the hands swell, the veins swell, etc., at the time. The symptoms pass off in a little time, and rubbing suggests itself as a natural remedy. But occasionally they manifest themselves in the day time also, and then principally when the patient sets about her ordinary work—washing, scrubbing, needlework, etc." The author has had several cases of the affection, and his observations agree, in the main, with the foregoing description. Though mostly seen in women at or near the climacteric age, it is occasionally met with in men, in whom it is likely to be more severe and obstinate. Some attribute it to anæmia, others to gastric disturbances. All of the author's patients recovered with rest, bromide of potassium, and galvanism.—*N. Y. Med. Jour.*

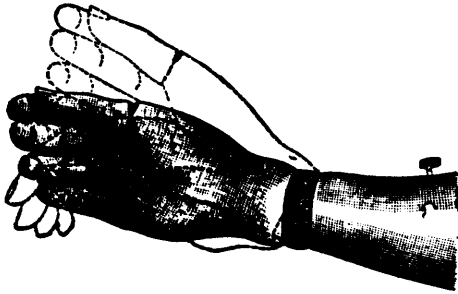
CORRELATION OF TONSILS AND GENITALS.—It has long been held by certain writers that the tonsils and genitals are in some way correlated. An opinion prevails that wasting of the testes may follow excision of these organs. At a recent meeting of the Hunterian Society, of London, Mr. Pierce Gould presented a man aged twenty-seven with genital absence of the tonsils, in whom the genitals were imperfectly developed and sexual desire absent. The man had a feminine appearance, and had neither beard nor moustache. The tonsils were represented by two small nodules between the pillars of the fauces. Mr. Gould held that there was no evidence for the popular belief in England that excision of the tonsils before puberty influenced virility, and he referred to a practice in Zanzibar of removing the tonsils from all male infants, which seems, in that country at any rate, to be without influence on the development of the testicles. It would be interesting to know of any genuine cases of failure of development of the sexual organs in persons who had been subjected to tonsillotomy. The tonsils were found normal

in two women in whom the ovaries were congenitally absent. It was the general opinion of those who took part in the discussion on Mr. Gould's case, that a relationship between the two organs had not been established.

Tonsillitis occurs with special frequency in adolescents, and in a recent Aberdeen thesis on this subject by Haig Brown, the author refers, without details, however, to the occasional atrophy of one testicle after removal of the corresponding tonsil.

An interesting point bearing on this question is the frequency with which acute tonsillitis occurs in newly married people. We have known the honeymoon interrupted in several instances by this painful affection, to which also Shepherd, of Montreal, has called attention, suggesting that it bears out the old idea of the intimate association of the tonsils with the genitals.—*Med. News.*

ARTIFICIAL HAND.—The accompanying cut represents an artificial arm with ball-and-socket wrist-joint, recently invented and manufactured by Geo. R. Fuller, successor to the late Dr. Bly, of Rochester, N.Y.



The improvement admits of placing the artificial hand in any position that can be attained with the natural hand, and is an important advance in the progress of prosthesis.

NEW OPERATION FOR FISTULA IN ANO.—Dr. Jos. M. Matthews, in *Progress*, advocates dilatation with laminaria tents of the fistulous tract, and subsequent bi-lateral division of its pyogenic membrane with Otis's improved urethrotome. He claims to have had good results. In fact he succeeded in curing such cases by this operation where the other means had failed.

SPEEDY CURE FOR GONORRHŒA.—Dr. Chas. C. Edson, *Chicago Medical Times*:—In reply to your question column I will give my three-day cure for gonorrhœa. R. Oil sandal wood; fl. ex. quillea sapo, aa \bar{z} iv. M. and shake. Add glycerine; aqua cinnamon, aa \bar{z} iij. M. Sig.—Teaspoonful four times a day.

R. Morphia sulph., gr. iii; muriate berberina,

gr. x; zinci sulphas, gr. viii; bismuth sub. nit., \bar{z} iv; aqua rosa, \bar{z} iv. M. Sig.—inject a small amount after each micturition. Keep the glans penis well covered with cloth so as to prevent the discharge from soiling the linen. This is a very necessary precaution for a speedy cure, as matter upon the clothing reinoculates and continues the disease indefinitely.

NITRATE OF SILVER STAIN.—Dip the fingers into a strong solution of cupric chloride. In about a minute the silver will be converted into chloride, and may then be washed off with hyposulphite of soda solution.—*Chemist and Druggist.*

NÆVUS.—Dr. W. J. Beatty (*British Medical Journal*) has cured eight cases of nævus, perfectly and painlessly, by painting the affected spot night and morning with liquor arsenicalis until ulceration took place. A cure is effected in from three to five weeks.

