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Original Communications.

TREATMENT OF PULMONARY TUBERCULOSIS.*

BY DELASKI MARR, M.B.,
RIDGETOWN.

IT is not my intention to give you a résumé of what is considered good treatment at the present time, but merely to give my own views upon this subject, in order that a discussion may be invoked which will enable me the better to cope with the many difficulties which cluster around the invasion and advancement of this disease.

Since the discovery of the bacillus of tuberculosis by Robert Koch, an impetus has been given to renewed exertion on the part of the whole medical profession, and from well-authenticated reports this exertion has not been in vain.

Tuberculosis is a communicable disease, and thus preventable, and, under certain conditions, curable. Many are the cases of healed tubercular lesions, demonstrated upon the post-mortem table, whose previous

* Read before the Ontario Medical Association, June, 1895.

history shows neither diagnosis nor treatment for tuberculosis. A good practical classification of these cases depends upon physical signs and clinical history, but these do not always correspond with laboratory examination. This fact may be accounted for partly by personal peculiarities, but this is not sufficient. For instance, one case may present a gradually increasing cough, no hæmoptysis, while fever and expectoration occur later. Physical examination shows the upper part of one lung consolidated and the opposite lung slightly affected. The usual grave symptoms appear, and eventually death ensues. Necropsy presents the familiar appearance of pulmonary tuberculosis, the disease having existed for twelve to sixteen months. In contrast with the above, I can refer to a stonecutter whose illness has lasted for years, while a third case is rapidity itself, differing from miliary tuberculosis in the fact that one lung alone is affected. These cases, though typical, cannot be said to be identical. Family history and personal environments may modify the course of the disease, but the result remains unchanged. I am of the opinion that these three cases are inflammatory in the beginning, and usually take the form of catarrhal pneumonias. This condition may be the "nidus," "favorable soil," or "culture medium," or constitute what was once called diathesis. This weakened state of the lung tissue, or susceptibility to germ invasion, has also been termed hypotrophy.

The generally accepted doctrine is that the primary etiological factor of tuberculosis is bacillary. Then why does it not develop in all catarrhal inflammations of the respiratory tract? The question of the existence of a pre-tubercular state is a much-discussed problem at the present time; but, in my own humble opinion, I am convinced there exists a something, either inherited or acquired, which permits of the lodgment and growth of the bacillus of tubercle.

The treatment I propose to present to you has for its purpose two principal objects: First, the strengthening and innervation of the tissues of the body so that the animal cells may be in such a condition as to successfully combat the invasion and increase of the bacilli of tubercle; secondly, the neutralization and destruction of the toxæmic substances already generated by the specific micro-organisms whose deteriorating influence on the blood is so well marked. As regards the anti-bacillary treatment, I have nothing to say. Our experience during the last few years has taught us to be extremely sceptical in this direction, although my sincere wish is that some one may be fortunate enough to place in the hands of the general practitioner some means to annihilate both the primary and secondary causes of this most fatal disease.

Climatology is a question of such vast importance, and needs such a thorough discussion, that it cannot be but excluded from the scope of this brief paper.

The following are the physical signs which, when found, render the diagnosis of pulmonary tuberculosis comparatively easy: Prolonged, harsh, or, more frequently, tubercular expiration, sibilant or sonorous râles, moist or crepitant râles at the end of inspiration, and tubular breathing. Patient complains of a gradual loss of weight and strength, gastric difficulty, cough, expectoration, anorexia, fever, malaise, hæmoptysis, night sweats, etc. The finding of the bacillus of tubercle in the sputum is always diagnostic, but its absence does not exclude the existence of tuberculosis.

Usually the patient first seeks advice for a catarrhal dyspepsia, which has existed for some time, and to which he attributes his loss of weight and cough. This has been the rule so much in my cases that I invariably examine the lungs and take the temperature in every case of long-continued stomach difficulty. Contrary to the usual custom, I place the patient upon creasote at once. I find the following combination easily borne by the stomach:

℞.—Morson's creasote - - - - -	min. 128.
Oil menth. pip. - - - - - -	min. 30.
Spts. chloroform - - - - -	2 dr.
Tr. gent. co. - - - - - - -	1 oz.
Tr. nux vom. - - - - - - -	3 dr.
Spts. frumenti, ad - - - -	8 oz.

Sig.—One drachm three, four, or five times a day in water (wine glass full).

In the above prescription I have found two things absolutely necessary to insure success in its administration, namely, the quality of the creasote and spts. frumenti should be the best obtainable. Creasote has a direct effect upon the blood. When given after food it produces an increase in the number of leucocytes, and, therefore, better phagocytosis. Creasote, in proper doses, arrests fermentation in the stomach dependent upon the presence of lower organisms, while the digestive action of pepsin is but slightly interfered with. To describe the action of each of the drugs used in this and the following combinations is needless, and would only take up your time, which, at this meeting, is especially valuable. Thus, to shorten this paper, I shall merely give symptomatic treatment.

For the pyrexia, with no indication of diarrhœa, quinine sulphate and podophyllum, but podophyllum is replaced by pulv. opii when there exists a tendency to diarrhœa. When fever rises to 101° to 103°, a cold pack over the heart, with the administration of digitalis and morphine sulphate, both relieves the tachycardia and lowers the temperature. Morphine sulphate, at times, seems to act almost as a specific, so marked are the benefits derived from its use, while constipation is seldom, if ever,

produced. When the pyrexia becomes excessively high, guaiacol, used externally, lowers the temperature by inhibiting the production heat by direct absorption into the blood.

The cough, which is due mostly to nervous irritation, is greatly benefited by one-tenth to one-sixth grain of morphine sulphate, while the following inhalation, or spray, tends to materially ease both the frequency and severity of these attacks:

℞.—Menthol ..... 5 gr.
Thymol ..... 1 gr.
Eucalyptol .....
Gaultheria ..... aa 10 min.
Phenol ..... 3 gr.
White petrol. oil ..... 1 oz.

Hæmoptysis has never been an alarming symptom under the administration of the following:

℞.—Ac. sulph. dil. ..... 4 dr.
Fl. ex. ergot ..... 160 min.
Ac. gallic ..... 4 dr.
Tr. cinnamon ..... 1 oz.
Aqua ad ..... 8 oz.

Sig.—Three to four drachms every four to six hours, till hæmorrhage ceases.

This, together with the inhalation of steaming vinegar, has minimized the danger from hæmoptysis.

When there existed marked anæmia, especially seen in the so-called pre-tubercular condition, or in the early stages of tuberculosis, iron is indicated, and may usually be combined with digitalis, arsenic, and strychnia.

In dispensing with that part of this paper set apart for drug treatment, I must say that no two patients are exactly alike in any one particular, so that we treat the patient rather than the disease, and, in order to do so intelligently and conscientiously, a strict inquiry must be made into the mode of living of each case, *i.e.*, as regards exercise, food, clothing, sleeping, location and size of day and night rooms, amusements, etc. Sleeping apartments should be large, airy, having a temperature of 70° and occupied solely by the patient. It should face the east, owing to the early sunlight, and should be divested of all articles not necessary to the comfort and happiness of the patient. He should rise at 7 a.m., take exercise as ordered by the attending physician, take a light cold sponge bath, rub dry with a rough towel, and then to breakfast.

The daily food should consist of boiled or roast meats, fish, oysters soups, eggs, cod-liver oil, butter, cream, vegetables, ripe fruits (being careful of apples and bananas), liq. peptonoids. Good fresh or peptonized

milk, mineral waters, egg-nogs, malt preparations, and coffee. Alcoholic drinks should be taken as prescribed by the medical attendant. The clothing should be light and of loose texture, according to the season of the year, the habit of wearing two to three suits of underclothing being unnecessary. A consumptive should be kept busy, when strength permits, and always in pure, fresh air, retiring at 9 p.m.

The teeth should be cleansed both before and after eating. Whether cuspidor or pasteboard receivers are used, the expectoration should be disinfected before allowing it to become dry. The excreta should be received in Condy's fluid, or some other disinfectant.

In concluding, I may say that no set rules can be laid down in the treatment of this disease, the immediate surroundings and constitution of each case regulating its management. I thank you, Mr. President, ladies and gentlemen, for the kind attention you have given me.

INDICATIONS FOR ELECTROLYSIS IN ANGEIOMA AND GOITRE.*

By Charles R. Dickson, M.D.,

Electro-Therapist to Toronto General Hospital, Hospital for Sick Children, St. John's Hospital for Women, and St. Michael's Hospital, Toronto, Ontario.

IT is a subject for much congratulation that electrolysis, so long misused, abused, and neglected, is, thanks to our improved apparatus and increased knowledge of fundamental principles, now allowed by the foremost surgeons of the day a place on the list of measures to be relied upon in certain conditions. And it is greatly to the credit of the surgeon of the day that he is dealing with the whole subject of electro-therapy in a broad-minded, intelligent spirit. Four Toronto hospitals have now recognized departments of electro-therapy, and it is a matter of much encouragement to me that my best friends in the city of my adoption are the leaders in our noble profession.

There are many conditions in which electrolysis is often most clearly indicated, and possesses many advantages over other surgical interference, but I shall refer to merely two.

First, to angeioma. Here the disfigurement is frequently the chief reason for consultation and incentive to operation, particularly when situated, as it so frequently is, on the face. In this location the probabilities of resultant scarring are much less than when other means are resorted to. Excision of the involved tissue is indeed, in many cases, quite useless, and the same applies to the cautery, scarification, and external applications, while the employment of injections is not free from danger.

It is not the purport of this paper to consider the etiology, the varieties, nor yet the pathology of angeioma. Suffice it to say that electrolysis is applicable in the majority of cases. While it is true that cure may take place spontaneously, and interference is often deferred on that account, it is likewise true that the angeiomatous condition may spread greatly, and if operated upon early the result will probably be more successful, and the scar, if any, pale away as the child grows up. When small and superficial, and the capillary vessels chiefly at fault, a single negative needle and

*Read at the twenty-eighth annual meeting of the Canadian Medical Association in Kingston, Ontario, on August 30, 1895.

mild currents may suffice to produce coagulation and blocking of the lumen of vessels; but when the vessels are much enlarged, it may be necessary to employ the positive to produce the characteristic contraction and resultant atrophy. The indifferent electrode in these cases may preferably be a large pad at the shoulders.

In cases of the cavernous variety of large size, electrolysis may be carried to the extent of direct destruction of tissue, both poles being in the tumor.

The treatment is one which I very frequently employ, but I select one case from my notebook which illustrates the difference between proper and unsuitable technique:

On June 16, 1893, at the request of Dr. J. A. Temple, acting on the suggestion of Dr. Grasett, I treated a child, one year old, who had been subjected to six previous electrical operations with little appreciable benefit. The left ear was fully one-third larger than the right, and projecting. At the back of the lobe was situated an ugly pendulous mass, while in front were three raised "strawberry marks," and a plentiful supply of very noticeably dilated capillaries. Chloroform having been administered, on careful examination I detected a spot on the back of the ear where, by pressure, I could lessen the circulation through the blemishes in front. In this I inserted a gold needle connected with the negative pole of the battery, while in the centre of the pendulous mass I inserted a similar electrode connected with the positive pole. Fifty milliamperes was used for seven minutes, and seventy-five milliamperes for eight minutes.

That the negative needle had transfixed the supply vessel as intended was quite apparent, for the bubbles of hydrogen gas could be readily seen meandering through the dilated vessels in front and along the "strawberry spots." On turning off the current, the needles were carefully withdrawn, and oozing controlled by pressure with iodoform dusted pads. The sites of punctures were then coated with iodoform collodion, which was renewed subsequently as often as necessary.

The effect in this case was steady and progressive; the spots gradually paled; the pendulous mass atrophied; the hypertrophy of the ear became less apparent, and the ear less projecting. No other interference was necessary, and to-day, the other ear having developed with age, there is little difference in appearance between them, certainly not sufficient to constitute a deformity.

Only one other condition will I allude to, namely, goitre. My researches, carried on for the past five years at the Toronto hospitals, and in my private practice in the treatment of the various forms of goitre by means of electricity, have attracted much attention, and have been most favorably

received by my confrères in that city. I may remark, in passing, that during this time I have treated over one hundred cases of the different forms of this disease, but confine my remarks to cystic goitre, as my methods of treating it differs from the usual technique.

The fluid is aspirated and replaced by a good electrolyte, that is, an easily decomposable conductor of electricity, various chemical solutions being used according to the indications. The aspirating needle together with the aforesaid electrolyte form an electrode conveying the current to the entire inner surface of the cavity, and through its walls also. The partially decomposed solution is removed on completion of the operation, and firm pressure kept up, with drainage if necessary. I aim to cause collapse and excite adhesive inflammation of the cyst wall, with atrophy, and in some cases secondary degeneration of the hypertrophied tissue. In this hope expectations are realized in the majority of cases, with very few exceptions; but old, very firm fibrous tissue may resist, as it is almost impossible to excite any reaction whatever in it.

A recent post-mortem on a case I had previously treated revealed the site of the former cyst a mass of cicatricial tissue, while the lobe had undergone calcareous degeneration.

As to instruments. The lumen of my cannula permits the easy passage into cavities of No. 3 drainage tubing when required. The tube of the cannula is constructed of platinum, that it may be used with the positive pole if necessary, and the addition of a second stop-cock renders it independent of the reservoir when introducing it; otherwise, this part of the apparatus is the usual Potain aspirator attachment. The use of chemical solutions corrodes metal parts; therefore for the injections I employ a second bottle with tubes of glass leading to and from it. A third tube has also been introduced to facilitate the introduction of the solution. By another arrangement the sac may be evacuated without polluting this reservoir.

Shall the general practitioner employ electrolysis? Yes, if he possess the necessary apparatus; knows how to take care of it; is endowed with the ability to use it skilfully; has a minute acquaintance with its fundamental laws, and can properly estimate the wonderful power of this alluring agent. Otherwise, a thousand times, No.

159 BLOOR STREET EAST.

Selected Articles.

ACETANILID AS AN ANTISEPTIC; WITH OBSERVATIONS ON ITS USE IN ONE THOUSAND SURGICAL CASES.*

By Thomas S. K. Morton, M.D.,
Professor of Surgery in the Philadelphia Polyclinic.

DURING the past six months I have been employing acetanilid locally in a large number of surgical affections, with results so surprising in some respects as to make it difficult to restrain enthusiasm in commenting upon the antiseptic properties of the drug.

Having noticed mention of the remarkable powers of acetanilid in preventing pus-formation in the articles of Drs. Harrell and Bodamer, I began cautiously to employ the substance, and have since been extending its trial in many directions.

The action of acetanilid upon wounds, especially granulations, when used in full strength, is to produce intense dryness, blueness, and to check at once and prevent the formation of pus. Upon extensive granulating surfaces and chronic ulcers a slight burning sensation is at first perceived, which is rapidly succeeded by a sedative or anæsthetic effect. If used in sufficient quantity, a thin scab of acetanilid, combined with the wound secretions, forms, under which healing rapidly progresses. If a very large surface is exposed to the action of the undiluted drug, toxic symptoms promptly supervene in susceptible individuals. It is probable that children and the aged are more sensitive to its absorption than are vigorous, middle-aged persons. It is also probable that anæmia might follow too prolonged application of large quantities of the substance, because of its destructive action upon the red-blood corpuscles. This, however, I have not seen. The powder does not, as a rule, stick to wounds or hold dressings fast; but, when it does so, alcohol causes instant release by dissolving the drug.

Under no circumstances does acetanilid irritate the skin or wounds, even when used beneath impervious protectives or antiseptic poultices.

* From a paper read before the Philadelphia County Medical Society.

What may be the best vehicles for applying acetanilid must yet be proved. Upon most of my cases the pure powder was used from a dusting-box. This, while usually safe, I think has been an unnecessary waste, for very recent experiments in dilution have shown me that a one-fifth of one per cent. mixture with petrolatum was sufficient to arrest suppuration, and secure rapid healing in an extensive septic scald. All pain vanished after the first application.

When absorption of the drug has been desired, it has been used either pure or mixed with an easily absorbed agent, such as lanolin. When employed for purely local effect in ointment form, I have usually prescribed a dram to the ounce of petrolatum.

Acetanilid dissolves in 5 volumes of alcohol, in 20 volumes of ether, and in 200 volumes of water. It is soluble in liquid petrolatum to the extent of 40 grains to the ounce. In chloroform it very freely dissolves. What powders will prove best as diluents remains to be proved, but boric acid does not appear to interfere with its action.

By diluting with water a saturated alcoholic solution of acetanilid, the drug will be thrown out of solution in the shape of fine crystals, and will remain perfectly mixed in suspension long enough to permit of its use in this form as an injection for abscesses or carbuncles, in gonorrhœa, etc.

I have used acetanilid gauze in many cases in which iodoform gauze would previously have been indicated. This gauze was made after the glycerin and soapsuds formula for iodoform gauze of a strength of 10 per cent. by the nurses of the Pennsylvania Hospital. At present the J. Elwood Lee Company, of Conshohocken, Pa., is making the gauze by several formulas and of various strengths for experimental purposes. I believe that for the average wound requiring packing a very weak gauze will prove satisfactory and safe.

In the large number of cases upon which I have freely employed acetanilid, but twice have toxic effects been noticed. One was in an infant aged fourteen months. I had excised the hip for tuberculosis and packed with iodoform gauze. Upon re-dressing a few days later the iodoform was replaced by 10 per cent. acetanilid gauze. Four hours later the temperature dropped five degrees, and there were great pallor and feeble pulse. The temperature rose upon withdrawal of the acetanilid. The second case was one of superficial suppurative scald of arms, chest, legs, and head in a man aged fifty-seven years, who had for six days been dressed with boric acid ointment. About two drams of finely powdered acetanilid were dusted over the surfaces at 12 o'clock noon. At 5 p.m. the patient became blue, respirations somewhat accelerated, pulse slow and very compressible; face and extremities covered with cold perspiration; temperature normal; mind clear. All acetanilid was at once

removed. At 8 p.m. he became maniacally delirious and intensely blue. He yawned to such an extent as to dislocate the lower jaw several times. Beginning with the first symptoms of poisoning, he was freely stimulated with digitalis and whisky, and at midnight of the same day was again in normal condition. The delirium, of course, may in part or wholly have resulted from the whisky. Practically no suppuration took place afterward, and he was soon sent home well.

I have found that all ordinary suppuration ceases in the presence of acetanilid, even when much diluted, in a manner equally astonishing and gratifying. Abscess cavities, boils, and carbuncles, when opened, and dirty, greasy wounds, produced by machinery or upon the street, have healed, as a rule, without further suppuration, and in an unprecedentedly short time, after acetanilid has been applied in the form either of pure powder, gauze, ointment, or dissolved in alcohol, water, or oil, as an injection. Sloughing septic lesions have been trimmed up, dusted with acetanilid, and sutured without drainage, yet have frequently healed by primary union. Clean wounds have been likewise freely dusted and sutured, and have healed similarly, thus proving that the drug does not interfere with healing in the absence of sepsis. So slight is the secretion of wounds so treated that many extensive ones have been healed under the collodion scab.

