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Original Communications.

THE PRESIDENT'S ADDRESS.

BY T. K. HOLMES, M.D., CHATHAM, ONT.

Gentlemen of the Canadian Medical Association,—When, a year ago, you paid me the high honor of electing me to the presidency of this Association, I will not pretend to deny that the distinction that appointment conferred afforded me the most lively gratification, which, however, was qualified by several considerations that were to me of quite a serious character. Not the least of these was the knowledge that I must address an audience distinguished for intelligence and scholarly attainments, both professional and general, and that the learning and ability of my predecessors in office would not detract from the difficulty of the task. Indeed I felt, and still feel, that my chief qualification for the position in which your kindness has placed me is an unswerving interest in the prosperity of this Association, which has influenced so strongly and so favorably the medical profession of this country. While expressing my most sincere thanks for the highest honor at your disposal, I feel sure that the same kindly feeling which prompted its bestowal will render easy the duties of presiding officer, and that the same zeal which has hitherto marked the scientific work of this Association will characterize the meeting now convened.

Romance and history combine to render the city of Quebec the most interesting spot in Canada, and our Association may well be congratulated on the privilege it enjoys this year in holding its session in a place rendered famous by so many circumstances. The adventurous quest and the indomitable will of the early navigators who laid the founda-

tion of civilization in this country when they planted the colors of France along the shores of the St. Lawrence, may well serve us as models for emulation in our more peaceful search after that scientific knowledge which contributes so much to the happiness of mankind. If our efforts be at all comparable to theirs, equal honors and equal blessings may be expected to result from our endeavors. In this connection I may express the wish that the same spirit of enlightenment and progress that characterizes our parent countries, France and England, may animate their descendants in this young Dominion, and that the Canadian profession of medicine may not be unworthy the great names of Harvey and Lawrence, of Hunter and Pasteur. It will certainly contribute greatly to the progress of medical science in this country if the two races whose ancestors have led the van in Europe go hand in hand and vie with each other in creating a professional status here inferior to that of no other country. Some of the means by which we may hope to accomplish this will be the subject of my remarks to-day.

The architect who aims at lasting fame, not only lays broad and deep the foundation of his work, but anticipates each step in the growing structure even to the crowning event of its completion. He selects the material, superintends each process of manufacture, shapes every part, and embellishes the whole until it rises in symmetry and perfection, and stands the glorious and enduring monument of his creative genius. In this land there is arising a temple whose foundation is based upon the accumulated labors of the greatest architects of human happiness. Their names shine with brilliancy unabated all down through the vista of past years, and animate and enlighten all who labor in the same profession, and emulate their achievements. We are the privileged architects of this temple of

medicine in our country and generation, and I trust that the marks of our skill may not be indistinguishable in the rising edifice. The progress of scientific medicine in the recent past is the result very largely of the development of the science of biology which has done so much to establish medicine on a scientific basis.

Until the study of life in its elementary forms was rendered possible by modern instruments of precision, empiricism necessarily entered largely into all medical progress, and it was maintained as an opprobrium that medicine was no more than an enlightened empiricism. This is true, but it could not have been otherwise since, until the birth of biology as a science, medical knowledge had either to remain at a stand-still or to progress by a series of empirical jumps which sometimes left it in a more advanced state of usefulness, and sometimes failed to do so even in the slightest degree. Although empiricism in medicine has been such a laborious means of advancement, we must admit that it generally contained some grains of truth, and that when it failed to accomplish what was expected of it, the reason of the failure lay, not in the worthlessness of the efforts at progress, but in the difficulty of separating the grains of truth from the abundant chaff in which it was contained. Each new fashion, while it has contained some truth, has failed and given place to another little in advance, not because it contained no truth, but because the truth it did contain was incomplete. When, however, the study of biology was established on a scientific basis, medicine, which is but an applied science of biological doctrine, became less empirical and more scientific, and by the aid of physiology and pathology, which are the necessary sequence of biological investigation, has advanced to the present high and satisfactory position it occupies. The very fact that morbid processes are viewed and studied from a physiological standpoint, and are estimated and measured by the laws that govern elementary processes of life, renders it certain that the progress of the recent past and of the present is on surer lines and firmer foundation than ever before, and that the future of medicine will be the glorious sequel of the present, as the present is the glorious sequel of the past. It justifies the belief, that the advantages to the human race likely to accrue from the prosecution of medical studies and investigation pursued on these lines, will be far greater in the future than in the past, that physiology and pathology, which are but in their infancy, are destined to illuminate the dark places in medicine and reveal the true cause of much human suffering and premature death.

We are accustomed to regard with wonder the achievements of modern invention in the art of war, and to contemplate with amazement the perfected instruments of destruction that strengthen the hands of modern belligerents, but the general who advances to battle with all these at his command has no greater advantage over a barbarous foe than modern medical searchers after truth in the realms of disease have over their empirical brothers of the prebiological period. Possessing these advantages, and stimulated by this prospect, it is reasonable to suppose there will, in the near future, arise men whose investigations, beginning where those of Sanderson, Koch, Virchow, and Pasteur leave off, will be equally brilliant and equally conducive to human happiness and longevity. The country that produces these men will be the country that affords the best medical education to those entering the profession, and that most facilitates original investigation for those who have chosen that field of labor. No physician in this country worthy of the profession to which he belongs can be indifferent to the position Canada shall occupy in the honorable and honored competition in which so many are and will be engaged.

The future of the medical profession in this as in any other country will largely depend upon the natural ability and the mental and moral training in childhood and youth of those entering its ranks; so that in considering any scheme for the creation of a high standard of medical qualification, domestic training and the plan of education pursued in public schools must be recognized as bearing an important part.

It has been said that poets are born and not made—a saying that is not untrue when applied to medical men, for a combination of mental and moral qualities which cannot be wholly acquired enters into the character of every great physician. It is cause for regret that greater discrimination is not exercised in directing young men in the choice of a business or profession, and that convenience and not natural aptitude should frequently determine a young man's course in life. There are so many examples of men rising from obscurity to great eminence in every vocation, that there has arisen a popular impression that all obstacles and natural defects can be compensated for, or can be overcome, by diligence and perseverance on the part of any aspiring youth. It would be wrong to underestimate the value of industry and high aspiration, but these, while they can improve all and can render mediocrity respectable, can never supply the place of genius. While it is impossible to create genius by any system of training, it is al-

most impossible to repress it altogether by any carelessness or neglect.

"That many mute inglorious Miltons lie buried in our churchyards, I venture to doubt: the fire of a Burns is not easily hidden under a bushel, but some smaller lights may be quenched, and the best of such men, like Burns himself, may be thwarted and broken in heart."—(*Dr. Allbutt.*)

Other things being equal, the child who, from infancy, is trained to think and to reason correctly and express its thoughts clearly, will be more likely to attain eminence in mature life in all pursuits of an intellectual character than the child not so trained; indeed, skilful training in early life is essential to success in persons of average natural capacity, and is of unquestionable importance to all.

The efforts to establish and to maintain an efficient system of education in this country are worthy the highest commendation, but the task is a difficult one, and there is danger of enthusiastic legislators over-stepping the mark and making our sons and daughters mere receptacles of knowledge instead of creators of knowledge, by failing to recognise that it is vastly more important that a man should think and reason correctly than that he be the possessor of multitudes of facts and definitions. Physicians, with such questionable elementary training, are like the artificer well supplied with the tools of his craft but lacking the skill to use them. It is not to such that we may look hopefully for real progress in our science; they make up the great army of routine practitioners who trouble themselves little with profundities, and are like Dr. Sangrado, who felt quite sure that those of his patients who, under the care of his pupil Gil Blas, died from excessive bleeding and the copious drinking of warm water, did so because this his panacea was not applied with sufficient vigor and determination.

It is probably not incorrect to say that most medical men in Canada are of opinion that the chief defect in our school system lies in the oversight here referred to. The curriculum for medical matriculants in Canada must create a higher average intellectually among young men aspiring to the profession, but there can be no doubt that a widening of the curriculum so as to embrace a more extensive knowledge of the natural sciences would greatly facilitate the acquisition of knowledge presented to, and required of, medical students. An acquaintance with the laws relating to climatology would serve a useful end in the study of epidemic and endemic diseases, and in an estimate of the influence of climate on disease in general; an acquaintance with minute organisms and histo-

logical structures, such as could be readily acquired in any high school provided with a microscope, would prepare the mental soil for the reception and quick germination of the seeds of knowledge sown by teachers of physiology and kindred subjects in medical schools. The medical student who learns something of biology, of cells and germs, and of bacterial life only after he has entered upon his course of medical lectures, is at a great disadvantage and loses much time in a bewildering effort to master names and technicalities, and I can conceive of no more irksome task for a teacher than to lecture to a class of young men laboring under this disadvantage.

The relations existing between medical schools and licensing bodies in this country are so satisfactory that little desire has been manifested to alter them, and it is beyond doubt that to these relations we owe in great measure the improved status of medical education here.

When the great discovery of Columbus opened to the old world the unknown and virgin resources of the new, the most progressive nations entered eagerly into keen competition for the advantages this discovery presented. National ambition and individual courage and endurance combined towards the great aim and object of colonization and development of natural resources of this continent. The results are patent to all; a newer and greater freedom and civilization in the new world are the rich fruits of these vigorous pioneer efforts, and the evidence exists in the glad and prosperous millions of the western world. Analogous to this is the meteoric brilliancy of the discoveries in medical science within the past fifty years. Physiology, pathology, the etiology of disease, physiological medicine, preventive medicine, these are some of the fields laid open to the modern physician, and they leave no lack of opportunity for the exercise of ambition, skill, and philanthropy. Nearly all European nations and the individual States of the neighboring Republic have shown their determination to participate in the honorable achievements in medicine thus rendered possible in the near future. Schools for the pursuit of original investigation have been liberally endowed by these governments, and this liberality has been supplemented by the wise and princely donations of private individuals.

Sanderson and Klein, Koch and Pasteur, our own Osler, and many others scarcely less distinguished, are devoting their lives with indefatigable zeal to the elucidation of scientific questions upon which rests the superstructure of medical practice, and they are enabled to do so only through the liberality of the various governments under

which they live. Research of this kind can only be carried on successfully by men naturally adapted to such work, and who are free from the care and anxiety inseparable from the lives of those engaged in the active practice of their profession. Hence the absolute necessity for the endowment of institutions of this character. The large expenditure necessary to the equipment of a laboratory for such work has greatly retarded it in Canada, and until means are provided we must be content to occupy an insignificant place in the great race now being run. Can it be that this country or its wealthy citizens will remain indifferent in this matter, while our nearest neighbor is lavishing millions of dollars to attain honorable eminence in the progress of medical science? Scarcely a State in the Union that has not its well endowed university, and the princely gifts of Cornell, of Johns Hopkins, of Mr. Stanford, of Mr. Vanderbilt and of Sir Donald A. Smith are the great beginning of greater things. Who can estimate the blessings to the human race that must arise from the wise munificence of these noble men! Millions yet unborn shall speak their names with feelings of reverence and love, nor will other monuments be needed to make their names immortal. In this connection, I would suggest that a committee of this Association be appointed, to report at the next annual meeting upon the best means of establishing one or more laboratories where original investigation in medical studies may be carried on.

Medical Societies constitute a most important factor in the advancement of medical knowledge, and it is much to be regretted that they are not everywhere established. It is safe to say that the maintenance of active local societies contribute immensely to the knowledge of their members by encouraging careful observations in private practice, and more extensive reading and research. Aside from a scientific point of view, the harmony engendered by these meetings eliminates much of the jealousy and misunderstanding that are so humiliating and so subversive of individual happiness and public respect. The general organization of small local societies would be a sure means of improving the representation at the larger ones, and would secure to them papers and discussions of a higher character. Provision has been made in Ontario by the Medical Act for the formation of territorial associations in the different electoral divisions, and in some of them most prosperous societies have existed for many years, and the reports of their proceedings constitute valuable additions to medical literature.

Of all the means of medical progress, few could be more advantageously utilized than the accumu-

lated experience of men in private practice if they could be induced generally to keep a systematic record of their more important cases. Time, skill, and the privilege of post-mortem examinations are essential to the successful recording of cases, and their absence is doubtless the chief cause of the neglect so universal in this matter. Time so consumed would be more than repaid by the increased skill acquired; the high standard of qualification now required of graduates should remove the second difficulty; and if requests for autopsies were made in all cases necessary to verify a diagnosis or to elucidate an obscurity, the prejudice now existing against them in the public mind would, to a great degree, disappear. Let rural practitioners who underrate their opportunities of contributing to the general fund of medical knowledge, remember that Jenner, McDowell, and Koch were not metropolitan physicians, and were unknown to fame until their great discoveries, wrought out by diligent study and observation, placed them among the great benefactors of mankind. Observation and reflection are the parents of discovery, and never fail to produce their offspring, although the gestation may be long and the labor hard. Every truth so revealed is like a lantern, the light of which may be turned on the dark places of our field of investigation, and new truths stand clear to our mental vision, and we walk boldly and safely on, using each new thought to illumine the obscurity that surrounds and precedes it.

The building up of a science is a slow and laborious process, and facts must be supplied by a multitude of workers. The scholar who deciphers the cuneiform inscriptions of ancient Babylon or the hieroglyphics of Egypt, and contributes to our knowledge of these nations, must be aided and preceded in his work by the archæologist who discovers, and the laborer who unearths, these imperishable records of past events. So in the building up of medical science, the humblest worker is not to be despised, for his contributions may be and often are essential; but to be available, his thoughts and observations must be recorded, that they may be weighed and winnowed by those suited to the task.

All who have read the lectures of Murchison on "Functional Diseases of the Liver," of Roberts on "The Digestive Ferments," or of our own Osler on "Malignant Endocarditis," must be impressed by the great impetus given to practical medicine by these, and will need no arguments to convince them of the desirability of the endowment of similar lectureships here. From a literary and scientific standpoint, the advantages accruing to

the profession from such lectures would be important, but of even more importance would be the encouragement afforded to the more gifted and aspiring of our own Canadian physicians and surgeons. As Canadians we may feel proud of our country and of its physical and political excellencies, but we may rest assured that, so far as we medical men are concerned, others will estimate us by the reasonable and practical standard of our contributions to medical knowledge and by our scientific attainments. No conservative clinging to obsolete methods on the one hand, or the multiplication of weak meretricious literature on the other, can impose upon the learned in the professional world, and the sooner we create strong incentives to scientific work the sooner will the workers be forthcoming. I would here offer the suggestion that this Association take into consideration the establishment of lectureships similar to those in England and other older countries.

Of all means enumerated for the advancement of medical science, individual effort undoubtedly ranks first. Associations can teach and stimulate, but they can never supply the place of study and observation. Truth only yields her wealth to him who lays siege to her shrine. Emerson says the hardest task in the world is to think. We try to look in the face an abstract truth, and we cannot do it. The mind swerves from the encounter, and thick darkness prevails. We return to the charge and try to force Truth from her citadel, and then in a moment, when we least expect it, a rift in the cloud comes, a ray penetrates our minds, light floods in more and more, until objects, dim at first from sudden light in dark places, become real shapes, and we gauge their dimensions and estimate their proportions with unerring exactitude. Few truths are discovered but by this laborious process, and because we evolve them slowly and often only partially by delving beneath the surface of things, it is better to labor so than not to work at all, for when the surface is broken and disturbed, others will see clearly what we only half perceive, others will perfect what we are able only to dimly outline.

It requires no prophetic eye to perceive the future greatness of Canada. Her vast extent, and varied and inexhaustible natural resources, everywhere abounding, are such that it would seem impossible for any series of unfortunate events to stem her progress, or to divert her course in the contest of nations for pre-eminence in all that constitutes true greatness. The spirit of progress is abroad and armed with the all-compelling weapons of modern invention, hampered by no medieval absurdities, and thwarted by no ignorant prejudices ;

we are justified in entertaining the most exalted and hopeful view of the future of our country, and may deem ourselves fortunate in bearing a part in the development of so fair a heritage. As physicians, the part we assume is not an insignificant one. To enact wise laws, to encourage commerce, to preserve peace within our borders, and to command the respect of neighboring nations are objects worthy of the most exalted ambition and the most patriotic determination; but will it be said that the aims of medical science are less exalted or less conducive to national prosperity or individual happiness? To cure disease, to alleviate suffering, to extend the limit of human life, to enlarge the field of human usefulness, to be able to prevent disease by removing the cause; surely the profession that devotes its energies to the accomplishment of these objects is entitled to the fostering care of governments and to the liberality of wealthy citizens.