For acute rhinitis in its incipient stages, of all the remedies tried by Dr. Sajous, the following has given the best results. In the doctor's words, "It acts like magic":

R Morphine acetat gr. iv.
Bismuthi subnit.
Pulv. talc. aa \bar{z} j. M.
Fiant chartæ, xxx.

Sig.—Use as a snuff.

Dr. Sajous states that this will check a very bad cold, or coryza, sometimes with only one sniff of the powder.—*Med. Summary.*

CHILDREN are being subjected to rather heroic treatment in some sections this summer, if the advice of some of the writers in the medical journals is being followed. One of these, for instance, advises that: "if the baby does not thrive on fresh milk it should be boiled." Another, in an article on nursing bottles, says: "When the baby is done sucking it should be unscrewed and hung up."—*Med. Age.*

CITRIC ACID vs. NEOPLASMS.—Because of its destructive action upon morbid cells and indifference to healthy normal cells, this acid has been employed topically to destroy new growths till healthy tissue was reached, or has been injected at the edge of new growth to limit their growth previous to operation. It has also been douched over the wound after operation as a prophylactic measure.

MUST BE THE RIGHT PLACE.—Tramp.—"Is this a lying-in hospital, mister?"

Janitor.—"Yes, this is a lying-in hospital."

Tramp.—"Then I guess its the right place for me, for I've been lying out these three nights."—*Med. and Surg. Reporter.*

THE CANADA LANCET.

**A Monthly Journal of Medical and Surgical Science
Criticism and News.**

Communications solicited on all Medical and Scientific subjects, and also Reports of Cases occurring in practice. Advertisements inserted on the most liberal terms. All Letters and Communications to be addressed to the "Editor Canada Lancet. Toronto."

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*The LANCET has the largest circulation of any
Medical Journal in Canada.*

DIPHTHERIA.

The prevalence of this dreaded disease during the latter months of 1886 demands attention. Although nothing new has recently been recorded concerning it, yet were each physician to relate his experience, his method of treatment, and his percentage of success or failure, some advance might be made, not only in treatment, but in our knowledge of its etiology and prevention. Science has not yet furnished us a specific remedy, although many agents have been tried, and various methods adopted, which have been more or less successful in restraining its ravages, since Bretonneau, in 1826, first drew special attention to it, and named it Diphtheria. Not that it was unknown prior to his celebrated treatise, for it can be traced back, under various cognomens, to the time of Homer. Macrobius speaks of a virulent epidemic in Rome, A.D. 340. Aretius describes it, under the name of Egyptian or Syriac ulcer. Numerous epidemics are recorded, to which space forbids reference. Briefly, it has prevailed more or less from time immemorial, occasionally becoming so virulent, that it was denominated "the plague," and swept off thousands in various localities. We purpose making a very brief synopsis of what is, to some extent, settled, regarding it, and outlining the treatment which has generally proved most successful, and is usually adopted at the present time.

It is an acute specific contagious disease, with a period of incubation of from three to eight days,

and may occur in any locality and under every condition. It attacks all classes, rich and poor, well-nourished and ill-nourished, under any and every hygienic environment. Bad hygienic conditions augment its virulence, rendering it more fatal; but good hygienic surroundings do not afford exemption. Temperature has little or no influence, although it is usually more prevalent in autumn and winter than spring and summer. Geological formation, conditions of the earth's surface, hill or valley, moist or dry, hot or cold climates, have little if any effect on its prevalence. Diathesis does not appear to have any influence, although some think struma a predisposing cause. It is a constitutional disease, with local manifestations. Children are most liable, although adults are by no means exempt. Nursing children are seldom attacked. One attack does not protect, but subsequent attacks are usually milder. The duration of the attack is from ten to fifteen days, and indications of recovery or fatality are apparent in about seven days. Public institutions are said to be singularly free from attacks, and some races of people to be remarkably exempt, as well as some localities, even in the immediate neighborhood of those virulently attacked. It is often followed by insidious pneumonia, albuminuria, depression, nervous debility, paralysis (local and general), impairment of vision, dulness of hearing, etc. These may follow mild as well as severe attacks, immediately, or not for several weeks subsequent to apparent recovery. Of those affected by paralysis, only about 10% prove fatal.

Treatment, after innumerable experiments, has generally settled down to—1st. Best possible hygienic conditions, unlimited fresh air, saturated with moisture and antiseptics, such as sulphurous acid vapor, carbolic acid, etc.