Tuberculous lesions appear to be affected in a much better manner by acetanilid than by iodoform—probably in large part, as in other wounds and conditions, by the intense dryness of the surroundings depriving the bacilli of their required pabulum. Tuberculous bone cavities have healed rapidly under acetanilid gauze (10 per cent.).

A number of fistulas have instantly taken on a healthy appearance after injection of alcoholic, watery, or oleaginous solutions of acetanilid, and have quickly closed.

Suppurating joints freely dusted with the drug after opening have ceased to form pus, and under subsequent packing of the wounds with acetanilid gauze have healed with excellent functional results. In acetanilid I believe that we have the safest dressing to ward off the infection of joints subsequent to operation through wounds, persistent fistulas, etc. It would appear that pus microbes cannot exist in the presence of the drug, and that skin bacteria do not multiply in its proximity.

In compound fractures the use of the agent is obvious, and the results, so far as the prevention of sepsis goes, excellent.

As yet I have not injected suppurating or tuberculous joints, or acute or cold abscesses with the substance, but am about to commence some experiments in this promising direction.

Upon chancroids the effect of acetanilid is, perhaps, most surprising

of all. These troublesome sores heal almost instantly under a crust of the agent. At the Out-patient Department of the Pennsylvania Hospital during the past two months I have been able to study the effect of acetanilid upon a large number of such cases, as well as upon other venereal irritations about the genitals. All of these soft sores and inflammations have uniformly healed in from one to seven days with a single exception. This one was of a phagedenic nature, and required cauterization by nitric acid before it would heal under the acetanilid. My habit at present is to prescribe a dram of powdered acetanilid, and direct the patient to wash several times daily, and subsequently to rub in the dry powder. If the sore is beneath the prepuce, he is instructed to leave a quantity of the drug inside. Presence of the powder prevents excoriations by urethral discharges. The entire absence of odor from the drug is especially gratifying to venereal patients.

Syphilitic chancres and condylomata are usually much improved by the dry powder, and some are promptly cured. Secondary and tertiary ulcerations are stimulated by the drug, and, when thus relieved of the septic element, are prone to more rapid cicatrization.

External and internal rectal affections are instantly benefited by applications in the form of powder or by ordinary cocoa-butter suppository containing two or three grains of the drug. One case, a child with an ulcer of the rectum, complained of pain after full-strength powder was used. Irritable or inflamed hæmorrhoids are at once relieved by this suppository, as a rule. Fistulas about the anus heal very well when split open and packed with the gauze.

Ingrowing toe-nails rapidly lose their irritative element when painted with the alcoholic solution and packed with cotton containing the powder.

In injuries of the head, involving bleeding from the ear, I have packed the external auditory canal with pure acetanilid in order to prevent the invasion of the inner ear or brain by sepsis from without.

Before experimenting with this drug it had long been my custom to paint suture lines, after closing a wound, with a saturated solution of iodoform in ether in an attempt to sterilize the surrounding skin of its normal bacilli. This has given way to the saturated alcoholic solution of acetanilid, with the effect of almost always preventing stitch abscesses.

I have seen much to lead to the belief that in acetanilid we have at last found a substance which will either destroy or render inactive the normal bacteria of the skin by its absorption into and through the epidermis. A few facts point likewise toward the possibility of controlling certain inflammations of the lymphatics and superficial tissues by contact with the drug during absorption from the surface into the economy.

Possibly we may be able to render operative fields sterile, even of the skin bacteria, by the previous local application of acetanilid. Should this prove practicable, then we can operate with what has never before been secured—an absolutely sterile skin.

Finally, it should be pointed out what great possibilities of usefulness this drug may have in first aid to the injured in factories and mines, upon railroads, in ambulance service, and upon the battlefield.—*Philadelphia Polyclinic.*

While acetanilid has been largely superseded as an antipyretic and analgesic by substances which are less depressing, if the experience of Dr. T. S. K. Morton be corroborated by other surgeons, it will become even more valuable to the surgeon than it promised to be to the physician.

UNCURED GONORRHŒA.*

By Edward Rush Palmer, M.D., †

Professor of Physiology and Genito-Urinary Diseases, University of Louisville, Louisville, Ky.

In February, 1892, I read before the Surgical Society a paper on "Uncured Gonorrhœa." I propose to-night to still further discuss the subject with reference to its characteristics and management in the male. I referred then to the inutility of the "cut-off" in the matter of extension backward to the deep urethra of this disease, the frequency of such extension, its marked dangers to the infected, and its latent dangers to others. The glass test, that has been so frequently and fully written up of late, shows the alarming frequency of the existence of active deep infection after all discharge from the urethra has ceased. For determining simply the existence or non-existence of posterior infection in reasonably recent cases, the simple collection of the patient's urine in two clean bottles will usually suffice. There will then be no shreds, but a general cloudiness of the water passed, in the first bottle only if the disease be confined to the anterior urethra, in both if it has invaded the deeper parts. One must always take the precaution of adding a few drops of acetic acid to the urine to determine that the cloudiness is not due to phosphates.

In chronic cases, cases in which the urine may be cloudy or flaky, and that have a history, subjective, objective, and clinical, pointing to deep and obstinate involvement, an important question of differentiation presents itself. In a general way we may say that as many as five different localities may be singly responsible for the similar symptoms presenting in different cases, namely, the deep urethra, the bladder, the ureters, the renal pelves, and the seminal vesicles. To exactly locate the disease in such cases is by no means a simple affair. It is, indeed, often an impossibility. More care must now be exercised in the glass test. The patient should be seen with a full bladder, which, except in acute cystitis, is usually feasible. The anterior urethra, back six inches, should be care-

* Read before the Louisville Academy of Medicine, 1895.

† Died, as a result of bicycle injury, July 6, 1895.

fully irrigated with some simple, cleansing hot wash by means of a fountain syringe hung seven feet from the floor, and a Jacque catheter, the patient standing. With a little practice this may be readily and effectively done. Two bottles are then used to receive the urine. The first represents the washings of the prostatic urethra, and, therefore, of the prostate and seminal vesicles; the second the washings of the bladder, and, therefore, of it, the ureters, and the pelves. A floating or sinking *tripper fadem* or two, with otherwise clear urine, would indicate a granular deep urethra, and, in the vast majority of cases, endoscopic examination will confirm this, and furnish us the royal means of at once and effectually working a cure.

It is surprising what strong solutions of silver nitrate may be so applied without any other than the wished-for result. I rarely use in such treatment a solution weaker than twenty grains to the ounce, while sixty grains to the ounce is frequently required and well borne, a striking contrast with the objectionable effects so often following one- or two-grain solutions of the same salt applied by means of a Keyes or Ultzmann syringe. I use exclusively in such cases the Otis-Klotz urethroscope, which is exceedingly simple of design and easy of application. By a simple trick the straight Klotz tube may be carried clear into the bladder. It should be passed gently as far as it will go, and then, with the thumb against the obturator to prevent its ejection, the flange should be steadily and firmly depressed between the patient's thighs until the distal end will be felt to pass through the cut-off. It should then be steadily pressed onward until the flange has packed the penis up against the symphysis pubis, and then the obturator withdrawn and the Otis lamp coupled on. The bladder not being wholly empty, a stylet armed with a bit of cotton should be used to remove the few drops of urine present, and the examination and subsequent application are but simple matters of detail. I have frequently, by such procedure, seen into the trigone. Proper care should be taken to limit the application to the deep granular parts. Silver nitrate is usually the agent used. Of late I have seen good results follow the use of Schering's argentamin.

If, as is, however, frequently the case, the entire volume of urine is cloudy, in the majority of cases the trouble is cystitis, the parts involved being the prostatic sinus and the trigonal region. Finger is the only authority with whom I am familiar who denies the existence of gonorrhœal cystitis. Ignoring here all discussion of the good that follows the internal administration of anti-blennorhagics and diluents, I desire to express my conviction that nothing will so speedily and so effectually cure this condition as persistent daily bladder-washing. Of the agents relied

on for accomplishing this end I may mention as best, saturated solutions of boric acid, potassium permanganate solutions, two to four grains to the pint, silver nitrate one-half grain to the ounce, bichloride of mercury 1 to 20,000 solution, and one per cent. trikresol. These are average strengths. The same method used in anterior urethral irrigation is used here, except that the catheter is carried into the bladder. Half a pint is injected and allowed to escape through the catheter; then, the second half-pint being introduced, the catheter is withdrawn and the patient allowed to void it naturally. Sometimes it is well to leave the second half, if mild, in the bladder for an hour or more.

The differential diagnosis between ureteritis and pyelitis is hardly possible. It should here, however, be borne in mind that those portions of the bladder, other than the trigonal region, are rarely, if ever, involved, and also that the location of the ureteral orifices and the character of their epithelial lining both favor gonorrhœal extension. Unless speedily cured by internal medication, it is probably only a question of time when gonorrhœal inflammation of the ureters will extend to the pelves. Topical treatment of the uterers in the female has recently been successfully accomplished by Dr. Howard A. Kelly, and also in the male with the aid of the cystoscope by Dr. James Brown, of Baltimore, and Nitze and Casper, of Germany. This procedure, however, so far as the male urethra is concerned, can hardly be considered practicable for other than exploratory purposes. In the instances wherein it has so far been attempted, the object has been to determine the condition of the kidney to be left in a contemplated nephrectomy.

Many a sufferer from pyelitis has had his healthy bladder washed for months, and not a few have submitted to cystotomies for the cure by rest and drainage of a cystitis that did not exist. The modern revival of suprapubic cystotomy has much increased the frequency of this blunder due to faulty diagnosis. If it has accomplished no benefit for the patient, it has at least taught the surgeon a valuable lesson in diagnostic art.

There are several symptomatic features that are common to both pyelitis and seminal vesiculitis. Of these, two are prominent: first, the obstinacy with which they persist after the most thorough topical treatment of prostate and bladder; and, second, their intermittent character, that is, their proneness to improve again and again to a point of apparent cure, only to relapse in a day or two to their old state of pronounced pyuria. Fortunately these features eventually narrow down our diagnostic work to these two diseases, and equally is it a matter of gratulation that this differentiation is a comparatively easy task. Of course there are other conditions, such as tuberculosis, neoplasmata, stone in the bladder, senile ulcerative states, etc., that produce persistent pyuria. It is not of such

but rather of the clearly gonorrhœal deep troubles in the otherwise healthy subject that I am speaking.

Ordinarily, the microscopic examination of bladder pus does not reveal much. When, however, we have concluded from persistent treatment and equal obstinacy on the part of the disease, from its intermittency, from rectal and, where possible, cystoscopic examination, that the disease is not in the bladder or prostate, the pus should be carefully examined, not with the expectation of finding tube casts, but with a view to the presence of the caudated and small oval epithelium that comes from the ureters and pelves, a useful yet not altogether reliable guide in diagnosis.

To outline the final elements in the differentiation between pyelitis and seminal vesiculitis, it is best to deal with the latter condition first. Each, it will be remembered, is characterized by obstinate resistance to bladder-washing and by intermittency of pyuria. Of the two pathological conditions, seminal vesiculitis alone has a pathognomonic symptom. The history of its occurrence, coincident with an absence of urethral disease, at once suggests the trouble. This is bloody semen. My first case of this sort was a classical one. He had resisted treatment for months, until finally the bloody mishap occurred as he was home-coming on a New Orleans sleeper. He brought the bloody shirt to me. It was some eight years ago. I was at a loss to account for it. He went to Hammond, who amputated a liberal section of his scrotum for varicocele. I do not know his history since. I have had a few similar cases. Two recent ones are: P., a married man, with history of a cystitis not diagnosed specific six months ago. He came to me with the statement that, having used a condom at home to prevent conception, he had noticed that its contents were bloody. He had slight pyuria. I made a deep injection of silver, one grain to ounce, and ordered ergot. I have not seen him since. T., an unmarried travelling salesman, treated for acute and declining clap for two months, and intermittent pyuria for two months more, made two trips, each time coming home uncured. He came home the third time, March 20th, with the history of two bloody nocturnal emissions. This case serves me as an illustration of diagnostic methods. I ordered a free saline purge and then examined per rectum. It has been wisely said, by Taylor, I think, that the most erudite touch cannot discover the seminal vesicles when healthy. In this case I could feel above the prostate and on each side and beneath the urinary bladder two bodies, much like unfed leeches, soft, round, and an inch or two in length. Milking these after the methods suggested by Fuller, of New York, I produced a pyuria. One case more in this connection. H., a patient well known to many of you, in that he has been operated on for cystic tumor seen by the cystoscope, but found wanting after a cystotomy. A free purge and a rectal search dis-

closed two cord-like, not leech-like, because this is an old case—two cord-like bodies, plainly thickened, and enlarged seminal vesicles. So we may hope, where the question lies between pyelitis and seminal vesiculitis, to include or exclude the latter by the history in some cases of bloody seminal discharges, and in most other cases by the presence after milking of pus in the urine.

The first case of pyelitis I ever saw to recognize was seen in consultation in Indiana some fifteen years ago, a septuagenarian, who, and this was considered the great feature of the case, had not tasted food in any form for twenty-one days. He had a fairly well-defined tumor over the right kidney. On three separate occasions in twenty-four hours I was able by manipulation to decrease the swelling and produce pronounced pyuria. Operative interference was denied, and he was gathered to his fathers. S., a young man of strumous habit, presented some eighteen months ago with a furious pyuria. History indefinite. After two months' bladder-washing, combined with cod-liver oil, diuretics, and tonics, the case was pronounced tuberculous kidney. He sought other treatment, and finally, *in extremis*, I learn, submitted to a nephrotomy, a quart of pus being evacuated. He subsequently died. Another case, that of D., a young man with chronic cystitis (?), so diagnosed by me. He was treated for a couple of months topically and internally with no benefit, and a perineal section done for rest and drainage, which was kept up with daily washings for one month. No benefit. Conclusion, faulty diagnosis, pyelitis, probably tubercular. He was sent to the country, and, while never particularly anæmic, he came home much improved, but still with pyuria. About two months ago he contracted a fresh gonorrhœa, which was speedily complicated with first single, then double, epididymitis. To-day he is relieved of these intercurrent troubles, but the pyuria goes on. He is a fairly robust man, a porter in a wholesale whisky house, and examination per rectum fails to show any enlargement of the vesicles.

How shall we diagnose either pyelitis or seminal vesiculitis other than by the methods I have so far laid down? Briefly, it cannot always be surely done, but in many cases the following methods will prove of much value: In examining for vesiculitis order first a saline purge or an enema. Empty and wash out the bladder until the returning fluid is clear. Then throw into the bladder four or five ounces of mild aseptic fluid. Leave it there and milk with the forefinger, per rectum, the vesicles. If you do not plainly feel them, crowd the forefinger deeply in above the prostate and sweep downward over the base of the bladder where the vesicles should be. Let the patient rest a short while, and then void the injected fluid. If the fluid is cloudy, purulent, it is a case of vesiculitis. If not, while it may still be of that character, suspect more strongly the kidneys. Exclusion of

the seminal vesicles, as I have indicated, goes a long way toward establishing the existence of pyelitis.

In the manipulative examination of pyelitis the procedure is practically the same. After washing the bladder and leaving four or five ounces of fluid in it, the patient should be made to lean over a chair or table, and the dorsal and lumbar region should be stroked *a la massage* firmly and for some time in a direction from over the kidneys downward along the course of the ureters. While this is not so sure a means of milking as the rectal process for vesiculitis, it is sometimes of much value. If it fails the first time, at a subsequent trial half an hour or more should be allowed to lapse before the fluid is voided from the bladder.

For those of you who may desire to further study these interesting questions I have prepared the following list of recent articles and their authors: "Diseases of the Seminal Vesicles," by Paul Thorndyke, M.D., Volume 1, Morrow's System; "Acute Urethritis," by George E. Brewer, Volume 1, Morrow's System; "Urethritis Posterior and the Diagnostic Value of the Modified Thompson Test," by Hermann Goldenburg, M.D., *Journal of Cutaneous and Genito-Urinary Diseases*, December, 1894; "Persistent Urethral Discharges Dependent on Subacute or Chronic Seminal Vesiculitis," by Eugene Fuller, M.D., *Journal of Cutaneous and Genito-Urinary Diseases*, June, 1894; "Gonorrhœal Pyelitis and Pyo-Ureter Cured by Irrigation," by Howard A. Kelly, M.D., *Bulletin of the Johns Hopkins Hospital*, February, 1895; "Catheterization of the Male Ureters," editorial in the *Medical News*, April 6, 1895; "Chronic Inflammation of the Seminal Vesicles," by Gardner W. Allen, M.D., Boston; and F. B. Robinson, B.S., M.D., "Disease of the Seminal Vesicles," the *Medical News*, May 7, 1892.—*The American Practitioner and News.*

Clinical Notes.

ATROPIA IN COCAINE POISONING.

By John B. Fraser, M.D.,
Toronto.

I HAD removed a tumor of several years' growth—from the region of the cervico-dorsal vertebra—using 80 or 90 min. of a 2½ per cent. solution of cocaine to control the pain; the patient having refused to take an anæsthetic. During the operation the patient did not complain of pain; but about fifteen minutes afterward said he was dizzy; he yawned frequently; complained of great weakness; the pulse rate was increased, but soft and weak; respirations shallow; perspiring freely, the skin cold and clammy; he was unable to walk, had dimness of vision, and a depressing sense of some impending trouble.

Matters were becoming serious, as unmistakable signs of cocaine poisoning had set in.

By using sp. ammon. arom. and sp. vini gallici matters improved, but only temporarily, both seeming to lose their effect in a short time.

Knowing that atropia would meet some of the symptoms, I used $\frac{1}{100}$ of a grain of the sulphate, repeating in fifteen minutes, the two doses producing their usual effect, and acting very satisfactorily. My reasons for using atropia were that:

Cocaine.	Atropia.
(1) Weakens the heart's action.	(1) Tones the heart's action.
(2) Increases the pulse rate.	(2) Decreases the pulse rate primarily.
(3) Pulse soft.	(3) Pulse firm.
(4) Relaxes pores of skin; allows perspiration.	(4) Contracts pores of skin, checks perspiration.
(5) Respirations increased, but shallow.	(5) Respirations full and steady.
(6) Causes nausea.	(6) Prevents nausea.

Knowing that one trial would not give conclusive results (although very favorable in this case), I would like others to try the drug, and kindly report the result in The Canadian Practitioner.