"A sound nation is a nation that is composed of sound human beings, healthy in body, strong of limb, true in word and deed, brave, temperate, sober, chaste; to whom morals are of more importance than wealth. It is to form character of this kind that human beings are sent into this world, and those nations who succeed in doing it are those who have made their mark in history. They are nature's real freemen and give to man's existence on this planet its real interest and value." (*Froude*.) In the not-distant future this Dominion will be the home of fifty millions of people with all the wealth and all the greatness that implies; a thought that may well inspire us with feelings of pride and satisfaction; but the wise man will not be so much impressed by the vastness of our territory, the multitude of our people, or the size and wealth of our cities, but will be more concerned in the problem of the social advancement, the civil liberty, the physical perfection, the scientific status and the moral rectitude of our teeming population. When that time comes may the science of medicine have contributed its share towards the creation of a people unsurpassed for physical perfection and mental sprightliness and for all those virtues that are born of these. Should these hopes be realized, then indeed would happiness prevail and prosperity sit as a ruling genius on the brow of every hill, the bosom of every lake and the bank of every stream; and the application to our country of the language of one of England's greatest poets would scarcely be considered hyperbolic, when he says:

"All crimes shall cease and ancient fraud shall fall,
Returning justice lift aloft her scale,
Peace o'er the world her olive wand extend,
And white-robed innocence from heaven descend."

ON THE IDENTITY OF MEMBRANOUS CROUP AND DIPHTHERIA.*

BY G. R. M'DONAGH, M.B., TORONTO.

Mr. President and Gentlemen,—The paper which I desire to read before you to-day was written with the object of bringing together some of the arguments and evidence which at present exist to prove the identity of the diseases croup and diphtheria. The subject is one which has seemed to me of considerable importance to the profession, owing to the large number of cases which occur every year in this country, and the great mortality therefrom. Up to the time of the epidemic of diphtheria in England, in 1858, the term "croup" (by which I mean only true or membranous croup, and not the varieties of false, catarrhal, or spurious croup) was used to designate an acute, non-contagious inflammation of the larynx, attended with a membraniform exudation of lymph. Since that time, however, much deep investigation has induced many to regard these cases as isolated examples of diphtheria. In France, where there had been much more opportunity of studying the disease than in England, the attention of the profession was first drawn to the consideration of the subject by Brettoneau's work on Diphtheria, and since that time much deep research has been devoted by Trousseau, Brettoneau, and many other French pathologists, to understand the true nature of the disease process, with the result that at the present time the profession in that country almost universally regard the two diseases as identical. Among the first in England to advocate the theory of identity were Dr. Hillier and Morell Mackenzie, in 1863. After that Dr. George Johnson, Dr. Semple, Sir William Jenner, and others, in able articles, maintained that the cause of disease was the same for croup and diphtheria, and influenced thereby public opinion very strongly. Diphtheria is described as an acute, specific, constitutional disease attended by inflammation of the pharynx, having as a result an exudation of lymph. It has a tendency to spread in all directions—to the nares,

to the mouth, to the larynx, and even down the œsophagus. From the larynx it may spread down the trachea and bronchi. But in so-called true croup we also get a membranous exudation of lymph in the larynx. The question then arises, are there two kinds of membranous inflammation of the larynx—one specific, and the other not? This is the point I wish to discuss. The views of those who believed the two affections to be entirely distinct were based, first, on pathological anatomical differences, and secondly, on clinical differences. It is said that in diphtheria we have an exudation similar to that in croup, but situated *in* the tissue of the mucous membrane itself instead of *on* the surface of it, as in croup. So that when we pulled away the membrane in diphtheria we always removed with it a part of the underlying tissue, leaving a bleeding surface, whilst in croup the deposit separated easily and left a surface intact, or, at the most, only hyperæmic. This view of the difference of the situation of the exudation, whether *within* or *upon* the mucous membrane, was first advanced by Virchow, but afterwards, on account of the numerous cases which passed into one and the same condition by insensible gradations, he admitted this view to be no longer maintainable. Virchow then adopted the theory that the anatomical characteristic of diphtheria consisted in the existence of a necrosis of tissue, which took place beneath the false membrane. He pointed out that this tendency to necrosis must be placed in the foreground, that is to say, that the peculiar feature of the diphtheritic process lay in the necrosis of the underlying tissues. Bamberger and Gerhardt both declared that this explanation was not admissible, considering the necrosis only a difference in degree rather than a real distinction, and this view is now generally held by most investigators; and, indeed, many cases are found in which, although clinically answering to croup of the larynx, there is exudation within the mucous membrane and also marked death of tissue; and, on the other hand, there are cases of true diphtheria with superficial membraniform exudation. On this point we have the testimony of Wagner, whose post-mortem investigations have been extensive

* Read before the Ontario Medical Association in Toronto, June, 1886.

Dr. Wagner says that in many cases of primary diphtheria of the pharynx, which had ended fatally through consecutive affection of the larynx, he has found the pharynx presenting normal conditions (*i.e.*, no tissue necrosis), both to the naked eye and also on microscopical examination, whilst the larynx showed the usual appearances of croupous inflammation. This latter theory, then, of Virchow's, that the death of tissue which occurred beneath the false membrane was characteristic of diphtheria, must be abandoned, as it is only a result of the advanced stage of the disease.

It has also been declared that the difference in the degree of adhesion of the membranes to the parts beneath, in croup and diphtheria, is an argument in favor of duality. But because we find a loosely attached exudation in the larynx and trachea, whilst in the pharynx it is more firmly interwoven with the tissues, we ought not to consider this a fundamental difference in the process, for it depends on the structural formation of the mucous membrane of the parts. Whereas we find in the pharynx a layer of squamous epithelium in intimate connection with the subjacent tissue, we find in the larynx a layer of pavement epithelium separated from the underlying tissue by a well-marked basement membrane. A fibrinous exudation can always be more easily removed from a mucous membrane with a sharply defined epithelial layer than from a part where the epithelial layer is less firm and passes gradually into the deeper underlying cell structures. Trendelenburg and Maier both state, in this respect, that the *firmer* or *looser* attachment of the exudation depends on the structural formation of the mucous membrane. Rindfleisch also holds this view, and Wertheimer, in an article on this subject, states that "the reason why the same disease cause produces an infiltration into the tissues in the pharynx and a croup-like change in the larynx is all due to the difference in the kind of epithelium," and the degree of separation from the tissue beneath by a basement membrane. On these grounds, then, I contend that these apparent gross pathological differences are not real, but are due to the physiological peculiarities of the parts, as well as to the severity and stage of the disease.

Turning now to the microscopical appearances, we find quite as little distinction. According to the examinations of Wagner, who has done the best work in this direction, the diphtheritic deposit is described as "a bright, homogeneous, glancing network, the cells of which are often without contents, but mostly, however, filled with lymph and pus cells," whilst the croup membrane consists of "a thick network of delicate fibrils, in the spaces of which were numerous elements resembling pus cells." The most superficial cells are much larger than lymph cells, but they decrease in size as they go deeper, until those adjoining the mucous surface are scarcely distinguishable from normal cells. The microscopical appearances of the exudation differ slightly, according to the stage of the disease, but pathologists now agree that it is impossible to distinguish between samples taken from a larynx affected secondarily to pharyngeal diphtheria and those from a case of membranous croup. Sir William Jenner says if you were to place in the hands of the best pathologist the larynx of a child who had died from membranous inflammation of the larynx, and that of one who had died from diphtheritic laryngitis, he would be unable to distinguish the one from the other. There is no anatomical character, microscopical or otherwise, by which he could say: "This is true croup;" "That is diphtheria." On pathological grounds, therefore, it seems to be impossible to distinguish these two affections. Let us pass on, then, to the consideration of the clinical aspect of the affections.

The first supposed clinical distinction is the difference of site in which the diseases manifest themselves: Diphtheria belonging for the most part to the pharynx, while croup is considered chiefly a disease of the larynx. But at once we must admit that difference of site cannot constitute any real difference. Syphilis, for instance, presents itself in many different situations, and so also cancer, rheumatism, and gout, and still remain the same diseases; but besides this we often meet with diphtheria in the larynx, and also cases clinically answering to croup beginning in the pharynx. Morell Mackenzie states that only about 10 or 12 per cent. of croup cases commence in the

larynx, and Sir William Jenner states that it is beyond question that true diphtheritic inflammation may be limited to the larynx, that in exceptional cases the pharynx escapes the exudation. The fact is, very often, when the physician is called to a patient in which all the symptoms point strongly to a bad case of croup, his first thought is how to relieve the patient of the immediate distress rather than to examine the pharynx for false membrane; but indeed a close inspection would discover it there also in the great majority of cases; and on the other hand, it is well known that in typical cases of diphtheria the laryngoscope will show almost always patches of membrane on the epiglottis, arytaenoid cartilages, or false cords, or elsewhere in the larynx. I have heard Prof. Stoerk say that he had repeatedly and time and again watched this process with the laryngoscope, and that it was impossible to distinguish the condition thus produced in the larynx from that in a case of regular membranous croup.

Next, it has been argued that croup has no tendency to spread, that it is not infectious. I fancy the experience of most of you will recall instances when you have treated cases clinically answering to croup of the larynx, and subsequently other members of the same family were attacked with diphtheria. I can distinctly remember such a case. The physician was called to a patient in whom all the symptoms pointed to simple, uncomplicated croup. Going upon the duality theory and the non-contagiousness of croup, isolation of the patient was not insisted upon, and several other children in the same family were taken sick later with diphtheria, and two died. I think the belief entertained by many physicians of the non-contagiousness of croup is strengthened frequently by an error in diagnosis. I am confident that many cases which are put down as true membranous croup are really not of this nature at all, but rather cases of simple acute diffuse laryngitis with subcordal oedema. This condition produces precisely the same symptoms, the same cough, aphonia and difficulty of breathing, as we meet with in true croup, and indeed, the two affections can only be distinguished during life by

the laryngoscope. I believe cases of this nature will explain many of the instances where supposed true croup does not spread.

But besides this, a single case of croup should no more be separated from diphtheria than a single case of scarlatina, because it does not spread, be separated from other cases of scarlatina.

Passing on now to the consideration of other clinical manifestations, we find the greatest stress laid on the different amount of the general toxæmic effect produced by diphtheria and croup; that in the former we meet with the severest symptoms of adynæmia, and as a further result of the septicæmia we have great swelling of the lymphatic glands and albuminuria, and still later in the course of the process, paralysis of different groups of muscles; while in croup we find none of these grave complications, no swelling of the glands, and no albuminuria, and no paralysis. Now it is true that when the exudation is thrown out only in the larynx there is not nearly, as a general rule, the same amount of constitutional disturbance, but this fact admits of easy explanation, inasmuch as it depends on the anatomical differences in the two parts. Starting out with the assumption now generally held by most observers, that the toxæmia is, in part at least, secondary and due to absorption of the septic matters from the diseased parts, we have in the abundant lymphatic supply of the pharynx a good explanation of the greater constitutional disturbance and the greater swelling of the glands in diphtheria than in croup. According to Luschka there exist in the soft palate, which is extraordinarily richly supplied, two different plexuses of lymphatic vessels: an anterior and a posterior plexus. Branches from each of these plexuses run down on each side, communicating with each other and with those at the base of the tongue, and those in the tonsils. The lymphatic absorbents also in the posterior wall of the pharynx are very abundant. Recklinghausen also has proved most completely that the mucous membrane of the pharynx, tonsils, and the follicular glands of the tongue has a very abundant lymphatic supply; and Dr. E. Klein in his work also refers to the very unusual abundance of the

absorbents in the pharynx. These lymphatic vessels have all free communication with the glands about the angle of the jaw. The lymphatic supply of the larynx, on the contrary, is much less developed. According to Luschka, all the vessels from the epiglottis and from the parts above the true cords unite into one main vessel on each side which runs between the great cornu of the hyoid bone and the superior border of the larynx, and empties into a single lymphatic gland. Those beneath the true cords, also, and those from the cricoid cartilage unite into a main trunk on each side which empties into a corresponding gland on each side of the membranous part of the trachea. This great abundance, then, of the lymphatics which we meet with in the pharynx, and their direct connection with the lymphatic and venous plexuses of the neck, afford a ready means for the passage of the septic matters from the diseased parts into the blood mass as compared with the scantier lymphatic supply of the larynx and trachea.

From this point of view, it will be readily understood how that there is likely to be a much greater toxæmic effect, and much greater swelling of the glands about the angle of the jaw, when the disease has its local manifestations in the pharynx than when in the larynx. In croup the glands in connection with the larynx are also enlarged, but they require to be felt for, as they are so few and so small. An excellent example *apropos* here is to be seen in the case of cancer. In cancer of the pharynx we find early and greatly marked affection of the lymphatic glands in the neighborhood about the angle of the jaw, whilst in cancer of the larynx the lymphatic glands are scarcely at all affected, and it is for this reason that extirpation of a cancerous larynx is a comparatively favorable operation.

Finally, with regard to the albuminuria and paralysis. This complication and sequelæ I hold also to be the results of the greater degree of blood-poisoning in diphtheria than in croup, and I believe they are due to the secondary blood-poisoning produced by the absorption of the septic matter from the diseased parts. It is greater in diphtheria because of the greater opportunity for that absorption, as

already explained. Not only do we meet with many cases of diphtheria without either albuminuria or paralysis, but we often meet with cases of the regular form of croup in which also albuminuria is present; and as for the paralysis, we have the authority of Hüter, who quotes a case of undoubted bronchial croup which was complicated by complete paralysis of the pharyngeal muscles. We cannot, therefore, either on pathological or clinical grounds, admit a difference between membranous croup and diphtheria, but we must refer the process in each case to the same etiology, and explain the difference in the symptoms by the difference in the degree of intensity, and the different situations of manifestation; and I think on this point the physiological anatomical differences in the epithelial layers and the absorbent lymphatic supply of the parts are responsible for much of the confusion.

I cannot do better than conclude these remarks with the opinion of Dr. George Johnson on the subject. He says: "I wish to express emphatically my entire concurrence with the conclusions long since arrived at by Trousseau, Brettoneau, and all the leading French pathologists, that all the cases of so-called croup which are associated with false membranes in the air passages are essentially diphtheria, and, on the other hand, what we call in this country inflammatory croup, or catarrhal laryngitis, never results in the formation of false membranes. It is surprising that practitioners of large experience can have any doubt on this subject, yet we find even in the most recent English text books that perplexing attempts are made to distinguish between what the authors call "true membranous croup" and "diphtheritic croup." The attempt is hopeless, and most confusing to the student, for it is certain that membranous croup and laryngeal diphtheria as we now see them are one and the same malady.

An exchange speaks of "Tonsillar orchitis and ovaritis." When a man gets orchitis in his tonsils, or a woman gets tonsillitis of her ovaries, the case must be interesting.—*Weekly Medical Review*.

ABNORMALLY SHORT CORDÆ TENDINÆ.

BY J. FERGUSON, B.A., M.B., TORONTO.

In the *Canadian Journal of Medical Science* for the year 1882, at page 292, I ventured to suggest this as at least one cause for regurgitation; and that the shortening might come from swelling of the part in cases of inflammatory rheumatism.

Since that date I have been able to procure some good examples of this condition. In two there was the history of rheumatism, but in the third there was no reason for thinking the person had ever had rheumatism.

In this latter case all the structures of the heart were perfectly healthy—the only abnormality being very short tendinous cords, which prevented the mitral valves from falling back with sufficient freedom to close the orifice. Hence a regurgitant murmur existed during life.

A condition such as this would naturally tend to get worse.

In the two cases where there had been rheumatic endocarditis, the swelling of the tissues had led to their contraction, and thus the cords in these cases were shortened.

Selections.

[We are indebted to DR. ZIMMERMAN for the translations from the French and many of the therapeutic notes, and to DR. R. B. NEVITT for the Italian translations.]—Ed.

UNSETTLED PROBLEMS ABOUT PNEUMONIA.

Clearer knowledge regarding the etiology and the pathological relations of pneumonia is one of the present *desiderata* of medicine. In spite of the abundant opportunities which we possess for studying the affection, we are still in great doubt regarding its true character and its proper place in the fraternity of disease. We allude to the subject, in order to indicate the lines which, we think, inquiry might take with advantage.

Three views are held on the subject: first, that pneumonia is a local inflammation, at-

tended by profound systemic disturbance; secondly, that it is a specific febrile disease, with a pulmonary inflammation as its constant local expression; thirdly, that the local condition is not truly inflammatory at all. We allude, of course, only to acute sthenic pneumonia, with which the epithet "croupous" has been unluckily and apparently inseparably conjoined.

The third theory may, we think, be put aside, partly because of the slender evidence on which it rests, and partly because our ideas of inflammation are so much derived from the examination of hepatised lung that, if pneumonia were pronounced non-inflammatory it would practically mean a reconsideration of the whole question of inflammation. Two theories remain for consideration—the local inflammation theory, and the specific fever theory; the former universally adopted by the laity, the latter commending itself more and more to scientific observers.