2nd. Local treatment. Tr. ferri chloridi, with pot. chlorat., diluted with water; carbolic acid, with glycerine; or, Tr. iodi., frequently applied, has each many advocates. But we believe the first is most reliable and most generally used by men of large experience. It is not now considered necessary to apply topical remedies so strong as to injure the mucus membrane of the mouth, nor to use any force to remove the membranous exudation. When the nasal cavities are affected, syringing them with one of the above remedies, in dilute form, must frequently be resorted to; inha-

lation of steam containing carbolic acid is important, especially when the membranous exudation has extended into the larynx and trachea. Externally, poultices, Tr. iodine, spts. terebinth, etc., have usually been thought advantageous.

3rd. Constitutional treatment is sustaining from the beginning. Depressant remedies are inadmissible at any period. Stimulants are very important in severe attacks, when prostration is severe from the effects of an excess of poison in the blood. Wine, spirits, amm. carb., etc., should be administered *ad lib.* When pneumonitis sepevenes, poultices to the chest and between the shoulders are essentials, with stimulant expectorants. Of internal remedies, a mild purgative should be administered at first; subsequently, little if any purgative medication is advisable. Internally Tr. ferri mur., with pot. chlorat., administered frequently, is chiefly relied on, by all. The Tr. ferri has the effect of preventing or removing the attendant dyscrasia of the blood, in this as well as other diseases, to a greater extent than any other known remedy; and the chlorate is a tonic and febrifuge of no mean power; while both have a specific action on the local disease, and are applied every time it is swallowed. We are convinced, by a somewhat extended experience, that calomel, in small and frequent doses, is also of much benefit, and especially when the membrane extends into the trachea. We are aware that many physicians in the past have condemned it as being useless, if not positively injurious, yet we know that the practice of administering it is gaining ground, notwithstanding the prejudice existing against it. Where suffocation is threatened, and all other remedies have failed, tracheotomy as a last resource should be performed, with the faint probability of rescuing the sufferer from otherwise certain death. When it is followed by paralysis, strychnia and electricity are the remedies chiefly relied on, while massage is important, as a substitute for the necessary exercise of the paralyzed muscles. Nourishing diet, tonics, reconstructive remedies, are all-important in every case, not only during the attack, but for some weeks subsequently.

MEDICAL REGISTRATION IN ONTARIO.

In another column will be found a letter on the above subject which is very timely. The question

as to registration is certainly a burning one, with the hundreds of students now in our colleges, who are, we believe, memorializing the Council for better terms than those proposed, of insisting on every practitioner taking the Council examinations. We may say that we are entirely in accord with the sentiments expressed by our correspondent. It seems absolutely absurd, in consideration of the action spoken of by our correspondent by the authorities in Britain, as also in our own Provinces of Manitoba and Quebec in regard to reciprocity, that our Council should undertake to build a wall around our little medical institution in Ontario, through which none may enter except by the door of Council examinations and Council fees. There has long existed a feeling that certain members of the Council look askance at practitioners who have registered here under old country licenses, even though such practitioners may have spent some time in attendance upon one or more of the great hospitals of London or Edinburgh. The old cry of "evading our laws," crops out from these men continually, though, as we have previously pointed out, laws must be made before they can be evaded. Surely a graduate of one of our Universities who spends say a year under the instruction of the best men in London and Edinburgh, and who secures a license to practice from one of the Colleges there, is a better man than he would have been had he simply passed the Council here. Why then should we insist on so close a corporation in medical matters, unless, as has been hinted by our correspondent, the fees are the object. Do the members of our Council wish to exclude British licentiates on the ground that their scientific or professional standing is lower than ours? If they do so, not only the members of the Council but the profession at large in Ontario may well become the laughing-stock of medical men wherever our name is heard. We hope the letter of D. E. J. may be followed by others showing the position held by the profession in various parts of the Province, on this very important question.

TAKING BLOOD DIRECTLY FROM THE LIVER.

Dr. Haley read a paper before the last British Medical Association, in which, among other therapeutical procedures for the relief of congestion of

the liver, he deals with the removing of blood directly from the liver by means of a trocar and cannula.

