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## Original Communications.

### TUBERCLE BACILLI.

By GEORGE WILKINS, M.D. M.R.C.S. ENG.,

Professor of Physiology and Pathology and Lecturer on Histology, University of Bishops College, Montreal.

The presence of the bacillus of tuberculosis is of such grave importance that any certain method of demonstrating its presence or absence, as the case may be, in the sputum, so that even one unaccustomed to frequent use of microscope can readily see it when present, is worthy of consideration. Koch's method is now almost entirely given up: it could be seen only with the high powers and special illumination. To see it with a Hartnack No. VII., or even with his No. 9 immersion frequently required a stretch of imagination.

Many experienced microscopists, some of them extensive workers in the wide field of Bacteria, have publicly expressed their inability to discover them when proceeding according to the methods suggested by Koch. Some of these, owing to improved methods, have recanted. Ehrlich, a pupil of Koch, gave the key to these in suggesting the addition of pure aniline as a base, and the use of an acid instead of alkali as a part of the process of preparation. Koch has now adopted Ehrlich's method. Heneage Gibbes, in the *Lancet* of August 5th last, suggests some slight improvements in Ehrlich's methods.

In a late number of the *Berliner Klinische Wochenschrift* Dr. Balmer and Professor Fraentzel slightly modify Ehrlich's methods. First of all they suggest that the cover-glass should be only 0.10 to 0.12 millimetre thick. A small portion of sputum is placed on a cover-glass; this is spread over by drawing it across another cover-glass until an even layer is obtained; they are now permitted to dry, and then slowly passed three times through the flame of a Bunsen burner. One gramme of fuchsin is dissolved in 50 of aniline water, freshly prepared; the cover-glasses are permitted to float on this,—sputum downwards,—for twenty-four hours. They are now washed in distilled water, and subsequently placed for about half a minute in diluted nitric acid (one part acid to three distilled water). This should completely remove the coloring matter (the bacilli if present retain this color). They are again washed with distilled water, and then placed for about half a minute in a concentrated solution of methylene blue, again washed in distilled water, and placed on filter paper until dry. Should they not dry rapidly they can be passed once or twice through the flame of a Bunsen's burner, and be subsequently mounted in a drop of Canada balsam.

We quite agree with these observers as to the necessity of placing the preparation twenty-four hours in coloring matter as first recommended by Koch. The results of our investigation justify us in saying that placing the pre-

paration for only half an hour in the staining fluid, and should no colored bacilli be seen, to conclude from that that none were present in the sputum, one would be very liable to err. We have in our possession now some preparations mounted as recommended by Gibbes, in which are only a very few scattered bacilli to be seen colored. With a HOMOGENOUS immersion lens, others can be recognized uncolored. Sputum of the same patient with the prolonged immersion in the staining fluid shew all that exist deeply colored. We may draw attention here to the great superiority of the homogenous immersion to the water immersion, and the advantage to be obtained by a wide-angled condenser such as Abbé's for illumination. Koch, in his brochure on "Wunds infectionen Krankheiten," draws particular attention to this fact: Unstained bacilli which were recognized only with difficulty by Hartnack's No. 9 immersion can be seen readily even by the uninitiated by a Zeiss' homogenous immersion illuminated with an Abbé condenser.

To refer again to the significance of bacilli in sputum: Balmer and Fraentzel state that during the months of May, June, July and August last they had made several examinations of the sputum in 120 cases of phthisis; they also examined the sputum of other cases in order to obtain positive results. Their examinations, besides enabling them to agree with other observers who state that "where tubercle-bacilli are found in the sputum, we have there tuberculosis of lungs," permits them to draw stronger conclusions: indeed they say that "where no bacilli are found in the sputum after repeated and accurate examinations, there is no tuberculosis of lungs."

In support of these assertions they mention that autopsies were held on all the cases that died during this period, and in none of the cases in which no bacilli were found during life did they find a tubercular condition of the lung. They consider that the results of their observations justify them in asserting amongst other things:—That the prognosis of a case of tuberculosis of lungs can be drawn from the number and degree of development of bacilli in sputum. All cases with abundant, well-developed bacilli give a bad prognosis. These cases improve proportional to the decrease of the bacilli. In all cases of acute tuberculosis bacilli are found in very large numbers. Their degree of development is very various; in many cases they are small, badly developed, and only occasionally

found with spores. In these cases their number is always small. Such bacilli are found in cases in which the disease progresses very slowly or is almost inactive, especially in old closed cavities surrounded by sound tissues.

In all rapidly progressing cases in which there is present fever, nightsweats, etc., the bacilli are much larger, the spore formations are more distinct and much more easily recognized.

The difference between the numbers of bacilli in the sputum of fresh cavities in the lung and in the walls of the cavity itself was very striking. Whilst they were present in large quantities in the sputum, there were very few in the walls. The sputum appears therefore a much better nidus for their development than the living lung tissue.

The access of oxygen to the cavities in the lungs cannot be the cause of their abundant development, as they found them equally abundant in the purulent exudation of the closed knee-joint of a patient with tuberculous affection of this joint.

They found there bacilli not only in sputum and the walls of lung cavities, but also in the tissues; in the discharge from tuberculous ulcers in lungs, in the walls of tuberculous intestinal ulcers, in pus of a tuberculous knee-joint inflammation.

They consider the presence or absence of bacilli is of importance in diagnosing ulcers, joint affections, etc., of a tubercular nature.

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## *Society Proceedings.*

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### MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

*Stated Meeting November 17th, 1882.*

DR. R. A. KENNEDY, PRESIDENT, IN THE CHAIR.

Dr. Osler exhibited the following Pathological Specimens:

(a). *Cerebral Aneurism and Hæmorrhage*, from a case in the Montreal General Hospital under the care of Dr. Molson. The patient, a woman, æt. 62, was admitted in a semi-unconscious state, with complete paralysis of the right side, following a fit she had had some three days before. As far as could be ascertained her previous health was good and her habits temperate. Death occurred on the 7th day after admission. At the autopsy was found a small saccular aneurism situated upon the left middle cerebral artery, which had ruptured and pro-

duced extensive laceration of the inner and anterior part of temporal lobe and hæmorrhage into the meninges at the base. The arteries were atheromatous, and from the exceedingly thin structure of the wall of the aneurism it is probable that it originated in an atheromatous ulcer, exposing the middle and outer coats which had yielded to the pressure. There was no heart disease and no special change in the other organs. Dr. Osler remarked that this was the sixth specimen of cerebral aneurism he had exhibited to the Society.

(b). *Verminous Aneurism in Horse.* The animal had been admitted to the infirmary of the Montreal Veterinary College with colic, and had died in about 36 hours. The post-mortem shewed intense engorgement, with great distension of the small intestines. The aneurism was from one of the mesenteric branches, and contained thrombi among which were numerous examples of the palisade worm, *Sclerostomum Armatum*. The so-called colic of horses is very frequently produced by these aneurisms, portions of the thrombi become dislodged and plug the terminal branches of the mesenteric arteries and cause infarction of the portion of the bowel supplied by the plugged vessel. In reply to a question by Dr. Gurd, Dr. Osler stated he did not think these cases could be distinguished from those of ordinary colic; Indeed Prof. Bollinger of Munich held that colic in horses was in the majority of cases of embolic origin and due to those verminous aneurisms.

(c). *Cancer of Stomach with enormous Secondary Cancer of Liver.* This case was also under the care of Dr. Molson, who gave the following clinical history:

L. P., æt. 52, healthy up to two months ago, when he began to lose flesh and get weak, with pain after eating and eructation of wind. On admission, November 3rd, 1882, was decidedly cachectic; great prominence with evidence of a tumor occupying the whole of the upper zone of the abdomen. Commencing on the right side and extending over towards the left in the median line, it extended two inches below the umbilicus and on the right side down as far as the ilium. Œdema of both legs and feet. Urine contained abundance of lithates, a small amount of albumen, and numerous granular and hyaline casts some days after admission. Jaundice set in gradually but this was never deep, and vomiting for the first time occurred. He died November 16th, p.m. The stomach shewed a small, flattened, slightly raised

cancer, situated on the lesser curvature, about  $1\frac{1}{2}$  inches from the pylorus; it had an excavated base, puckered and hard on the peritoneal surface, and a chain of enlarged glands extended along the lesser curve to the cardiac. The microscopic examination shewed it to be a cylindrical-celled epithelioma. The liver was enormously enlarged, weighing over thirteen pounds, and presenting innumerable masses of secondary cancer scattered through its substance.

(d). *Erosion of Internal Carotid in Cavernous Sinus* six weeks after a blow on the head. Fatal hæmorrhage from the nose. The patient, æt. 21, had received a blow over the left eye, being one of the victims of the "Beauharnois" boiler explosion. There was a long wound extending the whole length of the eye-brow, but it was not thought he had received any other injury, as he recovered quickly. Some time after, however, he noticed that the sight of that eye was failing, and he consulted Dr. Buller, who diagnosed commencing atrophy of the optic nerve, due probably to extravasation in the sheath. He had had several attacks of epistaxis, but not of an alarming character. One morning, about six weeks after the accident, while washing his face, profuse hæmorrhage took place from the nostrils, and he died before assistance could be procured. At the post-mortem the orbital ridge of the frontal bone was found indented at the site of injury. The orbital plate presented an area of superficial erosion about three lines in width, extending beneath the *dura* from a point corresponding to the external wound, to the body of the sphenoid. The left wing and body of the sphenoid slightly reddened, the surface of the bone eroded, and at one spot in the latter the bone was so soft that it broke on a slight touch. The sphenoidal and ethmoidal cells were filled with coagula. On slitting up the internal carotid in the cavernous sinus, just as the vessel turns up to enter the skull, there was seen an opening on its interior part leading directly into the sphenoidal cells. There was a small spot of red softening the size of a *ten cent piece* in the third left temporal convolution. Though no fracture of the sphenoid was evident, yet it was believed that at the time of the accident a slight fracture must have occurred leading to ulceration and erosion of the bone and subsequent perforation of the carotid. Dr. Osler remarked that the case was unique in many respects, but Mr. Prescott Hewitt, in his lectures upon fractures at the base, mentions an instance in

the practice of Mr. Scott of the London Hospital, in which after an injury a pulsating tumor of the orbit occurred, and during an examination profuse hæmorrhage from the nostrils took place, which was controlled by compression of the common carotid, and subsequently cured by ligation of that vessel.

(e). Specimen from a case of diphtheria, showing blocking up of the glottis by false membrane and extension down the trachea into the primary bronchi. Tracheotomy had been performed, but with only temporary relief. A point of interest in this case was the *coking* and hardening of the exudation at a point corresponding to the orifice of the tube, which must have materially interfered with the entrance of air.

Dr. Wilkins exhibited *Tubercle Bacilli* prepared by the *Ehrlich-Gibbes* method, with an important modification, as suggested recently by Balmar & Fraentzel. The sputum after being spread out in a thin layer on cover glass, and dried and passed through the flame of a Bunsen's burner, is now placed in a solution of *fuchsin* in *aniline* water, (one part of *fuchsin* to fifty parts of *aniline* water); it is kept in this for twenty-four hours, after which it is taken out and washed in distilled water, and placed for about half a minute in dilute nitric acid (one of acid to three of water). After being again washed it is placed in a concentrated solution of *methylene blue* for a few minutes. The specimen is then thoroughly dried, passed through a *Bunsen* flame once or twice, and mounted in balsam.

Dr. Wilkins read a paper on a case of *Obliteration of Superior Vena Cava*.

(The specimen was exhibited at a former meeting of the Society.)

The patient was admitted into the Montreal General Hospital on June 27th, complaining of great dyspnœa which condition existed through the whole course of the disease. A year or so before coming into Hospital he felt something give way on lifting a heavy weight, and has suffered more or less ever since.

Shortly after admission he became cyanotic, with an œdematous condition of the head and neck. About six weeks after entrance into Hospital fluid began to collect in the left pleural cavity, and subsequently also in that of the right side: he was tapped a great number of times, but only experienced transient relief—eight hundred and sixty-two ounces in the aggregate was drawn off. Patient's pulse, which previous to this never went above 104, now rose considerably, and the tem-

perature, which hitherto had been normal, rose to 102°. Dyspnœa became very severe; he was again aspirated, withdrawing twenty ounces of bloody fluid from the left side and forty ounces of clear fluid from the right. The patient finally died from exhaustion.