In favor of the view that pneumonia is neither more nor less than "inflammation of the lungs," we have the constancy of the local condition, the general belief that the disease frequently follows exposure, and the absence of decisive proof of its contagious character. Against this theory may be urged the facts that the local condition and the systemic disturbance are very loosely related, the latter often preceding the former, the former usually outlasting the latter; that the etiology of "chill" is often open to grave suspicion; and most important of all, that pneumonia undoubtedly occurs at times as a well defined and destructive epidemic. Obviously, the points that make against the "local inflammation" theory are *pro tanto* in favor of the specific character of the disease. To these may be added the fact that pneumonia pursues a fairly uniform course, with well marked rise of temperature, and a clearly defined crisis. The frequency of hepatic disturbance and the presence of the micrococcus must also be borne in mind in this connection. Some authorities further urge that the frequent presence of *herpes labialis* is the analogue of a specific cutaneous eruption. We think the balance of evidence is strongly against the theory which professes to

explain the disease as simply a local inflammation. Often the pyrexial period has run most of its course with great severity, before the most careful physical examination of the chest yields any result. A case occurred recently in our experience, where the disease began in a typical form, and with a profuse herpetic eruption; but an examination of three successive days by the hospital physicians, all on the lookout for the disease, proved quite fruitless. On the fourth day, the physical signs were developed in the usual way. Again, it is very common for the temperature to fall to normal with relief of the most urgent symptoms, while the lung still shows no sign of resolution.

Adopting, then, the view that pneumonia is a specific febrile disease, we have still a further problem to determine—Is it an ally of the contagious exanthemata, or of such systemic diseases with local manifestation as acute rheumatism? It is here that the question of etiology becomes vitally important. If pneumonia was proved to be usually due to "chill," we should be disposed to rank it with acute rheumatism; whereas, if its contagious character were established, that would go far to justify its inclusion in the list of specific fevers. Unfortunately, upon these points the evidence is most conflicting. Most observers are agreed that pneumonia is at least occasionally attributable to exposure; while, on the other hand, cases of apparent contagion sometimes arise, and the undoubted occurrence of pneumonia in an epidemic form suggests the existence of some infective property. The prevalence of pneumonia in the variable and treacherous weather, often characteristic of the spring season in this country, is a point in support of the favorite etiology; yet many cases where the disease is confidently attributed to chill do not, on close investigation, warrant this hypothesis. The theory is often too obviously a pure after-thought. In this country, chill is popularly regarded as the *fons et origo* of almost every conceivable malady, and the hypothesis of having caught cold presents a ready and satisfactory escape from all etiological difficulties. The more carefully we sift the history of a case of pneumonia, the more frequently do we find that the universally volunteered theory of having "caught cold"

rests on nothing better than a hazy conviction on the part of the patient, that his malady must have owed its origin to this cause. It is clear that pneumonia does not bear the same direct and unequivocal relation to atmospheric influences as bronchitis or rheumatism; nevertheless, it must be admitted that, in some cases, such a relation seems difficult to dispute.

On the other hand, the evidence of the contagious nature of pneumonia is still scanty. It is beyond question that the sporadic disease is very rarely communicated, and, we believe, the vast majority of practitioners enforce neither isolation nor disinfection; yet, occasionally a case of apparent infection comes under observation. Such isolated cases would probably attract little attention, were it not for the phenomena of epidemic pneumonia. It is unquestionable that such epidemics occur, and are often extremely destructive. Their occurrence is sometimes vaguely explained as due to a "pneumonic" influence in the air; but if this means anything, it points to the existence of some specific contagion. How are we to draw the line between epidemic pneumonia which appears to be infective, and sporadic pneumonia which is almost universally regarded as non-infective? It is barely possible that the two diseases are really distinct, but no attempt has hitherto been made to distinguish them.

As illustrative of the problems presented by the phenomena of pneumonia, we mention the following instance, brought forward by a speaker at a recent discussion in one of our provincial medical societies. A child was under treatment for pneumonia, when two other children in the same house were seized with the same disease. At first sight, the evidence of contagion seemed strong; but closer inquiry elicited the fact that the two children had been put to sleep in a disused room, and that the window had been accidentally left open all night. Here, argued the speaker, is an apparent case of infection clearly explained by an obvious source of chill. In reply to this, it was powerfully urged by a subsequent speaker that, on the broad principle of probabilities, the chance of two children (in a family where a third child was already suffering from pneumonia) becoming affected by the disease in con-

sequence of exposure to cold, would be almost infinitesimal. The probability that one at least would take a common catarrh, bronchitis, rheumatism, or other usual consequence of exposure, would be extremely strong.

We make no attempt to settle problems which are still insoluble with the evidence at our disposal. We think, however, that much light might be derived from a thorough investigation of the etiology in all sporadic cases of pneumonia, and still more from a diligent inquiry into all instances where the disease assumes the form of an epidemic. In this work every physician in general practice might aid.—*British Medical Journal*.

A NEW "SYSTEM" OF GASTRIC THERAPEUTICS.

One may well listen with respect to the teachings of a physician who has cured over one hundred cases of gastric ulcer. This is what Professor Leube, of Germany, claims to have done (*Bull. Gén. de Thérap.*, Jan. 30, 1886). Professor Leube is a specialist in the department of gastro-enteric pathology. He preaches a gospel of which the three chief points are the need of accurate diagnosis, strict regimen, and copious use of the stomachal siphon. Professor Leube is one of those who have introduced a system into practice, based, like all systems, on the belief that its adoption will cure most cases of the diseases for which it is intended. Already there are establishments in Germany instituted with the sole object of treating gastric disorders according to the *régimes de Leube*.

Prof. Leube has had an excellent training in physiological and chemical science, and having devoted himself largely for fifteen years to the subject of digestive disorders, it is not surprising that he should have evolved a "system" that merits attention.

The therapeutic principles upon which Professor Leube depends are four in number:—1. Dietary regulations; 2. The use of the stomach-tube; 3. The use of hydrochloric acid and pepsin; 4. The use of various other drugs, such as powders, bitters, etc.

Preliminary to all treatment it is considered absolutely essential to make a correct diagnosis

of the form of gastric trouble. To facilitate this the stomach-tube is used, and seven hours after a meal that organ is washed out. If there remain any food at this time it is an evidence of digestive trouble. By using various foods, and then subjecting the stomach to the seven-hour test, a list of most digestible substances is obtained. On the basis of many such experiments, Leube constructs his different regimens. They are as follows:—

Regimen I. Soup (*bouillon*), meat-juice, milk, raw and soft-boiled eggs, unsweetened crackers, and mineral waters. The digestibility of meat solution as compared with light foods, such as calves' brains, rice, and chicken, was shown by many clinical examples as well as by experiments. A few patients, however, through some idiosyncrasy, cannot digest milk or eggs.

The diet above given is suitable for chronic catarrh and gastric ulcer. After it has been persevered in for about ten days, Regimen II. is introduced. This consists of boiled calves' brains, boiled sweetbreads, boiled chicken, and boiled pigeon. They are digestible in the order given. The chickens must be young and the skin must not be eaten. Well boiled soups were also permitted; and for the evening re-past soups, with milk, tapioca, beaten eggs, and calves' feet. This regimen, to which may also be added Regime I., gives a considerable variety. Treatment may be commenced with Regimen II. if the stomach-washings show the inutility of the first. The patient should live upon these regimens for several weeks, or until his digestive powers will take care of them easily. Then he enters upon Regimen III.

Regimen III. This consists of Regimen II. with the addition of raw or very rare beefsteak. The best way of preparing it is to scrape as much meat from the raw steak as can be removed easily, and heat it up rapidly in a small quantity of fresh butter. Raw ham, scraped and cooked in the same manner, is also good, strange as it may appear. The ham must be tender. A small amount of mashed potato is allowed, a little bread (not too fresh), and small quantities of tea or coffee with milk.

Regimen IV. Roast chicken, pigeon, venison, partridge, hare, rare roast-beef (it is best cold), leg of veal, small fishes, macaroni, and soup,

with milk and rice; a small amount of butter in some cases. Later on a small quantity of Bordeaux or Rhine wine may be used, but cautiously. Great variety in diet should not be adopted too rapidly.

The number of meals *per diem*, and the quantity of food ingested, must be carefully regulated with reference to the seven-hour rule, and the conditions and peculiarities of patients. Leube finds that at the catamenial period digestion is considerably retarded. It should consequently be aided, or a longer time be allowed for it, and the food should be plain and simple.

Regimen IV. should be continued for several weeks, and, if necessary, for months. Its conditions should be rigorously adhered to. When it is decided that the patient may return to his habitual diet he is directed to make the change very slowly, and to keep himself informed as to his digestive ability by the use of the washing-out tube in all doubtful questions.

The only stomach affection in which dietetics play a secondary part is that which Leube describes as nervous dyspepsia. Patients will, however, do better, even in that malady, to adopt a definite dietary. Regimen IV. is recommended, and variety is advised in the use of it for such cases. Condiments may be used if needed, and hydrochloric acid with pepsin. It should be remembered that in treating nervous dyspepsia moral dietetics (*la dietetique morale*) has a preponderating influence.

Leube attaches considerable importance to giving the stomach certain periods of complete repose. For instance, he will wash out the stomach seven hours after luncheon, and give no more food until ten o'clock on the following day. At this time soup and beefsteak are given, and, generally, a stomach-washing in the evening will show that the meal has been digested.

The drugs most used are hydrochloric acid and pepsin, bitters, cundurango, and mineral waters. The acid and pepsin are not given in nervous dyspepsia or in cancer or ulcer. Bitters, including cundurango, are not thought much of, though the drug mentioned is one of the best. Mineral waters are prescribed in very moderate amounts (O ss. daily), and are to be taken slowly upon an empty stomach.—*New York Med. Recorder.*

EVOLUTION IN PATHOLOGY.

It needs no foresight to see that pronounced significance will ere long be attributed to the Darwinian aspects of pathology. There has, perhaps, been some tardiness in applying the all-embracing principles of evolution to phenomena which fall within the special cognisance of the pathologist; but progress in this direction has been made, and, though slow, it has been sure.

Already in this connection several lines of thought have been taken up; and, carefully followed, they promise results of the greatest interest. Many have been recently recorded in this Journal. It has been suggested that enchondromata of the limbs of man and of many animals are growths homologous with structures which always exist in the selachian fin, and that many other so-called abnormal developments may be regarded as instances of reversion. Darwinism teaches that the developmental history of the individual is an abbreviated history of the development of the race to which the individual belongs; and the above suggestion concerning the homology of certain enchondromata is one which arises out of a consideration of the supposed ancestral history of man. Regard, too, must be paid to the inter-reactions of incidental forces and living things, for such inter-reactions are largely operative in the production of varieties. There are, in fact, two sets of factors—heredity and environment—concerned in the coming into being of new forms of life. And in the coming into being of new diseases, Sir James Paget has pointed out how these factors are to be considered. There is, again, the matter of correlation (correlation of structures and association of functions), to which Darwin drew special attention; and it seems that a knowledge of it also is of profound importance, as serving to throw light upon facts of every-day clinical experience.

Another Darwinian line of thought has been forcibly presented by Dr. Aitken. It has for many years been maintained that close genealogical, or at any rate gradational, relation exists between the *materies morbi* of remittent, that of intermittent, and that of enteric fever;

again, between that of enteric fever and that of typhus; between also that of enteric fever and that of scarlet fever; and between that of scarlet fever and that of diphtheria. Dr. Aitken has been ably advocating extension of careful observation upon these and such like relations. Those who believe in the germ-theory as applicable to most infectious, contagious, and miasmatic diseases, and at the same time adhere to the creed of the evolutionist, see no reason for supposing that pathogenic micro-organisms form an exception to laws which are applicable, it would seem, throughout Nature. And though sceptical concerning many of the explanations which have been advanced in this connection, we may yet allow that some amount of truth lies behind; and this despite the fact that the conversion of *bacillus subtilis* into *bacillus anthracis* in the laboratory has been abundantly refuted.—*Brit. Med. Journal*.

LANOLIN AS A BASIS FOR OINTMENTS.—In a preliminary note in the *Russkaiia Meditsina*, No. 12, 1886, p. 207, quoted in the *London Medical Record*, Dr. L. K. Pavlovsky, of Kharkov, writes that his experiments with Liebreich's lanolin (first in Russia) enable him to arrive at the following conclusions: 1. Narcotic extracts, when combined with lanolin, are absorbed by the skin "quite satisfactorily," their pain-relieving action being obtained "with an almost perfect certainty." The dose used was only twice as large as that for internal use. 2. Hydrochlorate of quinine is absorbed also very easily. This statement is based on four cases of intermittent fever in children, where lanolin and quinine inunctions rapidly gave the effects desired. 3. When a lanolin ointment with iodide of potassium is rubbed in, iodine appears in the urine not sooner than two, four, or six hours after inunction, while Lassar obtained iodine from the urine about three minutes after friction. 4. In children, lanolin is better absorbed than in adults. 5. Washing the skin with ether considerably facilitates the absorption of lanolin ointments. 6. In general, lanolin is a substance which promises to supersede all other constituents for ointments, and even in certain cases to render superfluous the internal use of drugs.—*Brit. Med. Journal*.

CHIARA'S PORRO CASES.

The eighth operation in the general Porro record, and the fourth of Italy, was that of Prof. Chiara, then attached to the Santa Caterina Maternity of Milan; this was in August, 1879. During his service in that hospital he operated five times, saving his last three cases, and all of the five children. After his removal to Florence, having been appointed to a professorship in its University, he became attached to the Maternity in that city, and resumed his obstetrical labors. Here, in July, 1884, he performed his sixth operation, which proved fatal from kidney disease. On January 13, 1885, he operated for the seventh time; on May 18, 1886, for the eighth; and on June 21, 1886, for the ninth time, the three cases being entirely successful. By these nine operations six women and nine children were saved.

In a tenth case, Prof. Chiara made trial of the method of Sanger, by which Dr. Leopold, of Dresden, had saved eight of his nine cases, and all of the children; and was successful in saving mother and child. This favorable result will probably lead to the introduction, to some extent, of the Sanger method into Italy.

An additional Porro operation was performed in the Maternity of Florence by Dr. E. Fasola, assistant to Prof. Chiara, on April 19, 1886. Sanger's method was first tried, but was abandoned because of a severe uterine hemorrhage, and the method by amputation of the uterus substituted for it. It is generally believed that convalescence after the Sanger operation is more rapid than after the Porro operation, and this belief is strengthened by the experience of Prof. Chiara's Sanger case, in which the patient sat up for a short time on the tenth day.—*Med. News*.

DIPHTHERIA AND CROUP.

The arguments of the dualists have been again very clearly and forcibly stated by Dr. J. M. Clemens, of Louisville, in a paper read before the Medico-Chirurgical Society of that city, and published in the first number of *Progress* for July, 1886. The author seems to think that what he regards as the error of the upholders of the unity theory is to be explained

by the fact that they wholly ignore the existence of a non-specific, non-contagious, idiopathic membranous croup, and he maintains that such a disease does certainly exist, and that it is perfectly distinct and distinguishable from diphtheritic laryngitis. In support of his view he enumerates the points of difference between the two affections, which we reproduce in parallel columns for facility of comparison.

IN DIPHTHERITIC CROUP.

A prodromal stage of two or more days without hoarseness or cough; more or less profound constitutional disturbance; elevated temperature, which often subsides after the first onset of the disease, sometimes becoming subnormal, to rise again with the invasion of the larynx and trachea.

Mottled or irregularly reddened fauces, often more conspicuous on one side than the other.

Enlarged and painful lymphatic glands, particularly the sub-maxillary at the angle of the jaws.

Exudation on the tonsils in the fauces, sometimes in the nares, on the lips, etc.

Early appearance of albumen in the urine as a rule.

A fetid breath of a sweetish, musty odor, similar to that in scarlatina.

In addition to the signs above enumerated

IN TRUE CROUP.

A sudden onset, or following within a few hours on exposure to cold and wet; little or no constitutional disturbance; elevated temperature, continuing till amendment is established.

Uniformly pale-red or bright-red—never mottled—appearance of the fauces, which are conspicuously free from loose secretion.

There is never enlargement of the submaxillary lymphatics.

There is no exudation on the tonsils in the nares or fauces, except, possibly, in rare instances the intense inflammatory action having extended by sympathy of continuity to the territory immediately contiguous to the entrance to the glottis; by strongly depressing the tongue the upper border of the membrane may be seen.

Albumen is never found in the urine.

The peculiarly fetid breath is never present.

the author adds that diphtheritic croup is a general disease of markedly asthenic character, while true, or pseudo-membranous croup, is a local affection of sthenic type.

The importance of this question is most certainly one which can hardly be over estimated. For it has a bearing not only on the therapeutic management but upon the prognosis and the prophylaxis as well. But, while in the abstract an error is always wrong and to be avoided if possible, yet, unless the physician can persuade himself absolutely that he has to do only with a local, non-contagious, membranous laryngitis, he would do well, in the present state of our knowledge, to regard every case of membranous croup as diphtheritic in character, and to take his precautions accordingly. If err we must, it is better to err on the safer side.—*Med. Record.*

THE REMOVAL OF SUPERFLUOUS HAIR BY ELECTROLYSIS.

The method which I employed was, with some modifications, the same as that given in a previous article. Instead of placing the sponge electrode (+) in the patient's hand, I applied it at the nape of the neck, and kept it there constantly, while the electrode needle-holder (—) had an attachment, by means of which I could make or break the current at any moment. I was thus enabled to get along with fewer cells and without loss of time. The pain caused was of no consequence whatever. The needle used was a plain steel sewing-needle of fine quality.