This process he calls "hepatic phlebotomy." He first undertook to show that it is impossible to draw blood directly from the liver by means of cups or leeches, and that as compared with the withdrawal of an equal amount of blood from the arm, the leeching or cupping process is, if anything, inferior. Dr. Haley has long believed that the direct withdrawal of blood would be followed by great advantages in the case of hepatic engorgement, and at last succeeded in obtaining the consent of a patient and friends to the operation, which briefly was as follows: The patient was anæsthetized, and the liver was pierced in its upper part from right to left with an eight-inch trocar of the diameter of between a number 2 and 3 sized English catheter. The trocar was run in up to the hilt in the hope that in its passage it might wound sufficient vessels to yield a full stream of blood. On withdrawing the cannula an inch or two, a full stream flowed from its free orifice. Twenty ounces of blood were abstracted, a two-inch square piece of sticking-plaster applied over the external wound, and the abdomen tightly bandaged in order to bring the abdominal wall into close contact with the capsule of the liver to prevent any chance of hemorrhage. The liver, from the day of the operation, decreased in size, and by means of copaiba, resin and tapping, the ascites and anasarca which had existed disappeared, and the patient made a complete recovery from what Dr. Haley and Dr. Walker had considered a perfectly hopeless state.

It would appear from this that the liver may be safely punctured, and with great benefit to the patient. The operation certainly commends itself, and if future experience prove it to be safe, we shall no doubt soon have it established as one of the standard and remedial measures for chronic congestive hypertrophy and engorgement of the liver.

ELECTRICITY IN MEDICINE.—The large extent to which electricity is now used in the various departments of medicine has been the means of inducing a good many persons who have no special qualification for the work, to engage in the manu-

facture of instruments. Some of those offered for sale are really not worth using, and cause only vexatious disappointment when purchased and tried. We speak from experience when we say that the instruments manufactured by the Kidder Manufacturing Co., of New York, are without doubt the best in the market. The "Jerome Kidder" batteries are reliable and valuable instruments, and the well-known tip battery, the invention of Dr. Jerome Kidder, for convenience and practical utility has never been surpassed. The above-named batteries have received the highest endorsement of scientific authorities, and we heartily commend them to the attention of our readers.

OVARIOTOMY.—In a recent clinical lecture on Ovariectomy at the Hotel Dieu Hospital, Montreal, Dr. Hingston contrasted his earlier operations of twenty-five years ago with his later ones of the past couple of years. In the earlier operations the mortality was large—not often getting over three or four recoveries without a break—while lately he had reached sixteen recoveries without a break. And yet selected cases for the last sixteen recoveries embraced two removals of the uterus and all the appendages. Dr. Hingston attributed this decreasing ratio of mortality to better trained assistants, and hence less waste of time; to a more thorough cleansing of the wound before closing; and to a better system of nursing.

"NEWSPAPER ADVERTISING" AGAIN.—We regret to have to return to this unsavory subject again this month. The "Brockville Recorder" and the "Mitchell Recorder" of December 9 and 10, respectively, contain paragraphs which are, in the eyes of the profession, damaging to the medical men concerned. Paragraphs of the kind complained of may now and then appear in the papers, much to the disgust of the medical men concerned, but when they are repeated again and again, the parties so advertised must be held responsible if they do not put a stop to them.

DIPHTHERIA.—The *St. Louis Med. and Surg. Jour.* puts the case well in the following: "We venture to say that nine-tenths of the cases of so-called 'diphtheria' of which one hears, not only in St. Louis, but elsewhere, are simply follicular tonsillitis. We recently heard one young M.D.,

the down upon whose lip resembles the bloom of a peach, tell a young lady in an Olive Street car, that he had attended thirty-six cases of diphtheria during the epidemic, and *saved them all*. True diphtheria is a disease that kills—not every time, but in such a large proportion of cases that the physician who knows his business has a dread and respect for it scarcely second to that accorded to cholera.” This will strike a responsive chord in the breasts of many honest physicians who live in the neighborhood of these fortunate practitioners who “cure the diphtheria.”

THE PULSE IN HYPERTROPHY, PREGNANCY AND DURING MENSTRUATION.—The *St. Louis Med. and Surg. Jour.* states, and gives its authority for stating, that the rate of the pulse is invariable in all positions of the body in hypertrophy, and during pregnancy and menstruation. This last will be interesting to most readers, though it has been known for some time that position affects the rate of the pulse but little in the two former cases. It is a matter which may be easily proved by anyone, and no doubt we shall soon have theories enough to account for the fact, if it prove to be a fact.

DURATION OF INFECTIVENESS IN SCARLET FEVER.—Dr. Ashby (*Br. Med. Jour.*) summarizes a paper on the above subject as follows:

1. If desquamation is complete, convalescent scarlet fever patients may be discharged at the end of the 6th week, though, in order to secure absolute immunity from infection it is wiser to delay until the end of the eighth.

2. Cases complicated with nephritis, empyema, otitis, or glandular abscesses should be detained until the cure is complete.

3. That while it is important that desquamation should be as complete as possible, the detention of the patient beyond the 8th week, in order that the epidermis should be removed upon the soles of the feet, etc., is unnecessary.