300 Sherbourne Street.

A CASE OF INFANTILE SCURVY.*

By Henry T. Machell, M.D.,
Professor of Obstetrics, Women's Medical College, Toronto.

On November 15th, 1894, I saw Mrs. B.'s baby, aged eleven months, and was given the following history. Baby was perfectly well up to five weeks ago, when Mrs. B. went away for a short holiday, leaving the baby at home. The child seemed as well as usual the day the mother returned, but the following morning and subsequently it was noticed that she did not stand or bear her weight on her feet as well as before Mrs. B.'s holiday. This inability to stand, even after it was noticed and spoken of, was not always present. On asking how the baby had been while she was away, the mother was told that on one occasion both baby and high chair had fallen to the floor, and that while the baby had been badly frightened at the time she did not appear to mind it long. Within a day or two after Mrs. B.'s return home, the baby was tipped out of her baby carriage on the road. From this time she seemed to get steadily, though slowly, less able to bear her weight on her legs, and, in addition, she would cry out if the legs were moved suddenly, as in the act of changing the napkins. While the difficulty of standing seemed to be a matter of both legs, the mother noticed, especially during the last week or two, that movement of the right leg seemed to cause more pain than the left one, and that the baby often cried out if one of the other children ran up against either leg or foot. During the last week or ten days prior to my seeing her, marked pain always occurred on putting on or taking off the stockings. This pain was more marked in the right leg, and was more noticeable when the leg was flexed. During the few days before I saw her the mother had never put on or taken off the stockings, or changed the napkins, without giving rise to pain and discomfort. Sometimes the baby would scream out, at other times only fret. After the disturbance incident to putting on the stockings or changing her was over, she would appear to be as happy and contented, if in a sitting or recumbent posture, as she had ever been. She slept well all night, and also took her afternoon sleep as well as usual, though during the past week it had often been more difficult to get her to go to sleep.

*Read at the meeting of the Ontario Medical Association, June, 1895.

During the last five weeks, the baby, though ailing, had not lost flesh or color; in fact, she was looking well, was fairly fleshy, of the average size, had the usual number of teeth, and seemed to be supplied with as much red-blood as the average hand-fed baby. While the skin had not the pink color of the nursling, she was not pale, and her muscles were neither soft nor flabby.

I was told that she had been weaned at five months, and that since that time she had been fed on oatmeal gruel sweetened with cane sugar, and that almost as soon as the nursing was stopped the baby began to improve. She had been tried several times with the addition of a small amount of cream, but on each occasion it had to be stopped because it disagreed with her. The cream, though given in small quantities, always produced an acid condition of the stomach, and was followed by vomiting and diarrhœa. A return to the plain gruel resulted in a cessation of the vomiting and a better condition of the alsine evacuations.

With the exception of a short attack of cholera infantum last summer, she has been considered as strong as the other children. This is the fifth child and the first girl, and they have all been weaned about the same time (five months). With two of them the oatmeal seemed to disagree, but with the boy, now considered the strongest of the family, it agreed the best. With the exception of eczema in two of them, they have always been strong and healthy.

Present condition. The child looks well, and, lying in her mother's arms, seems as if nothing ails her. A reddish blush is noticed on the right ear. It is irregular in shape, a little larger than a twenty-five-cent piece, and erythematous in appearance. It was noticed about a week ago, and has not varied. It is neither tender nor hot. For a hand-fed baby, she is of average size and weight. The lips and mucous membranes of the mouth are a good pink color, the tongue is clean, there are six teeth, and the bowels are regular. She is bright, smiling, and seemingly happy, but, on the mother's attempting to put her across her knees, the child's brows begin to contract, and as the stockings are taken off she cries out, the more so as the right one is pulled off. As the mother raises up the hips to take off the napkin, she cries out again. As soon as she settles down in the new position the pain seems over, and she is bright once more. She moves either leg voluntarily, but seems careful as to the movements of the right one. There are a few faint, delicate petechiæ scattered from the knees to the ankles.

The ankle and knee joints appear normal as to size and movement. On making passive motion at the hips, there is decidedly more resistance at the right than at the left one. On comparing the joints, no difference is appreciable as to shape, size, or tenderness on pressure, but there is

more pain on flexing the right thigh, or rotating the head of the femur in the acetabulum.

Temperature and pulse normal.

There is no spinal curvature or tenderness, and no evidence of commencing Pott's disease.

The sacro-iliac joints are, apparently, normal.

There is no bursitis about the right hip-joint.

The absence of tenderness or swelling about the hip, or any other joint, would appear to exclude rheumatism.

The absence, also, of the initial acute inflammatory attack and the gradual onset would rule out infantile paralysis.

There was no free perspiration of the head, no beading of the ribs, and no thickening of the epiphyses, which, taken collectively, would exclude acute rickets.

The inability to stand on her legs, the pain on movement of either leg, and, more particularly, the right one, seem, in connection with the two falls about five weeks ago, to point to some commencing inflammatory condition about the hip-joint.

I could only suggest keeping the child as quiet as possible.

November 18. Dr. B., the baby's father, at home. Baby is very much as three days ago. Pain on movement of legs more marked, and, as at last visit, particularly the right one. Any movement of legs or pelvis gives pain and child screams out. Grasping the right leg anywhere about the foot or ankle or above or below the knee and moving the hip-joint in any direction seems to give pain. Some form of fixation apparatus to limit movement appears to be indicated.

Neither erythematous patch on ear nor petechiæ on legs have varied since last visit.

November 20. Thinking the cause of the pain was located in or about the hip-joint, Dr. B. E. McKenzie was asked to see the child, both for the purpose of clearing up the diagnosis, and also of suggesting some comfortable splint or appliance to restrict the movements of the right leg.

While acknowledging that movement gave pain, and that the baby was afraid to put its legs out straight or stand on them, Dr. McKenzie was not able to locate the seat of the pain even by the usual process of exclusion. The child was much more fretful and peevish than any time I have seen her, and at night was very much so. Temperature, 99½° in rectum; pulse, 120. The gums surrounding the upper four incisors look a bluish or purple color, and are considerably swollen. The blueness does not extend beyond the outer border of the second incisors. There is no blueness around the lower incisors. This condition of the gums has developed since my last visit. Another condition also occurring since the last

visit was a glazed or shining appearance of the skin of the legs and lower part of the thighs. Besides this, the heels were quite red and inflamed-looking, probably from friction. Dr. McKenzie suggested waiting.

November 21. Dr. B. came in to see me, bringing with him the last number of the London *Lancet*, and said an article by Dr. Barlow on "Infantile Scurvy" cleared up his baby's case most completely. The same article in the *British Medical Journal*, November 18, 1894, will well pay perusal by the members of this association who have not seen it. The diagnosis having now been made, the treatment was: equal parts milk and barley water, the yolk of soft-boiled egg, the red gravy of roast beef or mutton, and teaspoonful doses of grape fruit juice.

November 23. Baby apparently easier on moving her legs or thighs. The slightest squeezing of either tibia or femur causes pain. This is particularly marked in the left leg, not the right one, as heretofore. The rash on legs is less distinct, the gums are not so blue or spongy, and the erythematous patch on the ear is not so well defined as even two days ago. After this, improvement from one day to another could be seen. Within *five* days all swelling and tenderness whatever had disappeared from the legs. The gums were practically normal in seven days.

In the light of Dr. Barlow's article and the prompt improvement following the change in diet, I have no doubt whatever that this was a case of infantile scurvy. In this country at least these are uncommon cases. I have never seen one before in private practice, and what is more to be wondered at is that we have never had a case in the Hospital for Sick Children or the Infants' Home, both of which have been in existence more than twenty years.

SOME UNUSUAL CASES IN PRACTICE.*

By George Acheson, M.A., M.B. Tor.,
Galt, Ont.

THE title of this paper may, perhaps, not commend itself to some of my fellow-practitioners, especially to those who have been longer in practice, and have had more experience than I. But I think the cases I am about to relate are of sufficient interest to be recorded, if only because the ordinary text-books refer to them as being of comparatively rare occurrence; and a little discussion of them, by those in whose practice they may not be unusual, may be helpful to us all.

As these half-dozen cases, then, have nothing in common, except that they are out of the usual run, I shall say nothing more about them collectively, but proceed to briefly relate them in the order in which they came to my notice.

DOUBLE CEPHALHÆMATOMA, WITH ENLARGED THYROID.

On June 11, 1893, I was called to attend Mrs. H., in her second confinement. She had been delivered with forceps of her first child (female) after a tedious labor by another medical man some two years and a half before. She was a young, vigorous, and healthy woman, with no pelvic deformity. On my first examination everything was found normal, with the head presenting and just entering the brim. Pains were strong, and labor seemed to be progressing nicely; but the head stuck between the arch of the pubes and the promontory of the sacrum. After waiting for a considerable time, and seeing that no advance was being made, I applied the forceps, under chloroform anæsthesia, and with great difficulty extracted a vigorous male child weighing thirteen pounds. The blades of the forceps (Elliott's) had been applied, one behind the left ear, the other over the outer part of the right frontal bone, and in both these situations there was some contusion of the skin. But the most interesting appearance about the child was a well-marked fluctuating swelling over each parietal bone, bounded by a hard elevated circle with a soft centre, evidently due to an effusion of blood beneath the periosteum. These

* Presented at the Ontario Medical Association, Toronto, June, 1895.

tumors gave the head a grotesque appearance, and occasioned great alarm to the parents and friends. I assured them that all would come right in time without treatment of any kind. Next day, seeing that the swellings were larger and more tense, and that they seemed to interfere with the child's comfort in lying, I decided to aspirate them, and apply pressure by a bandage. I used a small trocar and cannula, taking all precautions for asepsis, and withdrew from each a quantity of dark fluid blood. In a day or two they filled again, but not to such an extent as before aspiration. As they did not appear to inconvenience the child in any way, except when pressed upon, I left them completely alone, and had the satisfaction of seeing the child's head gradually assume a more symmetrical shape, until, at the end of two months, all trace of the tumors had disappeared. True, cephalhæmatoma, of course, is not a very uncommon injury, but it is almost invariably unilateral; it is most frequently met with in first confinements, and is more common in males than in females.

Another point of interest in this case was an enlarged thyroid, the gland being uniformly and visibly increased in size. No treatment was adopted, and this, too, subsided almost completely in a couple of months. The cause of this enlargement I cannot well understand. It could not have been due to injury from traction on the head, though possibly it is to be explained by some lesion of the circulation of the gland caused by the extreme pressure on the head during delivery.

LEUCOMA.

In September, 1894, Mrs. C., æt. about 60, consulted me about a sore mouth, which had been troubling her for some months, and which was gradually getting worse in spite of all domestic methods of treatment. I found an irregularly shaped white patch occupying the inner surface of the lower jaw, just below the alveolar border on the left side, extending also a little past the middle line in front, and invading the floor of the mouth and under surface of the tongue. The teeth had all been extracted, and the patient was wearing upper and lower plates, though the lower plate hurt her so much that she wore it but seldom. There was no ulceration, the mucous membrane, if such it could be called, being thickened, white, smooth, and of a leathery feel. She said that sometimes pieces of white skin would peel off, leaving a very tender, painful, red surface, which would become gradually covered again by the white pellicle. In fact, the sensations described, with the history and appearance of the mouth, made it certain that this was a case of what has been called by the various names of leucoma, leucoplakia, psoriasis, ichthyosis, keratosis, etc. But this is a condition usually limited to the dorsum of the tongue, though not unknown in other parts of the buccal mucous membrane. It is very unusual, however, to find it in woman. Barker, in Holmes' System of

Surgery, has collected 110 cases, of which only 9 occurred in females. Of the 101 cases in males, 55 affected the tongue only; 33 the tongue and cheeks; 12 the lips and cheeks; 1 the hard palate; and in 4 the location was not mentioned. Of the whole 110, syphilis was certain in 33; while in 19 it was certainly absent; 75 were habitual smokers; only 4 did not smoke at all. In my patient there was no syphilis, nor was she a smoker, but I am inclined to ascribe the cause to the irritation of the lower plate, which, she said, had never been comfortable. Leucoma, in whatever situation, is always of interest, as being a possible precursor of epithelioma. The only treatment is palliative, and in this case I gave a wash of sodii bicarbonas, gr. x to 1 oz., with a little listerin and glycerin.

RETRO-PHARYNGEAL ABSCESS.

The next case is one of retro-pharyngeal abscess, complicating capillary bronchitis, in a male infant five months old.

I attended the mother when this child was born. The family history is excellent, and the child was unusually large, strong, and healthy until the middle of November last, when I was sent for to see him, and found him suffering from a not very severe gastro-intestinal catarrh. In two or three days this succumbed to ordinary treatment, but about ten days afterwards I was again summoned, and found that he had developed capillary bronchitis of a rather severe type. This ran the usual course, but, although the stethoscope showed that the pulmonary trouble was subsiding, the breathing, especially inspiration, was getting worse, and the general condition was becoming very serious indeed. A consultation was held, and it was feared that there was pulmonary atelectasis. All efforts were made to stimulate the patient, and to secure entrance of air to the pulmonary vesicles, but without much success. About this time I noticed a swelling on the right side of the neck, and that the head was carried stiffly towards the left side. It then occurred to me that the symptoms might be explained by a retro-pharyngeal abscess bulging forward so as to obstruct the entrance of air through the glottis. On examining the pharynx such a tumor could be seen and easily felt, and I at once decided to puncture it with a knife. I was rewarded by seeing a considerable quantity of creamy pus discharged from the mouth, with immediate relief to the breathing, soon followed by amelioration of the other symptoms. In a couple of days the dyspnœa and other bad symptoms had returned, and I opened it again. A smaller amount of pus escaped this time, and again the child's condition improved. It was necessary, however, to open it the third time, three days after, and from that time on recovery was progressive and rapid. This was about five weeks from the time I first saw the patient.

The points of interest in this case are the causation of the abscess, the unlikelihood of making the diagnosis, and the rapid and complete recovery.

DEEP ATHEROMATOUS CYST IN THE NECK.

The next case is of interest chiefly from a pathological point of view.

Mr. L., æt. 35. Consulted me about a year ago in regard to a swelling on the right side of his neck, which he had first noticed some months previously, and which was gradually increasing. I thought at first it might be a chronically inflamed lymphatic gland or group of glands, and prescribed rubbing in lin. potassii iodidi cum sapone. After using this for two weeks without producing any effect other than rendering the swelling softer, I examined it more carefully, and decided that it was a cyst. I punctured it with a trocar and cannula and evacuated a couple of ounces of sebaceous matter of the consistence of ordinary cream, which, under the microscope, showed epithelial cells in various stages of fatty degeneration, globules, and granular particles of fat, and crystals of cholesterin. This cleared up the diagnosis, and from the situation of the tumor—between the angle of the jaw and the clavicle—I concluded that it was a cyst of congenital origin developed in connection with the fourth branchial cleft.

In a couple of months it had filled again, and, as it was not convenient for the patient at the time to undergo any more radical operation, I simply opened it freely with the knife, and washed it out thoroughly with a $\frac{1}{1000}$ solution of corrosive sublimate. The skin wound healed immediately, and I hoped that the cyst would be obliterated by adhesion of its walls. But three months after the swelling was again quite apparent, and seemed to be extending farther anteriorly. He then decided to have the cyst dissected out if possible, and in February last, under chloroform anæsthesia, assisted by Dr. H. F. Mackendrick, I made an incision along the posterior border of the sterno-mastoid three inches long, and with considerable difficulty dissected out the whole cyst. It was about the size and shape of a lemon, and closely adherent to the deep fascia and intermuscular septæ. The wound healed kindly in three or four days, and has given no trouble since.

COMPLETE LOSS OF SIGHT IN ONE EYE FOLLOWING ACUTE DACRYOCYSTITIS, WITH STENOSIS OF NASAL DUCT.

The next case I shall refer to very briefly, and leave the discussion to the ophthalmologists.

Last December I was called to see Mr. B., a farmer of about 60 years of age. He had had stenosis of the nasal duct, with inflammation of the lachrymal sac on both sides years ago, and the canaliculus on each side

had been opened. He gave a history of recurrent attacks of inflammation, sometimes on one side, sometimes on the other. On this occasion the trouble was on the right side—the eye being completely closed by the swelling of the lids, especially the lower one, so that it was impossible to uncover the least part of the globe, and he was in acute pain. By the use of hot fomentations for twenty-four hours pain and tension were somewhat relieved, and it was then evident there was pus in the lachrymal sac which was burrowing in the cellular tissue of the lower lid. I opened the abscess by an incision in the lower part of the lid towards the inner side, and applied a moist antiseptic dressing for a couple of days. By this means the swelling and acute inflammation were subdued, and it was then found that the eye was completely blind. I afterwards used the nasal probes and overcame the stenosis of the duct; but the eye continued to be absolutely blind, though the ocular conjunctiva, cornea, and other parts of the globe were intact. I gave him pilocarpin and potass. iodide with no benefit, and the blindness persisted. Not being sufficiently expert with the ophthalmoscope, I cannot say what is the condition of the fundus. My friend, Dr. R. A. Reeve, to whom I mentioned the case, suggested that it might be due to a retro-bulbar neuritis, or to thrombosis of the arteria centralis retinæ.

MEMBRANOUS COLITIS.

The last case to which I shall call your attention has an especial interest for me, as the patient is one of my own family, a little girl 3½ years old.

About six months ago she began to fail a little in flesh, though she never was a very fat child. She had always, however, been perfectly well. It was noticed at this time, too, that she was becoming capricious in her appetite, some days eating scarcely anything; that she was getting very peevish, nervous, and irritable; and that every few days there was an abnormal looseness of the bowels, with the passage of a good deal of mucus. A dose of gray powder would always improve matters for a while, but the mucus diarrhœa invariably returned. After a while it was noticed that long shreds and tubes of membrane were sometimes abundant in the stools. Under the microscope, these tubes appeared to be fibrillated and studded with short lateral prolongations. They answered the chemical tests for mucin, but from their microscopical structure one would say that they were fibrinous. There was no pain complained of, and all that could be noticed was that the child was not thriving.

When the existence of membranous colitis, or tubular diarrhœa, as it is sometimes called, was discovered, the diet was more carefully looked after, saccharine and starchy substances being prohibited as far as possible, and large enemata of a solution of copper sulphate, gr. ij. to ℥i., or equal

parts of distilled hamamelis and water, were given daily, or every second day, after washing out the bowel with plain water. As an alterative and tonic, *m*xv. of liq. hydrargyri. perchloridi and *m*xlv. of syr. phosph. co. were administered three times daily after meals. This mode of treatment, with life in the open air, has made a great improvement, so that for a month or more there has been hardly any membrane passed, and the general condition is now about as good as ever. The injections and medicine have, of course, been stopped.