Mrs. W. had for the last ten years been annoyed by a strong growth of hair about her chin and upper lip. She had tried all conceivable remedies, with the result of only increasing the growth through the stimulation thus produced, so that when she came to me for relief she had a beard that would have done justice to a man.

It at first appeared almost hopeless; but, as she was so very anxious to have the growth removed, I determined to undertake the case.

The estimated number of hairs to be removed was fifteen hundred to two thousand, but I soon found that my estimate was too small, the number far exceeding two thousand.

At the first meeting I took out about one hun-

dred hairs, with an average allowance of ten seconds for each hair, and immediately afterwards washed that part with a weak solution of acetic acid, so as to neutralize the alkaline effect of the products of the (—) electrode.

On her return to the office the next day, I found the reaction so very slight that I ventured to take out over three hundred hairs at one sitting with equally good results. The following days I even exceeded this number, so that in nine sittings every objectionable hair on her face was removed.

In not one instance did I apply the needle twice to the same hair, and always applied it to about fifty or more before I stopped to extract them, which is very quickly done, the hairs after the electrolysis being perfectly loose.

After a lapse of about six weeks I found a return of about three per cent., which, after similar treatment, were also completely destroyed, so that now, after seven months, the face of the lady is in excellent condition.—*Jas. A. Bach, M.D., in Therapeutic Gazette.*

DELIVERY DURING HYPNOSIS.—A pregnant woman, aged 26, was admitted into the obstetrical clinic of C. Braun, in Vienna. Dr. Pritzel, who reports the case in the *Wiener Medical Wochschr.*, 1886, No. 21, says that it was accidentally discovered that she could easily be brought into a hypnotic state. The hypnotic sleep in her case set in rapidly and had no bad consequences of any kind. When, therefore, during the delivery the labor pains became very severe, he concluded to put her into the hypnotic state. He easily succeeded in doing so. The labor remained vigorous, the pauses became longer, and abdominal pressure continued to act; at the same time the os of the uterus dilated well, and the delivery was happily concluded. The placenta was then delivered into the vagina, and removed by the hand. On awakening, the patient felt very strong and did not remember any pain.

A remarkable fact was that abdominal pressure was brought about by reflex, for the patient being totally unconscious, no action of hers could have excited the pressure. Very little blood was lost during the delivery.—*Med. and Sur. Reporter.*

INGLUVIN.

A very learned name for a remedy is *ingluvin*. It is the essential principle of the gizzard, and bears the same relation to poultry that pepsin does to the higher animals. The honor of its discovery and utilization, in its crude state, remotely dates with the Chinese gastronomer, as well as to the Caucasian chemist in its refined condition. From time immemorial the inhabitants of the Celestial Empire have used the gizzard of chickens and ducks in nearly all made dishes. Their writers have recommended the practice as a sovereign treatment of dyspepsia, weak stomach, and vomiting. A favorite prescription of Chinese physicians for chronic indigestion is to cut up and digest chicken gizzards in hot water until they are reduced to a pulp, and then add some spices. A tablespoonful or two of the resulting paste is taken at each meal until the patient has entirely recovered. From China the practice passed to other parts of Asia, and was adopted here and there among the Mediterranean peoples. Strange to say, it was never learned by the great nations of Europe until the latter part of the present century. On the other hand, the organic chemists of Europe discovered, about 1850, a powerful nitrogenous radical in the gizzard. Experiments thereafter showed it to possess many of the qualities of pepsin. These experiments led to its isolation. Numberless experiments have proven it to be a very valuable addition to therapeutics. When pepsin refuses to act, and where in severe cases it has even been rejected by the stomach, *ingluvin* effected relief rapidly and with the greatest ease.

Prof. Roberts Bartholow, in his late work on "Materia Medica and Therapeutics," says:—
"Ingluvin: This is a preparation from the gizzard of the domestic chicken—*ventriculus callous gallinaceous*. Dose, gr. v.—ʒ j.

Ingluvin has the remarkable property of arresting certain kinds of vomiting—notably the vomiting at pregnancy. It is a stomachic tonic, and relieves indigestion, flatulence, and dyspepsia.

The author's experience is confirmatory of the statements which have been put forth regarding the exceptional power of this agent to arrest the vomiting of pregnancy. It can be

administered in inflammatory conditions of the mucous membrane, as it has no irritant effect. Under ordinary circumstances, and when the object of its administration is to promote the digestive function, it should be administered after meals. When the object is to arrest the vomiting of pregnancy, it should be given before meals.—*American Analyst.*

DIETETIC FALLACIES.

1. That there is any nutriment in beef-tea made from extracts. There is none whatever.
2. That gelatine is nutritious. It will not keep a cat alive. Beef-tea and gelatine, however, possess a certain reparative power, we know not what.
3. That an egg is equal to a pound of meat, and that every sick person can eat them. Many, especially those of nervous or bilious temperament, cannot eat them; and to such, eggs are injurious.
4. That because milk is an important article of food it must be forced upon a patient. Food that a person cannot endure will not cure.
5. That arrow-root is nutritious. It is simply starch and water, useful as a restorative, quickly prepared.
6. That cheese is injurious in all cases. It is, as a rule, contra-indicated, being usually indigestible; but it is concentrated nutriment and a waste repairer, and often craved.
7. That the cravings of a patient are whims and should be denied. The stomach often needs, craves for, and digests articles not laid down in any dietary. Such are, for example, fruit, pickles, jams, cake, ham, or bacon with fat, cheese, butter, and milk.
8. That an inflexible diet may be marked out, which shall apply to every case. Choice of a given list of articles allowable in a given case must be decided by the opinion of the stomach. The stomach is right and theory wrong, and the judgment admits no appeal.

A diet which would keep a healthy man healthy might kill a sick man; and a diet sufficient to sustain a sick man would not keep a well man alive. Increased quantity of food, especially of liquids, does not mean increased nutriment; rather decrease, since the digestion

is over-taxed and weakened. Strive to give the food in as concentrated a form as possible. Consult the patient's stomach in preference to his cravings; and if the stomach rejects a certain article, do not force it.—*Journal of Reconstructives.*

EGG DIET.—A patient had chronic diarrhœa of long standing and was much emaciated. The stomach, from taking a great many nauseous medicines (domestic practice stuff of "the-worse-it-is-the-better-it-is" sort) had become so irritable that the patient was in danger of starving to death from inability to retain anything in the way of nutriment. All medication by the mouth was stopped, and the invalid was put upon a diet of raw albumen, prepared and administered thus: The whites of six raw eggs were beaten up in a pint of cold-water, a little sugar and flavoring added, and the mixture given *ad libitum*, to be taken by sips during the day. The number of eggs was gradually increased until it reached fifteen or eighteen per diem. In addition to this diet the colon was filled once a day by means of a gravity injecting apparatus, with a solution of carbolic acid (1 part of medicinal acid to 720 parts of water), which was allowed to escape immediately, no effort been made to retain it. The first two injections caused subsequent griping and tenesmus, which were relieved by rectal injections of laudanum and starch water. The patient commenced to improve on the third day, and is now (five weeks later) entirely recovered, having gained 16 pounds in weight in this time. A curious feature is that the insipid albuminous drink, commenced from necessity, is continued from choice, the patient having become quite fond of it.—*Journal of Reconstructives.*

SOUR MILK IN ATONIC DYSPEPSIA.—This seems like a novel remedy, yet Dr. W. O'Neill tells us in the *Lancet*, August 29, that he has found sour milk a good remedy in many cases of atonic dyspepsia, or, at all events, it is a good adjuvant in the treatment of slow digestion where flatulence and a sensation of cramp in the stomach are prominent symptoms. The

good effects of sour milk were casually discovered by him some months ago, and since then he has prescribed it with satisfactory results in many cases of indigestion. If the curd of the milk should disagree with the patient it should be strained off, and the whey can then be given, or taken a short time after meals, warm. A gentleman who suffered much from flatulence and other disagreeable symptoms after meals, can now keep himself free from them by drinking, half an hour or so after eating, a tumblerful or half a tumblerful of ordinary cold sour milk, which to him is a most agreeable beverage. He believes the efficacy of sour milk in atonic indigestion is owing in a great measure to the lactic acid which it contains, which acid some physiologists say is one of the ingredients of the gastric fluid.—*Medical and Surgical Reporter*.

A METHOD OF CLOSING WIDELY-GAPING WOUNDS.—Herbert Snow writes as follows in the *British Medical Journal*: I first insert three or four silk interrupted sutures, making the needle enter and emerge from the skin at a long distance from the wound (three inches or more), and tie these as tightly as possible; the first twist of the cord being held by an assistant with dissecting forceps until the knot is completed. I then introduce a similar row of shorter ones, making the needle enter and emerge at about two inches distance from the wound; and then a third series, still shorter. By this time, the edges of the skin-incision are brought so closely together (in all but very extreme cases) that a continuous horsehair suture will serve to unite the whole length of the wound. The first and second rows of long sutures are now removed, having become flaccid and useless; but a few of the third are retained wherever there is very marked tension, for the first forty-eight hours—no longer. By this means, it is often possible to procure union by first intention in a wound which would otherwise take months to heal by granulation. It need hardly be added that careful support afterwards, by antiseptic strapping, will greatly promote a successful result.

Therapeutical Notes.

SUBSTITUTE FOR THE EAR-SYRINGE.—A rubber tube is used and the discharge sucked into a central glass portion.

CICATRICES OF THE FACE.—Let the cicatrix be cut clean off, and the dressing applied every day of perchloride of iron, $\mathfrak{z}\text{i}$; collodion, $\mathfrak{z}\text{ij}$. A barely perceptible line is left.

Iodine in one minim doses of the tinct. checks the vomiting of cholera. Dr. Senie regards it as a certain prophylactic, combined with 2 to 4 minims of laudanum.

FOR IODOL GAUZE.—R Iodol 1 part, resin 1 part, glycerine 1 part, alcohol 10 parts. Iodol is inodorous and non-toxic.—*Journal de Méd. de Paris*.

TASTELESS TURPENTINE.

R Syr. orange.....	25 parts.
Ether sulph.	5 "
Turpentine.....	8 "
Water.....	62 "

DIFFERENT PREPARATIONS OF THALLIN IN ENTERIC FEVER.—Dr. Mayrhofer, during an epidemic of enteric fever, occurring in a Bavarian regiment, employed thallin in three different forms, namely, the sulphate, the tannate, and the tartrate, and obtained highly satisfactory results from them all. He gave the drug according to Ehrlich's continuous system, the doses being generally 0.2 gramme, repeated when the temperature rose. From 1.0 to 2.0 grammes were given *per diem*. The total quantity required varied from 8 grammes in mild cases to 26 grammes in severe cases with relapses. After taking the medicine, a profuse perspiration occurred, which invariably appeared to improve the patient's condition. No unpleasant effects were ever observed. There were altogether eighty-eight cases, of which three (that is, 3.4 per cent.) died. It was not possible to say that one of the three preparations presented any marked differences in its action from the other two.—*Brit. Med. Journal*

SALICYLATED GELATINE FOR ECZEMA.—

R Acid Salicylic.....	10
Gelatine	30
Glycerine	10
Water.....	30

Dissolve by heat.—*Journal de Méd. de Paris.*

PARALDEHYDE.—Summer (*Neurol. Central*) states that paraldehyde must be given cautiously in alcoholics, as it causes cerebral congestions and phenomena of vaso-motor paralysis. He has noticed a profuse scarlatiniform erythema as a result of taking 4 grammes in 6 days.—*Bull. de Therap.*

PRURITUS ANI.—This is readily controlled according to M. Gaelléty (*Bulletin de Therap.*) by tepid lavements with one per cent. solution of boric acid, compresses of starch water and oxide of zinc ointment (one part of oxide to five of vaseline). If very severe a pledget of cotton soaked in cocaine solution may be used.

URETHAN AS AN ANTIDOTE TO STRYCHNINE.—Some interesting experiments have recently been made by Professor Coze on the physiological effects of urethan. It was clearly shown that in frogs the urethan had an antagonistic effect to strychnine, and it is probable that it may be found of service in strychnine poisoning and in tetanus.

FOR TOOTHACHE.—Spermaceti or white wax 2 parts, chloral 2 parts, carbolic acid 1 part. Melt the wax, and add the chloral and carbolic acid while stirring. Dip pieces of wadding in the mixture while fluid. They become solid on cooling. When used these are warmed and placed in the hollow tooth.—*Journal de Méd. de Paris.*

SWEATING FEET.—For three days bathe the feet for half an hour at a time, morning and evening, in tar water. At the end of the third day the pediluvia are omitted, and the soles of the feet are painted once a day with perchloride of iron. After four days more the epidermis is dry and hard. Complete cure has followed this simple treatment.

AYERS' COMPOUND SARSAPARILLA.

Fluid ext. sarzæ	3 ounces.
“ “ stillingia.....	3 “
“ “ yellow dock.....	2 “
“ “ May apple	2 “
Sugar	1 “
Potass iodide]	90 grains
Iron iodide	10 “

POISONING BY CORROSIVE SUBLIMATE.—Dr. Muller, of Berne, reports a case of carcinoma of the uterus for which hysterectomy was performed and a lotion of 1 in 4,000 of perchloride used in dressing the wound, the sponge being dipped in 1 in 2,000. Two days later albuminuria and diarrhoea with bloody stools set in. Death ensued on the third day, and there were ulcerations found in the colon.

SUBPREPUTIAL MEDICATION.—Dr. Taylor uses this method in obstinate gonorrhœal and urethral inflammations, and claims that all pain is at once relieved thereby. He rubs up morphine and cocaine in lanolin and inserts under the prepuce after thorough cleaning. From $\frac{1}{4}$ to 1 grain of cocaine may be applied at one time. Even in inflammation of the bladder it is beneficial.—*Courier Record.*

LUPUS ERYTHEMATOSUS.—Brocq (*Journal de Méd. de Paris*) reports a number of cases successfully treated by a paste of equal parts of white vinegar and yolk of egg. The mixture, after standing twenty-four hours, is pencilled on every second, third, or fourth evening. An energetic method is to apply a paste of vinegar and hard boiled yolk of egg, leaving it on all night, and in the morning washing with black soap.

ANTIPYRIN IN EYE DISEASES (Katzasurow).—The author has obtained extraordinary benefits from antipyrin in cases of headache from eye troubles. In 14 cases, 1 gramme sufficed to give complete relief. In 13 cases a second dose was required. In 2 cases (*neuritis optica et scleritis*), a third dose was needed. In headaches that follow cataract extraction, antipyrin is especially serviceable.—*Bulletin. Gen. de Therap.*

TRACHEOTOMY IN DIPHTHERIA.—In cases where tracheotomy is to be performed, Gaillard recommended the ordinary trocar and canula, puncturing with a quick thrust and semi-rotation and moderate and equable pressure. Hæmorrhage is avoided. Another good plan is to use an ordinary triangular pointed lancet heated to white heat. The wound is not so apt to be covered with false membrane, and the patient being in a semi-asphyxiated state, as a rule, little pain is felt.—*Dr. Watt, in Daniel's Medical Journal.*

OLEATE OF MERCURY AND MORPHIA.—Dr. J. H. Claiborne, of Petersburg, Va., recommends this as a capital remedy in acute glandular inflammation and phlegmonous inflammation threatening carbuncle. He has also used it together with constitutional treatment as indicated in carbuncle itself, and reports encouraging results in two cases; pain immediately diminished and soon vanished, and recovery was rapid and complete. No cutting—no carbolic acid—no caustic potash. Equally good results occurred in bubo; adenitis in children, acute or chronic, the result of local irritation, the sequel of scarlatina, or the concomitant of diphtheria.—*Gaillard's Journal.*

RESORCINE IN THE TREATMENT OF EPITHELIOMA.—Dr. Rubino Antonio reports a case of epithelioma developed on the side of the nose. The tumor was the size of a pea, but seemed adherent to the bone, and was surrounded by an inflamed zone of considerable size, the skin being to a great extent involved. An operation not being thought advisable, Rubino decided to employ resorcine. The tumor was washed twice a day with permanganate and an ointment applied composed of fifteen parts of resorcine to twenty of vaseline. Suppuration ceased almost immediately, the tumor diminished little by little, and at the end of five months there was only a small white circular scar visible.—*Journal de Med. de Paris.*

LAPAROTOMY PERFORMED UNDER COCAINE.—At the stated meeting of the Clinical Society of Maryland, June 4th, Dr. L. McLane Tiffany reported a case of laparotomy performed under

cocaine. He cut off the circulation from the line proposed for incision by pressing upon the abdomen a wire pessary covered with rubber and bent in the shape of a long narrow rectangle. He then injected along the line 30 minims of a 4 per cent. solution of cocaine. The incision when made was painless until it was extended beyond the line of injection of the salt, when the patient complained of pain. An amputation of the penis was made in the same manner without pain, the organ being constricted at its proximal end.—*Maryland Medical Journal.*

COCAINE.—1. M. Wenis reports a case of burn on the face, horribly painful; nothing seemed to give relief until cocaine muriate in solution was applied, and the pain at once ceased.

2. Hacker used a 50 per cent. solution with great benefit in erysipelas of the face. The vehicle preferred was palm oil or cold cream.