TYMPANITES IN HYSTERIA—Professor Talma relates some cases of tympanites in hysteria. He believed it due to contraction of the diaphragm. The size of the abdomen was considerably decreased during sleep, and under chloroform it became normal. Hiccough was a cause of great distress in

one case, it being greatly increased whenever any of the students approached her.

PRURITUS VULVÆ.—The *N. Y. Med. Jour.* gives the following as an application for pruritus vulvæ:

R—Glycerite of starch 30 parts.
Zinc oxide 6 „
Potassium bromide 10 „
Ext. of Indian hemp 2 „

Precede the application by a hot hip-bath.

ACNE.—Ringer recommends the following lotion as very useful in that form of acne common in young women at the menstrual period:

R—Sulphur ℥ j.
Glycerini f ℥ j.
Aq. ℥ x.—M.

Sig.—Apply twice or thrice daily.

ACUTE CONJUNCTIVITIS.—In this disease the following solution is a favorite one of Dr. Foxe's:

R Acid. boric., gr. xij
Zinci chlorid., gr. iij
Aquæ camph.,
Aquæ destillat., aa f ℥ij

M. Sig.—Use as lotion for eyes.

CHRONIC DYSENTERY.—Dr. Blomfield speaks highly (*Lancet*) of the efficacy of the following injection in chronic dysentery. After washing out the rectum with a pint and a half of water at 90° F. he injects two ounces by measure of the following: Quinæ bisulph. gr. x; tinct. camph. co., ℥iv; decoct. amyli ad ℥ij. If this be rejected it may be repeated in an hour to two. These injections given night and morning soon improve the patient's condition.

A SOLVENT FOR SORDES.—Dr. MacGregor gives (*Ed. Med. Jour.*) the following as a solvent for sordes: Boric acid, thirty grains, chlorate of potassium, twenty grains, lemon juice, five fluid drachms, and glycerine, three fluid drachms, yields very comforting results. When the teeth are well rubbed with this, the sordes quickly and easily become detached; little harm will follow from the acid present. The boric acid attacks the masses of bacilli and bacteria, the chlorate of potassium cools and soothes the mucous membrane, the glycerine and lemon juice moisten the parts and aid the salivary secretion.”

OIL OF TURPENTINE IN PAINFUL INTESTINAL AFFECTIONS IN CHILDREN.—Dr. Bedford Brown (*Jour. Am. Med. Ass'n.*), says that the oil of turpentine has a very soothing action on the irritated and inflamed mucous membrane, and checks the rapid exfoliation of epithelium which goes on during the inflammatory process. It is not only sedative in its action, but also acts as an antiferment, deodorant and antiseptic. He recommends it in the dyspepsia of young children brought up by hand, accompanied with severe pain with either constipation or diarrhœa. It is useful also in enteritis, dysentery, and intestinal catarrh. He recommends that it be combined with belladonna and alkali, or with simple peppermint. Dose for a child of one year 2 minims.

The *Med. Summary* gives the following as a good turpentine emulsion :

- R Oil of turpentine . . . 2 fl. ounces.
- White of Egg . . . 2 fl. ounces.
- Glycerine 4 fl. ounces.
- Syrup 4 fl. ounces.
- Water 4 fl. ounces.

Mix the white of egg and glycerine together, add the oil of turpentine, and shake thoroughly then add the syrup, and lastly the water, shaking them well together. This makes a nice emulsion and is easily made and as permanent as any turpentine emulsion. A teaspoonful dose will contain about 8 minims of turpentine.

FRESH MILK IN ACUTE ARSENICAL POISONING.—Dr. Jones (*Virginia Med. Month.*), says fresh milk, by enclosing the poison in its coagulum and thus, acts as a mechanical antidote. He instances a family of seven persons poisoned by arsenious acid, by the exhibition in large quantities of this simple remedy.

SCIATICA.—Dr. Da Costa frequently prescribes :

- R Olei ganeth.
- Olei trebinth, aa ʒ iv
- Syr. acaciæ, ʒ ii
- Aq. cassiæ, ad ʒ iij—M

S.—ʒl three or four times a day.

CIMICIFUGA IN CHOREA.—The *Boston Med. and Surg. Jour.* gives the names of several eminent men who speak highly of the use of cimicifuga in chorea. It acts speedily and thoroughly, but re-

quires to be administered in full doses, such as “develop its specific effects, particularly vertigo and confusion of sight.”

COCAINE IN LABOR.—Dr. Hertzorne recommends (*Lancet*) the use of a compound of six parts of cocaine, twenty-four of vaseline and twenty of glycerine, to be applied to the parturient canal during the second stage of labor for the purpose of producing anæsthesia of the parts, and so vastly lessening the pain incident to that stage.