At the autopsy the *superior cava innominate and internal jugular veins* were found obliterated by thrombi; the left pleura was covered with recent lymph; the azygos veins were widely dilated, and the foramen ovale was found to be permanent. Dr. Wilkins exhibited beneath the microscope a number of sections from various parts of the thrombosed vessels, the most interesting being those taken from the cardiac extremity of the superior vena cava, showing cicatricial thickening of a portion of the circumference of the vessel, to the extent of two millimetres, the vessel itself being but six millimetres in diameter, and filled with organized clot. No other lesion could be discovered accounting for its occlusion. Dr. Wilkins considered these changes to have arisen from a primitive phlebitis, commencing in the adventitia, causing changes in the intima, with subsequent thrombosis, this giving rise to secondary phlebitis of the vessels above, resulting in a thrombosed condition of these vessels also. Some of the sections showed fibroid thickening of the septa of the alveoli of the lungs, due to a passively congested condition of these organs. The cyanotic appearance was explained by the blood current being delayed until a collateral circulation was established. In accounting for the dyspnœa, Dr. Wilkins stated that the blood of the left bronchial vein reached the heart through the superior vena cava, and consequently when that channel closed it would necessarily return to a great extent by way of the pulmonary veins, thus distending them and helping to cause thickening of their walls; he considered the permanency of the foramen ovale an important factor in causing the dyspnœa, and the remarkably slight relief obtained by aspirating the pleura. As soon as the blood current from above was shut off by closure of the superior cava the current from the inferior cava, meeting with no opposed current, must lift up the upper segment of the *annulus ovalis*, and get into the left auricle, and so block up the blood returning from the lung.

Dr. Wilkins accounted for the larger quantity of fluid in the left side, from the fact that on that side the blood from the four superior intercostals reaches the heart by the superior vena cava, while

from only one on the right side. After thrombosis of the superior vena cava blood would reach the heart by enlarging the inosculation between the intercostals, and between these and the azygos veins.

*Discussion on Paper.*—Dr. Osler thought the only rational explanation of the affection was a phlebitis excited by inflammation in contiguous parts. He would not, however, attribute the same importance to the valvular opening between the auricle and ventricle as Dr. Wilkins had done; he had frequently seen this condition with an orifice of considerable size, and without giving rise to any symptoms.

Dr. Ross asked if it was not a fact that a small tube had been used in this case for continuous drainage, and had been followed by pleurisy. He had seen a case of ascites treated in this way, after tapping had been performed in the ordinary way without ill effect on two occasions; followed by fatal peritonitis in 48 hours. He was inclined to think this method was not altogether safe. In these cases is the inflammation the result of irritation or the inadvertent entrance of germs?

Dr. Roddick also asked how the occurrence of inflammation in these cases could be explained. He doubted if these short tubes always reached the cavity, and spoke of the possibility of their slipping back, and by their constant irritation of the peritoneal or pleural surface setting up inflammation.

Dr. Osler also mentioned a case of abdominal dropsy drained in this way and followed by fatal peritonitis.

Dr. Ross, in reply to Dr. Osler, said that Southey recommended his trochar only in conditions of anasarca, but that others had recommended its use in draining serous cavities also.

Dr. Hingston spoke of the great risk always attending puncture of the abdomen, either with or without a tube, and cited a case where death had followed a simple puncture in three or four days.

Dr. Roddick thought that in the case of ovarian dropsy, the operation of tapping should always be approached with great caution. He believed that an exploratory incision with antiseptic precautions was, as a rule, less likely to be followed by mischief in these cases. With regard to the operation of tapping in ordinary abdominal dropsy, he was in the habit invariably of closing the puncture with a catgut suture and dressing it with iodoform, as he had seen at least one case in which septic

peritonitis followed tapping where a leakage was allowed to go on for some hours.

Dr. Bell thought the history of the case did not show it to have commenced with a severe enough illness to have been a *phlebitis* and subsequent thrombosis at the time of the accident. Might not the cicatricial tissue which was found partially surrounding the vein, and which was probably the result of laceration of tissue and inflammatory action at the time of the severe strain described by the patient as the starting point of his illness have acted by constricting the vessel so as to retard the blood current, and thus cause a thrombosis which was followed by phlebitis? The history of the case seemed to show that the phlebitis was acute and recent when admitted to hospital, while he attributed his illness to an accident twelve months previous. The aspirations of the chest as shown by the report had been performed a great many times without any unpleasant consequences. The first time the *Southey tube* was used it remained *in situ* for twenty-four hours and then slipped out. After twenty-four hours it was again introduced, and in a few hours was followed by signs of pleural inflammation. He thought the continuous presence of the tube was the cause of this inflammation, and considered that it was almost, if not quite, impossible to leave a tube in any cavity for any length of time without air entering in at the sides, more especially in the pleural and peritoneal cavities where the action of the lungs and diaphragm exercised as it were a constant suction.

Dr. Wilkins, in reply to Dr. Osler, stated that he could quite understand, other conditions being all right, how a permanent foramen ovale could be unattended with interference in the usual course of circulation, but as soon as the current from above was cut off, the current from below would lift up the upper segment of the annulus ovalis. Dr. Wilkins shewed the patient's heart with this projecting considerably, and said, supposing a force pump attached to inferior vena cava, before opening the walls of the heart and water pumped in, it would be impossible to prevent it passing through into left auricle, there being no counter current from above. The projecting upper segment of annulus is directly in the course of the fluid from below, and as it must exercise pressure on the lower portion before it reaches the upper, it will unavoidably open the valvular orifice and allow escape into the left auricle. In reply to Dr. Bell, Dr. Wilkins said, in the absence of any tumor, the

theory advanced by Dr. Bell was the one he was most inclined to favor until he examined sections of various parts of the vessel. No cicatricial growth of any kind existed outside of the walls of the vessel pressing on the vessel causing its closure; but for a short part of its course, not quite half an inch, there was a very marked cicatricial thickening of the walls of the vessel itself; the cord-like feeling perceived at the autopsy was due to this and the firmly organized thrombus; the lesion was so very limited he did not think it could have resulted from the rupture of any vessel outside or in the vicinity of the origin of the superior vena cava. He did not see any reason why it might not have originated from rupture of some of the capillaries of the adventitia at the time of the patient's complaining of something giving way in his chest.

Dr. Henry Howard, in speaking of the great loss which the medical profession in general, and that of this city in particular, had sustained in the death of the late Dr. David, moved the following resolution, which was seconded by Dr. Hingston and carried. Resolved:—"That the Medico-Chirurgical Society of Montreal deeply regret the death of A. H. David, M.A., M.D., Dean of the Faculty of Medicine of Bishops College, and formerly a member of this Society. Always highly esteemed and respected by his brother practitioners for his many sterling qualities and honest bearing towards them, being especially kind and considerate to the younger members of the profession, his loss will be sorely felt, and his place can with difficulty be filled. That this Society tenders its sincere sympathy to the members of the bereaved family, and assures them that the profession sympathizes with them in their great affliction."

*Stated Meeting Friday, December 1st, 1882.*

DR. T. G. RODDICK, VICE-PRESIDENT, IN THE CHAIR.

#### PATHOLOGICAL SPECIMENS EXHIBITED.

*Pericæcal Abscess.*—Exhibited by Dr. George Ross. The following are the main clinical features of the case:

The first day there had been sudden acute pain in right iliac fossa, with great tenderness and high fever. Dr. Ross saw him soon after with Dr. Bell. They applied leeches freely, and gave opiates. Immediate relief followed, and the temperature fell.

For some days condition quite satisfactory. There slight fever and uneasy feelings in the belly. After the lapse of several days more a chill and increased fever. From this time the temperature fluctuated greatly, accompanied by irregular chills. It was believed that pyæmic absorption was taking place from localized suppuration—but still the most careful exploration of the affected region failed to determine any fulness, fluctuation, or other sign by which to localize the abscess. Dr. Ross had been strongly of opinion that a small abscess would be found behind the cæcum. The idea of operating with a view of finding the matter was earnestly discussed in consultation with Drs. Howard, Shepherd and Osler, but the difficulties in the way were believed to be insurmountable. The autopsy completely confirmed the diagnosis. A singular feature was the development of a very loud systolic murmur, so harsh that at first it was suspected to be of pericardial origin. No organic change was found in the heart.

*Post mortem.*—A recent peritonitis existed, with a moderate amount of exudation; the mesentery was swollen, particularly in the upper part; about the cæcum the parts looked pretty natural, except at the inner margin, just below the valve, where there was considerable pigmentation. On dissecting this point a small saccular abscess the size of an egg was found situated behind the cæcum, and the termination of the ileum, it was quite on the inner side of the cæcum, and did not extend to its outer border. It contained a creamy pus, and the walls were thick and dark. The cæcum itself was healthy. On slitting up the appendix the mucosa for half an inch looked healthy; the remainder of the tube was somewhat dilated, closely adherent to the sac of the abscess, and presented two perforations into the sac. The swelling of the mesentery proved to be an extensive abscess, involving a considerable portion of the membrane, particularly that attached to the jejunum; the mesenteric vessels in these parts were full of pus; the portal vein was distended with pus, the walls thickened, and when followed into the liver many of its branches were found dilated and in communication with saccular abscesses; there was no endocarditis.

Dr. Armstrong spoke of his having had two cases in his practice similar to the one described by Dr. Ross, and with his experience, if another such case presented he would be inclined to look for the matter, and let it out if possible. In the "Annals of Anatomy and Surgery" several cases are reported

as having been operated upon, and with favorable results. He asked if any foreign body or concretion had been found in the abscess cavity indicating that any perforation of the appendix had occurred.

Dr. Osler remarked that the situation of the abscess in this case was such that it could only have been reached by a caparotomy. No foreign body or concretion was found in the sac. In any case of perforation of the appendix the situation of the resulting inflammation would depend on the course of the little tube which, as was well-known, was exceedingly variable. In one case which he had examined the appendix passed out at right angles to the cœcum and was attached to the sacrum; it had perforated and formed an abscess in that region, which had ulcerated into the bowel, and produced fatal hæmorrhage. The ulceration was usually due to the irritation of some foreign body or, more often, of a small fœcal concretion, or, in some instances, the distal part of the tube gets cut off from the cœcal portion, the secretions accumulate and produce inflammation of the walls. In this case the patient had had typhoid fever and there may have been an ulcer in the appendix, which had produced the narrowing evident about an inch from the cœcum.

Dr. Osler exhibited a large aneurism of the thoracic aorta taken from a gentleman aged about 70, who had suffered for years with laryngitis and for the past two years with symptoms of intra-thoracic tumor, dullness at the left base, feeble breathing in left lung and pain with cough and blood expectoration. There was the doubt whether the case was one of aneurism or malignant disease. There was no external tumor, *bruit*, no pulsation. The whole of the thoracic aorta was dilated and from its anterior wall two aneurisms projected. The upper one, the size of a large fist, had a wide orifice and was densely laminated with old firm layers of fibrin. It projected into the left lung, which was much flattened by it and the bronchus almost occluded. The other sac sprang from the vessel just above the diaphragm, and was about the size of a lemon. The posterior wall of the aorta was very atheromatous.

The point of great interest in the case was the possibility of the large sac having existed for years, causing the laryngeal symptoms which had troubled him. In this situation aneurisms had been known to last for an unusually long time. Dr. Osler showed a plate from Ziemssen's *Archiv.* (1877) illustrating an aneurismal sac which had lasted from 1863 to

1876, and had at one time been diagnosed aneurism by Oppolzer and cancer of the lung by Skoda.

In reply to Dr. Henry Howard, Dr. Osler stated that caries of the vertebræ almost always followed aneurisms springing from the posterior wall of the descending aorta.

*Dr. Geo. Ross* showed specimen of *aneurism of the arch of the aorta*.