3. In hiccough, Dr. Campardor used hypodermic injections of $\frac{1}{100}$ gr. in a case of typhoid with very obstinate hiccough.

4. M. Labric obtained good results in pertussis by applying a 5 per cent. solution to the throat and parts adjacent.

5. M. Paul Bert has injected the bullæ of blisters and produced complete anæsthesia of the denuded surfaces.—*Journal de Méd. de Paris.*

TREATMENT OF BLENNORRAGIA.—No. I. Dr. Awssicidjiski has treated forty cases of blennorrhagia in the following manner:—During three or four days he administered 5 grammes (75 grs.) of salicylate of soda dissolved in 180 grammes of infusion of linseed, and ordered warm sitz baths. As soon as the burning sensation had disappeared he prescribed injections of boric acid 2 per cent. to the number of 4 to 6 daily for four days. Finally he ended by sublimate injections of 1 in 6,000 until a cure was established.—*Journal de Med. de Paris.*

No. II. Take three good lemons, neither too green or too ripe, freshly gathered, cut them in small pieces with their skins, and place them in an earthen jar; add 300 grammes ($9\frac{3}{4}$ oz.) of

water, and heat slowly until reduced to 100 grammes. Express and use the liquid as an injection three or four times a day. The results reported are very positive, though the trials were but few in number.—*Hesperidees, in Jour. de Med. de Paris.*

SCALD OF THE THROAT.—Dr. Whittie brought before an English Medical Society a child aged two years, treated by large doses of calomel for scald of the throat, caused by drinking boiling water from a teapot, causing the lips and fauces to be swollen and blistered; there was a hard cough, urgent dyspnoea, pulse 120, and general signs of collapse; tracheotomy was thought probable. After a mustard bath and fomentations, he was placed in a steam tent and one grain of calomel ordered every hour until green motions occurred. From one a.m. he took the powders all night without sickness or diarrhoea, but without relief. Pulse a.m. 124, temp. 100.8. Two grains of pulv. rhei. were given and the calomel continued till 12.30 a.m., when 41 grains had been given, and a green, slimy stool was passed. The breathing was improved. No swelling of the gums. Milk and water now could be swallowed. Calomel was stopped. Improvement began, and in five days bread and butter could be taken. Recovery followed. Dr. Bevan, of Dublin, had treated four cases successfully, giving 50 to 60 grains of calomel. Green stools may be expected in from eight to twenty-six hours from the first dose.—*Quart. Compend.*

DOVER'S POWDER AND ITS MODIFICATIONS.—

"If I could envy any one, as a therapist, it would be the old physician who originally had the happy thought of blending astringent opium with relaxant ipecacuanha, and both with a diuretic and laxative. I suspect that Dover's name, though so little is known of the man himself, is more frequently quoted than that of any other physician. This by the way; that which I have in my mind is to suggest that it is often very good practice to modify Dover's powder by combining the one grain of opium and the one grain of ipecacuanha with other salines than sulphate of potassa. The true Dover's powders contain nitrate of potassa as

well as sulphate, four grains of the nitrate to four of the sulphate, and it often seems to me reasonable to revert to this form, the nitrate of potassa being, in small doses, a good diuretic. I also very often venture to prescribe the powder with other modifications of the saline part, and with advantage. In acute rheumatic fever I usually substitute sodium salicylate for the potash salt; in gout, bicarbonate of soda; in remittent febrile cases, two grains of quinine with five of sodium salicylate; and in tonsillitis and other febrile throat affections, chlorate of potassa. It would surely be worth the time and skill of one of our scientific pharmaceutical brethren to prepare and bring out a series of Dover's powders in these modified forms."—DR. B. W. RICHARDSON, in *The Asclepiad.*—*Medical News.*

MASKING QUININE.—Various means have been recommended for disguising or concealing the intense bitterness of quinine, which renders it always so difficult of administration to children and many adults as well. While the compound elixir of taraxacum and compound elixir of licorice serve a tolerably good purpose if freshly mixed with the quinine before administration, they have never proven entirely satisfactory.

Prof. Hugo Engel (*Med. and Surg. Reporter*, Feb. 27) has recently discovered by what may be called a fortunate accident, that a combination of muriate of ammonia with powdered extract of licorice gives the most perfect disguise for the bitterness of quinine that has yet been found. He suggests the following formula:

R. Quiniae sulphatis,
Ammoniae muriatis aa gr. j.
Pulv. ext. glycyrrhizae gr. iv.
M. Ft. Pulvis.

For larger doses it is not found necessary to increase the licorice and the muriate of ammonia in the same proportion with the quinine, ten grains each of the licorice and the ammonia serving to cover ten grains of quinine.

The ammonia, muriate and the licorice must be kept finely powdered, and intimately mixed in a dry warm place.

In preparing for use, a small quantity of water should be added first and a paste made,

else the licorice will form little balls and swim upon the water, and will then be mixed with difficulty. As soon as all is thoroughly mixed to the consistency of syrup, the remainder of the water should be added, about half a tumblerful for twenty grains of the muriate of ammonia.

It is not stated whether this mixture will form a permanent disguise in mixtures to be prepared by the druggist, or must be prepared extemporaneously by patient at time of taking the medicine.—*St. Louis Courier of Medicine.*

THE
Canadian Practitioner.

(FORMERLY JOURNAL OF MEDICAL SCIENCE.)

To SUBSCRIBERS.—*Those in arrears are requested to send dues to Dr. Adam Wright, 20 Gerrard St. East.*

TORONTO, SEPTEMBER, 1886.

 We would call the attention of our readers to the Report of the Dominion Medical Association which appears in full in this number of the PRACTITIONER; also to the Address of the President, Dr. Holmes. These articles have increased our pages from thirty-two to forty, thus more than compensating for the few days' delay in issuing.

THE DOMINION MEDICAL ASSOCIATION.

A report of the proceedings of the above Association will be found in another part of this Journal. The meeting in Quebec was a small one, but the amount and character of the work done was quite equal to that of former occasions. The address of the President was one of great ability. It contained many excellent suggestions. We hope that our readers will give it a careful perusal. It seemed to be the opinion of many members that in order to have the future meetings of the Association large and successful they must be held in two or three of the larger cities of Ontario, and in Montreal.

A noticeable feature of this, as well as former meetings, is the absence of the older men of

the profession. We do not see why this should be peculiar to medical meetings of this country. Do the physicians die in early life, or do they lose interest in their profession as they become older? We are inclined to believe the latter to be the case. If many of those older men knew how much their presence at these meetings would be appreciated by the younger men, and how much their absence is deplored, they would make greater efforts to attend. We must not forget the notable exceptions to the rule—Drs. Howard and Fenwick, of Montreal; Drs. Workman, Covernton, and Canniff, of Toronto; Dr. McDonald, of Hamilton, Dr. Grant, of Ottawa, and a few others, have always had the interests of the Association at heart, and have actively participated in its deliberations.

Among those present were the following American visitors:—Dr. Ainsworth, U. S. Army; Drs. Carrier, Lafferty, and Imrie, of Detroit; Dr. Foster, Portland; Dr. Sherman, Ogdensburg; Dr. Potter, Buffalo, and Dr. Broughton, New York.

We feel assured that the medical men who came to this meeting were richly repaid, not only in attending the sessions, but also in visiting the various points of interest around the beautiful and ancient City of Quebec.

The members of the Profession in Quebec did not take much interest in the meeting. There was, however, one exception in the case of Dr. Russell, to whom the members of the association are especially indebted for his untiring efforts to make the meeting a success.

The next place of meeting is Hamilton. We sincerely hope that a united effort will be made to make it larger and more successful than any which have preceded it.

THE BRITISH MEDICAL ASSOCIATION.

The fifty-fourth meeting of this greatest of all Medical Associations was held at Brighton, England, August 10th to 13th, and was in no sense inferior to any of its predecessors. A number of eminent physicians from Canada and the United States were present, and took a prominent part in the proceedings. It will be remembered that the late Dr. Austin Flint,

sen., of New York, was invited to read the address on Medicine. After his death, Dr. John S. Billings, of Washington, was asked to take the place of Dr. Flint. He at once consented, and on the second day of the meeting delivered his address on "Medicine in the United States, and its Relations to Co-operative Investigation," which was well worthy of its distinguished author.

Among those who read papers were Drs. Lusk and Emmet, of New York, and Dr. Shoemaker, of Philadelphia. Dr. Davis, of Chicago, Dr. Billings, of Chicago, Dr. Grant, of Ottawa, and Dr. Hingston, of Montreal, were elected honorary members. Among others whose names appear in the reports were Dr. Brodie, of Detroit, Dr. Wilson, of Baltimore, and Drs. Gill Wylie and Hauks, of New York.

Dr. Davis, as President of the International Medical Congress, to be held next year at Washington, was well received, and extended a cordial invitation to the members of the British Medical Association to attend the Congress.

THE PROPHYLAXIS OF PHTHISIS.

Notwithstanding the recent discoveries made in the etiology of phthisis, very little progress has been shown in the successful treatment of this distressing malady. It is the painful experience of physicians to watch cases, from the earliest signs of consolidation in the apex, through their gradual downward course to a fatal termination. Occasionally the disease is checked for some years, and more rarely quite cured. The general experience, however, is a sad one, and the result can too often be certainly prognosticated from the beginning. The manner in which the disease can be prevented becomes, therefore, a question of vital importance. We must, in the first place, inquire what classes of persons are predisposed to the affection. These may be divided into two classes—first, those who belong to families in which there is a hereditary taint. It has been estimated that in about fifty per cent. of the cases there is a hereditary predisposition to the disease. We have here, then, a class of cases in whom we may employ all the means at our

command to prevent the development of the disease.

It is of great importance to begin this measure of prophylaxis in childhood. They should be, if possible, put under the most approved dietetic and hygienic conditions. "A healthy dwelling, on a dry soil, and with spacious sleeping apartments, perfect cleanliness, efficient ventilation, abundance of sunshine and fresh air, a life of vigorous activity, and a liberal and varied dietary, these seem to be essential conditions." How often do we see the first of these injunctions disregarded. In this country particularly, houses are often built in hollow, damp places, so that they may be protected from the cold winds during the winter. We have seen as many as six persons, members of the same family, die of phthisis in a house of this kind. When houses are better situated, how careless people often are about the condition of the basement! No house is quite healthy in this respect unless the soil is excavated under the whole house, and the floor cemented and thoroughly drained.

Another means of prophylaxis, and one which is most frequently disregarded, is the separation, as far as possible, of diseased from healthy members of the family. We are confident that phthisis is a contagious disease, and may be communicated from one to another. The degree of separation required is not of such a character as to distress the one affected. The patient should sleep in an apartment by himself, and when it is necessary that he should be waited on, some nurse outside of the family should, if possible, be procured, one in whom there is no hereditary tendency to the disease. Residence among the mountains and sea voyages may be of benefit to those who can afford them.

The second class of cases are those who have shown premonitory signs of the disease. Unfortunately in most cases there are no definite signs until the disease has become seated. The premonitory symptoms vary in age as follows— hæmoptysis, sudden and unaccountable failure of appetite, with derangement of the digestive organs and marked failure of strength. When these conditions occur in members of a tainted family, the most active prophylactic means should at once be adopted:

THE BRITISH MEDICAL ACT.

A perusal of the full text of the British Medical Act leaves no doubt about the matters to which we referred in our last issue. We find the following in clause 6: "On and after the appointed day a registered medical practitioner shall, save as in this Act mentioned, be entitled to practice medicine, surgery, and midwifery in the United Kingdom, and (*subject to any local law*) in any other part of Her Majesty's dominions, etc."

Among the definitions we find:

"The expression 'local law' means an Act or Ordinance passed by the Legislature of a British possession."

"The expression 'British possession' means any part of Her Majesty's dominions exclusive of the United Kingdom."

"The expression 'the appointed day' means the first of June, one thousand eight hundred and eighty-seven, or such other day in June, one thousand eight hundred and eighty-seven, as may be appointed by the Privy Council."

It will follow that the Ontario Medical Council, through the powers conferred on it by the Provincial Legislature, will have sole control of the registrations of medical practitioners after June of 1887. Graduates of Canadian Universities who pass any of the examinations of Great Britain and become registered as practitioners of Great Britain on or before that date, June 1st, 1887, will be entitled to registration in Ontario; while all registered in Great Britain after that date will have to conform with the regulations of the Council if they wish to practice in Ontario, *i.e.*, they will be compelled to pass the examinations of the Council.

THE AMERICAN PUBLIC HEALTH ASSOCIATION.

The meeting of this Association, which will be in session as our next number is published, means something more than a mere visit of pleasure from a number of ladies and gentlemen from across the border. It is a recognition of the work done, and the place taken by our Province in the regulation of public health, and it is a great compliment to Toronto. The meeting will be the fourteenth Annual Meet-

ing of the Association. Its annual volume of proceedings is the record of its vitality; its papers the best index of the quality of mental power among its members, and their power of grasping the vital questions of our every-day life and health.

We, as physicians, and the daily combatants of disease, are more especially interested in the work of the Association than any other class of our citizens. Our brethren on the other side always extend to us fraternal greetings on occasions of intercourse with them: we ask the profession here to welcome with cordiality those distinguished personages, professional and non-professional, who may come amongst us in October. We hope that the visit may not be barren—that an increase of membership may be obtained in Canada. Dr. Canniff, our energetic health-officer, is the Local Secretary, and can supply all information about membership.

GENERAL MEDICAL COUNCIL OF GREAT BRITAIN.

According to the recent Medical Act the General Council will control medical matters in Great Britain. It holds a position somewhat similar to that of the Medical Council of Ontario, and it will therefore be interesting to compare the composition and powers of the two bodies.

In Great Britain the Council will consist of thirty members, of whom twenty will be chosen by the universities and corporations, five will be appointed by the Crown, and five will be elected by the practitioners of the United Kingdom—*viz.*, three by those in England, and one each by those in Ireland and Scotland. The universities and corporations will thus have the controlling power, and the corporations will still be able to grant their cheap diplomas to all candidates, including the poor and needy. It will be the duty of the Council to secure a proper standard at all examinations, and with that end in view inspectors will be appointed to attend such examinations when required. It remains to be seen what good will be accomplished by such inspections.

Many in Great Britain were anxious to see a central Examining Board instituted, such as we

have in Ontario; but the opposition on the part of the universities and corporations was too strong to be overcome. It is hoped, however, that the powers granted to the General Council, which will enable it to insist on a fair standard at all examinations, will be productive of much good in the interests of higher education. It is well known that there is much room for improvement in this respect.

The Council of the College of Physicians and Surgeons of Ontario is composed of twenty-seven members: viz., twelve territorial, ten collegiate, and five homœopathic representatives. This arrangement prevents the collegiates from having a controlling voice in any legislation on the part of the Council. There has been some disposition to complain about the large number of the so-called school-men, and a desire expressed to increase the number of men from the territories. The most radical among the members of the general profession in Great Britain would be thoroughly satisfied with such an arrangement as we have, but their prospect of getting it appears almost hopeless. Under the circumstances there is little occasion for complaints in Ontario, especially as the school-men have never united to prevent any advances in medical education in the Province.

Meetings of Medical Societies.

THE DOMINION MEDICAL ASSOCIATION.

The nineteenth annual meeting of the Dominion Association took place in Laval University, Quebec, on the 18th and 19th of August.

At the

MORNING SESSION OF WEDNESDAY,

Dr. Sullivan, of Kingston, a past-president of the Association, took the chair.

The retiring president, Dr. Osler, of Philadelphia, was unavoidably absent.

Dr. Sullivan, in a short address, complimented the Association on holding its nineteenth meeting in the ancient city of Quebec, the place in which it was organized. Among other great national improvements which had been made since the organization of the Asso-

ciation, he mentioned the Canada Pacific Railway.

REPORTS FROM THE VARIOUS COMMITTEES

were then called for, but none were given except that of the Chairman of the Committee on Obstetrics—Dr. McKay.

In a short paper the doctor touched upon the various improvements made in gynæcological surgery, and gave briefly the opinions at present held by obstetricians in the treatment of some of the more serious complications of labor.

Dr. Campbell, of Montreal, in moving a vote of thanks to Dr. McKay, took occasion to say that many members of the various committees were not notified of their membership—a fact which accounted for the absence of reports.

Dr. Graham, of Toronto, in seconding Dr. Campbell's resolution, suggested that a different arrangement might be made; that the chairman of each committee should select a definite subject for discussion which should be introduced by him, and that the members of his committee should assist. In this way the most interesting form of discussion might be introduced.

The following gentlemen, guests from the United States, were then introduced: Dr. Sherman, Ogdensburg, delegate from New York State Medical Society; Dr. Carrier, junior, of Detroit, and Dr. Dawson, of Cincinnati.

Dr. Sherman then addressed the Association. He spoke of there being no dividing line between the two countries in matters of science, and gave as a proof of this the fact that Dr. Billings, of Washington, had given the address on medicine before the British Medical Association.

The Association then adjourned and the members, at the invitation of the authorities of Laval University, made a tour through the various museums, picture gallery, library, etc. The visit was very much enjoyed.