Progress of Medicine.

MEDICINE

IN CHARGE OF

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Treatment of Diphtheria by the Serum of Immune Horses.

The second paper, by MM. Martin and Chaillou, gives the result of the treatment of diphtheria by the serum of immune horses at the Hôpital des Enfants-Malades between February 1 and July 24, 1894. During this period 428 cases were sent into the diphtheria pavilion of this hospital, of which 20 died on admission. The remaining 408 received injections under the skin of the flank of 20 c.cm. of serum. The serum used had an immunizing power of about 50,000 to 100,000. After injection, an examination was in all cases made for the Klebs-Loeffler bacillus. In 128 it could not be found, and these must not be regarded as cases of true diphtheria, though some had croup and some false membrane. It is worthy of note that none of those not suffering from true diphtheria, but injected, contracted the disease subsequently, although they were exposed to the poison in the wards, and there is ground for believing that the injection of the serum acted as a protective. Each of the remaining cases of true diphtheria had a second injection of 10 to 20 c.cm. of serum twenty-four hours after the first. If the pulse and temperature remained high, still another injection of the same amount was given subsequently. Further injections were in some cases resorted to. The largest quantity used in any case was 125 c.cm., the smallest 20 c.cm. Of the total number brought to the diphtheria pavilion of the hospital 24.5 per cent. died after the habitual use of serum was commenced (between February and July). Of the 300 cases proved to suffer from true diphtheria 26 per cent. died. Now, the mean death-rate from diphtheria of the children's

hospital in the four years ending 1893 was 51.7 per cent., the lowest being 47.6 in 1892.—Martin and Chaillou, in *Annales de l'Institut Pasteur.*—*The Medical Chronicle.*

The Etiology of Suppurative Nephritis.

Von Wunschheim, of Prague (*Zeit. fur Heilkunde aus Prag.*, vol. xv., Nos. 4 and 5, 1894) says:—

From abundant clinical material and carefully-conducted experiments, this author comes to the following conclusions:

(1) Pyelonephritis is the result in the great majority of cases of infection by the bacterium coli commune, in a fewer number of cases through proteus or the more ordinary forms of suppurative cocci.

(2) In a certain number of cases in which the ordinary pyogenic microbes are the cause of irritation a consecutive pyæmia results.

(3) Pyelonephritis resulting from the irritation of staphylococci and streptococci is not to be differentiated from the other forms alone by the pyæmia present, but also microscopically by the marked necrosis of tissue, and the absence of increased inflammatory tissue-formation which is produced by the bacterium coli commune.

(4) It is not probable that the *typical* ascending pyelonephritis can be produced by the passage of micro-organisms from the bladder through the circulation.

Professor Klebs in America.

Prof. Edwin Klebs, of Strasburg, is at present in Asheville, N.C., where he is pursuing special investigations in connection with the cure of tuberculosis.

Prof. Klebs came to America on the invitation of Dr. Karl von Ruck, of Asheville, with whom he has since become associated. An experimental laboratory has been established in the Wingate Sanitarium for consumptives, and a course of practical instruction to members of the profession will shortly be given in the bacteriology, pathology, physical diagnosis, and the general management and care, as well as the specific treatment, of tuberculosis.

In his experiments on tuberculin, he has found it to contain alkaloid soluble in alcohol, toxin or toxalbumens, precipitated by sodic iodide of bismuth, while another albuminous substance, a soz-albumen, was found in the alcoholic precipitate. With the latter substance, now called antiphthisin, Prof. Klebs has cured guinea pigs entirely, and kept others alive for long periods, while the control animals perished under the usual course and manifestations of tuberculosis, and in the usual short periods of time

In connection with tuberculin, it was found that to the alkaloids were due the depressing and injurious effects on the heart; to the toxalbumens the fever, malaise, and inflammatory effects, while the soz-albumen or antiphthisin was free from these properties. The antiphthisin is being used experimentally by Dr. Von Ruck and Prof. Klebs as a specific germicidal product for the treatment of tuberculosis, and apparently with good results. It can be used in much larger doses than tuberculin, and does not give rise to the fever aching, malaise, and congestion of tubercular areas which occurred with the latter remedy.

It may be given by the hypodermic method, or by rectal injection.

Prof. Klebs could not have chosen a better place for his experiments. as the climatic and dietetic and other advantages which are to be found in Von Ruck's sanitarium afford valuable adjuncts to be used with a remedy for such an exhausting disease as pulmonary tuberculosis.

THE TREATMENT OF MALARIAL HÆMATURIA.

Drs. H. A. Hare and Wilmer Krusen present the results of a collective investigation, based upon one hundred and seven replies to questions which were sent out, the area covered being that having a death-rate from malaria of 70 per cent. or over. Thirty-two remedies were used: the first six were calomel, tincture of ferric chloride, arsenic, ergot, turpentine, and sodium hyposulphite, each remedy being used by ten or more physicians. Calomel is used in from 5 to 50-grain doses, and seems to be most in favor. Tincture of ferric chloride is used either alone or combined with arsenious acid in small doses of quinine. Arsenic is recommended in from 1 to 5-drop doses (Fowler's solution); the only caution stated is that the urine shall be clear. Sodium hyposulphite may be given in from 20 to 40 grains every three hours, after thorough purgation with calomel. Ergot is regarded as a hæmostatic. Turpentine, in capsule, ten drops every three hours until the urine clears, and a turpentine liniment in the lumbar region, may arrest renal hæmorrhage.—*Therapeutic Gazette*, 1895, No. 5, p. 291.

ULCERATIVE ENDOCARDITIS IN THE SEQUENCE OF SPECIFIC URETHRITIS.

Winterberg (*Festschrift zum 25, Jaehr. Jubilaeum des Vereins Deutscher Aerzte zu San Francisco*, 1894) has reported the case of a man, twenty-five years old, who, in the course of an attack of specific urethritis, complicated by right-sided epididymitis and enlargement of the glands in the groin, was seized with a chill, followed by fever and general malaise, together with swelling of both elbow-joints. Rest in bed, together with the administration of sodium salicylate, was at once prescribed, but improve-

ment failed to ensue. Cyanosis and dyspnœa set in, and speech became difficult and the sensorium obscured. There was general dullness on percussion of the chest, and moist râles were heard on auscultation, together with loud, blowing systolic and diastolic murmurs over the heart, especially in the aortic and pulmonary areas. The knees and ankles also became slightly swollen. The liver and spleen were enlarged, and the stools contained blood and the urine albumin. Death took place amid the signs of exhaustion.

Upon post-mortem examination both pleural cavities were found to contain a large amount of serum, compressing the œdematous lungs. The pericardial sac contained rather more than three ounces of sero-purulent fluid. The heart was enlarged, and the myocardium, which presented a grayish appearance, contained numerous purulent foci. The aortic and pulmonary leaflets were almost entirely absent, and replaced by friable caseous remains. The mitral and tricuspid leaflets presented similar changes, though not quite so advanced. The liver and spleen contained numerous small hæmorrhages, and the kidneys had undergone amyloid degeneration. The small intestine was the seat of numerous ecchymoses. Peyer's patches were reddened and swollen, but free from ulceration. Microscopic examination of fragments of the cardiac valves disclosed the presence of gonococci.—*American Journal of the Medical Sciences*, July, 1895.

THERAPEUTICS

IN CHARGE OF

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Eruptions Caused by Decomposition of Intestinal Contents, and Their Treatment.

Singer (*Wien. Klin. Woch.*, 1894, No. 3) states that the amount of indican in the urine is an index as to the activity of putrefactive processes in the contents of the bowels. An important point to note is that a group of dermatoses appear and disappear in direct relation with the decomposition of the chyme.

In six cases of acute and chronic urticaria Singer found that hydrochloric acid was entirely lacking. The administration of this acid in the form of medicine cured the skin disease.

Many cases of acne vulgaris and senile pruritus yielded only to intestinal antisepsis.

Menthol was commended as the best remedy, since it is not only an antiseptic and tonic, but also increases peristalsis. It was given as follows:

℞. Menthol, gr. iss.
Oil of sweet almonds, *m* v.

Make one capsule. Take six to ten capsules daily.

Cases of scarlatiniform eruption, œdema, and ecchymosis were at times benefited by this treatment. Copious antiseptic enemata are often serviceable, usually those containing boric acid and tannin. The best agents to take by the mouth are calomel and the earthy and alkaline sulphites. The application and powers of the former drug are well known.

The sulphites are non-irritating and extremely efficient, given in the form of sodium and magnesium sulphite, 1½ to 2 drachms in a pint of water, taken in divided dose, or as a powder, 5 to 8 grains.—*Therapeutic Gazette.*

Pilocarpin in Croup.

Dr. Sziklai strongly recommends the use of pilocarpin as a specific in all cases in which the mucous membrane becomes covered with a transudate apt to coagulate. The abundant secretion of mucus produced by the pilocarpin tends to loosen the fibrinous exudate adherent to the membrane, and it is readily expelled from the larynx. The pilocarpin not only assists in dissolving and removing the membrane present, but also tends to prevent its reforming. It can be adminstered to children from 1 to 3 years old in doses of 0.01 to 0.03 grammes; 3 to 6 years 0.3 to 0.04 grammes; 6 to 10 years 0.05 grammes; 10 to 15 years 0.06 to 0.07 grammes; adults 0.07 to 0.1 grammes. The author concludes as follows:

(1) Pilocarpin is a specific for croup.

(2) The therapeutic action of pilocarpin manifests itself almost immediately; the cure of croup follows in a few hours; pneumonia is cured in two or three days.

(3) The effect is the same, whether the remedy is administered subcutaneously or by the mouth. In case of necessity one may have recourse to suppositories or vaginal bougies.

(4) Subconjunctival injections are preferable to other methods where there is imminent danger of death, or where the membrane is very extensive.

(5) Pilocarpin not only abridges the course of the disease, but prevents a fatal issue.

(6) Administered early it also acts as a prophylactic.

(7) It can be administered in twice the officinal doses without danger. —*Wien. Med. Wochenschrift.*

A New Method of Applying Leeches.

The leech is placed in a large test tube partly filled with water. The open end of the tube is then placed against the part, when the leech promptly fixes itself to the skin.

The Treatment of Favus.

Having found that the growth of the favus fungus was killed by heat at 45 degrees to 50 degrees C. (113 degrees to 122 degrees F.) applied to cultures of the same, F. Zinsser has treated five cases of favus by means of heat at 113 degrees F., generated by passing hot water through a properly fitting coil. Beneath the coil there is a compress, saturated with bichloride solution, about 1 to 2,000. All but one of the cases were cured in a short time, apparently radically. The heat was applied continuously for twelve hours.—*Archiv. Derm. u. Syph.; Times and Register.*

The Effect of the Local Application of Guaiacol in the Reduction of the Temperature in Typhoid Fever.

McCormick has written a paper on this subject, and, in summing up the article, says he is convinced of the following facts:

(1) That guaiacol when locally applied is certain to reduce temperature.

(2) That with the care that a physician should always use in the administration of drugs, it is absolutely safe.

(3) That chills will not occur if the temperature is not reduced below 100° F.

(4) That no deleterious effect is produced upon any of the organs by its use.

(5) That it is easy to apply, and can be used by any one competent to nurse a typhoid fever case.

(6) There are no depressing effects following an intelligent use of the drug.

(7) That by continued use the dose can be gradually lessened.

(8) That it is far superior to the cold bath; that it can be used by one person; that no appliances are necessary for its use that are not obtainable in every home; that it is much more pleasant to the patient; that it is fully as effective; that patients are not subjected to the danger of moving, and they offer no resistance to its use.

McCormick has thoroughly tried the bath and cold packs, and knows that they have proved very efficacious in many cases, but with his experience with guaiacol has no desire to return to either of them.—*Medical News; Therapeutic Gazette.*

Antistreptococcic Serum in Puerperal Septicæmia.

Jacquot (*Presse Méd.*, May 18) communicated to the Société de Biologie the case of a woman attacked by puerperal septicæmia in which intra-uterine injections and quinine were without effect. The symptoms persisted, and the evening temperature reached 40.8° C. He then injected 30 c.cm. of Roger and Charrin's antistreptococcic serum. The same evening the temperature fell to 37° C. After three injections of the serum the patient seemed well, when, three days later, her mother contracted facial erysipelas. This seemed to be the origin of a new infection, for in two days the convalescent had a severe rigor and the temperature again rose to 40° C. Only one other injection of the serum, however, was required to arrest the process, and there was no further relapse. Jacquot remarks that this case, while showing the favorable action of the serum in puerperal septicæmia, and notably on the temperature, further illustrates the reciprocal relationship which exists between this disease and erysipelas.—*Epitome of Current Medical Literature.*

How Should Hydrochloric Acid be Employed in Diseases of the Stomach?

Huchard (*Journal des Praticiens*, February 16, 1895) considers that this acid is capable of exercising a double action upon the digestion—1, an enpeptic action; 2, an antiseptic action. As an enpeptic, it should be employed in hypochloric cases, in chronic gastritis, in cancer of the stomach, in pyrexias, in pulmonary tuberculosis; in a word, in all cases in which the digestive power is diminished and the amount of gastric juice is lessened. The following is the method of administration:

℞.—Acid hydrochlorici.....*m*xv.
Aq. dest.....f℥viii.

Sig.—A wineglassful towards the end of each meal and one-half hour after.

Or,

℞.—Acid hydrochlorici.....*m*xlv.
Aq. dest.. :.....f℥ixss. M.

Sig.—A tablespoonful in half a glass of warm or cold water at the end of each meal.

The contraindications to the employment of this drug are all forms of hyperchloride acidity, in ulcer (round) of the stomach, in dyspepsias accompanied by hyperæthesia. The treatment should not be continued for more than three weeks or a month, to be continued, if necessary, after a remission of fifteen days. As an antiseptic it has produced good results, in which fermentation has been produced with pyrosis due to the formation of organic acids, in dilatation of the stomach, etc. It should be given in these cases two or three hours after the meal.—*Therapeutic Gazette.*

Loeffler's Solution in the Treatment of Diphtheria.

The solution consists of:

Alcohol, 60 parts.
Toluol, 36 parts.
Liq. ferri perchloride, 4 parts.

For the relief of pain menthol may be added. The infected patches are to be swabbed with this every two to four hours.

Antipyrin in Pruritus.

F. Arnstein (*Gazeta Tekarska*) reports two severe cases of pruritus successfully treated by antipyrin. One of the cases was the mortenale senile form. The antipyrin was administered at bedtime, in gramme doses.

OBSTETRICS

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A Method of Preventing Thirst Following Cœliotomy.

Dr. William H. Humiston, of Cleveland, O., explains his method as follows (*American Journal of Obstetrics*): The patient should have the usual preparation for cœliotomy—*i.e.*, diet, daily baths, cathartics, etc. For three days prior to operation, order the patient to drink one pint of hot water an hour before each meal and on retiring, thus drinking two quarts of water each twenty-four hours, *the last pint to be taken three hours before the time set for operating*. Do not omit to give the water the day previous to the operation, while the patient is restricted to a limited amount of liquid nourishment and the bowels are being unloaded. We thus restore to the system the large loss of fluid occasioned by the free catharsis, and we have the great satisfaction of seeing our patient pass through the trying ordeal of the first thirty-six hours after the operation in comparative comfort, with no thirst, a moist tongue, and an active renal function.

Tubal Abortion.

Muret (*Rev. des Sc. Méd.*, April, 1895) discusses this subject. The termination of tubal pregnancy during the early months is little recognized, but is nevertheless frequent, and perhaps more frequent than rupture of the gravid tube. Complete tubal abortion takes place all at once. The ovum is expelled into the abdominal cavity with corresponding symptoms more or less marked. Uterine decidua are expelled, and an intraperitoneal hæmatocele is formed. Then resolution occurs, and there is no repetition of the onset. Tubal abortion should be considered a favorable termination of tubal pregnancy, not requiring operation and capable of diagnosis. If the abortion be incomplete, part of the ovum

is retained in the tube, and a tubal mole is formed. As in incomplete uterine abortion, so with incomplete tubal abortion, hæmorrhage occurs repeatedly till the oviduct is evacuated. The blood effused in the tube empties itself into the abodminal cavity, through the patent ostinum abdominale, and forms a hæmatocele which gradually increases. The symptoms of incomplete tubal abortion are tubal colic, the expulsion from the womb of decidua without chorionic villi, and repeated attacks of intermittent pain with symptoms of internal hæmorrhage. Locally, there is perceived first a swelling of the tube, and then the development of a gradually enlarging tumor. At first the symptoms of anæmia are much less serious and less acute than in the case of rupture of a gravid tube. Sometimes a very considerable thinning of the tubal wall takes place at the summit of the insertion of the tubal mole, and Muret thinks that this may be due to the fact that at first hæmorrhage is localized between the ovum and the wall of the tube, and that in this way rupture of the tube might be caused even though the ostinum abdominale were patent. In incomplete tubal abortion abdominal section is always indicated.—*Epitome British Medical Journal.*

SURGERY

IN CHARGE OF

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THE ADMINISTRATION OF THE ANÆSTHETICS PRACTICALLY CONSIDERED.

In a recent issue of the *Therapeutic Gazette*, Dr. F. M. Strouse urges that better protection be given those to whom an anæsthetic is given.

We are at one with him when he protests against the selection of a student or recent graduate to act in this capacity, and feel that, when at all possible, one should be chosen who has given the subject more than ordinary attention.

To the careful surgeon, it is gratifying to see the anæsthetist enter upon his work fully equipped with the necessary apparatus for all emergencies.

A case containing the following articles is considered by the writer indispensable: Allis' ether inhaler and ether bottle (graduated), Esmarch's chloroform inhaler and chloroform bottle (graduated), hypodermic syringe and tablets of morphine, morphine and atropine, atropine, strychnine, digitalin, and nitro-glycerin, whiskey and aqua ammonia F., mouth-gag, throat sponge-holder and small sponges, catheter, pocket-case, and tracheotomy tubes. By many the battery is considered an additional safeguard, although the writer has found little or no use for it.

A transfusion apparatus may be among the emergency instruments when, from the character of the operation and the condition of the patient, it is deemed prudent.

The hypodermic syringe should be perfectly clean and in good working order, and the catheter likewise thoroughly aseptic.

When time permits, the attending physician should never fail to have the urine analyzed.

The following history, when obtainable, is always appreciated by the anæsthetist:

The age, physical condition, including organic or functional trouble temperament; if addicted to alcoholic excess; has an anæsthetic been previously administered? if so, which of them, and its effect at the time.

Food must be abstained from for several hours.

Whiskey may be given at short intervals prior to operating, and peptonized enemata also when the condition of the patient requires it.