The history of the case was as follows:—About one year ago was consulted by J. R. for a troublesome cough Dr. Jas. Bell had already seen the patient and suspected aneurism. J. R. was a well-built; powerful looking man of 32 years of age. Had been only a short time in Canada. In England he practised gymnastics a great deal, and sometimes assisted in public at feats of strength. He still did some running, and even a few days previous to seeing Dr. Ross had been on snowshoes over the mountain. Never complained of shortness of breath, but had lately had a teasing cough which was increased by exertion. He had never had either syphilis or rheumatism. Patient had a constant, short, hacking cough with a marked goose-like character. On examination, distinct evidence from the state of the circulation and from murmurs was found of aortic regurgitation. Physical signs of aneurism were entirely wanting with two exceptions, slight pulsation deep in the episternal notch and very marked tugging at the trachea. A positive diagnosis of small aneurism pressing on the trachea was given. He was treated by rest in bed and potass iodide for several months. He entirely lost the cough. No new sign showed itself as to the chest. Repeated careful examination failed to discover pulsation or *bruit* other than those from the heart, no indication of pressure on either bronchus. Two months ago he suffered from severe bronchorrhœa with fever and general disturbance and fits of intense suffocation; cough accompanied by the expectoration of great quantities of purulent matter. This entirely subsided in about two weeks. For several months the right radial pulse had been absent. He was so much better that he attended to his business till a few days ago. Death was caused by rupture into the trachea, and a vast flow of arterial blood from the mouth.

The interest in the case lay in the recognition of the disease from the peculiar character of the cough, confirmed by the very marked impulse against the trachea in the absence of all other

physical evidence. The laryngoscope aided also by excluding disease of the larynx and pressure upon the laryngeal nerves. Dr. R. would look upon this as an example of combined aortic valvular disease and aneurism induced from the constant over-exertion or strain of excessive gymnastic exercises.

Dr. Mills gave the following report of the laryngoscopic examination. The laryngoscope was used with a view of determining the cause of the altered breathing, and assist in locating if possible the aneurism. The position and movements of vocal cords found normal. The patient was asked to produce as much difficulty in breathing as he could. Upon doing so the position of the vocal cord remained practically unchanged. It was therefore clear that the cause of the dyspnoea was not in the larynx. Since the air seemed to enter each side of the chest equally well, pressure on the bronchi was excluded. The diagnosis therefore was tumor pressing on the trachea.

Upon holding a double stethoscope close to the open mouth, it was noticed that with both inspiration and expiration there was a wavy interruption of the breath current. This seemed to confirm the diagnosis. Dr. Mills thought this method of investigation might be of considerable value in doubtful cases.

At the autopsy the following condition was found. There was a small projecting tumor the size of a walnut beneath the manubrium. On slitting up aorta there was a circular orifice the size of a copper at the site of the innominate, and this opened into a saccular aneurism of this vessel which projected downward and backward between the arch and the trachea. A small extension of it passed anteriorly and appeared beneath the manubrium. The sac was lined with fibrin at the peripheral part. The subclavian and carotid arose from the upper part of the sac. The trachea was narrowed by the projection of the sac, and about an inch above the bifurcation a rupture the size of a five-cent piece had taken place. The aorta was atheromatous, and the valves thickened, curled and incompetent. Heart hypertrophied, particularly the left ventricle.

Dr. George Ross then read a paper on *two unusual forms of paralysis* under his care in the Montreal General Hospital.

I.—*Case of Paralysis of the Tongue, Lips and Soft Palate—Acute Onset.*

J. M., æt. 45, was admitted into the General

Hospital on the 8th November, 1882. He has thick, indistinct utterance, and complains of dizziness and dull pain in the head. His trouble dates from July, 1881, and came on suddenly.

The following are the particulars obtained from him: He has been a hotel porter for 25 years, and always enjoyed excellent health and was strong and robust, used to drink pretty freely, but for two years has entirely abstained. Had gonorrhoea many years ago, but never had syphilis. Has had two attacks of inflammatory rheumatism, but both occurred many years ago.

One year ago last July, whilst driving a *bus*, he was suddenly seized with a *dizziness*, which was taken for sunstroke. Finding himself falling, he dropped the reins and held on to the seat. He broke into a profuse perspiration, and felt a most uncomfortable dizzy sensation in the back of his head. He was lifted from the *bus* and carried into a drug store. He was then unconscious, and remained so for some hours. When he came to he was carried home, for he could not walk. At home he felt very weak, found he could not speak, and felt very dizzy. He remained in bed and on a chair for three weeks, during which time he spoke so badly that he could barely make his friends understand what he wanted. By this time he could walk about the house. Power of articulation gradually improved. He remained weak and unable to work for about nine months.

Patient is a low-sized man, well-nourished. Presents a slightly dull expression of countenance. He speaks slowly, with hesitation and difficulty—all words are pronounced with varying degrees of thickness; there is no nasal intonation. His defective articulation resembles completely that of a man much intoxicated. When directed to protrude the tongue, he does so imperfectly, and with considerable effort. It trembles violently. When first projected, the tip is turned down over the lower lip but is almost immediately retracted; still he tries hard to hold it out, and shuts his teeth upon it in order to do so. It is observed that at the same time the lips become quite tremulous, and the lower jaw assumes a quivering movement. When he tries to whistle, he can only succeed in imperfectly closing the orbicularis muscle, short puffing expirations alone are produced, accompanied by a blubbery motion of the lips. He can masticate food well, and swallows without difficulty. On examining the soft palate, it is seen to be much relaxed; the uvula hangs loosely on the

root of the tongue, and handling it produces no reflex contractions of its muscles. Sensation in the lips and tongue appears good. Sense of taste unimpaired. Other special senses unaltered. He walks with perfect freedom, and grasps well with either hands. Reflexes normal. Heart normal. Pulse 62. Fundus oculi presents no change. Urine of natural quantity and appearance, and contains neither albumen nor sugar.

November 13th.—Has complained every day of pain in the back of the head, which he says often prevents him from sleeping.

## II.—Case of Paralysis of Right Side of Face, Tongue and Soft Palate.

A. B., mulatto, æt. 53, was admitted into the General Hospital, 20th Nov., 1882, with difficulty of speech and drawing of one side of the face.

Has always been a strong and hearty man. Went to bed in his usual health on the night of the 16th inst; about midnight awoke, and found that he could not speak; the next day he managed to speak, but with great difficulty, could hardly make himself understood. With very slight improvement this condition has lasted up to the present time. There was no loss of power in any of the extremities.

*Status præsens.*—A. B. is a man of large muscular form, arteries stiff, and somewhat atheromatous, arcus senilis well marked, the right side of the face is observed to be flattened, smooth, and wanting in expression. The mouth is drawn towards the left side, and the right angle is drooping. He can wrinkle; the forehead equally on the two sides; closes the two eyes equally strongly; cannot whistle, in making the attempt the right side of the mouth does not move whilst the left flaps. The tongue is protruded somewhat to the right side; with the mouth wide open, he cannot raise the tip of the tongue against the roof of the mouth on the incisor teeth. In speaking the lingual and dental consonants give the most trouble, and the voice has an appreciable nasal intonation. There is no difficulty in swallowing, solids collect inside the cheeks and cannot be removed from inability to use the tongue. The closed temporal and masseter of the right side appear less firm than the corresponding muscles of the opposite side. On moving the lower jaw forwards it assumes an oblique position, the inclination being towards the paralyzed side, specially noticeable when the mouth is widely open. The uvula is club-shaped, inclined to the right,

and the soft palate does not contract at all upon being touched or handled.

Iodide of potassium has been administered, and the patient has markedly improved. Speech is quite intelligible, and he seems otherwise well.

*Remarks.*—These two cases present certain features in common and still are strikingly different. They both have thick speech and paralyzed lips, without disturbance in the limbs, the result of a sudden seizure; but the chief distinction between them is the fact that, in the first case, the paralysis is bilateral, and in the second it is unilateral. Both have arisen, I think, from a cerebral hemorrhage which in either case must have been small. In the case of J. M. the lesion is situated, I infer, in the *medulla oblongata*. It is hardly possible to find any other situation where a single lesion could thus injure the function of these particular branches of both 7th nerves and both hypoglossal nerves. If this be true the case presents an unusual form of *bulbar paralysis*, the more serious accompaniments of this trouble being markedly absent, viz., difficulty in swallowing, difficulty in mastication, and disorder of circulation and inspiration. Unusual such forms must be when we consider how closely the important centres for these functions are grouped together in the small medulla oblongata.

I might summarize the case thus: This man whilst in apparent health had a sudden giddiness and rapidly became apoplectic, remained so for some hours, could not walk for three weeks, was weak for several months. Coincident with the attack he lost the power of articulation, which still remains very imperfect. Has marked motor paralysis of the tongue, lips and soft palate. I should infer that he suffered from cerebral shock with apoplexy at the moment of the bleeding, then a complete paralysis of the tongue and an incomplete paraplegia. That the latter was caused only from functional interference with the motor parts, and was therefore entirely recovered from. That the centres of the hypoglossal and facial have been permanently injured, and hence persistent paralysis of these nerves remains.

The second case showing paralysis of the hypoglossal and part of the facial on one side must be due to a lesion removed only a short distance from the contiguous seats of origin of the two nerves.

*Remarks.*—Dr. Proudfoot mentioned a case of an old gentleman, aged 81 years, subject to attacks

of congestive apoplexy, but never followed by paralysis until June last, when, following an attack, he suffered from paralysis of the tongue and soft palate, great difficulty in swallowing and disturbance of speech; these symptoms have all since disappeared, with exception of difficulty in swallowing, which still exists to a slight extent.

Dr. Major read a paper on a case of *Cancer of the Œsophagus*.

The patient, a female, æt. 47, was first seen by him on the 1st July last. She had suffered from difficulty in deglutition from childhood, not being able to swallow anything larger than a *barley-corn* without great difficulty; this continued with more or less varying exacerbations up to the age of forty (seven years ago), when it became so distressing that she consulted a physician, but no apparent cause was made out. When seen by Dr. Major, in July last, she was considerably emaciated, and appeared to be the subject of some wasting disease. On making a *laryngoscopic examination* the disease was found confined chiefly to the right side, the tissues between the right arytenoid and œsophagus being especially involved; and on this side a very red swelling appeared, about the size of a *pigeon's egg*, its surface studded with four or five yellow points, from which some discharge escaped. The *posterior arytenoid space* was pressed upon to such an extent that the *right arytenoid* was rendered invisible. A guarded opinion at this time was given, the possibility of its being a *chondritis with formation of abscess* being considered. Iodide of potassium with a bitter principle was prescribed, and a weak spray of carbolic acid with bicarbonate of soda used to correct a slight offensiveness of the breath and to aid in the removal of accumulated mucus. This was followed by some temporary improvement, the patient became a little stronger, liquid nourishment was taken more freely, and her breathing was more easy. She was again seen and examined on the 2nd of September; her condition at that time was not so favorable, the difficulty in swallowing was increased, and her breathing was more embarrassed, the *bright red swelling* had developed into a dirty greyish mass, about the size of an acorn, and shewed a more clearly-defined œsophageal origin. The general debility advanced very rapidly, and each subsequent examination revealed local changes taking place. Softening occurred first on the left side and caused increased difficulty in the breathing by prolapse of a mass of broken-down tissue on to the

larynx, and at this time a marked alteration in the voice was first noticed. Death occurred November 25th. At the autopsy the upper two and a half inches of the œsophagus was found involved in a cancerous mass, which almost completely obliterated the lumen of the tube. On microscopic examination it was found to be *epithelial in character*. All the other organs appeared normal.

Dr. Major remarked that the interesting features in this case were the great length of time that had elapsed between the first symptoms and the well recognised cancerous condition suggesting the existence of an originally fibrous stricture which had subsequently become malignant, and the absence of *indurated glands* and of *pain* to within a few hours of death. In reply to Dr. Ross, Dr. Major said that for seven years she had taken nothing but liquid diet, not on account of *pain* but from tendency to regurgitation.

Dr. Proudfoot spoke of a case in his memory where ordinary fibrous stricture was diagnosed, and the patient subsequently died of malignant disease.