THE AFTERNOON SESSION

commenced at two o'clock—Dr. Holmes, the president-elect, in the chair.

In the absence of Dr. Yeomans, of Mount Forest, chairman of the Committee on Public Health, the chairman called on Dr. Cassidy to read the report on that subject.

Dr. Cassidy, in his report, referred particularly to the question of quarantine, and to the regulations recently made by the Dominion Government. The writer concurred in the regulations made, but thought some of them should be more stringent.

It was moved by Dr. Eccles, seconded by Dr. Clark, that the Canadian Medical Association, at the annual meeting convened at Quebec, view with pleasure the action taken by the Dominion Government in the issue of the quarantine regulations which have been put in force during the present month. We consider this prompt action to be of great importance to the general public, and moreover that, when intelligently applied, the regulations are calculated to conserve the best interests of the trade and commerce of the Dominion.

THE PRESIDENT THEN READ HIS ADDRESS,

which was of more than ordinary merit, and which was well received by the Association. It appears in full in this number of the PRACTITIONER.

Dr. Howard, in moving a vote of thanks to the president for his address, spoke of the preliminary education of medical students. He thought that the tendency at present was to make it broad and superficial, and that in some respects it might be better to go back to the old system of requiring a deeper and more thorough knowledge of the subjects prescribed. He was in favor of making an Arts' course compulsory.

Dr. Sullivan, in seconding the vote of thanks, differed from Dr. Howard in the necessity for a compulsory Arts' course. He did not find that Arts' graduates made better students or practitioners than those who had not taken a university course. He thought, also, that the emoluments of the profession were not so great as to warrant the taking of such a prolonged and severe course. The Association then divided into sections.

MEDICAL SECTION.

In the Medical section Dr. Canniff, of Toronto, was appointed chairman, and Dr. Jenner, of Picton, secretary.

Dr. Daniel Clark then read a paper on

THE MEDICAL JURISPRUDENCE OF CRIME AND RESPONSIBILITY.

The writer stated that the legal profession was governed by precedent, whereas the views of the medical men were constantly advancing with the increase of our knowledge of brain pathology. For this reason, the views of the two professions on the subjects of crime and responsibility are now much at variance.

The writer drew the following conclusions:

(1.) The natural history of crime shows that brains of chronic criminals deviate from the normal type, and approach those of the lower creation.

(2.) That many such cases are impotent to restrain themselves from crime as are the insane.

(3.) That the moral sense may be hidden from expediency by the cunning seen even in the brutes until evoked by circumstances.

(4.) No man can make himself free from the physical surroundings in which he is placed.

(5.) Crime is an ethical subject of study outside of its penal relations.

(6.) Insanity and responsibility may co-exist.

(7.) Some insane people can make competent wills because rational.

(8.) The monomaniac may be responsible should he do acts not in the line of delusion, and which are not influenced thereby.

(9.) Many insane are influenced in their conduct by hopes of reward or fear of punishment, in the same way as the sane.

(10.) Many insane have correct ideas in respect to right and wrong both in abstract and concrete.

(11.) Many insane have power to withstand being influenced even by their delusions.

Dr. Sherman, of Ogdensburg, spoke in the most complimentary terms of the paper. He thought that if the principles enunciated were thoroughly understood and carried out by the legal and medical profession, as well as by the laity, it would be to the great advantage of the human race.

Dr. Howard thought that no two opinions existed among medical men with regard to these matters, and regretted that the legal profession could not take the same view.

Dr. Sullivan was of opinion that exact rules for diagnosis should be laid down for general practitioners, and wished to know if general practitioners should presume to give evidence in courts in cases of insanity.

Dr. Clark, in reply, stated that no man should hastily give an opinion on obscure cases of insanity. Certain forms of insanity may be diagnosed by the general practitioner. There are cases in which even experts can scarcely come to a conclusion. Now that students receive lectures on insanity, the profession will shortly be in a better position to give opinions on these matters.

Dr. Dupuis then read a very interesting paper on

DIABETES MELLITUS.

He went over the Canadian mortality statistics, showing that diabetes exists to a much greater extent in rural districts than in cities, and is more frequently found in men than in women. The writer related several cases which had occurred in his own practice, and concluded that the best treatment was strict attention to diet and the administration of O'emen's solution of arsenite of bromine.

Dr. Ross spoke of the importance of distinguishing between simple glycosuria and true diabetes.

Dr. Graham thought that it was necessary to make three clinical divisions, temporary glycosuria, mild, and severe diabetes. The mild form was amenable to treatment, whereas the severe form was not.

Dr. Campbell, of Montreal, related two cases of temporary glycosuria, one of which occurred in the case of a merchant, in whom sugar appeared in the urine when he indulged in much saccharine food. The other case was that of a physician who had temporary glycosuria after a stormy sea voyage.

Dr. Holmes had found the solution of arsenite of bromine of the greatest service in the treatment of diabetes.

Dr. Jenner, of Picton, then read an excellent paper on

ALIMENTATION IN SICKNESS.

He first spoke of the importance of alimentation and hygiene, both in health and disease. He then stated that in many cases medicine was

not needed so much as strict attention to diet and general regime. He related some such cases which had occurred in his own practice.

Dr. Dupuis spoke of the difficulty of carrying out hygienic rules in country houses, as many had a prejudice against fresh air and sunlight for sick people.

Dr. Eccles agreed with the opinions expressed in this paper. He instanced the prejudice many people had against suppers. He thought that in most cases light suppers promoted health, and prevented sleeplessness.

Dr. Howard spoke in highly complimentary terms of the paper, and thought the reader had accomplished a great deal when he was able to persuade such people and their friends that in their cases medicines were of secondary importance.

Dr. Campbell, of Montreal, did not agree with the writer when he stated that the subject of dietetics was not taught in Canadian schools. In Montreal, at any rate, great importance was given to this branch.

The section met in the evening at 8 o'clock.

Dr. Playter read a paper on

VITAL STATISTICS.

He first gave the history of the origin of mortality statistics in England, and of the high state of efficiency found in that branch of the service to-day. He urged the necessity for the establishment of a bureau for statistics in this country, and stated that he would, at another time, move for the appointment of a committee to petition the Government with regard to the matter.

Dr. Graham then read a paper on

CONTAGIOUS PNEUMONIA.

which will be published in a future number.

Dr. Howard had not met with a single case of contagious pneumonia. He believed that such rare cases must be of a different character from those of ordinary lobar pneumonia. He did not think that the relationship which exists between bacteria and the pneumonic disease had yet been clearly made out.

Dr. Ross was also of opinion that such cases were rare, and formed a distinct disease.

Dr. Foster, of Portland, related the history of two epidemics of pneumonia which had

occurred in that city. In one, which was quite extensive, the cause was found in the impure water from a well which was used by the families in which the disease appeared. The well was found to have almost direct connection with the drain from a number of outside water-closets. The other epidemic occurred in a home for orphans. In the first epidemic the consolidation appeared invariably in the left apex, whereas in the latter it occurred in the right side. All of the cases presented symptoms similar to those given in the paper.

Dr. Cassidy related instances of epidemic pneumonia, and had met with one instance of it.

Dr. Graham, in reply, stated that he believed in the unity of lobar pneumonia. He thought this view was confirmed by investigations into the parasitic nature of the disease. He was also of opinion that the soil upon which bacteria is grown influences the character of these growths. He related the investigations of Dr. Steinberg in confirmation of this point.

Dr. Gardiner, of London, read a paper on,
THE INHIBITION OF THE HEART IN DIPHTHERIA.

He related two cases which had occurred in his own practice, in which death had resulted from heart failure. In both cases the pulse became remarkably slow. In one it was not more than twenty-eight to the minute. He thought that these grave symptoms were brought on by irritation of the nerves of the throat at the seat of the disease and consequent inhibition of the heart. He instanced tetanus as an example of similar nerve irritation.

Dr. Graham was of opinion that the phenomenon could be best explained on the supposition that a poison existed in the blood which acted on the nerve centres. He spoke of the investigation of French pathologists who found toxic principles even in normal excretions, as in urine. When that was the case, how much more likely that such principles exist in pathological states.

Dr. Ross was of the same opinion on this etiology of the disease as the last speaker. He spoke of the gravity of heart failure in diphtheria. Some cases appeared to be hopeless from the commencement, but many terminated

favorably. The rapid fatty degeneration of the heart might explain some cases.

Dr. McDonald, of Wingham, gave instances of some cases which occurred in his own practice, and was also of opinion that fatty heart and the paralysis of that organ might explain the symptoms related by the reader of the paper.

Dr. Gardiner did not think that either fatty degeneration or paralysis could account for the phenomenon. There was a slowing of the pulse and no diminution of volume, two conditions which would not be likely to follow fatty heart.

THURSDAY MORNING.

The Association met at 10 o'clock, the President in the chair.

The minutes of the last meeting were read and adopted.

ELECTION OF OFFICERS.

The following report of the Nominating Committee was then read and unanimously adopted.

Place of meeting for next year: Hamilton.

President, Dr. J. E. Graham, Toronto; Vice-Presidents: Ontario—Dr. Dupuis, Kingston; Quebec—Dr. Russell, Quebec; New Brunswick—Dr. Currie, Fredericton; Manitoba—Dr. O'Donnell.

Local Secretaries: Ontario—Dr. McKeough, Chatham; Quebec—Dr. Bell, Montreal; New Brunswick—Dr. Lunan, Campbellton; Nova Scotia—Dr. Trueman, Sackville; Manitoba—Dr. Chown, Winnipeg.

Chairman of Local Committees in Hamilton Dr. Malloch.

Dr. Graham moved, seconded by Dr. Sheard, that the Committees on Medicine, Surgery, Obstetrics, and Therapeutics be abolished, and in order that this change take place at once, the by-law requiring notice of motion be suspended. This motion was carried unanimously.

Dr. Campbell then moved, seconded by Dr. McFarlane, of Toronto, that the by-law authorizing the formation of a Committee whose duty it is to make Reports at the Annual Meeting on Medicine, Surgery, Midwifery, and Therapeutics, having been suspended by a unanimous vote of the Association, the President do name at this meeting readers of addresses upon

specific subjects in Medicine, Surgery, Midwifery, and Therapeutics, and that these gentlemen be at once notified of their appointment by the Secretary. In the event of the gentlemen named by the President declining the appointment, he shall have the right to name substitutes.

This resolution was carried unanimously.

The following resolution by Dr. Playter was then passed unanimously by the association:—

"That the following be a special committee of this association to consider the question of a system of vital statistics for the Dominion, and to urge upon the Federal Government the desirability of making provision at an early day for obtaining full returns of births, marriages and deaths, throughout the different provinces of the Dominion, namely: Hon. Sen. Sullivan, Kingston; Drs. F. W. Campbell and Larocque, of Montreal; Daniel Clarke (P.L.A.) and Canniff, of Toronto; Ahern, of Quebec; and Grant and Playter, of Ottawa."

The Association then divided into sections.

PROCEEDINGS OF MEDICAL SECTION.

(Continued.)

In the Medical Section, Dr. F. W. Campbell read a paper on "The Treatment of Whooping Cough by Quinine." He spoke of the obstinate and distressing character of the disease. The writer commenced to use quinine after it had been advised by Dr. Dawson, of New York. He had notes of over one hundred cases in whom the remedy had produced excellent results. The essentials in the quinine treatment are, (1) The drug must be pure; (2) It must be dissolved in acid and not disguised by syrup or aromatics; (3) It must be given freely. For young children the dose is from five to eight grains; for adults ten to forty grains.

The writer is of opinion that whooping cough is a parasitic disease, and that quinine acts as a germicide. He spoke also of the use of a solution of quinine in the form of spray.

Drs. Trenholm, Graham, and Gardiner took part in the discussion, and gave their testimony to the efficacy of the quinine treatment. The latter two gentlemen did not think it necessary to leave out the syrup or other aromatics.

Dr. R. A. Reeve then read a paper on

GLAUCOMA,

which was illustrated by charts of various pathological conditions of the eye in this disease. The essential pathological condition of glaucoma is an obstruction to the outflow of the secretions of the eye.

Dr. Buller stated that you may have subluxation of the lens without glaucoma following for at least a long time.

Dr. R. A. Reeve in his reply condemned the free use of atropine, and considered it an occasional cause of glaucoma.

*Domium Medical Association
continued from last month*

SURGICAL SECTION.

WEDNESDAY, AUG. 18TH.

Dr. Desjardins, of Montreal, read a paper on

"KERATOSCOPY AS A MEANS OF DIAGNOSIS IN ASTIGMATISM."

After defining the term astigmatism, he said that errors of refraction affect the vision injuriously, although the optic nerve be healthy. It was formerly supposed that the fault was in the lens, but it is now known to be due (as was first pointed out by Donders) to the curves of the cornea. The lens, according to later investigators, partakes of the same deformities as the cornea. Accommodation is not without influence on refraction.

Dr. Jas. Bell, of Montreal, read a paper on

"TRACHEOTOMY IN MEMBRANOUS LARYNGITIS,"

in which he advocated dispensing with the tube in the after-treatment of tracheotomy. He said that the methods of stitching the cut edge of the tracheal to the edge of the neck wound and the use of the cannula had proved of but little benefit in actual practice.

He preferred late to early operations in membranous laryngitis for the following reasons, viz.: (1) If patient were operated on early, many would be operated on unnecessarily; (2) Extension of membrane takes place more rapidly after tracheotomy; (3) If the obstruction is not rapidly produced, membrane is separated and expelled. The recoveries after early operations were 25-33 per cent.; after late

operations, 5-10 per cent. ~~A greater percentage recover without operation.~~ He next entered ~~on the question as to whether the extension of the membrane is due to general or local causes, and thought that the weight of opinion is that extension is due to purely local causes, and gave a number of cases illustrating this point.~~ After discussing the subject ~~as to whether diphtheria is or is not primarily a local disease, he gave his reasons for not liking the tube in tracheotomy:~~ (1) The tube never accurately fits; (2) When the tube is in place, the incisions into the trachea cannot be kept under observation; (3) Occasionally the tube from not being in the middle line, and being left too long in the trachea, ulcerates through, and an artery may be opened; (4) When the tube is in the trachea, there is difficulty in expelling through it pieces of membrane; (5) The tube causes sometimes exuberant granulations and warty growths. In place of the tube Dr. Bell has devised an instrument which he thinks does away with the objections to the tube. It consists of a pair of "clips," which catch the edge of the trachea and holds it apart. They are held in position by a tape which goes round the neck. He had experimented with the clips on a number of dogs, and found that they held well and no ill results followed.

In speaking of the place of operation, Dr. Bell ~~stated that he preferred the low operation because there was more room, and also because, by it, we get further away from the disease.~~ In the after-treatment of cases in which the "clips" are used, he withdraws the mucus, etc., from the trachea by means of a glass pipette. He said he did not believe in the close camp bed which is now so often used, but preferred a free current of air. After operation he plugs the trachea or larynx above the wound with antiseptic sponge; this absorbs the discharges and helps to localize the membrane. Over the wound he keeps a piece of gauze; and he occasionally introduces vaseline into the trachea. When the tube is used, after two or three days the breathing becomes dry, and the end of the tube becomes coated with inspissated mucus; below this, in the trachea, is a cone of dried exudation, which helps to block up the passage. Dr. Bell gave the histories of two cases of

diphtheria in which he had operated and used his "clips." One case died, and the other—aged twenty-five months—recovered. In nine cases of tracheotomy in which he has used the tube, all, with one exception, died.

He summed up by saying that the excessive mortality after diphtheria was due to defects in the after-treatment. The presence of a tube is a source of irritation and prevents the application of remedies to the trachea itself.

Dr. A. L. Smith, in the discussion which followed, said that when house surgeon to a children's hospital in London, he had a large experience with cases of tracheotomy. He believes that the "clip," introduced by Dr. Bell, will prove of the greatest possible benefit and will in all probability reduce the mortality after the operation. He had seen one death from ulceration of the tube into a large vein.

Dr. Kerr, of Winnipeg, said that he had considerable experience in tracheotomy whilst in Nova Scotia. He had performed it twelve times, and never had a good result. He did not think that tracheotomy is a good operation, and had seen most desperate cases recover without it. If Dr. Bell's treatment without a tube reduced the mortality, it would be a great gain. ~~Dr. Kerr went on to say that the after-treatment of tracheotomy is always a source of anxiety; the tube is apt to get displaced during fits of coughing. In his last case he dispensed with a tube and stitched the edge of the cut trachea to the edge of the wound, as recommended by Post. He did not like this method, for when the patient's chin was depressed, the opening closed. He thought that with Dr. Bell's instrument he could do better.~~ As to the question of the general or local origin of diphtheria, it was too large a subject to discuss at the present time. His last tracheotomy case lived three weeks and died of paralysis, so that it is not always the extension of the membrane that kills after tracheotomy, and the best after-treatment will fail to produce a good result. He was very doubtful about the good that would result from plugging the trachea above the wound.