By speaking encouragingly and assuring the patient that the anæsthetic may be inhaled with perfect safety, confidence is often promptly obtained. It is not considered wise to inform the patient that there is any danger to be anticipated from its administration.

The heart and lungs are examined, the arteries for atheroma, the cornea for senile arc, the artificial teeth removed and the fauces inspected, the clothing loosely and comfortably arranged, and the head placed nearly, or quite on a level with the body; and, to readily notice the respiratory movements, it is best to have little covering on chest and abdomen, but always sufficient for protection.

One of the finest accomplishments is the knowledge how to properly handle the patient. Patience and gentleness are the noteworthy requirements, and with their aid one is promptly and safely brought to the stage of unconsciousness, a decided contrast to the rough handling of a frightened, struggling patient, usually the result of "pushing" the anæsthetic.

Ether, the safer anæsthetic, is to be employed when it is but a matter of choice.

The patient is asked to use his best effort to refrain from interfering. He is permitted to breathe a few times through the dry inhaler; then about a teaspoonful of ether is poured upon it, holding it at a distance from the face, and, as the inhaler is gradually brought close to the face, ether is added in small quantities. If the patient requests it, the inhaler is removed for a breath of air. In a short time the inhaler may be kept permanently in position.

The nervous or hysterical patient, or one exhausted from chronic invalidism, is the seemingly unmanageable one, and it is here that gentleness and tact demonstrate their superiority.

However, at times are found those that are positively uncontrollable; some may have taken ether the usual way, and fear a repetition of the same methods. It is best then to place ether and inhaler temporarily aside and use chloroform until the patient is unconscious. When the exciting stages are encountered and restraint becomes necessary, pressure should not be applied to the chest; it is simply required to hold the shoulders and lower extremities.

To the writer the best results are obtained by keeping the inhaler applied to the face throughout, if possible, and using the ether in drops,

thereby maintaining a uniform condition. If the inhaler is placed aside from time to time, the patient is liable to become semi-conscious and embarrass the operator. With insensitiveness of the cornea, anæsthesia is most generally obtained.

When disturbances present themselves they are usually respiratory. Regular abdominal movements assure us that the respiration is satisfactory, but irregular abdominal movements denote irregular diaphragmatic action.

The hiccough-like, the stertorous, and the wheezing breathing are all signs that the danger line has been reached, and in any of these conditions the face may assume a purplish hue, denoting deficient aeration.

The slightest irregularity of respiration demands prompt action. Ether is, first of all, dispensed with, and that may suffice to bring about the natural order of things. When active measures become necessary, they are, in regular order, pressing the jaw forward from behind the angles, separating the jaws and rhythmical traction on the tongue, dilatation of sphincter ani, artificial respiration, respiratory stimulants, and, finally, the battery.

Recent laboratory and clinical studies have proved that chloroform kills most frequently by failure of the respiration; nevertheless, we know that the heart is often easily overcome, and it behooves us to be ever-watchful of its behavior.

Chloroform should never be forcibly administered, for with resistance there are always exaggerated respiratory movements, and there may be rapid absorption of a large quantity of chloroform, and alarming symptoms, with no previous warning.

It is essential that the head be placed low during anæsthesia, and especially when chloroform is used, for here we have cerebral anæmia as a physiological result.

With the bottle, whereby chloroform may be used drop by drop, the inhaler may be retained in position during the entire operation.

The same unpleasant manifestations are liable to occur as with ether, and are usually more prompt in presenting themselves.

It is often a difficult and dangerous matter to commence anæsthesia in a patient addicted to alcoholic excess, and it is here that bromide of ethyl proves its value; a drachm or two on the inhaler and the patient promptly relaxes, after which it is best to prolong the narcosis with chloroform.

The A. E. C. mixture is about as unpopular as it is unscientific, and is considered by many men of experience an unsafe combination.

Vomiting occurs as frequently with chloroform as with ether, and post-operative vomiting usually after ether. Morphine is sometimes administered to prevent vomiting, but seems to have little or no power in that respect, and is likely to induce vomiting, post-operative.

The surgeon is to be promptly informed of an approaching attack of vomiting, for, owing to the straining effort, much harm may be done at times if the field of operation is not protected.

Mucus can usually be removed from the pharynx with a small sponge attached to a holder. A large quantity of ropy mucus may embarrass respiration, and, if necessary, vomiting may be induced by tickling the fauces or permitting the patient to partially recover.

The pupil should be contracted and respond to light. Marked dilatation following contraction is a danger signal and a warning to discontinue the anæsthetic.

The frequent tapping of the cornea is uncalled for. It is sufficient to elevate the upper lid, when, with returning reflex, there will be an unconscious effort to close the lids.

At the termination of all operations, whether they be trivial or serious, the anæsthetist must be fully assured of the satisfactory condition of the patient before leaving the room.

To hasten anæsthesia, hypodermic injections of morphine are often given; it may do so, but as frequently prolongs the narcosis unnecessarily.

The preference for a particular ether inhaler is usually the result of one's experience, and the writer has used the Allis with marked satisfaction, and finds that there is very little waste of ether with its use.

GENITO-URINARY AND RECTAL SURGERY

IN CHARGE OF

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Ichthyol in Fissures of the Anus.

Van der Willigen warmly commends ichthyol in the treatment of fissures of the anus (*Journ. de Méd.*, No. 32, 1894; *Monatshefte fur Praktische Dermatol.*, No. 10, 1894). The pure drug is introduced into the anus by a brush. The contraction of the sphincter forces this into all the folds of the mucous membranes. Little pain is excited. Treatment should be repeated daily. The patient is given liquid diet, and occasionally castor oil. The first patient, who had previously been treated by every means short of operation, was cured in eight days, the other three in two or three weeks. One had already been subjected to operation without benefit. There was no recurrence.—*Therapeutic Gazette.*

Latent Gonorrhœa in the Female.

Dr. W. R. Pryor (*Med. Surg. Bull.*) states that after normal delivery and a normal puerperium he often observed an acute gonorrhœal endometritis. The explanation was that the labor caused sufficient bruising to render the tissues susceptible to the influence of the gonococcus. In his opinion a latent gonorrhœa in women may become acute by any process which will reduce the vitality of the tissues. He also believes that purulent-urethritis and endocervicitis in the overwhelming majority of cases are due to gonorrhœa. As to the treatment he remarks as follows: "In the urethra I use strong solutions of nitrate of silver—thirty grains to the ounce. For gonorrhœal endocervicitis I have given up the use of carbolic acid or chloride of zinc, preferring the use of as strong a solution of iodine as I can obtain. It is more potent in this locality than any preparation of chlorine. For chronic vulvitis I use nitrate of silver. Chronic vaginitis I treat in the same way, except that I keep the vagina packed with iodoform gauze. In very young children affected with gonorrhœa of the

genitalia, I have frequently been compelled to use only a saturated solution of boric acid. The prevalence of gonorrhœa in the female I believe is not due to neglect in treating the male, but to the difficulty of reaching and treating it in the female. Women who contract gonorrhœa usually stop treatment as soon as the acute and painful symptoms disappear.

Orificial Surgery

Dr. J. M. Mathews (*Mathews' Medical Quarterly*, January, 1895) in an article on "Some Points in Rectal Surgery," refers to the subject of orificial surgery as follows:

At the International Medical Congress at Washington, I had the honor of reading a paper the title of which was, "The Anatomy of the Rectum in Relation to the Reflexes." In that paper I endeavored to show that much elucidation could be thrown upon many suspected diseases by tracing their origin to disease in the rectum. I meant only to convey the idea that many reflex symptoms could be made manifest through the nerve distribution from the affected part to the distant parts of the body. The idea herein inculcated has been run away with in a wild manner by the so-called orificial surgeons, who are in the habit of removing an inch or two of the rectum for the most trivial cause of self-imagined reflex. I wish here to enter a most vigorous protest against this abominable practice. Such practice cannot be too severely condemned by the medical profession, for in its wake lie many wrecked and wretched bodies.

Acute Gonorrhœal Rheumatism.

Dr. Howard Lilienthal has a preference for oil of wintergreen and sodium bicarbonate, with considerable atttention to the alkalies, in the treatment of this disease. The diseased joint should at once be put at rest upon a splint of such proportions that as much comfort as possible may be obtained. Gentle compression over a dressing of ichthyol ointment twenty to fifty per cent., or over mercurial ointment, or over an ordinary wet dressing, should be applied by bandage. If the disease seems to be manageable, gentle massage is valuable during convalescence; but if ankylosis is inevitable, it should be assisted by perfect fixation in plaster of Paris. The indication is for forced feeding; meat, eggs, milk and its preparations, besides other simple and easily digested food, should be forced upon the patient every two hours or oftener, and accurate record should be kept of all nourishment taken.—*Boston Medical and Surgical Journal*, 1895, vol. cxxxii., p. 75.

The Treatment of Uric-acid Gravel.

Dr. Vaughan Harley states that the treatment takes two directions, according as we desire to increase the solubility or decrease the amount of uric acid formed. In the majority of cases uric acid deposits are due to an increased tendency to precipitation, and not to excessive formation. In cases due to an increased tendency to precipitation drugs which help to hold uric acid in solution should be given. Piperazin has been found to be of service in those cases in which gravel has been due to diminished solvents and not to excessive formation, but it has no action whatever on the quantity of uric acid daily formed in the organism. In such cases it should be given with alkalies, as the alkaline waters or potassium bicarbonate, combined with the iodides, and the alkalies should be given at bedtime. Here the diet is not of so much importance except in favor of salines and vegetables. If there is excessive formation, a carbohydrate diet is the most useful. Starch, sugar, and vegetables should, therefore, be the staple diet, and meat and fish in only small quantities. Sugar does not cause an increase of uric acid, but alcohol does, and, therefore, should be prohibited. Quinine and arsenic decrease the quantity of uric acid, because they diminish the quantity of leucocytes, and, therefore, in cases where gravel is due to excessive formation of uric acid, they are most valuable. While moderate muscular exercise is of service, excessive exercise is harmful. In cases of excessive formation, although alkalies are of some assistance, they, like piperazin, are of only secondary importance by increasing the solubility of the uric acid formed.—*British Medical Journal.*

Prostatic Abscesses.

Casper, at the meeting of the "Hufeland'sche Gesellschaft," November 22, 1894 (*Allg. Medicin. Central Zeitung*, No. 97), presented the following treatment:

The presence of pus, fever, and retention are indications for immediate interference. The fact that occasionally spontaneous retrogression and absorption occurs, as shown in a case of the author's that refused operation, does not militate against the general rule.

Three methods are available: the abscess can be opened from the rectum; or from the perinæum; or, following Dittel, the intestines may be separated from the gland by a pre-rectal incision, and the prostate then incised. Our choice depends on the nature of the case. If suppuration is abundant and the abscess prominent, incision through the rectum or perinæum is indicated. Casper did the former operation eighteen and the latter three times. In the latter cases there was a large perineal projection, the skin over which was reddened and thinned.

To reach the deeper-seated abscesses from the perinæum would mean the performance of a median section, and this is the less justifiable, as there is the greatest danger of dividing the ejaculatory ducts and causing sterility.

If the tumor projects mostly into the rectum, the opening should be made from the cavity. Dittel's operation is suitable for the remaining cases, in which neither perinæum nor rectum shows a marked fluctuating tumor.

The objections that have been made to the rectal operation are that it cannot be done antiseptically, and that there is danger of hæmorrhage, pyæmia, and fistula formation. These may be avoided by the following measures: The narcosis must be deep, to overcome, as far as possible, sphincteric resistance. The trivalve speculum gives a suitable and well-exposed operation field. After thoroughly cleansing and irrigating the latter, the rectum above is thoroughly closed with an iodoform gauze tampon. An incision is then made down into the gland, and by bilateral pressure the pus that it contains is squeezed out. A drainage tube is then put in, which projects out of the anus. The rectum is irrigated three or four times daily. In three or four days the drainage tube is removed and the wound allowed to heal.

Hæmorrhage is not to be feared, as the operator has an open field. Fever and other complications occurred in none of the writer's cases. The fistula heals spontaneously, or can easily be closed by operative procedure. Pyæmia may be excluded, since after the lapse of several days infection can hardly occur. Before the operation laxatives are to be given, and after it opium.

Little can be said of the treatment of peri-prostatic abscesses and phlebitis paraprostatica. The former calls for rectal incision; the latter leads to pyæmia, and must be treated in the usual symptomatic and fruitless way.—*International Journal of Surgery.*

[NOTE.—It is well to bear in mind that many symptoms that point to an abscess in the prostate may arise from an inflammation of the seminal vesicles—when the *abscess* points in the rectum that it may be a much-distended vesicle. Abscess of the prostate is a rare disease, while vesiculitis is fairly common. Those so-called spontaneous emanations of prostatic abscess through the urethra are most likely a distended vesicle emptying itself through the easiest route.—E.E.K.]

GYNÆCOLOGY

IN CHARGE OF

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A Mode of More Easily and Rapidly Dilating the Cervix of the Unimpregnated Uterus.

Dilatation of the unimpregnated uterus is necessary chiefly for two purposes, namely, for the treatment of certain cases of dysmenorrhœa, and in order to examine the uterine cavity with the finger for diagnostic purposes. The object of the following short paper is not to estimate the value or utility of dilatation, or to consider in what cases it should be done, but to point out that when it is done for either of the above reasons the time chosen should be the last day of the menstrual period, just when the discharge is ceasing or has ceased. The directions given as to the best time for dilatation in text-books, if any are given (and usually there are none), are to dilate between the periods, and this, I believe, is the universal practice, and it is the one I myself always at one time followed. I have generally dilated with smaller-sized Hegar's dilators until some resistance is met with, which usually occurs when Nos. 9 or 10 are reached. Then a large laminaria tent is introduced, or possibly two or even three smaller ones. On the next day the dilatation is completed by the larger-sized Hegar's, and, if a most unyielding os internum is met with Reid's screw dilators are employed. I believe, however, that this plan is a mistake as to the time chosen, and, as a sequence of this, a mistake as to the mode of operating.

The os internum between the periods firmly resists dilatation, and only yields to considerable force. All who have tried the use of laminaria tents must be familiar with their appearance when withdrawn, showing a narrow ring corresponding to the tight undilated os internum, all the rest of the tent being fully expanded. Moreover, as stated, it takes two sittings on consecutive days to dilate with tents and dilators, and even then it is often very imperfectly accomplished. Not infrequently a rise of temperature and rigor will follow the introduction of a tent, and the continuance of these symptoms with pain may necessitate its early removal.

Rapid dilatation without tents in the intermenstrual interval must necessarily be imperfect, for if done by Hegar's, or Galabin's, or Duncan's dilators, great upward pressure is required to introduce them when the larger sizes are passed, and this pressure may be, and frequently is, so great as to cause the vulsellum or hook used to steady the anterior lip of the uterus to lacerate it, and possibly tear out. If the dilatation is begun with Hegar's dilators, and continued with Reid's screw dilators, the power is so great that the narrow parts must yield; this, however, cannot be called dilatation, but stretching, and is probably accompanied by minute lacerations of tissue. Unless the dilatation, in whatever way it is done, is thorough, a permanent cure does not result in dysmenorrhœa, and is insufficient to admit the finger, if diagnosis is the object.

Many years ago I found out, accidentally, that if the dilatation is done on the last day of the period, just when the discharge has ceased, the parts are perfectly elastic and soft, and have very little resisting power. Hegar's dilators can in many cases be passed in, one after the other, until No. 17 is reached. This admits of the passage of a medium-sized index finger. An anæsthetic is necessary, as the patient would not remain sufficiently quiet. Two Sim's hooks close together, so that the handles are held as one, are better than a vulsellum. They hold better, and are less likely to scratch the operator's finger. This process should be done leisurely, but it does not take above twenty minutes. The smaller sizes of the dilators should have the terminal inch a little curved forwards, and less in size, so as to enter more readily.

This plan opens up quite a vista of utility in other cases than those of dysmenorrhœa; for instance, it is often next to impossible to examine with the finger the interior of the uterus of a sterile woman over forty. The parts absolutely refuse to dilate sufficiently. But by dilating on the last day of the period it can be done very easily. Every uterus does not yield so readily as described, and, indeed, now and then a tough cartilaginous os internum is met with, which almost refuses to yield at all, but even this is more dilatable than it would be in the intermenstrual interval.

A very interesting case of menorrhagia was recorded some years ago which had been under two of the most eminent men in the country, and in which subsequently the womb was removed entire on the Continent. It was then found that the cause of the hæmorrhage had been a small fibroid not as large as a boy's marble. This had never been diagnosed.

Another case was read before one of the London societies, in which vaginal hysterectomy was performed in consequence of incurable hæmorrhage. It was thought to be cancer of the uterine cavity; but, on examination of the uterus after removal, the cause was found to be a small fibroid polypus projecting into the cavity near one cornu. In these cases, if the

finger could have been inserted for examination, no doubt it would have been.

By adopting the plan recommended such examinations become easier, although such small fibroids, and so situated as in these two cases, must always be very difficult to diagnose. Much assistance is given by curving the intra-uterine finger well forwards and pressing the fundus down upon it by the right hand outside. For this purpose the patient should lie on her left side, as the recti muscles are thereby relaxed. It might be supposed that the anæsthetic would cause sufficient relaxation; but it often does not.

In conclusion, the advantages of the plan recommended are:

(1) Danger from sepsis by the use of tents is avoided.

(2) Inflammation, if rise of temperature with rigors and much pain indicate it—traumatic rather than septic—is also avoided.

(3) The process, both to patient and operator, is more easy, and is incomparably quicker.

(4) Less structural injury is done to the parts, as they dilate more kindly and without much resistance.

(5) The dilatation is more complete and perfect, so that if used for dysmenorrhœa a permanent cure is more likely to result, and, if for diagnostic purposes, examination is possible in cases in which otherwise it would have been impossible.—*James Braithwaite, M.D., in British Medical Journal.*

PÆDIATRICS AND ORTHOPÆDICS

IN CHARGE OF

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ORTHOPÆDIC SURGERY.

Dr Henry Ling Taylor, of New York, writes of Infantile Scorbutus. Some have considered this condition due to the use of sterilized milk. At the age of six to eighteen months the baby begins to fail in health—grow peevish, restless, and sensitive, and develops a peculiar cachexia, characterized by a dusky complexion and emaciation. The gums are usually dark, swollen, and spongy. There may be ulceration, bleeding, and fetor.

The general sensitiveness becomes so marked that the child is handled with great difficulty. At the same time fusiform swellings, due to the effusion of the blood beneath the periosteum, appear near the hip, knee, or ankle. These are very sensitive, but are devoid of local elevation of temperature. There may be fever in acute cases.

A simple change of diet to raw or pasteurized milk, with the juice of an orange and a little raw beef juice daily, produces rapid improvement unless some accident, such as the separation of an epiphysis, has occurred.