Dr. Ross said the case was a remarkable one, from the prolonged difficulty in swallowing, and he thought Dr. Major's explanation of *mechanical obstruction from simple fibroid stricture* was very reasonable. The next question to solve would be the probable cause of such a stricture, possibly from injury during childhood. The disease also being so high up, where strictures are almost never found, without traumatic origin.

In reply to Dr. Roddick, in regard to œsophagotomy, Dr. Major said there was no means of making out or limiting the extent of the disease.

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## *Progress of Medical Science.*

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### CODEIA IN TREATMENT OF DIABETES.

R. Shingleton Smith, M.D., B.Sc. Lond., M.R.C.P., Physician to the Bristol Royal Infirmary, gives in the *British Med. Journal* of June 24th an analysis of three cases of diabetes mellitus, in which the beneficial effects of codeia in the treatment of this disease are well shown. The patients all exhibited marked improvement while taking the codeia, which improvement ceased when the drug was withheld, being renewed on its repetition. Morphia had a good effect in two of the cases, but the improvement was less marked with it than with the other alkaloid. We quote from his preliminary remarks such paragraphs as refer directly to opium and its alkaloids in the treatment of diabetes:

Glycosuria having been shown to depend primarily on diseases of the nerve-centers, it is not a little interesting to observe that the drug which most controls it is one which affects nerve-tissues more especially. Opium has, indeed, been used empirically in the treatment of diabetes ever since the time of Aetius. Lecorché observes that since the time of Willis opium has become, so to speak, the panacea of diabetes. . . .

Dr. Lauder Brunton says that under the influence of opium the thirst diminishes, the excretion of urine becomes correspondingly less, and the proportion of sugar present in it falls. He might have added that the weight of the patient ceases to diminish, and generally improves. Recent observers have not been content to rest with this knowledge but have endeavored to ascertain to which of the alkaloids contained in opium the beneficial effect is due. Morphia has been found to act in a way similar to that of opium; and there appears to be little or no difference of opinion that the one drug, morphia, is equally useful as the other, the watery extract or some other preparation of opium. Codeia was first recommended by Pavy, and was preferred by him, inasmuch as it might be given in large doses without producing drowsiness.

This question of dose is an important one, and is at the root of the use of codeia in diabetes. Some authors recommend small doses; but Dr. Brunton states that "diabetics bear large and sometimes enormous doses of opium and codeia; and in administering these remedies it is well to push the dose until the sugar either disappears from the urine, or until increasing drowsiness obliges us to discontinue it." Dr. Brunton says, "The two remedies which are most serviceable in lessening the excitability of the nervous centers in diabetes are opium and its alkaloid, codeia. The latter may be given in doses of a quarter to half a grain three times a day at first."

Dr. Pavy gives a remarkable series of cases in which daily records of the composition of the urine were made, and in which careful analysis of the urine showed that the sugar disappeared entirely under the influence of opium, morphia, or codeia with the aid of restriction in diet. The drugs were given in gradually increasing doses: opium in doses of one grain up to nine grains, thrice daily, morphia up to three grains, and codeia up to ten grains three times a day. The great advantage of codeia over opium and morphia was found to be that, while equally efficacious in controlling the disease, it does not exert the same narcotic effect. When given in a small dose to begin with and increased gradually nothing may be perceived beyond its effect upon the disease.

Dr. Cavafy has subsequently reported a case in which he gave fifteen grains thrice daily with a good result.

Dr. Ord has also reported the case of a woman aged thirty-three, with diabetes of four months' standing, who gained seven pounds in one week

with one grain of sulphate of codeia twice a day, after diet alone had failed to produce any good effect.

Although I can not claim such satisfactory results as those given by Dr. Pavy, yet the cases to be reported show that the drug employed has a remarkable power of checking the elimination of sugar, and that a corresponding improvement in the health of the patient results. It would appear that alkalies, and all other methods of treatment are far inferior to the treatment by codeia, which may be considered to have almost a specific action on the disease. The facts before us seem to justify decided language with regard to the use of codeia, which should not be permissive, but imperative, in all cases of advanced diabetes mellitus: whatever else may be given, codeia should first be given, and in fairly large doses, until some physiological effect is produced. Even dieting appears to sink into insignificance by the side of codeia; in one case given by Dr. Pavy the codeia alone was sufficient, without any restriction of diet, the patient being on a mixed diet during the whole time.

It has been supposed that codeia is a dangerous drug. Barnay says, "The tendency of codeia to produce convulsions is so great that it should be excluded from therapeutics." It has been stated as a result of Bernard's experiments on the opium-alkaloids that while narceine is the most soporific element, codeine is that which most tends to convulsions. The literature of codeia does not bear out this statement, and I have never observed any thing to support it.

I have now endeavored to show that the utility of codeia is by no means universally recognized, but that it is fully deserving of confidence—nay, more, is imperatively demanded—in the treatment of diabetes in cases where treatment other than dietetic is required.

#### APHONIA OF SINGERS AND SPEAKERS.

For this affection Dr. Corson recommends the patient to put a small piece of borax (two or three grains) into the mouth, and let it dissolve slowly. An abundant secretion of saliva follows. Speakers and singers about to make an unusual effort should the night before take a glass of sugared water containing two drams of potassium nitrate (saltpeter) in order to induce free perspiration. In similar circumstances this gargle may also be used:

Barley-water.....	℥ vj;
Alum.....	℥ i-ij;
Honey.....	℥ ss.

Mix, and use as a gargle.

Or again, an infusion of jaborandi, made by putting two scruples of the leaves into a small cup of boiling water, may be drunk in the morning before getting up. The free sweating is said very quickly to restore the strength of the voice.—*Revue Med.; Lond. Pract.*

## HEADACHES IN CHILDREN.

When a child complains of headache our most careful scrutiny is demanded, and if it be too young to describe its sufferings its manner and appearance are highly suggestive of some cerebral disturbance. Look at the little child of some ten or twelve months old, who is well developed and comes of healthy parents. There is the excitement of dentition, and the little thing is observed to put its tiny hand to its head, which it rolls, perhaps, from side to side, and the anxious mother at last detects a slight irregularity in the muscular movements of the eye ball. Reflex nervous irritation is conveyed through the fifth nerve to the brain, and irritation so awakened may be followed at any moment by a convulsion. The child is wakeful, uneasy, and restless. The brain, so needful of rest at this early period of life, is susceptible of mischief. I think there is hardly a practitioner among us who on looking back has not, in the course of his early experience, had reason to think he has overlooked these significant symptoms, and at the same time felt surprise at having neglected them. Habitual headaches in older children indicate an exhausted and irritable brain, and if intellectual exertion be carried too far in such cases mischief is likely to ensue. It seems extraordinary that educated men who have the care of young persons should not see this danger in the anemia produced by over-study, the irritability and excitability of manner, and the impossibility of concentration, so necessary to the accomplishment of any undertaking. If intellectual exertion be carried beyond a certain point the brain becomes anemic, fatigued, and the nutrition in the ganglionic cells of the cortex becomes impaired, diseased, or in some way altered from health. Whatever may be the exact change in these cells, due perhaps in a great measure to the absence of healthy blood, the inference is most probably correct that children so suffering can not readily grasp new ideas; and if strong and powerful efforts are put forward in this direction the knowledge is not retained, the object is frustrated, one idea is mixed up with another, and confusion results. This, I apprehend, is just enough to illustrate the grand problem that the body must be looked to as well as the mind; and the younger the child, the greater is the necessity for the delay of intellectual training. And it does strike one as very extraordinary that the nervous system, which is the last to attain complete development, should be the first to be overtaxed in this age of forcing and strain, when revolutionary ideas are apt to overrule the judgment. It is not that the moderate exercise of the brain in early life is injurious; on the contrary, it is conducive to health. The mind is then flexible and plastic, impressions are enduring, and habits of concentration are easily acquired. It is the premature and excessive exercise of it which is prejudicial, when the bodily powers need the chief attention.

No rigid rules, no cast-iron system, will do for

the training of all children. All are not cast in the same mould. Any system of education must be elastic, since mediocrity is the rule; and it more be expected of some children whose physical development is at the same time feeble, then disease or premature ill-health is the consequence.

Headaches are often *hereditary*. They have attacked children of the same family who have been brought up at a distance from one another, and whose surroundings have been quite different. In such cases there is something peculiar in the nervous system itself—a tendency to nervous disease. It will, I think, be often found on inquiry that the parents of such children are liable to nervous disease, nervous exhaustion, paralysis, etc., and perhaps some children of the family have had epilepsy, chorea, or asthma. In many instances, too, there is some faulty condition of the blood. The brain, badly nourished through a scanty supply of blood, and that poor in quality, loses its balance and can not resume its tone.

I will now briefly allude to some of the varieties of headache in children. *Neuralgic* headache (one-side headache) is not a very common type in children, but it oftener occurs than is generally supposed. So far as my experience goes, it has been met with chiefly among *three* classes of children: 1. Those of the nervous temperament, whose nervous system is easily fretted, excited, and therefore sooner exhausted. If such children are pressed too much with their studies, then they the more readily suffer. Any degree of intellectual exertion is exciting to children of timid and delicate constitution, who are not only too anxious to learn, but can not throw their studies off the mind. 2. Those children who have been reduced by some long and exhausting illness, in-door confinement, and bad air. 3. Those born of delicate parents, and who are badly fed.—*W. H. Day, M.D., in Medical Press and Circular.*

## ON THE TREATMENT OF CONVULSIONS IN CHILDREN.

Eustace Smith, M.D., F.R.C.P. (London *Lancet*):

When called to a case of convulsions the practitioner should lose no time in questioning the attendants, but should have the child placed in a warm bath of the temperature of 90° F., and apply sponges dipped in cold water to his head. This is the time-honored remedy. It is certainly an innocent one; it may tend to quiet the nervous system; and it is one the efficacy of which is so generally recognized among the public that it would be unwise to court unfavorable criticism by neglecting to employ it. The bath must not be continued too long. In ordinary cases the child should be allowed to remain in it for ten or fifteen minutes, according to his age. If, however, the patient be an infant who has lately been reduced by an exhausting diarrhoea, he should not be allowed to remain more than two or three

minutes in the hot water, and cold applications to the head must be dispensed with. If the convulsions have ceased when the case is first seen the bath need not be used; but we should not omit to have the child completely undressed, and then to see that he is placed, lightly covered, in a large cot, and that the room in which he lies is well ventilated and not too light. Care should be taken to unload the bowels by a large enema of soap and water, and if the child be noticed to retch, his stomach may be relieved by a teaspoonful of ipecacuanha wine. In the case of a teething infant opinions differ as to the propriety of lancing the gums. There is no doubt that this operation is a useless one if employed with any hope of hastening the evolution of the teeth; but if the object be to relieve pain and tension I consider the practice judicious, and never hesitate in such circumstances to have recourse to it. If it be desirable to remove all sources of irritation, surely such a source of irritation as a swollen and inflamed gum should not be disregarded. Lastly, if it can be discovered that the child has had pain in the ear, or if the tympanic membrane can be seen to be red, the ear should be syringed out and fomented with hot water, and, if thought desirable, a leech may be applied within the concha, the meatus being first plugged with cotton wool.

If, in spite of these measures, the convulsions return, or signs are noticed of continued irritability of the nervous system, it is best to administer a dose of chloral. Two or three grains can be given to a child between six and twelve months old; and if the patient be unable to swallow, half as much again may be administered by the rectum dissolved in a few teaspoonfuls of water. If necessary, the dose can be repeated two or three times a day. Bromide of ammonium and balladonna are also largely employed in these cases. The former can be given in three or four grain doses every two hours to a child of from six to twelve months old; the second in ten or fifteen drop doses two or three times a day to a child of the same age. Infants are so tolerant of this drug that it should be given to them in a dose which can produce some appreciable effect. In the convulsions of hooping-cough where the spasm of the glottis is extreme, treatment by bromide of ammonium or potassium is especially indicated. The bromides are well borne by quite young children, and we should not fear ill consequences from what may appear a very large dose. Chloroform is often employed, but it is decidedly inferior to chloral and much more troublesome.