Dr. F. J. Shepherd said that he had performed tracheotomy a number of times both in hospital and private practice. His first ten or

a dozen cases were all fatal, but during the last two and a-half years he had performed tracheotomy in private practice sixteen times, and had had five recoveries. In hospital practice his results were not so good. He thought that the kind of instruments used did not matter much; it was important that the wound should be kept aseptic. He removed the tube as early as possible, never later than the fifth day, in one successful case he removed the tube on the third day; they were all cases of diphtheria. ~~He preferred the low operation because the trachea is opened at a greater distance from the disease, there is more room, and it is not necessary to cut the cricoid cartilage. In the high operation division of the cricoid had to be frequently undertaken and often resulted in necrosis. Again, stenosis more frequently occurred after the high operation.~~ Dr. Shepherd believed that after operation it was useful to have a warm room (75°-80° F.), and that the atmosphere should be saturated with moisture. He always used a croup or closed bed, and the steam of the kettle was conveyed into it by a huge spout. The inner tube was removed every hour and the outer one on the second day, lime-water was occasionally dropped into the tube. He thought that the tube favored expulsion of membrane. With regard to the antiseptic plugging of the trachea, he did not think it of much benefit. Very often the membrane extended, at the time of the operation, below the wound, and if it did not, the continuity of the mucous membrane could not be interfered with. ~~He had never seen the conical plug in the trachea described by Dr. Bell. All the cases of death after tracheotomy he had seen had been due to extension of the membrane. Theoretically Dr. Bell's instrument was perfect, but it remained to be seen what it would do in practice.~~

Dr. Russell, of Quebec, had not seen half a dozen cases of diphtheria in twelve years, but during the last year he had seen a great many cases of membranous croup. He thought this disease was more fatal than diphtheria. He was formerly opposed to tracheotomy, but now thought early operation advisable; if the operation did not cure, it always relieved. He had performed tracheotomy six times with two

recoveries. He thought Dr. Bell's instrument a very ingenious one, and likely to prove very useful. ~~In the after-treatment he was strongly in favor of using lime-water spray.~~

Dr. Fenwick, of Montreal, said that he preferred the high to the low operation. Dr. Bell's instrument appeared to answer very well. ~~Dr. Marshall Hall, many years ago, devised a somewhat similar instrument made of wire. He had seen one of Dr. Bell's cases treated with the "clips," and formed a most favorable opinion of the instrument.~~

Dr. Fenwick, of Montreal, read a paper on
TREATMENT OF TUBERCULOUS GLANDS OF THE
NECK.

He believed that scrofulous glands are intimately connected with tubercle. After giving a sketch of the history of tubercle and Koch's discovery of the tubercle bacillus, he said that there must be some predisposing condition in the individual so that he can contract tubercle—the proper soil must be present. The glands of the neck are specially liable to infection, especially the submaxillary and those over the large vessels. Enlargement is rarely single and occurs generally at first on one side of the neck only. ~~Often there are no external signs of softening of the gland, but when the glands break down and open externally indolent ulcers and sinuses are left. The disease generally first shows itself in a single gland and then spreads to other parts; very little is known of the mode of entrance of the tubercle bacillus.~~ In scrofulous enlargement of the glands of the neck the author strongly advised early removal of enlarged glands. After removal the general health of the individual improves; if they are left, the patient runs the risk of general tuberculosis, and if he recovers it is with impaired health and a number of disfiguring scars on the neck. ~~The author preferred removal to laying open and scraping out the gland or the cautery puncture of Mr. Treves.~~

Dr. Kerr, of Winnipeg, said that if we accepted the principle of the identity of scrofula and tubercle much confusion would be removed. ~~He was not satisfied with the results of operations and did not now operate so often as formerly; he found the operation not only~~

very tedious but difficult and dangerous, and the results were not always so good as represented. ~~Dr. Alexander, of Liverpool, who formerly operated some twelve years ago very frequently in these cases, has now given up the operation.~~

Dr. Shepherd, of Montreal, confessed that the results of operation were not always so perfect as were described by the enthusiastic advocates of the operation, but in many cases the results are entirely satisfactory. ~~Occasionally there are high temperatures after operation; sometimes attacks of cellulitis. He had operated in a good many cases, and had removed as many as twenty to thirty glands at a time. Apparently solid glands not infrequently come to pieces during removal, and are found to be quite soft in the centre. These conditions always complicate the operation.~~ After incising the deep fascia, he prefers removing the glands with the fingers, and an occasional cut with a knife. He has never had any accident attending the operation. Although he has had no experience with Treves's cautery puncture, he does not think it suitable for glands deeply placed. In sinuses and scrofulous ulcers, he has had most excellent results from scraping out the parts with Volkmann's spoon.

Dr. Trenholme, of Montreal, read a paper on
SOME DETAILS OF UTERINE AND OVARIAN OPERATIONS.

He said the instruments used in these operations need not be numerous or complicated. After describing the usual precautions that should be taken regarding the cleanliness of hands, sponges and instruments, he said that he prefers No. 1-20 shoemakers' thread to any other form of ligature. Before use the thread should be immersed for twenty-four hours in pure carbolic acid, and not put into water at all. In closing the abdominal wound, he uses silver wire for the deep sutures and horsehair for the superficial. He laid great stress on the importance of not enclosing any muscular tissue in the suture. ~~The incision should be midway between the umbilicus and pubis, and should not extend to within one and a half inches of the pubis.~~ He advised short incisions of two or two and a half inches. Muscle should never be cut in the incision, as it gave great trouble

afterwards. The pedicle of the tumor should be ligated in small segments, and the large vessels should be ligatured separately and the ligature cut short. The cavity of the abdomen should be thoroughly cleansed with sponges, and drained when necessary. ~~He objects to abdominal bandages, and has only used them after the removal of the largest tumors.~~ He allows his patient after the operation to move freely in bed; this favors the reposition of the bowels. In uterine fibroids, when large, he always divides the mass in the median line, then each half is enucleated. The stump should be cut in shape of a V, and the edges brought together with a running suture and quilted with the shoemaker's stitch. He has found linseed-tea enemata of great service after operation; fomentations to the abdomen were also very beneficial. No after medicinal treatment is needed, except when there is vomiting; in this he has found sipping hot water useful, and also ipecacuanha in homeopathic doses. He uses the third dilution.

Dr. Macfarlane, of Toronto, would have liked to hear Dr. Trenholme say more about dietetics. In his operation he had found vomiting to be a very troublesome complication; warm water with a flavoring of brandy he had found of great service in these cases, also frequent small doses of Epsom salts as recommended by Lawson Tait. He never gave any medicine at all when there was any threatening of peritoneal trouble. He never used drainage unless the adhesions were extensive.

~~Dr. Sherman, of Ogdensburg, would like to have heard more details regarding the preparation of the patient, also as to whether he referred, when speaking of fibroids, to extra or intramural growths.~~

~~Dr. Macdonald, of Wingham, Ontario, would like to have heard more details as to the closure of the wound and also as to the value of the clamp in securing the pedicle and whether operation for ovarian tumors should be performed early.~~

Dr. Kerr, of Winnipeg, had seen hernia follow the operation, due to failure of union in central portions of wound. ~~He would like to know why Dr. Trenholme objected to including muscle in his sutures.~~

Dr. Shepherd, of Montreal, thought that ~~wounds of the abdomen are much the same as wounds of other parts, and that abdominal surgeons make a great ado about their special methods of healing this abdominal incision. General surgeons who are operating every day in every part of the body have no fear of including muscle in their sutures. He did not understand why an abdominal wound should heal so differently from wounds in other parts. So far as he himself was concerned, in performing abdominal section he treated his incision as on ordinary wound. He used silk or catgut sutures, and passed them through the whole thickness of the wall of the abdomen; union invariably took place by first intention. Every gynecologist thinks it incumbent upon him to have some special mode of treatment of the abdominal incision, and seems to think that general surgical principles are not applicable to it. Dr. Shepherd had not much faith in ipecac used in the third dilution.~~

Dr. Fenwick said he had operated a number of times for ovarian tumors with fair success. He agreed with the remarks of the last speaker. He always used silk sutures, and objected to horsehair, because knots made in it did not hold well. In treating the pedicle he first clamped it, and then tied all the large vessels; afterward, he tied the pedicle with the Staffordshire knot and removed the clamp. He had used hot water occasionally to cleanse the abdomen.

Dr. Trenholme, in reply, said he spoke of interstitial fibroids. He formed the pedicle out of the labial borders of the uterus in such a way that he left the broad ligaments to sustain the pelvic viscera. He used the shoemaker's stitch to secure primary union. With regard to the external wound, he thought that the conditions found in the abdominal cavity existed nowhere else. It is of the greatest importance to secure primary union so that there shall be no subsequent hernia. For vomiting he used hot water over the wound, and ipecac in minute doses. In preparing the patient, he avoided purgatives as much as possible. In cold weather he kept the extremities of the patient wrapped up in cotton-wool.

Dr. Shepherd, of Montreal, next read a paper on

EXCISION OF THE TARSUS IN TUBERCULOUS DISEASE OF THE BONE.

le
He commenced by saying that formerly when there was carious disease of the bones of the foot the only resource was amputation, but with the advent of antiseptic surgery and the establishment of conservative principles of treatment, other methods of procedure have been adopted with success. *He remarked that*

In cases of tuberculous and carious disease of bones the necessity for amputation is not immediate, and it is the duty of the surgeon to endeavor first to remove the local disease before sacrificing the foot. It is not necessary to perform a Hey's, Chopart's, or Syme's amputation in these cases, but merely to remove all the disease, however extensive. The reader of the paper illustrated this principle by giving the histories of several cases. In one case, where there was disease of both feet, he removed on the right foot the cuneiform, scaphoid, cuboid, and bases of the metatarsal bones, and on the left the lower end of the tibia, astragalus, part of the os calcis, the scaphoid, and cuboid. The result was excellent, and the patient, a girl aged seventeen, was able to walk about comfortably. In children it is often sufficient to remove the diseased portion with a Volkmann's spoon, and in them amputation is hardly ever required.

Dr. Macfarlane, of Toronto, had followed out the principle advocated by the reader of the paper for years. He believed it is the proper method of treatment and should be extended to caries of the spine. In dressing the wound left after excising tarsal bones he never stuffed the wounds with anything, but placed the foot in a good position and left the rest to nature.

Dr. Dupuis, of Kingston, said he recently had a case of disease of all the tarsal bones in which he performed amputation; afterward the tibi necrosed and he had to reamputate. He also reported a case of frost bite in which he had removed the greater part of the tarsus.

Dr. Holmes, of Chatham, remarked that Dr. Shepherd's paper was a good exemplification of conservative surgery. He had several times excised the ankle joint with the best results.

Dr. Kerr, of Winnipeg, said that patients, after operation, should not be allowed to walk about too soon, as they were apt to have a splay

foot. He did not believe in leaving the wound to nature altogether, but preferred keeping it in an aseptic condition.

Dr. Russell, of Quebec, also insisted that the wound should be carefully protected, and that antiseptic dressings should be applied. If the wound were left to nature, it would soon become putrid, and all the dangers incident to such a condition would be incurred.

Dr. Fenwick said he could mention a number of cases in which he had resected the tarsus with the happiest results. He related the case of a gentleman (a medical man) who had been wounded at the battle of the Alma, and had carried the bullet in his heel for nearly thirty years. The os calcis was trephined, and the bullet removed, with result of a rapid closure of the cavity and a useful foot.

Dr. Kerr, of Winnipeg, read a paper on the

EVACUATION OF AN ABDOMINAL HYDATID CYST.

The patient was an Iclander, who came into the Winnipeg Hospital last winter, with a large abdominal tumor. From the history, and as the result of exploratory puncture, the attending physician, Dr. Whiteford, made the diagnosis of hydatid cyst, and handed the case over to Dr. Kerr, for operation. The operation was performed in two stages, as recommended by Volkmann. A cut was first made down to the growth, and six days after it was incised. To open the cyst he had to cut through two inches of the liver. The cyst was then emptied and washed out with a solution of iodide. The patient did well, and went home in two months. He remarked that these are rare cases. Up to 1880, only 155 cases have been reported. This is the second case that has been seen in the University Hospital. The other patient was operated on, but died on the table.

Dr. Eccles, of London, Ont., related the history of a case which had been treated a year ago in the London Hospital.

THURSDAY, AUGUST 19TH.

Dr. Kerr reported two cases of,

GUNSHOT WOUND OF THE HIP-JOINT. *le*

Both cases were caused by the accidental discharge of small shot. The soft part was much torn, the trochanters in both cases were split,

and the joints laid freely open. In the first case the patient was not seen till three weeks after the accident, and had had no treatment; his condition was deplorable. The whole wound was in a sloughy condition, and horribly fetid. The patient was in a septic condition. The wound was thoroughly cleansed, the sphacelated portions freely excised, and the wound irrigated and packed with iodoform gauze; an anterior wire splint was also applied. The improvement at first was marked, but the patient died of septicaemia and exhaustion in a short time. The second case was seen immediately after the accident; the wound was treated in the same way, and the limb fixed in an anterior Smith's splint; a posterior splint was also employed, so that immobility was secured, and recovery with a useful limb resulted. Dr. Kerr referred to other methods of treatment, viz., excision and amputation. In these cases the mortality was high. He brought these cases before the Section in order to show what could be done by conservative methods in such cases.

Dr. Clark, of Toronto, said that a number of cases of gunshot injuries of the hip were reported in the *Surgical History of the American Rebellion*. He had seen several cases treated when with the Federal army in Virginia. They were treated under canvas, and did well.

~~Dr. Russell, Fenwick, and Shepherd also joined in the discussion.~~

Dr. Buller, of Montreal, read a paper on

THE TREATMENT OF ACUTE PURULENT OPHTHALMIA. *le*

Dr. Shepherd, of Montreal, read the notes of a case of

AINHUM, *le*

which he had treated in the Montreal General Hospital. The disease affected the little toe of the right foot of a negro, aged forty seven, born in North Carolina. The little toe became affected some six years before. He first noticed a small ulcer on the digito-plantar fold, then a constriction surrounded the toe at this point which gradually deepened. The toe was much larger than normal. He suffered greatly when walking. The toe was amputated and on dissection appeared to consist of much thickened

skin and fibrous tissue. The bones of the toe were much atrophied and the joint had disappeared; the proximal phalanx looked somewhat like a claw.

Dr. Fenwick, of Montreal, reported a case of

AMPUTATION AT THE SHOULDER-JOINT FOR MYELO-SARCOMA OF THE ARM.

Dr. A. Laphorn-Smith read a paper on

ALEXANDER'S OPERATION, AND THE TREATMENT OF DISPLACEMENT OF THE UTERUS.

After describing the operation minutely, and also giving a discourse on the anatomy of the parts, Dr. Smith went on to say that the round ligaments are really muscles, and are not in a state of tension except during coition. They are the homologues of the cremaster muscle in the male. Dr. Smith considered that the risks of the operation are great, and that it is not a justifiable one except in extreme cases, and when performed did not permanently cure displacements of the uterus. He prophesied that it would soon fall into disuse. The author said that displacements of the womb could be corrected by lessening congestion, by keeping the liver clear, and the lower bowel empty. The paper was illustrated by diagrams and tables.

Dr. Trenholme agreed with Dr. Smith that the operation was one that would soon be known only in history. ~~He had operated once, but had failed to find the ligament. He himself, many years ago, suggested a similar operation.~~

Dr. Shepherd had frequently dissected the round ligament, and had performed operations on the dead subject. The uterus could be easily elevated by pulling on the ligaments. He did not think the fact that a few muscular fibres had been found on the ligament proves that it is now in active use as a muscle; it is, rather, a fetal remnant of the ligament of the Wolffian body, and the homologue of the gubernaculum testis of the male.

Dr. Ahern, of Quebec, said that the round ligament is frequently abnormal, and that at its insertion it is often much atrophied. In cases where the uterus is fixed, tightening it will not correct displacements.

The section then adjourned.

Slut

A GENERAL MEETING

of the Association took place at 2 o'clock, Dr. Canniff in the chair, as the President was absent.

Dr. McEachren, the Principal of the Veterinary College, gave an address on

THE PLEURO-PNEUMONIA OF CATTLE,

which was illustrated by pathological specimens. The principal difference between pleuro-pneumonia in cattle and that of man is that in the former the disease is first, and essentially, an inflammation of the inter-lobular connective tissue; the alveoli are only secondarily affected.

Votes of thanks were then given to the authorities of the Laval University for the use of the building, and to the railroad and steambot companies for the courtesy shown by them to the Association.

The Association then adjourned.

HAMILTON MEDICAL AND SURGICAL SOCIETY—REGULAR MEETING.

Dr. Malloch exhibited a specimen of a soft catheter. The patient had been using a soft catheter for some time; one night, from some cause or other, he allowed the catheter to slip into the bladder. Not thinking anything serious would result, he allowed it to remain in the bladder for six or seven days. Dr. Malloch was called to see the patient, and introduced a lithotrite with the object of removing the catheter; this proving ineffectual, he performed the operation of median lithotomy with success, and removed the catheter with a pair of forceps. The catheter, from the length of time it had been in the bladder, was covered with a considerable deposit.