The cause of the disorder is clearly to be found in the diet.

The pseudo-paralysis is one of the most striking of the limb symptoms.

The trunk and other extremities may also be affected. The limbs and trunk usually lie motionless; the head and arms can generally be moved, and handling causes acute suffering.

The pseudo-paralysis is not wholly due to prostration, nor is it entirely explained by the local hæmorrhages, nor is it any essential paralysis, for the knee-jerks are normal, and recovery may take place in a few days.

It is suggested that movement is inhibited by the sensitive and damaged condition of the muscles and their insertions, or that malnutrition of the nerve centres from impoverishment or toxicity of the blood is the cause of the pseudo-paralysis.

The muscular rigidity might also be due in part to reflex action from joint irritation, or from peri-articular or intra-articular swellings.

They may be easily distinguished from other infantile paralytic affection by the hyperæsthesia and accompanying symptoms of the scorbutic dyscrasia, by the normal knee-jerks, and by its speedy subsidence and anti-scorbutic diet.—Trans. Amer. Orth. Assoc., vii., p. 129.

NOTE.—The following are some of the references to the literature of this interesting subject:

Amer. Medical Surg. Bull., Feb. 1, 1894.
" " " " March 15, 1894.
N. Y. Medical Journal, Dec. 12, 1891.
" " " Dec. 12, 1894.
Keating Cyal Dis. of Children, Vol. II.
Lancet, Sept. 30, 1893.
Practitioner, June, 1893.

ETIOLOGY OF RICKETS.

Hagenbach-Burckhardt (*Berl. klin. Woch.*, May 27, 1895) discusses the etiology with special reference to rickets being an infective process. Theories attributing the disease to deficiency of lime salts, to lactic acid, are no longer tenable. Kassowitz, under certain circumstances, is disposed to admit various micro-organisms as the cause of rickets. Poisons due to micro-organisms can readily be supposed to set up the lesions found in the disease. The temperate zone is the one in which rickets abounds. The cases of rickets increase at the beginning of the cold season, when children are kept in the house. The greater the altitude, the less frequent is rickets. The infective theory would explain the prevalence of the disease in vitiated, and its infrequency in pure, atmospheres. Both rickets and tuberculosis are most developed in large towns and in notoriously unhealthy streets. Enfeeblement of the individual by acute or chronic disease predisposes to both diseases. Measles also predisposes to both. In early age chronic infective processes are frequently localized in the bones. There is nothing in the clinical picture of rickets against the view of its being an infective disease. Acute rickets is known. The spleen is frequently enlarged. The objections to the view are that no micro-organism has been found, and that similar changes in bone may be produced experimentally in animals by withholding lime salts. The

author thinks that the disease set up in this way is not identical with rickets, nor does he think that fœtal rickets has been shown to be identical with the ordinary disease. He would look upon defective feeding, vitiated atmospheres, acute and chronic infective diseases, as predisposing causes only.—*Epitome British Medical Journal.*

Biliary Cirrhosis in Children.

Seven cases are reported by Gilbert and Fournier (*Rev. des Mal. de l'Enf.*, July, 1895). These seven cases presented all the symptoms observed in the adult; but, in addition, in many instances there was hypertrophy of the spleen. So marked is the splenic enlargement that in cases where there is not great enlargement of the liver the true nature of the disease may be easily mistaken. The writers believe that this associated enlargement of the spleen is peculiar to cases of biliary cirrhosis commencing in childhood. A further peculiarity of the affection as seen in children is the frequency with which clubbing of the fingers may be observed. In some instances there was enlargement of the ends of the femur and tibia. The backward and stunted appearance of the affected children indicates the influence of the disease on the general nutrition.

Condensed Milks.

The commission appointed to examine into the milk supply of London have discovered that in the case of condensed milk by far the greater number of brands are prepared entirely from skimmed milk. In all, seventeen brands of milk were examined by Dr. Dyer and Mr. Cassal. Out of this number fourteen were found to be prepared from skimmed milk, and showed an average of 0.72 per cent. of fat. Three brands prepared partly from skimmed milk show an average of 3.14 per cent. of fat.

Genuine condensed milk, prepared from milk in its entirety, should contain from ten to twelve per cent. of fat.

In the present state of the law, as interpreted by the judicial authorities, condensed skimmed milk, that is to say, milk deprived of one of its chief constituents, may lawfully be labelled "condensed milk," although when sold uncondensed it must be distinctly stated at the time that it is skimmed milk.—*British Medical Journal*, July 27, 1895.

PATHOLOGY

IN CHARGE OF

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ASSISTED BY

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Upon the Biology of the Bacillus of Tetanus.

Righi (*La. Rif. Med.*, 1894, No. 205) asserts that he has been able to secure the growth of the tetanus bacillus *aërobically*. The process by which this was accomplished was the transplantation of the highest part of old agar-agar puncture cultures. In the highest parts of these the bacilli were accustomed to a certain amount of diffused oxygen, and by the frequent transplantations readily allowed themselves to be introduced gradually to the free atmosphere. By this means, Righi secured aërobic growths upon agar-agar and upon gelatin.

Mixed Infection in Pulmonary Tuberculosis.

Notwithstanding the proof of Fränkel and Troje (*American Journal of the Medical Sciences*, June, 1894, p. 744) that the tubercle bacillus alone is quite competent, under proper conditions, to produce pulmonary tuberculosis of the most diffuse nature, the impression has steadily grown that in very many cases of phthisis a "mixed infection" occurs at some time in the course of the disease, and that an important *rôle* in determining the progress of the disease is played by the bacteria causing the associated lesions at such times. This impression has had its foundation in the frequent clinical observation of exacerbation of chronic phthisis during and after influenza, lobar pneumonia, and after the various complicating broncho-pneumonias, as, for example, after the broncho-pneumonia of measles in children. It has been suggested that, were it not for the contributing conditions of the mixed infection, the body would be able to protect itself in a very large proportion of cases from encroachment of the tubercular process. Whether this latter extreme view be correct or not, it

becomes of the greatest importance, from both prophylactic and therapeutic standpoints, to determine the germs most frequently contributing to the progress of the tubercular process, and to investigate the most efficient means of lessening their influence.

With a view to throwing light upon the first of these questions Spengler, working at the Institut für Infectionskrankheiten, in Berlin, under Koch's guidance, has examined the sputum of fifty patients suffering from phthisis, using every precaution to exclude any sources of error (*Zeitschr. f. Hygiene u. Infectionskrankheiten*, 1894, xviii., 343). Stained cover-glass preparations of the sputum, and cultures from it by both Pfeiffer's and Kitasato's methods, were carefully studied, and careful microscopic and bacteriologic examinations of the diseased organs were made in all the fatal cases. In only five of the fifty cases studied was the tubercle bacillus alone found. Three of these died, and in the lesions of all the tubercle bacillus was alone.

In nearly eighty per cent. (39) of the cases the *streptococcus pyogenes* was associated with the tubercle bacillus, and in twenty-one of these the streptococcus was believed to have been an active agent in the production of the lesions, because of its presence in large numbers in the sputum coincidentally with the occurrence of fever of a peculiar type, and because of its presence in the lesions post-mortem. In fifteen cases the streptococcus appeared to be present as a passive accompaniment of the tubercle bacillus. In these there was comparatively little fever, the progress of the cases was very slow or stationary, and in the majority the streptococci seemed to be present as a residue of an acute condition which had subsided some time previously. Eight of these cases had had the advantage of a residence at Davos, in the Tyrolean Alps; and Spengler suggests that the benefit therefrom depended chiefly upon the rapid recovery from the associated affection, the streptococci in all these cases quickly diminishing in numbers, and in several of them ultimately disappearing entirely from the sputum.

The *diplococcus pneumoniæ* was found to be the associated germ in one case, and in one each the *micrococcus tetragenus*, the influenza bacillus, and the pseudo-influenza bacillus were associated with the streptococcus.

The important practical deduction from this work is that in the prophylaxis and the treatment of tuberculosis of the lungs, careful consideration should be given to the part played by the associated bacteria. Persons affected with slight or transitory inflammations of the respiratory tract should be removed as far as possible from all sources of infection by the tubercle bacillus; they should under no circumstances be placed in the same wards in hospitals with consumptives. Similarly, great care should be used to exclude from persons already affected with tuberculosis all sources of infection with the bacteria which have been shown to exert so deleteri-

ous an influence upon the progress of the disease. This would seem to be best accomplished by the removal of the tubercular patient to a high mountainous region, or to one, at all events, where the air is free from the germs of suppuration and pneumonia. And, furthermore, in the treatment of cases of phthisis, the first care of the physician should be to rid the lungs as quickly as possible of the associated bacteria, for so long as their hurtful influence continues it is useless to institute specific treatment of the tuberculosis.—*American Journal of the Medical Sciences.*

Sarcoma of Kidney.

The frequency of malignant as compared with benign tumors of the kidney is notable. Sarcoma may be primary or secondary: primary usually involves only one kidney. Morris says that the only primary bilateral sarcomata of kidney are the myosarcomata *i.e.*, striped-muscle-containing sarcomas. In other cases one kidney has been infected from the other.

Rapid growth is characteristic, and this occurs along the renal vessels; the consistence is soft and vascularity is marked. A weight of several pounds is often attained. Either kidney may be affected, and the renal form is often well preserved in the growth, the capsule of the organ limiting the neoplasm also.

The connective tissues of the cortex or the subcapsular or submucous tissue are the seats of origin, and thus the growth surrounds rather than infiltrates the kidney substance.

Histologically, the round-cell varieties are more common than the spindle, and the various degenerations from which sarcomata suffer else where occur here also.

The causation is obscure. Some are undoubtedly the result of ante natal pathological conditions, being congenital; the irritation caused by renal calculus is thought by some to be operative in starting growth. Traumatism is also spoken of. Really the causes are unknown.

The majority of these growths occur during the first decade of life, and sex seems to be of no account. Their course is rapid, a fatal termination often happening within a few weeks from the time when first noticed. Six weeks to six months may be taken as the usual limits of duration.

Recurrence after removal has been so constant in those that survive nephrectomy, and the danger from the operation itself so great, that Butlin, Thornton, and others advise against interference. Others (*e.g.*, the author of this paper) have had much better results, and say that operation is indicated in all cases if the patient be seen early.—*Abstract of paper by D. A. K. Steele, in Medicine for April, 1895.*

HYGIENE AND PUBLIC HEALTH

IN CHARGE OF

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The report of the Montreal Board of Health in favor of the establishment of a bacteriological department in connection with the board has given rise to much discussion as to the practical value to the city of such an institution.

Dr. Laberge, the City Medical Health officer, has prepared a report on this feature of the case and submitted it to the board.

Bone Tuberculosis a Field of Litigation.

At the recent meeting of the Mississippi Valley Medical Society Dr. Emory Lanphear read a paper on "Tuberculosis of Bone and Joints the Future Field of Litigation against Corporations," in which he advanced the opinion that, "multitudinous as have been the suits brought in the past upon the plea of concussion of the spine, they are few, indeed, as compared with those liable to be instituted as soon as attorneys and the common people come to understand the fact that slight sprains and twists lead to the development of bone and joint tuberculosis."

Hygiene and Race Development.

If prevention is the keynote of the medical thought of the day, it is the height of wisdom to pay heed to the sources of moral contamination. Overcrowding in cities, child-labor, unnatural and unremitting toil by the mothers, are some of the most potential of these causes, and they appeal to the hygienist and to the legislator on the basis of race deterioration and loss to the State.

The absolutely dissolute should be isolated and their labor made productive ; first, to prevent the transmission of their pernicious qualities ; secondly, to relieve the State of the burden of their maintenance in asylums and reformatories.—H. H. Longsdorf.

Voluntary Admission of Patients to Hospitals for the Insane.

The following resolution was adopted at the session of the Medico-Legal Society held on March 13, 1895:

"Resolved, that in the opinion of this society the adoption of a law permitting voluntary admission to the hospitals for the insane of such persons as may desire treatment therein is eminently proper and desirable, and the highest interests of the insane demand the incorporation of such a law among the statutes of the State of New York."

Ontario Factory Act.

The Ontario Factory Act, as amended and improved during the recent session of the Legislature, has just been published by the Ontario Government, and should have a wide circulation. There are a nnmber of entirely new clauses. The first of these is designed to make more stringent the obligation upon employers to provide sufficient sanitary arrangements, the new act providing that where two or more persons occupy the same room or premises to carry on a business which employs in the aggregate six or more persons each of the employers shall be responsible for the sanitary arrangements of the place. The next additional clause provides that except in the business of canning or desiccating fruits no boy or girl under fourteen shall be employed in any factory. New precautions against accidents are found in section fifteen, a clause being inserted ordering the most secure guarding possible of dangerous parts of mill gearing machinery, flumes, doors, bridges, etc., while considerable latitude in ordering precautions is given to the inspectors. More stringent fire escape provisions are made, a rope being ordered for every window in a factory above the ground floor. Other clauses direct that the inspectors must be notified of explosions and injuries within twenty-four hours under penalty of a fine of $30. The appointment of a female factory inspector is authorized, and an extra clause added to make prosecutions more effective. These are the chief amendments to the Act, which was previously a valuable charter of the rights of the workers, and it should be in the hands of all interested in the matter.

Ophthalimia Neonatorum.

The statistics given by Haussman of the inmates of blind asylums made blind by this disease was: In Copenhagen, 8 per cent.; Berlin, 20 per cent.; Vienna, 30 per cent.; and in Paris, among 208 blind, young subjects, 45 per cent. In 1876, among the young persons admitted to the blind institutions of Germany and Austria, 33 per cent. had been made blind by this disease.

In different countries the variation was from 20 per cent. to 79 per cent. In Philadelphia, in 1871, out of 167 inmates of the blind asylum, about 20 per cent. had been admitted for this cause.

Since prophylactic measures have been resorted to in lying-in hospitals it had the effect of reducing this number from 12 per cent. to 3 per cent. in Halle, and in Leipsic, where Crede used his own method, the cases fell from 7.5 per cent. to 0.5 per cent. The treatment consisted in putting a single drop of a 2 per cent. solution (gr. x to ℥j of water) of nitrate of silver between the lids of each eye. Practically the same results have obtained in the United States. In the 158 inmates of the Berkeley Institute, California, of 36 cases of binocular blindness 25 per cent. was caused by blennorrhœa neonatorum.

Howe found that while from 1870 to 1880 the population of the United States had increased 30 per cent., the number of cases had increased 140 per cent., the number decreasing from the east to the west, but increasing from the north to the south.

Castration of Criminals.

Several medical journals are advocating castration as the one penalty for bestiality, pederasty, and the like abominations. The arrest and imprisonment of Oscar Wilde for a "nameless crime" and the recent exposure of the perverted sexual sense among many of the British aristocracy has awakened a feeling among many that imprisonment or fine is too mild a dose for such moral debauchees.

The Ohio State Food Commission has brought ninety indictments against grocers and druggists for selling adulterated articles in their respective lines.

A case of tuberculosis of the face, the result of infection from shaving, has been reported.—*Kansas Medical Journal.*

Editorials.

RESPECTABLE MEDICAL JOURNALISM.

WE regret that in a short editorial in our last issue there appeared a slight typographical error in our *French* which has caused some confusion in certain quarters. We will now explain in simple English. The journal referred to publishes two separate editions: one on poor, cheap paper, possibly forty-five pounds to the ream, and sent free to all physicians in the Dominion—or, more correctly speaking, to as many as the limited number published will allow; a second printed on better paper, probably weighing seventy pounds to the ream, and sent to advertisers only. As to our other comments on the peculiar business methods of the combined journal, which was unanswered in its August editorial, we have nothing further to say.

For ourselves, we have to state that THE PRACTITIONER did *not* try to make a combination with the *Ontario Medical Journal*. That is not however, a matter of much importance. It appears to us far more important, as far as our patrons are concerned, to publish a good journal, and to avoid everything that is unprofessional and disreputable. We have been told that, if we copied, to some slight extent at least, the methods of the free advertising journals, we would gain some pecuniary advantages. Perhaps we would; but we decided some time ago not to make the trial, and we see no reason now for altering our decision. In fact, we have an old-fashioned idea—perhaps an outcome of our "concomitant fossilization"—that honesty and respectability are necessary for the lasting success of any medical journal.

Free journals, conducted on speculative principles in the interests of advertisers, have had a fair trial in Toronto, and have not been found satisfactory. The *Dominion Medical Monthly and Ontario Medical Journal*, one of the most typical of the modern free journals, brings to our attention an important fact in the following words: "Our journal is the official medium of the Medical Council." The history of this official medium business is fairly well known. We fancy the Council itself has lately recognized that a mistake was made, but many of its members felt

that it was just that men who were carrying out a certain engagement with that body should have a fair chance to recoup themselves for certain investments necessarily connected therewith. The late transfer has removed any such sentimental considerations, and the Council has now only to consider the matter on its merits. Surely the time has arrived when the Council can decide unanimously that no reason now exists why it should adopt or officially recognize any single journal—and certainly none that has connected with it even a suspicion of unprofessionalism.

THE BRITISH MEDICAL ASSOCIATION.

WE have frequently given expression to the opinion that the British Medical Association is the greatest medical society in the world; and we are, consequently, quite ready to endorse the statement made in the *British Medical Journal* to the effect that the recent meeting was the "greatest medical assembly that our profession has ever known." The *Journal* goes on to say: "We do not forget the great International Congress; . . . in mere numbers, for aught we know, some of these meetings may have surpassed the Association meeting of this week. English medicine has, however, this week shown itself in numbers vast enough to fire the most sluggish imagination; while, on the other hand, the age, standing, and prosperity of our Association give a unity, a dignity, and an impressiveness to its chief assemblies which are wanting to the more or less motley and fortuitous gatherings which have not a national character."

Among the visitors were many physicians from Canada and the United States, including the following: Drs. Walter B. Geikie, Wm. Oldright, H. A. Bruce, J. H. Cotton, D. N. McLennan, N. M. Harris, and C. W. Thompson, from Toronto; Drs. I. H. B. Allan, T. Johnson Alloway, George E. Armstrong, H. S. Birkett, D. Macrae, and Sir William Hingston, from Montreal; Drs. K. N. Fenwick and N. R. Henderson, from Kingston. There were about seventy-five from the United States. We understand that these visitors were, as a rule, well pleased with the treatment they received from the British physicians and surgeons, and were, at the same time, much interested in the proceedings of the meeting.

THE CANADIAN MEDICAL ASSOCIATION.