If the child has been lately the subject of exhausting discharges warmth should be employed, and stimulants, such as the brandy-and-egg mixture of the British Pharmacopœia, be given energetically. If the convulsive attacks are followed by signs indicative of intracranial mischief, such as stupor, squinting, ptosis, etc., the child should be kept quiet and an ice-bag be applied to his head. In all such cases the treatment must be conducted

according to the condition from which the convulsion is supposed to have arisen.

When the convulsions have ceased, and signs of irritability of the nervous system are no longer to be observed, we must take steps to improve the general condition of the patient. His bowels should be attended to, and his diet be carefully regulated. If rickets be present it must be treated. Most children in whom the convulsive tendency exists are benefited by iron, wine and cod liver oil, for their nutrition is usually at fault, and both the alcohol and the iron contained in the wine are beneficial, while the oil is of the utmost value in supplying nutritive efficiencies. Fresh air, too, is of the utmost importance, and the child should be warmly dressed and be taken regularly out of doors. *Louisville Med. News.*

### SODIUM NITRITE IN THE TREATMENT OF EPILEPSY.

By W. T. LAW, M.D., F.R.C.S. ENG.

In addition to the extensive list of remedies employed or recommended in the treatment of epilepsy, I wish to suggest a trial of another which I was led to select upon theoretical grounds in a case of this disease which recently came under my immediate and close observation for eighteen months. As evidence of my facilities for noting the effect of the remedies tried, it is proper to state that the patient, Mr. M., ætat. 29, was received into my own house for supervision and treatment, and that arrangements were made by which any attacks occurring either out of doors or during the night, could be noted. Briefly, the history and condition were as follows:—Patient's father died of apoplexy, but no other family story bearing on nervous disease could be elicited. Mr. M.'s habits were said to have been unexceptionable as regards drink and morals, and there was no suspicion of syphilis. In mind he had always been "below par," and though sent to various schools, learned very little. He had no fits at this time, but suffered from severe headaches, which often kept him in bed. At length he entered a college, and, after a good many years spent in trying to pass examinations, had his first distinct attack of epilepsy about a year and a half before he came under my observation. From that time he had numerous fits, but as he was not under complete surveillance, and the attacks were perhaps mostly nocturnal, it is impossible to estimate their frequency. In the summer of 1880, after a journey to see a relative, he had a seizure, followed by maniacal excitement for some hours, after which he was seen by Dr. Wilks, who recommended careful supervision in the house of a medical man. When he came under my charge I noticed that he was above the middle height, fair and muscularly well-developed; clean shaven, nearly bald, congested face, neck and hands. The latter were nearly always moist and often cold; nails much bitten. Contracted pupils, marked want of intelli-

gence in manner, slow speech, and great deliberation of movement. When walking, he partially extended his arms, as a rope-dancer might, and would touch any object he passed as an aid to muscular co-ordination, while the gait was jerky, uncertain and slightly ataxic in character. His mental powers were enfeebled and memory defective, though he exercised control over his property. In disposition he was reserved and secretive, and would carefully treasure up dirty fragments of paper and other rubbish found in the street. Curiosity and cunning were largely developed, and when a seizure was approaching, uncontrollable fits of giggling occurred. He resented the imputation of ill-health strongly, and cling tenaciously to the hope that, contrary to the opinion of various medical authorities who had seen him, he would shortly be able to resume his college studies. His great dislike of medication and intense desire of concealing his fits when they occurred rendered him difficult to treat, and he would deceive me as to his sensations, condition of bowels, &c., whenever possible. After much trouble I got him to take one daily dose of bromide of potassium, forty grains in the morning, with which I at once began, as a wound on the bridge of the nose indicated a recent attack. From this date, August 9th, 1880, fits occurred at the rate of two a week on an average, but always during the night, until November 18th, when I watched a seizure from the commencement at about 9 p. m. He was dozing over a newspaper held upside down which he had been pretending to read, when a low, peculiar cry indicated an attack. The eyes became fixed and staring, the chin advanced, and the face livid (I noticed no initial pallor). The chest walls seemed motionless and respiration suspended, but a gurgling sound resembling retching closely followed the initial convulsion of the limbs, which began in the arms and legs, which were forcibly extended, the former being rotated inwards and the fingers extended. Both sides seemed equally affected, or nearly so. With this the head rotated strongly to the left, the jaws closed firmly, and the pupils slightly deviated from their usual contracted state. Accompanied by deepening lividity, clonic spasms of the usual kind, and twitchings of the mouth succeeded, and I think most affected the right side. The convulsive stage lasted about twenty seconds, and terminated in relaxation and stupor; saliva, tinged with blood from a bitten tongue, running freely from the mouth. The lividity disappeared, and the pulse, which during the paroxysm had been frequent and tense, was now slowed and softened, and perspiration moistened the skin. The sphincters were unaffected, and I found the urine normal the next day. Thinking the bromide was losing its effect in warding off day seizures I gave borax till December 20th. In this time two day fits and seven at night were noted. Then followed bromide as before, with short intervals of iron aloes, till May 30th, with the result of

eleven attacks in the waking and fifteen in the sleeping state. Belladonna in twenty-drops doses with bromides of potassium and ammonium were given till October 30th, when three day and twelve night seizures were observed. Nitrite of sodium in twenty-grain doses was then administered until February 6th, when he passed from under my care. During this period a remarkable improvement took place. Three fits only were noted, diurnal on December 15th and January 10th, and nocturnal December 16th. During these latter months, the gait and general manner showed a change for the better. The giggling which formerly generally heralded a seizure almost entirely disappeared. A disposition to over-eat, and post-prandial drowsiness, greatly lessened, and his friends declared they had never seen him look so well before. Among the few particulars, however, in which but little improvement took place, was one I omitted to mention in its proper place, an offensive exhalation from the skin resembling the odor of corduroy, and differing from any I have observed among mental and nervous cases. To make the effect of remedies more easily apparent I subjoin a tabular statement, in which time is expressed by weeks in round numbers.

The general treatment was uniform, and consisted in careful dieting, restrictive in bulk, absence of all excitement, attention to the bowels as far as practicable, and constant watchfulness to repress the tendency to mischievousness which so often accompanies brain deterioration.

Weeks.	Seasons.	Number of Fits.		Total.	Remedies used.
		Day.	Night.		
14½	Summer.	—	28	28	Bromides of pot. sodium and ammonium.
4½	Winter.	2	7	9	
23	Winter and Spring.	11	15	26	Borax.
22	Summer.	3	12	15	Bromides, with intervals of iron and aloes.
14	Winter.	2	1	3	Bromides with belladonna. Nitrite of sodium.

The object in this paper is to advocate the claim of nitrite of sodium to a trial in epilepsy. One case of course is of little value, and I am far from wishing to do more than suggest a trial; and, as it is not likely to be equally valuable in all forms of this malady, I thought it best to describe rather fully the present case in which it seemed of great service. So far as I am aware, this drug has not been used as a remedy for epilepsy, but, assuming that the nervous discharge or explosion is associated with cerebral anæmia—a view which receives clinical support from the initial pallor of the face and high tension of the radial pulse, as well as from the usefulness of belladonna in certain forms, and of nitrate of amyli during the paroxysm—it seemed natural to look for a remedy capable of influencing the vaso-motor apparatus, and, although I am aware that nitro-glycerine—an agent of this class—failed in the hands of Dr. Gowers, I tried sodium nitrite, a drug whose action

is believed to be similar to that of amyl nitrite, but more persistent, with the results shown in the above table. In this statement the number of seizures only is dealt with, but they really varied little in severity, as I have purposely excluded those slighter attacks of momentary duration which occurred now and then, and were not recorded.

On three or four occasions (under bromides) the bladder and rectum emptied themselves, but, so far as I know, evacuation of the vesiculæ seminales, voluntary or otherwise, was not a feature of this case. The fits nearly always took place after dinner, from 8 to 9. 30 p. m. Mr. M. denied any aura or warning, but I believe headache often heralded a seizure, as did certainly giggling without cause, and drowsiness. He would eat bread in large quantities if allowed, and I am firmly convinced of the truth of Dr. Radcliffe's dictum that epileptics should be rather under-fed than otherwise. It is unnecessary to dwell at further length upon the features of a case which, save in respect of treatment, is of no unusual kind, and I must therefore conclude my remarks with the hope that those members of the profession who have the opportunity will test the value of nitrite of sodium, and the nitrites generally, and make public their results.—*Practitioner.*

## THE TREATMENT OF GONORRHOEA.

By J. R. STURGIS, M.D.,

Clinical Professor of Venereal Diseases in the Medical Department of the University of the City of New York.

It is important to bear in mind the distinctions into which the gonorrhoeal affections should be divided, according to their seat, viz., urethritis, vaginitis, metritis and the like.

This lecture I propose to devote to a consideration of the local treatment of urethritis in the male as contra-distinguished from the constitutional or internal treatment, which I shall reserve for another lecture.

Many teachers and writers on medicine decry the use of injections under the plea that the cure is worse than the disease, that the use of injections induces swelling of the testicles, inflammation of the bladder, etc. Now, I wish to tell you here, at the outset, that this is unqualified nonsense. There is no better nor more speedy way of curing clap, and of preventing the severe, and, at times, dangerous complications than a proper use of injections. Injections, then, are the main-stay in the treatment of clap; but to derive the most benefit from them they should be given understandingly, and the rules for so doing I propose giving you to-day.

I wish you now to recall some of the points I laid down about the course and progress of a urethritis.

First, as to its course: it begins within the first half inch of the urethra, and invades the deeper

portions of the canal continuously; and, secondly, as it attacks the different portions of the canal it goes through the different stages of commencement, stasis and decline, marked by different characters in the discharge.

Some cases of clap, especially first attacks, are attended by a very marked amount of inflammation, in which the penis is enormously swollen, hot and red, and in which micturition is only accomplished with extreme difficulty, and in drops, often accompanied by blood. In such cases the treatment must be antiphlogistic and expectant. Abstraction of blood by the application of leeches to the external abdominal rings, to the perineum, to the inside of the thighs (never to the penis itself), is both proper and effective, and this should be followed by frequent and prolonged douching of the inflamed genitals in as hot water as patient can bear, to the point of producing faintness. In this stage no injections can be used, and it is probably from non-observance of this rule, and from the attempt to abort a clap by using strong injections that these latter have acquired such a bad name. About this abortive treatment of clap I shall have a few words to say in a minute. For the *ardor urinae* I know of nothing that will afford the unlucky patient more comfort than by making him pass his water under water, i.e., in a mugful of hot water. Drugs internally are of little, if any, service; the two best are the homœopathic tincture of cannabis sativa given in v-x minim doses every two or three hours, or the oil of cubebs, x-xv minims in the same manner. If the fever run high, the use of the tincture of aconite root (Fleming's)  $\pi j$  every hour may be used with advantage, but the patient, while using this remedy, should be carefully watched, as the drug is very active and poisonous. The diet should be bland, what is technically called "slops," and all meat, and stimulating food carefully excluded; the drink should be of the same character—milk or water, or the two combined, but nothing else.

When the next stage, that of stasis, is reached, a decided change in treatment takes place.

First, all antiphlogistic treatment is stopped, and the patient is placed upon a good, nutritious diet; no starving now, gentlemen, but a healthy regimen.

The drinkables, however, are not increased; all stimulants, fermented or distilled, are absolutely forbidden, and the patient's liquid refreshment confined to milk, water, and milk and water, or tea and coffee, of which one-half is milk. But more than this savors of evil, and is not to be thought of.

Now is the time for injections, but to be of service they must be properly used. The abortive method, which at one time was frequently tried, I advise you to have nothing to do with. The *modus operandi* was to give one or two injections of a very strong solution of nitrate of silver, and to induce increased irritation in the hope that the greater would remove the lesser. But, vain hope, gentlemen, the course of a clap can seldom be aborted, and the risk run is too great. Severe hemor-

rhage, œdema of the penis, swelled testicle, and stricture, are some of the penalties paid for this experiment, and I pray you, remember, in this, as in some other instances, that with too great haste there may be less speed. We will adopt, then, what is known as the continuous treatment, and the two requisites are a syringe and a medicated fluid for injection.