There was considerable discussion on this case, but it was decided that the median operation was preferable. Dr. Malloch also exhibited a specimen of a calculus from the pelvis of the kidney. Patient had been suffering for about fifteen years—had been operated upon for stone in the bladder. He first saw the patient ten years ago: she then had a fistulous opening. One year ago he probed the opening and detected a stone. Five months ago it was removed. Drs. Rosebrugh, Mullin and McCar-

gow took part in the discussion and related cases which had come under their notice.

Dr. Stark related two cases of puerperal eclampsia treated by the hypodermic injection of pilocarpine. A lengthy discussion followed in which Drs. Leslie, Malloch, Mullin, White, Shaw and Ridely took part.

F. E. WOOLVERTON, Sec'y.

Correspondence.

LETTER FROM VIENNA.

The following was received too late for insertion in the August number of PRACTITIONER. It properly forms a continuation of J. H. D.'s letter which appeared in that number:—

Case No 2 (Demonstrated by Dr. Jacks, Nothnagel's Klinik).—Young man; always strong and healthy till the present difficulty commenced. Denies having had rheumatism. Was very active, and attributes his present loss of health to too much running and dancing.

Ten months ago, found his breath becoming short and heart palpitating on exertion; cyanosis became marked; hydroperitoneum and œdema of the lower limbs followed. These symptoms steadily increased till within a few days, when slight improvement occurred—to be mentioned later. The patient is stoutly built, fairly nourished, with a slightly livid color in face. The veins of the neck are full and pulsate distinctly; a wavy motion is communicated to the whole præcordial and epigastric surfaces; retraction of the chest wall a little to the left of the left mammary line in the fifth intercostal space is noticeable with each heart systole. Temperature is normal, though it has occasionally risen to 100° F.; pulse regular, very feeble 136. Respirations rapid during rest, and much increased on the slightest exertion; patient is much troubled with a dry, hacking cough. Percussion reveals enormously extended heart-dulness; absolute dulness at the basis of the lungs shows, with other signs, the presence of fluid in both pleuræ. Auscultation normal; vesicular murmur over the whole of both lungs. The heart valves, as the natural result of heart dilatation, are not doing their work

well, but auscultation gives no evidence of actual valvular disease. Examination of the abdomen shows slight enlargement of liver and spleen, and a small quantity of fluid in the abdomen; the feet are slightly œdematous. The urine, though still scanty, is more abundant than previously, and a slight trace of albumen is present; both these changes have taken place since the latest "therapie" employed. The bowels are constipated.

Diagnosis—Adherent pericardium, with consequent degeneration of the heart muscle and dilatation. Treatment—Digitalis was given in full doses for some days, without benefit; calomel has since been given, with marked improvement. Ascites and œdema have almost disappeared, and the quantity of urine is greatly increased. Albumen has since appeared in urine. Prognosis unfavorable.

Professor Bamberger, in his excellent work on diseases of the heart, says: "Adherent pericardium, which is a pet subject for the writers of the present day, is always the result of a previous pericardial inflammation." This may, as Dr. Heilter remarks, be a chronic and unobserved insidious inflammatory process, without distinctly traceable cause. The pericarditis may be acute, but years may pass before symptoms of adhesion make themselves apparent (Dr. Jacks). Bamberger says that this condition, as such, has no important symptom, but generally results in degeneration of the heart-muscle itself, and consequent symptoms, which, however, are the symptoms not of adherent pericardium, but of the other diseased conditions of the heart which may have resulted from it. There has been much discussion as to whether it results in hypertrophy or atrophy of the heart-muscle.

The above-cited cases show the justice of the last-mentioned author's statement that both results occur. He further remarks that dilatation with slight hypertrophy is, so far as his experience goes, the more common result. Skoda has probably collected more cases of this diseased condition than any other writer on the subject; he gives the following symptoms as characteristic:—(1) The area of heart-dulness is unaffected by the expansion of the lungs in the respiratory act. (2) The absence

of systolic impulse at the heart's apex, and often a diastolic apex-beat occurring instead. (3) Retraction of that portion of the chest-wall in contact with the heart's apex, coincident with its systole. (4) In case the pericardium is adherent to the vertebral column there is retraction of the lower end of the sternum with each heart systole, and also a systolic impulse over the base of the heart.

The first of these symptoms is very judiciously objected to by Cejka. He remarks that the above-mentioned symptom (1) is a symptom of adhesion of the pericardium to the chest-wall, and not as here to the heart. As regards treatment, digitalis is evidently not what is wanted. A stimulant to heart-muscle such as digitalis requires some moderately healthy muscle to stimulate before it can become effective. Calomel in the above case has been of signal benefit by acting on the kidneys. Dr. Jacks remarks that it is useful in dropsical conditions from heart disease only when the kidneys are moderately sound; in other cases it is decidedly contra-indicated; in any case it is only palliative. The anatomical conditions are incapable of cure, so that we must always give an unfavorable prognosis.

J. H. D.

LETTER FROM VIENNA.

TUBERCULOSIS OF THE VULVA.

Prof. Chiari exhibited at the Physician's Society, in Prag, specimens of tuberculosis of the vagina and vulva taken from a patient suffering from chronic tuberculosis. On her admission to the hospital, last January, there was a large ulcer in the right labium, which rapidly increased in size and spread into the vagina. On microscopic examination, partially cheesy, miliary tubercles, with unmistakable giant cells, were seen; sections were also examined for bacilli, which placed beyond doubt the nature of the ulcer. The uterus and tubes were free from disease, and Prof. Chiari was of the opinion that the miliary tubercles found in the vagina and vulva, and the presence of the tuberculous deposit could only be accounted for on the supposition that the patient had infected herself from the tuberculosis of

the bowel which existed. The entire rectum was a mass of ulcers which extended to the anus, and were also developed in the surrounding skin.—*Wiener Med. Blätter.*

SUN BATHS IN THE TREATMENT OF CHRONIC HYDROCEPHALUS.

Under this title Dr. Somma sends a communication to an Italian journal, which was copied into the *Medizinische Blätter*. He recommends that the little patient be held in such a position as to allow the rays of the sun to fall only on the back of the head, the first few days for but a short time, afterwards the sittings to last thirty or forty minutes each day. There is a sweating of the head, and, as a result of the increased temperature, an irritation of the vaso-motor system which serves to further a better absorption of the fluid. As indications for this treatment the author considers it necessary that the case be chronic, without brain complications; the organs healthy, and that the disease be not too far advanced.

Since Prof. Liebrich introduced lanolin as a basis for ointments, much attention has been paid to it and many preparations introduced. From those used at the Berlin Clinic we take the following:—

Unguent Diachylon :	
Emplast plumbi simplex	50
Oli olivarum	20
Lanolini	30
Unguent Hydrarg album :	
Hydrarg precip. albi	10
Adepis suilli	10
Lanolini	80
Unguent Hydrarg Rubrum :	
Hydrarg oxydat	10
Adipis suilli	30
Lanolini	60
Unguent Iodoformi :	
Iodoformi	10
Adipis suilli	10
Lanolini	80
Unguent Argent Nitric :	
Argent nitric	1
Lanolini	9

TREATMENT OF PERICARDITIS.

BY PROF. H. NOTHNAGEL, VIENNA.

A Digest of a Clinical Lecture Published in the *Wiener Med. Zeitung* of August 3rd.

Gentlemen,—The treatment of a typical case of acute pericarditis is as follows:—

When you are called to see a patient complaining of pain in the præcordia, with feverishness, and you discover a pericardial exudation and a friction sound, you should at once apply 3, 6, 8, or 10 leeches to the præcordia, according to the intensity of the affection and the constitutional condition of your patient, to be repeated in 4, 5, or 6 days—this is the first and most important point. In some cases you may, instead of leeches, use dry cups, although they are inferior, for the reason that you cannot locate them so accurately. Secondly, you should apply the iceberg, or Leiter's apparatus, *i.e.*, a coiled arrangement of tubing through which cold water may be circulated; and now I take this opportunity of strongly urging against the use of cold compresses, simply because they are never cold; if used they must be applied directly from ice-water and changed every five minutes, a procedure too difficult to be satisfactorily undertaken. You will, moreover, frequently have the opportunity of observing that these so-called *cold* compresses are *warm*. Regarding the administration of medicine, there is one agent, applicable, however, only under certain conditions. I refer to digitalis, which should be employed in cases where the heart is weak and signs of its failure are present. It is best to administer it in moderately large doses every ten hours, not only at the onset of the affection, to steady the heart's action, but also in the later stages when special signs of its enfeeblement are present, indicated by irregularity and reduced pulse tension—beyond this, internal administration is of no avail. Other symptoms rarely demand attention, for the pain is scarcely noticeable, and when present it is generally relieved by the leeching and the cold. The fever is rarely so high as to require attention, even if the temperature rises to 103° it matters not; you need not give quinine, for you will notice that the fever reduces with the decline of the inflammation. What are we to do when

exudation exists? Endeavor by the use of counter irritants to bring about its absorption. In the later stages of the disease blood letting and cold are out of place, and counter irritants, particularly painting the præcordia twice a day with equal parts of tincture of iodine and tincture of galls, or if you choose you may take emp. cantharides, allowing it to remain in place for from eight to twelve hours. In the earlier stages of the disease, when the process is less rapid and the case assumes a subacute character with but slight elevation of temperature, and when friction sounds are present, Spanish fly may also then be used to attain the absorption of the fluid. Medicines have been advised, but the only one which we can recommend, and from which good results may be expected, is digitalis; not because it has the power to directly influence absorption, but because it has the known quality, to a certain extent, to conserve cardiac strength. Other agents—the so-called absorbents, iodide of potassium, and iodide of sodium—are valueless in this connection, for in no way do they assist in lessening the quantity of fluid in the pericardial sac. If, constrained by circumstances, you must prescribe something, you may as well write out iodide of sodium, but I would impress this upon you, that you need expect from it no beneficial effect. When the life of your patient is in imminent danger from mechanical interference with the heart's action and paralysis of that muscle, one means alone can serve you, and that is *paracentesis præcordia*. It has often been employed, and not with discouraging results; the operation, must of necessity be performed with the greatest of care, not using an ordinary aspirating needle, but a trochar of special construction, to avoid wounding the heart. Beyond this, we can do nothing but bring into play the beneficial influences of good nourishment and patience, waiting till absorption is complete, after which, unfortunately, adhesion of the pericardium is frequently established, with that train of symptoms which generally follow therefrom.

W. H. B. A.

BARBERS AND SURGEONS.—The *Boston Post* says that "Barbers were originally surgeons," and adds, apparently with much feeling, "A great many of them are now."

Obituaries.

DEATH OF DR. MOXON.

With deep regret we notice the death of this eminent physician. We quote as follows from the *British Medical Journal*:—"Dr. Moxon, after a hard day's work on Wednesday, including an oral examination at the College of Physicians, prior to returning to his home at Highgate, went to his consulting rooms in Finsbury Circus, where he was engaged for some time in correspondence. As he failed to return home at his usual hour before midnight, messengers were despatched to Finsbury about two o'clock on Thursday morning, and Dr. Moxon was found to have been dead for some time lying in his consulting room."

FRANK HASTINGS HAMILTON, M.D.,
LL.D.,
NEW YORK.

Dr. Hamilton, the distinguished surgeon and author, was well known and highly respected in this country. For ten years he had suffered from pulmonary phthisis. Late in July he became seriously ill, and died, August 11th, in New York.

WALTER MOXON, M.D. (LOND.), F.R.C.P.

Dr. Moxon was one of the most distinguished and brilliant of the physicians that have been connected with Guy's Hospital. He was one of the Lecturers in Medicine, and earned a high reputation as a Clinical Teacher. He had been in poor health for some time suffering from headaches and sleeplessness, and died rather suddenly, July 22nd.

DR. L. L. HOOPER,
EXETER, ONT.

Dr. Hooper was a young physician, with good abilities and bright prospects. He was a student of the Toronto School of Medicine, and graduated in 1885. He then went to England and took the L.R.C.P. of London. He returned to Exeter a short time ago, and, we understand, had septicæmia from a comparatively slight wound, which caused his death, August 20th.

DR. C. G. MOORE,

LONDON, ONT.

Dr. Moore was one of the oldest and most successful physicians in London, having been engaged in active practice thirty-seven years. He died suddenly, from apoplexy, August 17th.

Book Notices.

A Manual of Practical Therapeutics. By EDWARD JOHN WARING, C.I.E., M.D., F.R.C.S. Lond., etc. Edited by Dudley W. Buxton, M.D. B.S., Lond., Assistant to the Professor of Medicine at University College, London, etc. 4th edition, 744 pages. Cloth, \$3. Philadelphia: P. Blakiston, Son & Co.

This is one of Blakiston's new series of Manuals and Text-books, some of which it has been our pleasure to review favorably in former issues. Of the whole series we cannot speak in too high terms. It contains Galabin's Midwifery, Yeo's Physiology, Potter's *Materia Medica*, Goodhart and Starr's *Diseases of Children*, the present work, and others. They are all marked by a high type of excellence and are furnished by the publishers at the low price of three dollars each.

Waring's *Therapeutics* is marvellously complete; in fact it would seem scarcely possible to convey so much information in so practical a way in so limited a space. A great deal of labor has evidently been expended in the revision for this fourth edition, and all new remedies of any value have been introduced. We can confidently recommend it to students and practitioners as a thoroughly good work in every respect.

THE ABUSE OF TEA.—The *British Medical Journal* in an article on this subject enumerates the evil effects of the abuse of tea as follows:—"Nervous irritability, palpitation, insomnia, and sense of brain fatigue are among the most prominent of the neurotic symptoms. The digestive symptoms are impairment of appetite, pain and flatulence during the process of digestion, and defective intestinal action—the symptom, in fact, of one of the varieties of atonic dyspepsia."

Miscellaneous.

The Editor of the *British Medical Journal*, Mr. Ernest Hart, was urgently pressed to contest a seat for Parliament as a Gladstone liberal; but his health was such that he was positively forbidden to undertake the contest.—*Medical Record*.

OF COURSE!—Professor (to class in surgery) —“The right leg of this patient, as you see, is shorter than the left, in consequence of which he limps. Now, Mr. Sorter, what would you do in a case of this kind?” Sorter—“I’d limp, too.”—*Journal of Reconstructives*.

THE MILK DIET.—“Why will you persist in drinking tea and coffee?” asked the doctor. “A milk diet is the healthiest, it contains all the elements of the human blood.” “Very true,” replied Boggs, swallowing a third cup of coffee, “but then, you know, I am not blood thirsty.”—*Medical World*.

Dr. I. Hun Su, of Peking, China, treats uncomplicated typhoid fever very successfully with the following prescription:

R. Three inches dried umbilical cord.
One dried snake skin.
One fresh tom-cat’s head.

M. Boil in five pints of water for two hours and strain. Sig. Tablespoonful every four hours.

NEWS FROM BELOW.—The managing editor of the CANADIAN PRACTITIONER, who is now in Vienna, has been heard from. He reports that his satanic majesty, while on a recent visit to this planet for a cargo of sulphur, was shown a sample of iodoform. He immediately countermanded the sulphur order and substituted iodoform, saying, “Not in all my realms below does any perfume so please my senses.” In other words, the odor of iodoform beats sheol.

A veracious newspaper story comes from the West of a man who, in a fit of despondency, swallowed a bottle of somebody’s hair restorer,

and on his death, with obscure symptoms, some years later, the whole abdominal cavity was found to be lined with a thick growth of hair, attesting the unfailling action of the hair persuader; which sounds like the chestnut regarding a kindred remedy, which, being accidentally spilled on the floor, produced a door mat.—*Boston Med. and Surg. Journal*.

A NEW SPECIES OF TAPEWORM.—Dr. Curran, in the *Southern Practitioner*, writes that some of his townsmen go to Los Angeles for treatment, and return home with yards of tapeworm in bottles, very handsome and doubtless worth all they cost, “warranted to last in any climate,” as they are celluloid. The ingenuity of the nation that originated wooden nutmegs has, it appears, made great strides. It started with imitating the products of “the spicy breezes that blow soft o’er Ceylon’s isle;” it has now succeeded in manufacturing imitations of the inhabitants of another region where the breezes, however favoring, are not so pleasantly spicy.

ARTIFICIAL IMPREGNATION.—This subject has been discussed, and has its advocates. The *Gazette Hebdomadaire de Médecine et de Chirurgie* reviews at length a new novel with the suggestive title of “Le Faiseur d’Hommes.” The romance is nothing more nor less than a plea in favor of artificial impregnation; the *dramatis personæ* are a childless count and countess and a highly scientific physician. A certain abbe is also introduced, in order to fill out the religious side of the picture. Not to enter into the details of the subject, which are better suited for a treatise on gynæcology than for a popular novel, it suffices to say that the experiment is successful, the result being a son, who is afterwards known at court as the “child of the syringe.” He should have been called “a son of a gun.”—*Gaillard’s Med.*

AD HOMINEM.—First Doctor—“I am sorry to see you in this condition, Doc. Who is prescribing for you?” Second Doctor—“I am, myself.” First Doctor—“Great Scot! Don’t do it! You are committing suicide!”—*Puck*.