THE meeting of the Dominion Medical Association recently held in Kingston was a very satisfactory one in all respects. We have no recollection of any meeting of the association when the different provinces of Canada were better represented. One hundred and

ten members signed the register. This may be considered a fairly good number, especially when we consider the fact that at the last meeting held in Kingston in 1883 there were only about eighty present. Taken altogether, the papers were above the average in character, and some of the discussions were animated and interesting. The local members were exceedingly hospitable, and entertained in a royal fashion.

The meeting for 1896 will be held in Montreal, and, as a matter of course, is bound to be successful. The physicians of that city know how to organize for a good meeting, and they also know well how to entertain. Dr. Thorburn, of Toronto, one of the oldest and for many years one of the most active members, was elected president for the next meeting; and his friends—who are many—think he well deserves the honor. It was expected by many that Toronto would be chosen as the place of meeting for next year; but in consideration of the fact that the meeting of the British Association for the Advancement of Science is likely to be held in that city in 1897, it was thought better by the majority of those present to hold the meeting of our association in Toronto at the same time. Pleasing recollections of the remarkable success of the Montreal meeting in 1884, under similar circumstances, largely influenced the members in reaching their decision. Among the distinguished guests from Great Britain on that occasion were: Mr. Lawson Tait, of Birmingham; Dr. Struthers, of Aberdeen; Dr. MacAlister (Editor of *The Practitioner*), Drs. George Harley, Heywood Smith, and P. Smith, of London; all of whom attended the meeting faithfully, and joined in the discussions on the various papers that were read.

There was much satisfaction felt in Kingston over the attendance of a goodly number of representatives of the maritime provinces. The genial, charming, grand old man, the President, Dr. Bayard, of St. John, readily captured the hearts of the physicians of central and western Canada. May there still be in store for him many years of usefulness and happiness is the sincere wish of all those who had the pleasure of meeting him. We hope to see him and his friends, Drs. Farrell, White, Muir, Warburton, and many others, especially, at the meetings of '96 and '97.

LODGE PRACTICE AND THE I.O.O.F.

WE have at hand the report of the Grand Secretary, Mr. J. B. King, of the Independent Order of Odd-Fellows, that contains some very important information for the medical profession. We have perused the tables of sickness and mortality with great interest, and know of no other order or jurisdiction of this order that publishes so complete tables as those we find in this report.

The total membership in Ontario is 21,685, of which 3,019 members were sick during the year 1894; *i.e.*, one out of every 7.17 of the total membership received sick benefits. Taken altogether, the sickness of the 3,019 extended over 14,558$\frac{6}{7}$ weeks; or an average of 4 weeks, 5 days, and 13 hours each. The table further shows that if this sickness had been spread over the entire membership that each man would have been ill 4 days, 16 hours, 16 min., 14 sec. Another table shows the age of each member that was ill. Here we see that between the ages of 45 and 56 the average sickness is over one week per member, excepting 46, 47, 49, and 54, in which it is over 5 days.

These statistics are very valuable to the profession, but it also demonstrates another very important element in the question of lodge practice. In these tables is also included one that shows the total amount paid lodge physicians, and we see the amount of work that was necessary to earn this honorarium. It makes the matter more serious when we remember that in some lodges the medicine is supplied free by the physician.

The sum of $6,333 was paid as surgeons' fees, and $2,171.64 for nurses. We have continued these averages, and find that altogether the physician received an average of 25 cents per member (21,685 members; $6,333 fees), with an average sickness of 4½ days, or about 5 cents per day of sickness; or, if the entire fees had been paid for the 14,558 weeks' sickness, it would allow the munificent sum of 43 cents per week to the doctor.

These figures show clearly the injustice and absurdity of certain contracts for lodge practice. Just consider for one moment that if only one visit per week was made the fee was less than fifty cents; and, as any one well knows, these cases demand much more frequent visiting—say, four a week—and that for a little over ten cents a visit!

This is the first opportunity that we have had of putting the lodge practice case on a dollars-and-cents footing. While physicians will attend at these rates for the sake of the advertisement, all we can say is that it is a costly advertisement, accompanied by a very marked loss of professional dignity.

EXCESS OF ZEAL IN CROWN OFFICERS.

WITHIN the last few weeks we have had our attention very forcibly directed to the consideration of the thinness of the ice—so to speak—upon which the practising members of our profession continually walk.

A practitioner of high standing, both professionally and as a member of the community, Dr. E. C. Stevenson, of Bradford, had occasion, some time ago, to induce abortion in the case of a patient who was apparently

dying of inanition from prolonged vomiting. The operation was undertaken only after trial had been made of the other less heroic measures at the doctor's disposal, and after consultation with, and by advice of, a brother practitioner. There was no attempt at concealment of the character of the operation; the woman's husband was informed and gave his consent, and a neighbor was brought in as a nurse. Unfortunately, skilled advice had not been sought soon enough, and the patient succumbed shortly afterwards. In spite of the openness of the whole procedure in connection with the case, rumor was soon busy, and to so good purpose that ultimately the body of the woman was exhumed, a post-mortem examination made, and an inquest held.

The result of the investigation was what all, except some of the Crown officials, expected, viz., the complete vindication of Dr. Stevenson and his consultant, Dr. Foxton.

To the ordinary observer, the whole proceedings in this case may appear to be proper; indeed, we have heard it said more than once that an investigation was absolutely necessary to clear up the case and put Dr. Stevenson right before the public. There is another side of the question, however. It must be remembered that the affair is reported in the various newspapers, and that the physician involved sees his name heralded abroad as a suspected criminal abortionist. This in itself will certainly cause annoyance enough; but we must also remember that a greater or less outlay of money follows, since a lawyer is almost necessarily engaged to look after the unfortunate doctor's interests at the inquest. Such being the case, Dr. Stevenson is entitled to ask, "Why has my character been called in question? What ground had the Crown for suspecting that my patient came to her death unfairly?"

It will not do for the officials engaged to say, as they sometimes do, "You are not accused; this is merely an investigation, and can do no innocent man any harm." The affidavit, in virtue of which an inquest is held in such a case, specifically states that good grounds of suspicion exist, and the individual concerned (Dr. Stevenson in this case) is warned that he need not give sworn evidence unless he choose, as it may be used against him. Surely, then, every precaution ought to be taken by the Crown to inform itself fully and accurately, so that a hitherto respectable citizen may not find himself practically accused of criminal conduct unless the information be unimpeachable. Especially in the case of medical men does it seem to us that care should be observed, since the nature of his relations to the public is such that the malicious can readily enough find him in compromising situations.

We are sorry to say that in this case the investigation itself showed that Dr. Stevenson was being assailed without any good ground what-

ever, and merely to satisfy the spleen of a man who had, on a previous occasion, demonstrated to the satisfaction of the Crown itself that he was utterly unreliable, and worthy of punishment as a perjurer.

It is conceivable that under certain circumstances it may be a difficult matter for officials to decide as to the credibility of information supplied them, but we can conceive of no valid excuse for the acceptance of the unsupported statement of a professional rival (we apologize to Dr. Stevenson!) with a criminal record as sufficient ground for the pursuit of a man of Dr. Stevenson's standing and past history. So far as we can judge, those concerned simply swallowed the story of abortion brought to them, and had forgotten—if ever they knew—that all abortion is not criminal abortion. It appeared, too, from the inquest, that, although a detective was at work upon the case, the Crown had failed to grasp the fact that the informant had been dismissed from attendance upon the sick woman for incompetency, and had been succeeded by Dr. Stevenson.

When we speak of Crown officials we wish it understood that no reference to the coroner who held the inquest is intended. All who know him know that there is none more jealous of the good name of the profession, and that nothing better could have happened Dr. Stevenson than that the investigation should fall into his hands.

Correspondence.

RE ASYLUM DISTRICTS.

To the Editor of THE CANADIAN PRACTITIONER:

DEAR SIR,—From the frequent inquiries addressed to the superintendents of the several asylums by medical practitioners in the province who are interested in having patients admitted, it would appear that the recent changes made in the districts allotted to the respective asylums are not generally known by the profession.

Some delay and annoyance has resulted to medical men in consequence of the new arrangement of the districts, and I have no doubt it would benefit a large number of the profession if you would have inserted in your journal the redistribution of the counties and their allotment to the several asylums.

I enclose you a paper-cover copy of my report for 1894, on pages 16 and 17 of the introduction to which you will find a statement of the asylum districts, as sanctioned by Order in Council, and from which you are at liberty to transcribe, if you approve of giving the matter a place in THE CANADIAN PRACTITIONER.

Yours very truly,

R. CHRISTIE, Inspector.

ASYLUM DISTRICTS.

The following is the statement of asylum districts extracted from Mr. Christie's report, which he kindly sent to THE PRACTITIONER:

After carefully considering the varied interests involved, I have concluded that the allotment of the districts to be attached to each asylum should be as follows. And, with the view of more explicit reference for the future, I would recommend that they be numbered, commencing at the western section of the province, designating it No. 1, or London District, to embrace the counties of Essex, Kent, Elgin, Lambton, Middlesex, Oxford, Huron, Bruce, and Perth, these having a combined population of 540,839, for which there is provision in the district asylum for 1 patient to every 537 inhabitants.

No. 2, or Hamilton District, to embrace the counties of Halton, Wentworth, Welland, Lincoln, Haldimand, Norfolk, Brant, Wellington, Waterloo, Dufferin, and Grey, having an aggregate population of 454,043, for which there is accommodation in the district asylum for 1 patient to every 493 of the population.

No. 3, or Mimico District Asylum, to embrace the counties of Peel, Simcoe, Ontario, Victoria, Peterborough, and the Districts of Muskoka, Parry Sound, Nipissing, Algoma, Thunder Bay, and Rainy River, having an aggregate population of 318,728, for which there is accommodation in the district asylum for 1 patient to every 569 of the inhabitants.

No. 4, or Toronto District, to embrace the city of Toronto and county of York, having an aggregate population of 245,101, for which there is accommodation in the district institution for 1 patient to every 518 of the inhabitants.

No. 5, or Kingston Asylum District, to embrace the counties of Durham, Northumberland, Hastings, Lennox, Addington, Prince Edward, Frontenac, and Renfrew, having an aggregate population of 267,170, for which there is accommodation in the district institution for 1 patient to every 477 of the inhabitants.

No. 6, or Brockville Asylum District, to embrace the counties of Leeds, Grenville, Dundas, Stormont, Glengarry, Prescott, Russell, Carleton, and Lanark, having an aggregate population of 288,440, for which there is accommodation in the district asylum for 1 patient to every 487 of the inhabitants.

The territorial district allotted as No. 4, or Toronto, may appear, at first sight, to be comparatively small, but it must be borne in mind that in the higher pay wards there is provided accommodation for 230 patients, which leaves only 478 beds available for warrant cases. The higher pay wards are available for patients from all sections of the province, and are not limited to any territorial division from which they may be admitted.

Meetings of Medical Societies.

CANADIAN MEDICAL ASSOCIATION.

THE annual meeting of the Canadian Medical Association convened in Kingston, Ontario, August 28, 29, and 30. The President, Dr. Bayard, of St. John, N.B., occupied the chair. The meeting was held in Queen's University.

WEDNESDAY MORNING.

WHAT IS THE BEST TREATMENT FOR RETROVERSION OF THE UTERUS?

This was the title of a paper by A. Lapthorne Smith, of Montreal. The paper consisted of a statement of how to replace the uterus in cases uncomplicated by inflammatory adhesions, or accompanying tubal or ovarian disease by the knee-chest position. In the more intractable cases where the round ligaments (which were muscular) had become relaxed he recommended the Alexander operation, the technique of which he described. In those cases where inflammatory adhesions were found, he considered the operation of ventro-fixation the better way of dealing with the organ. The method of doing this he also described.

THE PRESIDENT'S ADDRESS.

The first item of the afternoon session was Dr. Bayard's address. He said that his years were so far spent that honors did not possess the same charm they did years ago, but he no less appreciated the great honor of being chosen to preside over the deliberations of the Canadian Medical Association, representing, as it did, four or five thousand practitioners of medicine, scattered over a country so many thousands of miles in extent. He did not expect the honor, and he did not deserve it, as circumstances had prevented his attending many of the recent meetings. Such meetings were great educators, both of the head and the heart. It was a great stimulus to its members. It was at such meetings that they could compare the scientific phenomena they had observed in their practices. The progress of medicine was, in a great part, due to such associations of medical men. The social meeting, too, was a most pleasing element in such gatherings, where the friendly handshake and many expressions of brotherly love were manifested. This spirit of unity was a sign of progress.

The President then spoke of the status of the profession, contending that it should stand second at least among the professions. Its noble work was not sufficiently appreciated. Its portals were guarded by stricter examinations than all others. They were trusted by all classes; they went into the abodes of the sick, and, exercising their glorious art, succored those who were smitten with the breath of pestilence, when deprived of all other friends.

"Hour after hour each busy day has found
The good physician on his lonely round."

Its members performed more gratuitous work than all other professions in relieving suffering humanity. It had been asked, Was it right and just that the State and public should allow the medical profession to do their medical charity when it received such scant recognition at the hands of either? It might be safely claimed that the remuneration paid by the State to any of its medical officers would not equal that paid to a third-class lawyer. It was estimated that in London one out of every two persons received charitable medical relief. This great and laborious work was freely given, no plaudits being asked for except Heaven's "Well done." When hospitals were State-supported and endowed, and were sustained by pay patients, they should pay their physicians, like members of other professions were paid for services performed. The State had no claim upon them, and it was certain the tax-gatherer did not forget them.

In the next part of the address, he reviewed the work physicians were doing in the line of preventive medicine, and the great saving to life resulting from the introduction of sanitary measures. The way medical health officers were treated in the way of remuneration came under the aged doctor's lash. The authorities made provision for grants to railroads, schoolhouses, and for the improvement of breeds of cattle, but only doled out a pittance for preventive medicine. The provinces of the Dominion did not spend the one-half of one cent *per capita* for that purpose. How long was this incongruous state of affairs to exist?

The President then dealt at length with the question of over-education, a subject he had touched on in his address at the meeting in St. John last year, and for which he had been taken to task. He still contended that education was being pushed to the sacrifice of the many school children's health, particularly that of the girls, who were to be the future mothers in this country.

The question of liquor-drinking also came under review; the various methods of regulating it being spoken of. As to prohibition, the doctor thought that it was an impracticable thing. It had been tried in Eden, and failed there. He believed in the establishment of asylums for the inebriate. In speaking of the immense value of the study of bacteriology as a means of diagnosis, he had only to refer to its application to diph-

theria. By this exact means it was estimated that only about half the cases that would have been formerly called diphtheria were genuine cases. As the appliances necessary to carry on such investigations were not within the reach of the ordinary practitioner, he recommended the employment of a pathological expert by the State, one of whose duties it should be to carry on this special work.

PHYSICAL TRAINING AND DEVELOPMENT AS A THERAPEUTIC MEASURE.

A paper with this title was presented by Dr. B. E. McKenzie, of Toronto. He stated that in view of the remarks of the President on the matter of over-education of girls his paper would appropriately follow; for many of the cases of deformity he had to deal with were of the female sex, and caused by improper training. The first thing recommended in these cases of commencing deformity was to show the patient before a mirror her exact condition, and how much it could be corrected by her own unaided efforts. Encouragement was to be given to assume and maintain the corrected attitude as often as possible. Another feature was the class training of this class of patients—a method much more satisfactory than dealing with the individual separately. The doctor had found that as a result of the inculcation of self-control, and re-education, the patient was benefited in many ways: the appetite improved, the circulation became equalized and more rapid, and the nervous system much strengthened. The doctor reported the history of cases.

Dr. Louis Sayre, of New York, who was very warmly received, said that he felt it an honor to be present at the meeting. No more important subject could be brought before them than the one Dr. McKenzie had spoken of. The profession generally should have a keener perception of its importance. He was glad that it was receiving the attention it was. Up till recently it had not been attended to at all as it should have been. The nation would go to ruin if attention were not paid to it. The health of the growing generation must be attended to. The poor children, he complained, were packed off to schoolrooms and placed in ill-formed seats, with no place for their little feet to rest and no support to the back. This was one of the factors in the production of spinal curvature. This deformity could be rectified without splints or supports of any sort, simply by training.

Dr. Reginald Sayre, of New York, referred to the astonishing results accomplished by persevering effort with these cases. By this developmental system the effect on the mental system was most marked. He commended Dr. McKenzie's lateral curvature stretcher. In some cases support was necessary where the muscles were not sufficient to maintain the body in the correct position, until by training the muscles were able to perform their function.

Dr. Roddick, of Montreal, concurred with the previous speakers as to the value of class culture. He had introduced an idea he had got in Egypt recently—where he had noted there were no cases of spinal curvature due to the custom of carrying water-bottles on the head—of asking the patients, as one of their exercises, to carry weights on the head for a certain time daily.

EVENING SESSION.

The address on surgery was delivered by Dr. I. H. Cameron, of Toronto, who took for his subject the recent advances in cranial surgery.

TUMOR OF THE MEDULLA OBLONGATA.*

Dr. J. E. Graham, of Toronto, related the history of a case of tumor of the medulla oblongata. The symptoms pointed to a tumor of the cerebellum. Charts were exhibited showing the position of the tumor. The bibliography of the subject was then gone into.

REMOVAL OF THE MEMBRANI TYMPANI AND OSSICLES.

By Dr. Buller, Montreal. He pointed out that this procedure was applicable to those obstinate cases of middle ear trouble not amenable to other forms of treatment. Histories of cases were given, showing how the hearing had improved, and, in cases where the discharge recurred, how much more easily and effectually its seat could be treated.

The committee appointed at the last meeting of the association to look into the question of interprovincial registration expressed their regret that, by the system which at present obtains, a graduate in one province is not free to exercise his functions in all the provinces of this large, but sparsely settled, Dominion; that this condition of things prevents the names of medical practitioners in this Dominion being placed on the British register, becoming thereby British practitioners, a boon which the Council of Medical Education of Great Britain has more than once signified its willingness to grant; with this end in view, that it is therefore most desirable that a uniform standard of medical education, and a uniform method of examination for the whole Dominion, be established. In order to effect this purpose, that the secretary be instructed to communicate with the various provincial councils before the next meeting, asking that each council discuss the position, and appoint one or more delegates to a Dominion committee, for the purpose of adjusting a suitable curriculum to carry out the suggestion herein contained, and that each committee be requested to forward their finding to each of the provincial councils and to the secretary of this association before the next annual meeting.

FIVE YEARS' EXPERIENCE WITH THE COLD BATH IN THE TREATMENT OF TYPHOID.