HYPODERMIC ADMINISTRATION OF STRYCHNIA.—Dr. Austie says the full effects of this drug are rapidly developed when administered hypodermically. He proposes a solution of the sulphate, grs. ij. ad aq. dest. ʒj., of which the proper commencing dose is m̄ij. (gr. ʒ½). If the dose exceed gr. ʒv, unpleasant toxic effects follow.

VOMITING OF INFANTS.—The vomiting of young infants may often be cured by the exhibition of one-third of a grain of hyd. c. cret. every three hours, though sometimes it proves intractable and even dangerous to life.

THE SPECIFIC ORGANISM IN HOG CHOLERA.—Dr. Salmon states that he has certainly found the microbe which is the cause of the swine plague. It is a bacterium, and produces all the symptoms of the disease.

NITRITE OF AMYL IN OPIUM POISONING.—It is reported (*L'Union Médicale*) that a case of opium narcosis was relieved by nitrite of amyl after belladonna had failed, and the patient was almost beyond help.

TETANUS FROM THE HORSE.—M. Verneuil, of Paris, has undertaken to show that tetanus is due to the germs derived from the horse, the germs being introduced into a wound in the human being.

MORRHUOL.—The active principle of cod liver oil has been obtained by a Parisian. He says it gives excellent results when used instead of the crude oil.

METHOD OF REMOVING NITRATE OF SILVER STAINS.—Dip the fingers into a strong solution of cupric chloride. In about a minute the silver will be converted into chloride, and may then be washed off with sodium hyposulphite solution.

APPOINTMENTS.—Dr. Theo. S. Covernton, Jr., of Toronto, has been appointed Examiner in Hygiene and Medical Psychology in Toronto University.

WE regret to announce the death of John P. Gray, M.D., LL.D., Medical Superintendent of the State Lunatic Asylum, Utica, N.Y., aged 61 years. He was for many years editor of the *Am. Journal of Insanity*. It will be remembered that he was shot by a lunatic in 1882. He never fully recovered from the effects, and finally succumbed to Bright's disease. He was one of the foremost alienists on this continent.

ANGINA PECTORIS.—Iodide of Sodium, is highly recommended by Hichod, in the treatment of Angina. Laschkevitch (Rev. de Med.) speaks highly of the effect of cocaine in doses of from $\frac{1}{2}$ to $\frac{1}{3}$ grains three times a day.

DR. WILLIAMS (*Boston Med. and Surg. Jour.*) says he has averted a great many felons, by keeping a rag tied loosely around the finger, constantly wet with cold water. They must be taken in the earliest stage.

M. DOYEN (*Br. Med. Jour.*) recommends the following in inflamed eczema and ulcerated impetigo: Salicylic acid, 2 grammes; lanolin, 50 grammes; zinc oxide, 24 grammes; starch, 24 grammes.

DR. ILLINGWORTH recommends the tincture of perchloride of iron in five drop doses, sweetened with glycerine, in enteric fever.

Books and Pamphlets.

THE PRINCIPLES AND PRACTICE OF MEDICINE; for the use of Practitioners and Students of Medicine. By Austin Flint, M.D., LL.D., late Professor of Medicine in Bellevue Medical College, New York, etc. Sixth Edition, revised and re-written by the author, assisted by W. H. Welch, M.D., Prof. Pathology in John Hopkins's University, and Prof. Austin Flint, jr. Philadelphia: Lea Bros. & Co., 1886.

The following Extracts from the Preface to the sixth edition will be read with interest, as evincing alike the enormous personal experience upon which the author founded his opinions and

the very complete manner in which he has presented to the fellow-members of his profession the matured results of his life's labors.

"The basis of the work is an unbroken series of records of cases in private practice and in hospitals, begun in 1833 and continued for more than half a century, covering sixteen thousand nine hundred and twenty-two folio pages of manuscript, written with the author's own hand. These records embrace carefully-written histories of cases in all departments of practical medicine, observed under varied conditions of life, climate and general surroundings; cases observed in the experience of a quarter of a century of a general practitioner and of more than another quarter of a century as a consulting physician, including the epidemics which have occurred in this country within the last fifty years—the experience derived from these various sources of observation, carefully recorded, studied and analyzed, was finally used in the composition of this treatise, the first edition of which appeared in the year 1866. In the meantime the author's original contributions to practical medicine, embodied in special treatises, in communications published in medical periodicals, and in transactions of medical societies, have left their impress upon many departments which, in recent years, have been classed as specialties; although he was always a physician, never a specialist. A student of the history of practical medicine will often find observations and ideas, assumed to be of recent date, which had been anticipated by the author many years before.