[Here Dr. Sturgis describes several defective hard-rubber syringes, and then refers to one which meets his approval. The description he gives of it, as will be seen below, fits the "Royal" Excelsior "P" Syringe, illustrated on one of the advertising pages of this journal.—Editor RETROSPECT.]

The last one, C, is the best of all, and combines all the requisites of a good urethral syringe. First, in capacity, it holds about half an ounce of fluid, a quantity needed to distend most urethrae, and to obliterate the folds of mucous membrane in which the discharge is retained; second, its conical end is admirably adapted to put the injection where it will do the most good with the minimum of irritation; there is no nozzle to scrape and tear an inflamed membrane. The apex, as you see, is smooth and even; third, flaring out, as it does, from the very apex, it closes the meatus completely without the necessity of pinching the penis, and the injection does not flow over nor stain the patient's clothing; and, fourth, the piston work easily and smoothly, throwing the fluid into the canal without producing pain or discomfort.

Now, as to the manner of injecting. Some among you may laugh at the fussiness of these details, but let me tell you that carelessness in this respect has been the cause of many an innocent clap. Before using the injection the patient should be directed to empty his bladder, and the penis should be grasped between the middle and ring fingers of the left hand, the palm looking upwards. This leaves the thumb and index finger free to open the meatus, which should be done laterally, and not from above downwards. The syringe, already charged with the injection and freed from air, is then inserted between the distended lips of the meatus, where it is steadied by the index finger and thumb of the left hand, while the index of the right hand is placed at the end of the piston of the syringe and gently presses the injection into the canal. If these directions are carefully carried out no fluid escapes. As soon as the urethra is well distended the syringe is rapidly withdrawn and the fingers of the left hand stationed at the meatus are approximated, closing the canal and retaining the injection within, while with the fingers of the right hand, now released from duty, the floor of the urethra is stroked from *behind forwards* to press the injection towards the fossa navicularis, where during the early stage the disease is situated. In the later stages of gonorrhœa this process is reversed, as the disease then lies further back.

The injection is the next thing to be considered, and the simpler it is the better. There are two which I commend for use, viz., the acetate of zinc

and boracic acid. They should be used rather weak at first and increased as occasion requires, but should never be made so strong as to produce severe smarting. All that is requisite is a slight degree of warmth for three or four minutes duration. The following formulæ are the best:

℞. Zinci acetatis...0.12—0.36—(grs. 2 to 6)  
 Aquæ distil.....30 (℥ j).  
 and  
 Acidiborac...0.48—0.96—(grs. 8 to 15)  
 Aquæ distil.....30 (℥ j).

In addition to the local methods an internal treatment is employed, the consideration of which we will take up at the next lecture.—*Medical Gazette.*

### FOREIGN BODIES SWALLOWED.

At a recent meeting of the Boston Society for Medical Observation (*Boston Med. and Surg. Jour.*) Dr. Reynolds introduced the subject of swallowing foreign bodies, and said: The profession possesses in its classical treatises accounts of an endless variety of foreign bodies that have passed in safety through the alimentary canal. When, however, unusually large or very ill-shaped bodies are to encounter the delicate structures of the intestine in very young subjects, the attendant often finds it hard to put once more unlimited confidence in the natural powers. It is, therefore, perhaps not unwise to place on record any such instances.

A girl of eight years, holding between her lips a smooth, oblong stone, as large as the last phalanx of an adult thumb, suddenly threw herself back on the floor, and in doing so swallowed the stone. The enemy was voided at stool between forty and fifty hours later. The child ate heartily after the accident, took no medicine, and suffered neither pain nor disturbance of health. Unfortunately the stone cannot be exhibited, as the nurse, thoughtlessly, threw it away. It was, however, well known, and was easily recognized.

Dr. H. I. Bowditch related a case in which a little girl, three years old, swallowed a leaden button. The parents, being much alarmed, gave her, with the consent of a physician, a dose of castor oil. Afterwards nothing special was done, and at the end of a week the button was passed from the anus without suffering. Dr. Bowditch said that in his opinion the oil was unnecessary. Certainly repeated dosing, from the liability to produce ill health, should be avoided. A plenty of substantial, rather loosening food, so as to keep the bowels easily and normally opened, was better. Bullets often lie in various parts of the body, and are harmless. Why, then, be alarmed in such a case as the above?

Dr. Brown said it was bad practice to give cathartics or watery substances in such cases. The aim should be to solidify the fœces so as to envelop the object, and milk would be a good diet for this purpose.

Dr. Ingalls reported a case in which a man had swallowed a peach stone. It had come as far as the rectum, but could not be passed further. As it was too high to be reached with the finger, the patient was etherized, and the stone was extracted by the aid of forceps.

Dr. Bush said that it was the custom with persons who attempted to pass spurious coin to swallow them, often, to avoid detection. In such cases their diet was composed of hard-boiled eggs, they having found by experience that this diet rendered the foreign body harmless, by enveloping it in a coat, and in about three days the coin would be found in the faeces.

Dr. Fitz said that if the junction of the pharynx with the œsophagus was the narrowest part of the alimentary canal, anything which will pass this point will pass through the other parts without trouble. Hence if a body of good shape has been actually swallowed, no alarm need be felt.

#### SUBCUTANEOUS INJECTION OF ETHER IN PNEUMONIA.

From experience in fourteen cases, Dr. Barth, *Lyon Med.*, strongly advocates the subcutaneous injection of about one gramme of ether in adynamic pneumonia. Almost instantly respiration becomes easier, pulse gains in strength and fullness, while the color of the face becomes more natural. In two or three minutes the ethereal odor is noticed in the breath, showing that the volatile liquid has reached the air passages. It is necessary to use the injection at least twice a day, and in severe cases four doses may be thus administered in twenty-four hours without inconvenience. Dr. Barth has not exceeded this dose, nor has he experienced any trouble from the punctures, in the way of serious irritation.—*Glasgow Med. Journal.*

#### TREATMENT OF PUERPERAL MASTITIS BY IODIDE OF LEAD OINTMENT.

The breast being thoroughly dried and perfectly cleansed, we smear its surface with the official ointment of the iodide of lead, and then gently rub it in until a considerable quantity is absorbed. Soak a piece of sheet-lint, of a size sufficient to cover the breast, in the following solution: acetate of lead from 3 ij to ̄ ss to the pint, of a one-to-four solution of alcohol. If we desire a more elegant preparation, eau de cologne may be substituted. If there be much pain, it is often used to apply an ice-bladder upon the sheet-lint covering the breast. The lint should be frequently dipped in the lead lotion. The following phenomena will present themselves: first, a cessation of pain, fullness and uneasy feeling of distention, which is so annoying. It is common for the patient, who has been exhausted by pain, and consequent loss of sleep, to fall into a refreshing slumber even after

the application is made. In the course of three or four hours, the breasts may be completely emptied by an experienced hand. The ointment should be used as a lubricant during the manipulation. By applying the iodide freely twice, or thrice, daily, the secretion will be gone in less than one week, as a rule. The pivotal point in the treatment is the use of this ointment; the evaporating lotion, and cold being only adjuncts. I have proved by repeated trials that, when applied alone, it is capable of exerting an absolute control over the secretion. I believe we here invoke a specific action from the lead iodide. A point of considerable moment is the partial anesthesia it is capable of inducing, which thus enables us to empty the glands, where before even slight pressure was badly borne. Its action without doubt extends to the epithelial cells and inhibits their secretory activity, as is seen in its action, in cases like the above, in causing the drying up of the secretion.

\* \* \* \* A word as to the use of belladonna. I must confess that I have met with poor success from its employment. My experience may have been exceptionally unfortunate, but reasoning from it alone, I could not recommend it as capable of accomplishing more than the expectant treatment—*Dr. Thomas T. Gaunt, in American Journal of Obstetrics, October, 1882.*

#### MIDWIFERY IN THE SANDWICH ISLANDS.

The brother (non-medical) of one of our members resident in Honolulu, gives the following description of the *modus operandi* of the Hawaiian midwife. "The midwives here are for the most part men—usually old men. When the woman's time draws near and labor commences, she is placed sitting on a man's knee with her back to him. He then clinches his hands over her abdomen, and with all his strength hugs the woman, until the child is actually forced into the world, falling to the floor between the operator's feet. The umbilical cord is then cut, and always left very long. Then the woman is placed upon her feet, and the midwife takes her tongue, and draws it steadily until she gulps, or retches, this action causing the prompt ejection of the after-birth. After this she goes and flounders about in the sea, and returns to land, ready for such domestic duties as may fall to her lot or inclination. Native children are—as may be inferred from the way in which they are introduced to existence—very easily born; but should the baby stick at all, or make any bother about being born, then the mother knows it is going to be half white, as this latter kind of baby is so much bigger in the forehead. It is a wise child that knows its own father in this country. So well recognized is this fact that natives never ask, 'who is your father?' but only, 'Who is your mother?' when they desire any acquaintance with one another's genealogy."—*Brit. Med. Journal.*

### TREATMENT OF GONORRHOEA BY INJECTIONS OF SULPHUROUS ACID DILUTED WITH WATER.

For some time I have treated all cases of gonorrhoea with injections of sulphurous acid diluted with water, and as the results in my hands have been very satisfactory, I write in the hope that others may be induced to give this method a trial.

I do not offer any theory on the subject, I simply state the fact that I have now treated sixteen cases of gonorrhoea, using no other medicine, and they all returned to duty in an average of six days. I have not observed a relapse or any bad effect. The majority of the cases were second attacks, but those suffering from primary attacks of the disease recovered equally fast.

When I commenced this method of treatment I used much stronger injections than I do at present. I find sulphurous acid one part to fifteen of water quite strong enough for most cases. The rules of treatment I recommend are: place the patient on low diet, and administer injections of sulphurous acid diluted in water one to fifteen, three times a day, no other treatment being necessary. I find it is necessary for the attendant to give the injections, for if it is done by the patient it is never well done, most of the fluid escaping back outside the nozzle of the syringe. The injection should be kept in the urethra from three to five minutes. If the patient complains of much pain, or if there is a tendency to chordee, it will then be sufficient to administer the injections once or twice in twenty-four hours.

If these instructions are strictly followed the purulent discharge will become scanty at the end of the first day, and on the third it will be replaced by a thin, gleet discharge, which also disappears in a couple of days. While this watery discharge lasts I usually administer only one injection daily. I find that the first injection frequently causes pain, which is not so much complained of afterwards.

I, therefore, in a few cases give the first injection very much diluted—one in twenty, afterwards using one in fifteen. It is necessary to see that the sulphurous acid is fresh and good before it is diluted to the required strength—*W. D. Wilson, M.B., in London Lancet.*

### TO HASTEN THE ACTION OF QUININE.

Dr. Starke, in *Berliner Klin. Wochenschrift*, advises that before swallowing powder or pills of quinine, a weak tartaric acid lemonade be taken. This procedure not only greatly accelerates the solution and absorption of the quinine, rendering its physiological action much more prompt, but also obviates that unpleasant gastric irritation so common after the administration of large doses of this drug.

### THE TREATMENT OF CROUP WITH "HYDRARGYRI SULPHAS FLAVA."

In 1880 Dr. Fordyce Barker, of New York city, published an article in *The American Journal of Obstetrics* on the treatment of croup which was thorough, indeed exhaustive in character, and elicited favorable comment at home and abroad. The chief reliance of Prof. Barker was upon the therapeutic properties in such cases of the turpeth mineral.

His reasoning, to my mind, was so clear, and his success so uniform, indeed, wonderful (for he tells us for twenty years since he began the use of this drug in croup, he has not lost a case), that I was determined to give the agent a fair and impartial trial.

Dr. Barker insists upon the early administration of the drug; indeed, he regards it of the first importance that it should be given in the very incipency of the attack, and in order to meet this early necessity, he advises the families in which he is the medical attendant to keep turpeth mineral powders in three-grain doses always at hand, and to give one at the very beginning of the attack. For twelve years, after the manner of Dr. B., I have been using the turpeth mineral in the treatment of this disease, and I have, since the adoption of this plan, lost no case of croup.