Dr. Wm. Osler read a paper with this title. He stated that he had not followed Brandt's method to the letter of giving the plunge bath to all cases. In markedly asthenic cases, in very mild cases, and in those with

*Will be published in THE CANADIAN PRACTITIONER.

serious complications, the bath was not used. These constituted 58 cases out of a total of 356. In the 298 bathed cases the death-rate was 6.3 per cent.; in the other cases 10.2 per cent. Of course it was not to be forgotten, in considering these statistics, that hospitals were given the worst cases. In the bathed cases no other treatment was employed except where there was cardiac weakness, when strychnia and alcohol were administered. The diet consisted of milk, or broths and egg albumen. The paper referred to the excellent general effect, as well as the antipyretic one, from the use of the baths.

A skin clinic was then given by Drs. J. E. Graham, of Toronto, L. Duncan Bulkley and A. R. Robinson, of New York. Of the patients presented, one had alopecia areata, two other psoriasis, and a third eczema seborrhœacum. Dr. Graham discussed the diagnostic points in the cases; Dr. Robinson, the pathology; and Dr. Bulkley, the treatment.

The members of the association were then entertained by the Kingston physicians to a seven-hour cruise down the St. Lawrence among the Thousand Islands.

Evening Session.

The evening session was held in the parlor of the Frontenac Hotel.

OPERATIVE TREATMENT OF INJURIES TO THE HEAD

was the title of a paper by Dr. A. J. McCosh, of New York. The essayist gave all the prominent features of the modern method of dealing with the cranial injuries, and reported the history of several interesting cases in which he had operated. Drs. James Bell, of Montreal; Geo. A. Peters, of Toronto; and W. W. White, of St. John, took part in the discussion.

The address in medicine was given by Dr. Edward Farrell, of Halifax, and dealt with the progress made in the different departments of medicine.

NEWER REMEDIES IN DISEASES OF THE SKIN.

Dr. L. Duncan Bulkley read a paper on this subject. The essayist said that he was rather slow in introducing the many newly vaunted remedies for the skin. He liked to stick to the old-time remedies. Among the newer remedies to which he referred was resorcin, ichthyol, theol, aluminol, beta-naphthol, europhea, aristol, cocaine, and others, pointing out the therapeutic use of each.

OBSTINATE DYSMENORRHŒA.

Dr. J. Campbell reported a case in which dilatation of the os was tried, local applications and electricity, but without avail. Finally a laparotomy was resorted to, involving removal of both ovaries and tubes, with complete relief to the patient. The only pathological condition to account for the trouble was a cystic condition of the ovaries.

"Hydatids" was the title of a paper read by Dr. A. Bethune.

THE IMPORTANCE OF EARLY TREATMENT IN CUTANEOUS CANCER.

Dr. A. R. Robinson, of New York, presented a paper. The speaker's presentation of the subject was a study of the pathological conditions found in epitheliomata of the skin. Charts were exhibited showing the method in which the neoplasms extended. There was an abnormal proliferation of epithelium. This proliferation was associated with the production of poisons which were injurious to the tissues. Then there was a change in the connective tissue with epithelial invasion by the lymph glands. At the first this cancer was a purely local disease, and progressed slowly, usually by reason of the resistance of the tissues. In this stage it was perfectly curable. It was a matter of regret that general practitioners allowed these cases to run on and on till it was too late for removal to save the patient. Too often they were dallied with by careless applications of silver nitrate, which only tended to materially aggravate the disease.

CACHEXIA STRUMIPRIVA*

was the title of a paper by Dr. Wesley Mills, of Montreal. It was illustrated by the presentation of two cats with both thyroids removed, and a dog with one-half the thyroid removed some four days before. The dog had passed his worst symptoms, and was improving. The cats were rapidly dying. They were greatly emaciated, having no desire for food; consequently they were scarcely able to walk. Tonic spasms of the legs were to be noted. The dyspnœa was marked. The paper dealt with the effects of removal on the blood plasma, and upon the leucocytes and red cells. The various theories of the functions of the typhoid were reviewed in connection with blood elaboration.

THYROID FEEDING IN CASES OF STUPOR

was the title of a paper by Dr. C. K. Clarke, of Kingston. In a number of patients whose histories he gave the effect was very pronounced, a permanent cure resulting. In other cases it failed. He had given as high as 20 grains of the extract at a dose.

Dr. Louis Sayre, of New York, gave a clinic on hip disease, presenting two children, one in the second stage, the other showing the third stage. He outlined his treatment of the disease, when in the first and second stage, to be the fixation of the limb in the position of ease, with extension, keeping the patient quiet in bed during the process of straightening, which might occupy a few weeks; then he would apply any approved fixation splint and let the patient go out into the open air.

*Will be published in October issue.

ACUTE URÆMIA, FOLLOWED BY GANGRENOUS ABSCESSES OF THE LUNG,

was a paper read by Dr. McPhedran. The patient was a man aged 52, who gave a history of vesical irritation for two years preceding the uræmic attack, which was sudden and severe. A large quantity of albumen was found in the urine. Free diuresis, diaphoresis, and catharsis relieved the condition. Two weeks after a gangrenous odor of the breath was noted, accompanied by slight cough. The sputum was also offensive, and contained elastic fibres. It passed off in a few days, and improvement slowly followed. Evidences of disease showed itself in the anterior surface of upper lobe of the left lung. During the winter he had recurrent attacks of hæmoptysis. The lung gradually healed, and general improvement followed.

Dr. Reeve read a paper, explaining the different parts in the construction of the ophthalmometer, and speaking of its great value in discovering the presence of astigmatism.

SOME PROPOSED CHANGES IN THE CANADIAN MILITIA SERVICE.

Dr. W. Tobin, Halifax, presented a paper on this subject. It recommended that militia medical officers should receive such instruction in military surgery, ambulance drill, and the routine of military medical administration generally, as would enable them to discharge satisfactorily their duties in the field and in military hospitals. It also advised the formation of bearer companies in localities where regiments were brigaded together, to receive aid in stretcher drill and first aid to the wounded.

Surgeon-Colonel O'Dwyer, principal medical officer of the Imperial forces in Canada, gave his experience of the departmental and the regimental systems, and approved of the formation of bearer companies.

On motion of Dr. J. H. Mathieson, seconded by Dr. Bethune, it was resolved to forward these recommendations to the government.

Dr. Webster, of Kingston, gave the history of a case of cerebral tumor* in an insane woman, whose mental derangement was due to the presence of the neoplasm.

"A Case of Nephrectomy" was dealt with by Dr. Ahern, of Quebec.

"Some Indications for Electrolysis in Angeioma and Goitre,"† by Dr. C. R. Dickson, Toronto.

"Hernia of the Vermiform Appendix," by Dr. R. W. Garratt, of Kingston.

After the usual votes of thanks, the association adjourned.

The members at the close of the session visited Rockwood Asylum and the Penitentiary, and were courteously received by the authorities of each.

The meeting next year will be held in Montreal.

*Will be published in THE CANADIAN PRACTITIONER.

†See page 644.

Book Reviews.

LESSONS ON PHYSICAL DIAGNOSIS. By Alfred L. Loomis, M.D. French revised edition. 8vo., 290 pages. New York: Wm. Wood & Co.

The tenth edition of this well-known and extremely useful text-book, while maintaining the many excellencies of former editions, is rendered more complete by the addition of a new chapter on chemical microscopy. In this article microscopic examinations of blood, urine, sputum, vomit, fæces are clearly described. Altogether, the book is to be recommended as an excellent guide in all forms of physical examination.

TRANSACTIONS OF THE COLLEGE OF PHYSICIANS. Philadelphia, 1894.

The College of Physicians of Philadelphia have collected and published in a neat volume of 300 pages the papers read during the year. There are exhaustive papers on "Acute Appendicitis," "Acute and Chronic Appendicitis," "Non-Albuminous Nephritis other than Typical Fibroid Kidney," "Hydrophobia in the United States." The book contains reports of many rare and interesting cases. There is a full report of discussion on registration of tuberculosis. The book is edited by G. G. Davis, M.D.

A SYNOPSIS OF THE PRACTICE OF MEDICINE. By William Blair Stewart. This volume of some hundred pages is certainly nothing more than the author claims for it.

However busy the practitioner may be, should he be deeply interested in his work, he will make more opportunities for reading than he finds. When, however, the opportunity does present he likes a readable book, which this cannot pretend to be. Fortunately, nowadays, students have ample time in a four or five years' course to read thoughtfully the excellent text-books suggested by the school calendars, and we believe that most intellectual students can review their favorite authors more rapidly and to better advantage than by resorting to an unfamiliar synopsis of many writers.

Whilst the work touches upon most of the cardinal points of treatment and diagnosis, it is so fragmentary as to the information it affords, and so monotonous in expression, that we doubt its usefulness to either the student or practitioner.

SURGICAL PATHOLOGY AND THERAPEUTICS. By John Collier Warren, M.D., Professor of Surgery in Harvard University, and Surgeon to the Massachusetts General Hospital. 832 pages. Illustrated. Subscription price, $7.00. Philadelphia: W. B. Saunders, 925 Walnut street.

The subject of Surgical Pathology is one that has not been over-written; it has rather been neglected. In the present work we have a classical treatise on a most valuable subject. The author, than whom no more competent person could have undertaken the task, has combined the pathological with the therapeutical aspect of surgery. This is of great advantage to the student in his reading, enabling him to study the cause and effect simultaneously with the removal of the result. The practitioner can reap a bountiful harvest of knowledge from its pages, since the study of morbid results has so vastly changed during the past few years, and in this work the matters treated of are up to date. No work on pathology that does not include bacteriology can be complete. The work in review opens with a chapter on bacteriology, dealing with its history and development, and following through the general means adopted to detect and recognize the same. This is followed by a chapter on surgical bacteria, and fully presents the *rôle* they play in the production of unpleasant sequences after operations, and also of those that are found in cases of tetanus, anthrax, tuberculosis, syphilis, etc., etc. The three succeeding chapters are devoted to hyperæmia, simpler infective inflammation, an intimate knowledge of which every practising surgeon should be possessed of. Process of repair, shock, pyæmia, septicæmia, etc., etc., are all elaborately described. We feel sorry that space will not allow of a more extended notice. No surgeon is thoroughly equipped who has not the work in his library; we know of no work in any language that is equal to it. The publishers have spared no expense in having the illustrations well done—they are a great aid to the text. The typography is beautiful and clear.

The following books and pamphlets have been received:

NARCOTIC ADDICTION. By Stephen Lett, M.D., Medical Superintendent of the Homewood Retreat, Guelph, Ont. Reprinted from *The Canadian Medical Review*, Toronto, July, 1895.

EVISCERATION OF THE EYEBALL. By L. Webster Fox, M.D., Philadelphia. Abstract of a paper read before the American Medical Association, Ophthalmic Section, held in Baltimore, May 7, 1895.

BURNS OF THE CORNEA; ELECTRIC-LIGHT EXPLOSION CAUSING TEMPORARY BLINDNESS; TRAUMATIC INJURIES TO EYES—HYPOPYON. By L. Webster Fox, M.D., Professor of Ophthalmology in the Medico-Chirurgical College, Philadelphia, Penna.

ADDRESS ON THE FOUNDING OF THE ILLINOIS HOSPITAL. By Seth Scott Bishop, M.D., Professor of Diseases of the Nose, Throat, and Ear, in the Chicago Summer School of Medicine; Professor in the Post-Graduate Medical School and Hospital, Chicago. Reprinted from *The Journal of the American Medical Association*, June 29, 1895.

Medical Items.

DRS. WALTER B. GEIKIE and Fred LeM. Grasett, of Toronto, have recently returned from Europe.

THE meeting of the British Association for the Advancement of Science for the year 1897, will be held in Toronto.

THE Mississippi Valley Medical Association held its twenty-first annual meeting in Detroit, Michigan, September 3, 4, 5, and 6.

DR. K. C. MCILWRAITH, who spent a year in the Hamilton General Hospital after graduating in the University of Toronto, has commenced practice in Toronto.

DR. G. S. GLASSCO, after spending a year in Europe, where he was engaged in post-guaduate work, has returned to Canada, and commenced practice in Hamilton.

DR. W. W. POTTER, of Buffalo, and Dr. L. S. McMurtry, of Louisville, Kentucky, paid a flying visit to Toronto, August 20, and were the guests of Dr. James F. W. Ross.

THE twenty-third annual meeting of the American Public Health Asso ciation will be held at Denver, Colorado, on Tuesday, Wednesday, Thursday, and Friday, October 1, 2, 3, and 4.

JOHN D. MCCONNELL, M.B.—The body of Dr. McConnell, who died in London, August 1, (as mentioned in our last issue), was brought to Toronto; and the funeral took place from his late residence on Dundas street to Thornhill, August 24.

THE fifth annual meeting of the American Electro-Therapeutic Association, was held in the building of the College of Physicians and Surgeons, Toronto, Tuesday and Wednesday, September 3 and 4. On the evening of September 4, a "reception" was given to the society by the profession of Toronto in the Athletic Club.

DR. W. OSLER, of Johns Hopkins Hospital, Baltimore, spent a few days in Toronto during the latter part of August. He had just completed the revision of his work on the "Practice of Medicine," and the second edition will soon be issued. The Appletons did remarkably well with the first edition, having sold in the neighborhood of twenty-five thousand copies.

SENATE ELECTIONS, UNIVERSITY OF TORONTO.—The following have been nominated as candidates, in the coming election for the Senate, to repre-

sent the graduates in medicine of the University of Toronto and the University of Victoria College : Drs. L. McFarlane, J. E. Graham, I. H. Cameron, W. H. B. Aikins, and A. H. Wright. The graduates in medicine are entitled to elect four representatives. Votes will be received by the Registrar, by post or otherwise, between Wednesday, September 11, and Wednesday, October 2.

THE MASSACRE OF MISSIONARIES IN CHINA.—It is melancholy to reflect that while Dr. Smyly, of Dublin, was participating in the business and pleasures of the annual meeting, his sister, Mrs. Stewart, and her children were the victims of the horrible massacre at Whasang. On that terrible 1st of August he was present at a large luncheon party at Sir William Priestley's house, and in the evening he went to the Ladies' reception at the New Gallery, unconscious of the awful fate which had befallen his sister that very day.—*Brit. Med. Journal.*

HOSPITAL SUNDAY AND THE MEDICAL PROFESSION.—While pleading the cause of London hospitals on Sunday in Westminster Abbey, the Rev. Canon Wilberforce did not omit to speak in words of high commendation of the fidelity and ability of the medical profession. Not only was allusion made to Sir Andrew Clark and others of our civil brethren, but a touching reference was also given to the noble services of an army medical officer, Surgeon Langdon, who, at the action on Majuba Hill, when seriously and afterwards fatally wounded, rendered aid to those requiring assistance. The medical profession owes a debt to Canon Wilberforce for bearing testimony to their thoughtfulness and self-denial under trying circumstances.—*British Medical Journal.*

TESTIMONIAL TO SIR JOSEPH LISTER.—Sir Joseph Lister will, on July 30th, be presented with his portrait, painted by Mr. J. H. Lorimer, A.R.S.A., at a meeting to be held at 4 p.m. on that day at King's College Hospital. The presentation will be made by Sir John E. Erichsen, President of University College. When Sir Joseph Lister retired from active hospital and teaching work last year, it was felt that the occasion ought not to be allowed to pass without showing in some tangible way the regard and esteem in which he is held by his former colleagues and pupils. The honorary secretary of the testimonial fund is Dr. J. Frederick W. Silk, 29 Weymouth street, Portland Place, W., to whom applications for admission to the ceremonial should be addressed —*British Medical Journal.*

OBITUARY.

A. K. MERRITT, M.B.—This bright and clever young physician died suddenly at the village of Mount Pleasant (Scotland P. O.), in the county of Brant, September 12. He took by mistake an overdose of strychnine, and died from the effects in half an hour. He was educated in the University of Toronto, and received his degree of M.B. in June last. He was an excellent student, at his final examination was first on the list, and received as a consequence the Faculty gold medal. He was deservedly popular with lecturers and students, and his untimely end is very deeply deplored. Drs. McKay, Sheahan, and Chapman, three of his fellow-graduates, went from Toronto to attend his funeral, which took place in Scotland, September 14. Dr. Chapin, of Brantford, another graduate of 1895, was also present at the funeral.

DAVID EARL BURDETT, M.D., M.R.C.S.E.—Dr. Burdett died at his home in Belleville, after a long illness, August 25, at the age of 67. He was born in Prince Edward county, Ontario, and received his degree in medicine from Trinity College, Toronto, in 1855. After practising several years he went to England for post-graduate work, and became, by examination, M.R.C.S.E., and Lic. Mid. R.C.P. Edin. He had a large practice in Belleville, and was also well known outside of medical circles. He was for a time a member of the municipal council, coroner for the county of Hastings, and surgeon-major to the Argyle Light Infantry. In addition to his widow and one daughter, who survive him, there remains one son, Dr. Harry Earl Burdett, who graduated at Queen's in 1886, and is now practising in St. Paul, Minn., where he holds a prominent position in the leading university of that city.

WALTER ROBERT GILLESPIE, M.D.—We have to record with deep regret the death of a very worthy young physician, Dr. W. R. Gillespie, which occurred at Penetanguishene, August 23. He took his medical course in the Toronto School of Medicine, and graduated in Victoria University in 1887 For a time he practised in West Toronto Junction, and, while there, had an attack of scarlatina, followed by acute Bright's disease, which finally assumed the chronic form, and caused his death. Shortly after his attack of acute nephritis, which did not appear to be serious in character, he went to Penetanguishene and entered into a partnership with his brother, and was able to do a certain amount of practice until a few weeks before his death. The remains were brought to Cannington, the home of his boyhood, and buried, August 28.

DR. EDWARD RUSH PALMER, of Louisville, Ky., died on the night of July 5-6, 1895, from the effects of an injury received in a bicycle collision while riding on the Third street boulevard in the city of his home. The accident occurred late in the evening of July 5, by which he was hurled headlong against the curbstone. He almost immediately became unconscious from a fracture of the base of the skull, and was taken to the Norton Infirmary, where he died at 12.30 a.m., July 6. Edward Rush Palmer was born at Woodstock, Vt., November 18, 1842. He served in military hospitals in Louisville and Lebanon, and at the end of the war returned home, where he entered upon the general practice of medicine. About ten years ago he abandoned his large family practice to devote himself to the specialty of genito-urinary surgery, in which he became celebrated. In 1868, he was chosen professor of physiology in his *alma mater*, and held a chair in that institution until he died. In 1893 he was elected president of the American Association of Genito-Urinary Surgeons, and attended its last meeting at Niagara Falls, May 29-30, 1895. It is not often that we are called upon to record such a painful incident in these columns. Dr. Palmer was a man who took great enjoyment in life, and, though turned well into the fifties, he was as fresh and vivacious as a boy in his 'teens, while yet strong in his well-ripened manhood. He leaves a wife, daughter, and two sons to mourn his untimely end. We publish in this issue a late paper from Dr. Palmer's ready pen.