Among the entirely new articles, special attention may be called to the following: Infectious Tumors; Syphilitic Diseases of the Lungs; Cerebral Syphilis; General Considerations relating to Inflammatory and Structural Diseases of the Spinal Cord; Spastic Cerebral Paralysis of Children; Hereditary Ataxia; Myxedema; Multiple Neuritis; General Pathology of Fever; and Milk Sickness. In addition to these new features, many articles have been entirely rewritten; and in nearly every article changes and additions, some of them very important, have been made.

The sixth edition also contains a full consideration of recent discoveries concerning the bacterial origin of various infectious diseases, as will be rendered evident by a consultation of the article on Vegetable Parasites in the chapter on Eti-

ology, and articles in the chapters treating of Tuberculosis, Typhoid Fever, Cholera, etc.

RHEUMATISM: ITS NATURE, ITS PATHOLOGY, AND ITS SUCCESSFUL TREATMENT. By T. J. MacLagan, M.D.: New York, W. Wood & Co.

This is a valuable book. The publishers seem to have known the fact, for they have not hung out any broom. Perhaps the author has no string of medico-algebraic signs of unknown quantities, from which to construct a caudal flourish. Whether so or not, we have been thankful for the absent appendages, and we entered on the perusal of the book with the determination of judging of its merits according to the evidence presented by the contents.

The style is clear, simple and inviting, and the diction is happily free from those grammatical oversights which too often disfigure the pages of some other treatises issued by American publishers.

The book consists of twenty chapters, in which the following subjects are treated of. 1st. The varieties and symptoms of Rheumatism. 2nd. The duration of Rheumatism. 3rd. The seat of Rheumatism. 4th. The nature of Rheumatism. 5th. The nature of the Rheumatic poison. 6th. The Lactic Acid theory of Rheumatism. 7th. The Miasmatic theory. 8th. The nature of Malaria. 9th. Its mode of action. 10th. Rheumatism of the loco-motor apparatus. 11th. Rheumatism of the vasculo-motor apparatus. 12th. Endocarditis. 13th. Pericarditis. 14th. Myocarditis. 15th. The treatment of Loco-motor Rheumatism. 16th. The mode of action of the Salicyl compounds in Rheumatism. 17th. The treatment of Vasculo-motor Rheumatism. 18th. Cerebral Rheumatism. 19th. The relation of Rheumatism and Chorea. 20th. Rheumatic Hyper-pyrexia.

These headings certainly present an appetising bill of fare. The reader will not be disappointed in either the savor or the digestibility of the viands. The author shows that he is well acquainted with the existing literature of his subject; and the modesty and impartiality evinced by him in his criticisms, merit high commendation. It is to be hoped that succeeding writers, who may question the soundness of his views, will be governed by a similar delicacy.

Perhaps the points most inviting to demurring

criticism, will be found in his views on malarial poison germs as the *sine qua non* efficient factor in the causation of rheumatism, and his consequent committal to this lately born morbid agent: and in inevitable association with this must come his advocacy of Salicyl as the appropriate germicide. His repudiation of the lactic acid theory of rheumatismal causation, must also provoke controversy. It may, too, seem strange to some readers, that the profuse sweatings, provoked, as he says, by redundancy of lactic acid in the blood, should be the efficient cause of the high degree of bodily heat in certain cases of acute rheumatism. Sweating has heretofore been regarded as a natural cooling process, and it is doubtful whether the cutaneous irritation caused by this substance, may not be compensated by the process of coincident evaporation attendant on it. It may also be alleged by scrupulous critics that Dr. MacLagan is rather forward in his assumption of the existence of a thermal centre in the cerebro-spinal axis. At all events it is questionable, as yet, whether it is quite safe to locate this centre in the medulla spinalis at the point assigned to it by the author. His *a priori* arguments, in advocacy of this structural provision, as an arrangement complementary to those of other corporeal functions, are ingeniously plausible, and well worthy of the reader's serious attention. The final chapter, on Hyper-pyrexia, in which this matter is ably treated of, will not fail to command the admiration of every lover of fledgling theories. It is truly a captivating production, and it is well worth while to peruse assiduously all that precedes, in order to reach this dazzling culmination.

Finally, we are constrained to say, that if all the monthly issues, or even a handsome minority, devoted by the enterprising house of Wm. Wood and Company, to the medical profession, were as well deserving of approbation as this treatise of the tailless Dr. MacLagan, medical science would be largely enriched.