My treatment has been, immediately upon being called to a case, without stopping to interrogate very closely as to whether I have a croup reflex, catarrhal, or true croup, to administer at once a dose of the agent (from two to five grain, according to age) in honey, syrup, or sugar of milk, and if there is no decided emesis within fifteen minutes, to repeat the dose; and I have never known it to fail to vomit at the second dose; almost immediately a satisfactory response is secured by the first administration. The vomiting is usually free, without effort, and without depression. The powder is tasteless, small in bulk, prompt in action, and thorough in effect.

The virtues claimed for it are sedative and revulsive. "It depletes the mucus, which is thrown up; it removes from the larynx, by the forced expiration which it causes, any albuminous or fibrinous exudation which may be there in diffused state, and which, by remaining, may become, subsequently, pseudo membrane; it acts as a powerful revulsive, and thus diminishes the capillary circulation in the trachea and larynx; and thus it becomes a most effective agent in arresting the inflammatory forces."

If the croup persists after removing the causes of reflex action, then, of course, other therapeutic agencies will need to be essayed; but throughout the attack, be it short or long, whenever the breathing becomes suffocative from the accumulation of mucus in trachea of larynx, I give the turpeth mineral in the manner and according to the conditions and plan above designated.—*E. R. Duval in Ark. State Transactions.*

## TREATMENT OF PHTHISIS.

W. H. Hughes, M.D., in the *Medical Bulletin*, in an article entitled "Treatment of Phthisis," writes: While there has been advancement in the knowledge of the cause and symptoms of phthisis, the treatment has not progressed sufficiently to enable us to control its terrible effects to any degree. Having a large number of applicants suffering from this malady he has adopted, after devoting considerable time and study to the various modes of treatment, a method which he has employed in practice and from which he has obtained valuable results. The agent he employs is petroleum mass. It acts as an anodyne alternative, and reduces the irritation and inflammation of the bronchi and trachea, relieves the cough, and by its healing and soothing qualities prevents further destruction of the organ. When an abscess has formed, a cicatrix may be secured which enables the lung to resist the deposits from becoming embedded in the tissues, and prevents the formation of additional abscesses. Out of nearly one hundred cases Dr. Hughes has treated during the last thirteen months, there were but three whom this remedy would not relieve. Seven died, and sufferings were greatly relieved by the use of this remedy. The formula used is petroleum mass, one ounce; powdered cubeb and Dover's powder, each half an ounce; sulphate of cinchonidia, two drachms; make into pill mass. Divide into four grain pills; one every three or four hours. The following results are to be expected from its use: Diminished expectoration, alleviation of the cough, cessation of night sweats, disappearance of tightness and soreness of the chest, gradual restoration of appetite, digestion and strength. As no living thing can exist in petroleum oil, may not the favorable results of this remedy be due to its action on the microscopic parasite?—*Chicago Med. Rev.*

## MINIMUM DOSES OF IODIDE POTASSIUM IN FRONTAL HEADACHES.

Dr. Haley draws attention to the powerful anticephalagic properties of this drug when used in small doses. As a rule, a heavy, dull headache situated over the brows, and accompanied by languor, chilliness, and a feeling of general discomfort, with distaste for food, which sometimes approaches to nausea, can be entirely removed in about ten minutes by a two-grain dose of iodide of potassium dissolved in about half a wineglassful of water, this being quietly sipped, so that the whole quantity is consumed in about ten minutes. This class of headache seems to have no particular or definite cause, belonging apparently to the class of sympathetic headaches. In many cases the effect of these small doses is simply wonderful, and their great advantage is the rapidity with which they act.—*Australian Medical Journal.*

## BORACIC ACID OINTMENT.

M. J. L. Championnière recommends an ointment made of vaseline and boracic acid as an antiseptic mixture, which can be preserved indefinitely, and is of great value, being non-irritating.

It forms a bland ointment suitable for superficial ulcers or wounds which are not to be irritated; it is applied on a cloth, on salicylated or absorbent cotton batting.

It can be used with advantage as an application for eczema and intertrigo, which, although not parasitic, give rise to lesions containing and keeping them. There is no better topical remedy for the erythema of the buttocks of infants. It is an ointment always clean and aseptic to grease the finger and instruments. Wherever there is an irritated wound it is a most valuable topical application.

Boracic acid is a less energetic antiseptic than carbolic acid; but its action is nevertheless powerful. The author has successfully employed it in very fetid eczemas, and in fetid sweating of the feet. After washing the feet the ointment is applied in the interdigital spaces; the effect is very good.

The following is the formulæ of the ointment:

Boracic acid, finely powdered.....1 part.  
Vaseline.....5 parts.

The acid must be very finely powdered and sifted, and not dissolved in glycerine or alcohol, as this renders the mixture irritating.—*Jour. de Med. et de Chirurg. Prat.*

## DEFICIENT KIDNEY-ACTION IN ECZEMA.

Dr. L. Duncan Buckley (*New York Med. Record*) states that deficient kidney-action is a common symptom of eczema of the anus and genitals. In this disease the urine is seldom that of health. The most varied conditions may be reported, but a most common one is a copious deposit of amorphous urates. Frequent and imperative micturition is not at all uncommon, and the repeated calls to urinate at night and the itching will often act and react upon each other, rendering sleep almost impossible. For this condition Dr. B. recommends:

℞ Potass. acetatis..... ℥ j;  
Tinct. nucis vomicæ..... ʒ ij;  
Infus. quassiaë..... ℥ iv.

M. Teaspoonful after eating, in water.

This is often continued during the entire course of treatment. A large amount of oxalate of lime is sometimes found in the urine of eczematous patients. The oxaluria may be quickly relieved by strong nitric acid, internally, in doses of about two drops taken after each meal.

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## VITAL STATISTICS AND PUBLIC HEALTH.

The Board of Health of the City of Montreal is deserving of much praise for the persistency with which (under the direction of Dr. Larocque, their health officer, and Alderman Mooney, their chairman) it has followed up the question of Vital Statistics and Public Health. During the past year it held several conferences with the Medical Societies of Montreal, and at the last session of the Quebec Legislature a Health Bill, the result of their efforts, was introduced and reported by Committee, but, as the House was about to close, it did not advance further. In the meantime the Hon. Mr. Chapleau handed over the reins of government to the Hon. Mr. Mousseau, who, in November last, received at the Government offices in Montreal a deputation on health matters. It did not seem to be very clear to the mind of the Premier of the Province of Quebec what powers in such matters were, by the Act of Confederation, relegated to the Local Government. It was accordingly arranged that the deputation should on a certain date proceed to Ottawa and interview the Hon. Minister of Agriculture on the subject; the Hon. Mr. Mousseau, in the meantime, coming to an understanding with the Dominion Government as to its jurisdiction and that of the Local Governments. On the 7th of November the Hon. Mr. Mousseau met the deputation in Ottawa, and informed it that the question of Vital Statistics belonged to the Federal authorities, and matters of Public Health to the Local Parliaments. He subsequently accompanied the deputation to the Hon. Mr. Pope, Minister of Agriculture, who, after hearing their opinions, stated his own very great interest in the subject, and promised to do something to meet their views at the approach-

ing meeting of the Dominion Parliament. In the meantime the Montreal Board of Health put itself in communication with Charlottetown, P.E.I., St. John, N.B., Halifax, N.S., Quebec, Montreal, Ottawa and Toronto, and, after exchange of correspondence between these points and the Government, the latter asked that a deputation from these various centres should, at its expense, proceed to Ottawa, and, after conference, lay the result of their united deliberations before them. The deputation assembled in Ottawa on the 7th of December last, to the number of about fifty, and held two long sessions in the Russell House, the chair being occupied by Alderman Mooney, chairman of the Montreal Health Board, the result being the adoption of the following resolutions:

*Resolved.*—That, in the opinion of the meeting, in order the better to prevent disease and preserve human life, it is advisable that the Dominion Government should organize and sustain a uniform system of vital statistics for the Dominion.

*Resolved.*—That, as immediate action is necessary, the Federal Government be invited to initiate at once a system of vital statistics, where organized Local Boards of Health are established, so that the statistical information may be utilized by these bodies.

*Resolved.*—That, as Provincial legislative action is necessary, it is suggested to the Federal Government that it communicate with and secure the co-operation of the Provincial Government to pass such legislation as will harmonize with and obtain the object of the preceding resolutions.

*Resolved.*—That it is desirable that a central bureau of statistics be established, and, if found to be within the province of the Federal Government, a comprehensive system of health returns.

The following day, December 8th, the deputation proceeded to the Railway Committee room in the Parliament buildings, and met the Hon. Sir Charles Tupper, M.D., who, after reading the resolutions, stated that in his opinion they were to be commended for their very moderate tone. He then said that when he left London, just previous to the passing of the British North America Act, he was fully of the impression that matters of public health, like Quarantine, Vital Statistics, and kindred subjects, had been assigned to the Dominion Government. When the Bill passed, and he received a copy of it, no one was more surprised than he was to learn that Public Health matters have been relegated to the Local Houses. He said he had no hesitation in saying that, in his opinion, this was

a great mistake, a mistake so serious that he felt justified in suggesting to the deputation that they pass a resolution drawing attention to the fact, and suggesting to the Dominion Government the propriety of, at an early day, approaching the Imperial Parliament, with a view of having the Act of Confederation amended in the direction he had indicated. Sir Charles then withdrew. Acting upon this suggestion Dr. F. W. Campbell drew up the following resolution, which was moved by the Hon. Dr. McNeill Parker, seconded by Dr. Campbell, and carried unanimously :

*Resolved.*—That, inasmuch as it appears by the British North America Act that matters of public health are relegated to the Local Government this delegation has not included it with the subject of Vital Statistics ; nevertheless they are of opinion that it would have been better had it been under the direction of the Federal Government, and beg to suggest that an effort be made to obtain an amendment to the constitution in that direction.

The Hon Mr. Pope, Sir Charles Tupper, M. D., and the Hon A. P. Caron, then entered the room, when Alderman Mooney in a few words stated the object which the very large delegation had in visiting Ottawa, and then presented the resolutions. Hon. Mr. Pope said that he was deeply interested in the subject, and, as his ideas were of course crude, he felt deeply indebted to the delegation for the valuable assistance they had given him in the resolutions which they had presented. He would lay them before his colleagues, of whose sympathy and co-operation he felt assured. Sir Charles Tupper and the Hon. Mr. Caron also spoke, the former alluding in forcible terms to the financial saving which the country might gain by a proper use of the information obtained through the collection of vital statistics. He believed no more important subject could engage the attention of a Government. The delegation then withdrew, and almost immediately afterwards met at the Russell House, when Dr. Taché, the Deputy Minister of Agriculture, laid before them a scheme for the collection of vital statistics, which he had prepared at the direction of the Hon. Mr. Pope. At present it is intended to confine their collection to cities of about 25,000 inhabitants, and to gradually extend the operation of the scheme to other places, and eventually to embrace the whole Dominion.

The cost of the collection from the principal cities is estimated at \$15,000, which sum it is understood will be voted at the forthcoming meeting of Parliament. No new legislation is required

on the subject, as, under the Census Act of 1879, the Government has the requisite authority.

We consider that much has been obtained by the united efforts of the last delegation, which was a most influential one. If the Government will but put into operation the ideas of the convention, which views seemed to meet with the full sympathy of the members of the Government who were present, Canada will before long be free from the reproach which now attaches to her, of not taking an active interest, in the sanitary welfare of her population. In no small degree will credit for this be due to the members of the Montreal Board of Health, who, while working for their own interest, have shown a breadth of view which we might suggest it would be well if some other portions of the Dominion were to imitate.

We had almost forgotten to mention that the Hon Mr. Pope entertained the members of the delegation to a sumptuous banquet, at the Russell House, on the evening of their arrival. The toast of the host was proposed by Dr. F. W. Campbell, and the Hon. Mr. Pope in replying said that, concerning the details of the great question, which had brought them to Ottawa, he was comparatively ignorant, while to his guests it was one, with which they were quite familiar. He hoped they would be moderate in the demands which they would make, but that before a great while the country would become educated upon the question, when a full and complete scheme might be put in operation.