A TEXT-BOOK OF HUMAN PHYSIOLOGY, INCLUDING HISTOLOGY AND MICROSCOPICAL ANATOMY, with special reference to the requirements of Practical Medicine. By Dr. L. Landois, Prof. of Physiology in the University of Gröfswald; with additions by William Sterling, M.D., Sc.D., Brackenbury Prof. of Physiology and Histology in Owen's College, Manchester, etc. Second

American from fifth German edition; pp. 922, with 583 illustrations. Philadelphia: P. Blakiston, Son & Co. Toronto: Hart & Co. 1886. Cloth, \$6.50; leather, \$7.50.

This classic on physiology has passed through four editions in Germany since its first appearance in 1880. At present, when thoughtful men are trying by every means to apply their physiological knowledge in their practical work, such a book is well-nigh invaluable, for the author appears to have kept steadily in view the idea of making the work practical, and of "forming a bridge between Physiology and the Practice of Medicine."

The subject-matter is so arranged as to be easily understood, a matter of great moment in a work which claims to be comprehensive and at the same time concise. The histology is more fully dealt with than is the case in most text-books on physiology, while the *résumé* of pathological variations appended to each section, not only draws the student's attention from the first, to the relation between normal and pathological processes, but enables the practitioner to refresh his memory, by "passing backward" from the abnormal to the normal processes of the body. The various methods of investigation which may be used by the general practitioner, are fully and clearly described, a matter of importance at present, when Pharmacology is considered one of the important branches of a medical education.

The translator has performed his task well, and has not only presented the work in a truly English form, but has made many valuable additions where such seemed necessary. The work is, as we intimated before, a classical one, and we heartily recommend it to all students and practitioners of medicine.

ERUPTIONS; THEIR REAL NATURE AND RATIONAL TREATMENT. By Dr. Barr Meadows, L.R.C.P. E., M.R.C.S., etc., etc. Ninth edition; pp. 84. London: George Hill. Toronto: Hart & Co.

The author proposes to demonstrate the symptomatic nature of eruptions generally, and to lighten the burden of the student and practitioner—caused by the cumbrous classification now in vogue, and to point out the natural mode of treatment in accordance with the general principles of medicine. The work will repay a perusal.

A TEXT-BOOK OF MEDICINE, for Students and Practitioners, by Dr. Adolf Strümpell, of Leipsic. Translated from the 3rd German edition by H. V. Vickery, M.D., assisted by P. C. Knapp, M.D., Boston, Mass. 111 illustrations. New York: D. Appleton & Co. Toronto: Williamson & Co.

The above work, which is new to most of our readers, has achieved great success in Germany,

having reached the third edition in a very short time. It has been introduced as the text-book on medicine in the Harvard Medical School. The work is especially commendable in its treatment of nervous diseases, which are dealt with fully, concisely and clearly. The pathology of disease, as might be expected from so eminent a teacher, has received due and careful attention, and this is another strong feature of the work. The details of treatment are not as satisfactory as could be wished, but what is given is based upon the practical experience of the author and are probably sufficient for the needs of most practitioners. The author gives in this work the results of the experience and observation of more than six years active work in the medical clinic in Leipsic. We heartily commend the work to the attention of our readers.

MANUAL OF OPERATIVE SURGERY by J. D. Bryant, M.D., Prof. of Clinical Surgery Bellevue Hospital Medical College, New York, with about eight hundred illustrations. New York: D. Appleton & Co. Toronto: Williamson & Co.

The apology given by the author, if any apology be needed for the appearance of so excellent a work, is the frequent request on the part of those whom it has been his pleasure to instruct in operative surgery during the past few years, to make a book based somewhat on the plan he has employed in teaching this subject. We have perused this work with great pleasure and profit, and can bear testimony to the care and attention which the author has bestowed to make the book a benefit to his co-workers in the same field. The cuts are numerous and well executed, and the text clear and well printed. The various operative procedures are clearly and concisely described, and the results of the various operations briefly stated. The chapter on the treatment of operation wounds is worthy of special mention. The work is fully abreast of the most recent advances in operative surgery, and we have much pleasure in recommending it to our readers.

Births, Marriages and Deaths.

On the 24th October, Dr. A. E. Croucher, of Bridgewater, N.S., aged 50 years.

On the 1st ult., G. A. Neal, of Ruthven, Ont., aged 37 years.

On the 6th ult., James O'Shea, M.D., of Campbellford, Ont., aged 36 years.

At Peterborough, on the 24th December, Dr. W. H. Burritt, aged 78.

On the 26th ult. Dr. Robt. Hobbs, of London, Ont., aged 86 years.

On the 24th ult., Dr. W. B. Nicol, aged 74 years.