#### STUDENTS' TROUBLES.

Medical students it seems have their troubles as well as other people. The Royal College of Physicians and Surgeons of Kingston, perhaps better known as the Medical Faculty of Queen's College, have this year (and we think also last year) among their students seven ladies. The relationship between them and the male students seems to have been at least fairly cordial till a week or two ago, when the ladies took umbrage at something uttered in the class of Physiology, and in a body left the class room. Immediately the male students were up in arms, and insisted that females should not be taught with them. For a brief period the Faculty were firm in resisting the demand. The male students were equally determined, and decided to leave the school in a body if their request was not granted. They telegraphed their situation to all the other medical schools in Canada, some of

which offered favorable terms. This brought the Faculty to a full realization of their position, and the flank movement of the students was successful, the Faculty granting all they asked. In future male and female students will not study together in Kingston. We think the decision a wise one. If females will become doctors, and the public think they should, then they must be educated alone. Capital is being made of the fact that one school insisted upon the students at Kingston having their three months attendance certified before accepting them. This, of course, was simply refusing them, and Kingston has a right to feel grateful, but that does not prove that the other schools who offered better terms did wrong. We believe each school knows best how to conduct its own business, and acted accordingly. It was their action which brought the Kingston Faculty to terms, and perhaps in the long run it may turn out that after all they caused the Royal College of Physicians and Surgeons of Kingston to act in a way which will redound to their best advantage.

The Primary students of McGill Faculty of Medicine have this month revived in a spirited way a grievance which almost every year for the past twenty-five years has come to the surface. They complain that the lectures given by the Rev. Dr. Wright, Professor of *Materia Medica*, are not such as they require; that they are by far too minute, and that as they cannot find the matter in books they have to depend upon notes. These they cannot take as the Professor lectures too fast. They have petitioned the Faculty, but this has been done before, and has never resulted in any improvement, because, if we understand the matter right, the Faculty are powerless to act. They intend also to petition the Governors of the University, and we hope these gentlemen will deal with the matter as it deserves to be dealt with. We sympathize with the students because we know that the grievance is a real one. Our only wonder is that it has been allowed to continue so long.

#### OBITUARY.

Dr. R. H. Russell, a distinguished physician of Quebec City, died on the 7th of December. Although in poor health for some time, he continued practice up almost to the time of his death. Dr. Russell was for many years a Governor of the College of Physicians and Surgeons, and had filled the Pre-

sidential chair. He was an M.D. of Edinburgh University.

Dr. J. R. Dickson of Kingston, Ont., died late in November. He had for several years been laid aside from active work. He came to Canada in 1837, having received his medical education in Glasgow and Belfast. In 1854, when the Medical Faculty of Queen's College was organized, he was elected its President and to the chair of Surgery. Up to his death he took a warm interest in its welfare. He was the first President of the Ontario College of Physicians and Surgeons.

#### THE ANNUAL MEDICAL DINNERS.

Hitherto in public estimation noise and boisterous conviviality have generally been considered characteristic features of Medical Students' Dinners; not because improprieties were more common or glaring than in other similar gatherings, but because the reputation for recklessness and dissipation earned by medicos in years gone by has ever since clung pertinaciously to them, no matter how well-regulated their conduct may now generally be. In order to improve the reputation and elevate the tone of Students' dinners, many medical schools have instituted an *Annual Medical Dinner*, where students, graduates and professors meet on equal terms to enjoy friendly social intercourse; and that the very suspicion of reproach may be obviated, the dinner is usually conducted upon temperance principles. Last year Bishop's College inaugurated this plan in Montreal with decided success; this year both Bishop's College and McGill held an annual medical dinner upon temperance principles at the Windsor Hotel, Bishop's on the 13th and McGill on the 18th inst. Besides students, graduates, professors and representatives from other colleges, the Consul-General of the United States and many prominent citizens were present as invited guests. If a good dinner, good music, good songs and speeches, and general good humor are any indications of success, both these reunions must be pronounced eminently successful.

#### COLLEGE OF PHYSICIANS AND SURGEONS, PROVINCE OF QUEBEC.

Drs. Henri J. Girouard, of St. Johns, P.Q., Herbert E. Shepherd, of Portage du Fort, and Henry Harkin, of the city of Montreal, have been registered under the new law.

John Bishop, over 25 years practicing medicine in the township of Dudswell, county of Wolfe, has been prosecuted as an unqualified practitioner, has paid the fine, and promised to not practice any more.

A second action has been taken out against a man by the name of Joseph Rendpré, residing at Ste. Anne de la Perade. This unqualified practitioner paid a fine in June, 1881.

Two actions have been taken out against a man named Isidore Provençal, residing in the parish of Windsor Mills, county of Richmond. One of these actions is for acting as an accoucheur, and the other is for the illegal practice of medicine.

#### CALENDARS OF BISHOP'S COLLEGE.

If any of the readers of the RECORD have in their possession copies of the fifth Annual Announcement of Bishop's College Faculty of Medicine, the Faculty would feel obliged by their being sent to the Registrar. College announcements were at one time thought not to be of any value, after the Session for which they were issued had passed. Their importance as historical records is, however, now recognised, and quite a number wish to complete sets.

#### A NEW SIGN OF PREGNANCY.

The *American Journal of Obstetrics* says that Jorissenne (*Arch. de Tocologie*) has furnished a sign by which we can diagnose pregnancy during the first two months. Starting with the assumption that in pregnancy there is a hypertrophy of the heart (and this assumption, if erroneous, will not affect Jorissenne's results), he has found that, while in health there is a variation of from ten to twenty beats in the radial pulsation, according as the body is upright or horizontal, in pregnancy, no matter what the position, the beats number the same. Jorissenne has been able to diagnosticate pregnancy as early as the first month, when no other sign except the missing of a menstrual period was present. When examining a patient for this sign, it is necessary to proceed with deliberation, first counting the radial for the space of fifteen seconds while the patient is standing, then sitting, then reclining. The order may then be reversed, and uniformly the same number of beats will be recorded. Jorissenne promises an explanation of this phenomenon in a future paper.

#### PERSONAL.

Dr. H. E. Poole (M.D. McGill, 1880) has located in Ormstown, Que.

Dr. J. C. Shanks (M.D. McGill, 1881) has settled in Howick.

Dr. J. W. Cameron (C.M., M.D. Bishops, 1882), lately House Surgeon to the Woman's Hospital, has commenced practice near Brasher Falls, N.Y.

Dr. Prendergast (C.M., M.D. Bishops, 1882) has his shingle out at Cote des Neiges, near Montreal.

Dr. Jameson (M.D. McGill, 1877) is President and Professor of Chemistry of the University of Kansas City.

Dr. Wilkins, Professor of Physiology, University of Bishop's College, has been appointed Examiner in Physiology and Pathology at the University of Toronto for the year 1883.

Drs. Sullivan and Lavallé, of Queen's College Faculty of Medicine, were in the city a few days ago, and were well taken in hand by several of our Medicos, and shown all worth seeing in our city. We believe they return home with a high estimation of the genial hospitality of Montreal's medical men. The "female students" were, to use an American phrase, the means of their having a visit to our city and have a "good time."

#### HOSPITAL REPORTS.

OCCURRING IN THE PRACTICE OF THE MONTREAL GENERAL HOSPITAL.

CASE OF EMPYEMA—EXCISION OF RIB.

*Under the care of Dr. Wilkins.*

Reported by Dr. W. T. DUNCAN, House Physician.

Felix L. was admitted into Hospital 9th May, 1882, complaining of cough, dyspnoea, and pain in the left side. Ten weeks previously, he had a chill, followed by severe catching pain in left side, slight hacking cough and elevation of temperature. Has been laid up ever since, losing flesh, but free from chills and sweating.

Patient is a large man, but much emaciated.

*Left Lung*—Percussion note is flat over left side of chest, both front and back. Breathing is blowing above second rib in front, and scarcely audible below this point. Behind it is feeble and distant, a few moist râles being heard towards the apex. Tactile fremitus absent, vocal resonance dim-

inished, left side of chest bulging, measures one inch more than right side; intercostal spaces full.

*Right Lung*—Normal, except an occasional moist râle at the base.

*Heart*—Displaced slightly upwards and to the right side.

Cough is severe, with copious offensive, dirty-looking, purulent expectoration. Expectoration began suddenly four weeks ago, two pints of pus being brought up in one night. Ever since copious purulent expectoration has continued. Temp. 101°; pulse 100; resp. 38.

Was ordered stimulants, iron and quinine, and cod liver oil.

*12th May*—Cough is very severe, at least 12 oz. of frothy purulent matter being expectorated in twenty-four hours. Patient cannot lie on right side. Physical signs unchanged; left side of chest was aspirated, 10 oz. of thick pus being drawn off. A free incision was then made into the pleural cavity, with antiseptic precautions, and 41 oz. of bloody purulent matter removed. Owing to the closeness of the ribs, a tube could not be introduced. This wound was dressed antiseptically.

*15th May*—Passed a good night. No pain in side. Expectoration during last twenty-four hours was 3 oz. The wound was dressed, and several ounces of fluid were discharged.

*19th May*—Wound is dressed daily, 2 to 4 oz. of matter coming away each time. Cough is less, and temp. normal.

*25th May*—Wound has been closed by granulation for two days, and pain is again felt in side. Percussion is dull, and breathing very weak over lower portion of left lung; a few clicking râles at the apex.

*27th May*—Under ether, Dr. Wilkins excised two inches of the 6th rib, making an incision parallel with the rib between the nipple and axillary line. Several ounces of purulent matter came away. A large silver tube was introduced and dressings applied, the pleural cavity to be washed out daily with Carbolic Acid Solution 1×100. Antiseptic precautions were not employed.

In two days the temperature fell to normal and the patient began to improve. In three weeks a soft rubber tube was substituted for the silver one, the discharge having fallen to about 1 oz. daily. A stronger carbolic solution (1×80) was now employed and the cavity washed out twice a day, with the result of removing all foetor from the discharge. The improvement was thenceforth rapid; cough

disappeared, and breath sounds began to return; four weeks after the operation, patient was able to sit up and walk about; three weeks later the discharge ceased, and the wound was allowed to close up.

*5th August*—Percussion note fairly clear, down to the 5th rib, and the breathing audible, though weak. Was discharged from Hospital.

*Six weeks* afterwards he reported himself in good health, with neither pain nor cough, left side of chest expanding well, and air entering the whole lung freely.

## REVIEW.

*Lindsay & Blakiston Visiting's for 1883.* P. Blakiston, Son & Co., Philadelphia.

The oldest and one of the best Visiting Lists published. We have used it for 20 years, and are thoroughly satisfied with it.

*The Medical Record Visiting List for 1883.* New York, Wm. Wood & Co.

This useful and handy list continues to maintain its high standard of excellence. Less bulky than most of the others, it is convenient as well as sufficiently complete. Among its new features this year we notice a card-board gauge for Urethral Sounds according to the French and American scales. It may be obtained for either thirty or sixty patients, with or without dates.

## USE OF NITRITE OF AMYL IN PARTURITION.

Dr. Fancourt Barnes, physician to the British Lying-in Hospital, and assistant physician to the Royal Maternity Charity, reports in the *British Medical Journal*, for March, 1882, the use of amyl nitrite to counteract the effects of ergot. The midwife hoping to hasten the third stage of labor had given the patient ergot, directly after the child was born, which caused hour-glass contraction of the uterus. The os internum, and muscular fibres above it were so contracted as only to admit a finger. The umbilical cord had been separated from the placenta. He administered three drops of the nitrite to the patient by inhalation, which immediately arrested the uterine spasm, so that the os, that had been absolutely undilatable, steadily yielded under the influence of the drug, till he was enabled to introduce the whole hand into the uterus and detach the placenta, which was universally adherent. There was no hemorrhage whatever, and the placenta itself presented a remarkably exsanguine appearance.—*Medical Tribune.*