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Original Communications.

KOCH LYMPH IN PRACTICE.

BY FRED. WINNETT, M.D., M.R.C.S. ENG., TORONTO.

1889. CASE I.—Nurse, æt. 19 years, suffered from anæmia and chlorosis; menses irregular; weak, indigestion and constipation. When a child was scrofulous. Some bones of hand removed and fourth finger. First metatarsal bone of left foot and right big toe, right elbow curretted. Occasional rise of temperature.

Oct. 24th.—Entered hospital and remained till Feb., 1890. Had hæmetemesis on three occasions. Acidity of stomach went up to $\frac{1}{10}$ of 1%. Stomach was washed out thirty-seven times. Took up work as nurse.

1890. Oct. 4th.—Entered hospital again. Lungs found intact. Lupus of nose, from which she suffered for seven years; had been cauterized five times, the last occasion was May, 1890. At present it appears healed, but surrounded by whitish nodules. Treated again with thirteen washes of stomach, and was going to leave, when Koch's remedy was introduced. To test if the lupus was cured, an inoculation was made.

Nov. 21st, 10 a.m.—0.005 c. c. injected. 6 p.m.—Resp. 42; temp. normal. 10 p.m.—Resp. 34; temp. 38° Centigrade.

At 8 p.m., while temp. was normal, nose presented the appearance of erysipelas. The nodules grew to be projections; the nose was of a dark red and nodules of a bright red, and were normal before nodules sprang up in region of cicatrix. Temp. fell next a.m. 37.8°.

Nov. 22nd.—Larynx, which was before normal, showed a characteristic tubercular ulcer on the first tracheal ring and patient complained of pain

in right chest. At this point, corresponding to lower portion of scapula, very harsh vesicular breathing. Patient, who never had sputum, now had 100 c. c. purulent nummulated sputum, but, in eight preparations of large slides, no bacilli.

Nov. 23rd.—Temp. normal; resp. normal. Found dulness at this point, corresponding in area to size of palm of hand. This dulness did not reach to base of lung, and over it were found small crepitant râles.

24th.—She has less cough, and no more sputum; dulness less intense, râles still audible.

25th.—Reaction on nose lessening, since lung changes less evident. 0.010 injected. In morning temp. was normal. Dulness gave way to tympanitis; râles only occasional. At no time did we hear bronchial breathing. 3 p.m.—Rigors; resp. 60; pulse 138; temp 38°. Extreme constitutional disturbance. Renewed cough and expectoration of same purulent character. 12 p.m.—Temp. 40°; dyspnœa less; pulse 120.

26th, 9 a.m.—Temp. 38.5°; resp. 42, feels better. Reaction continued till 6 p.m. 6 p.m.—Dyspnœa; resp. 68; temp. 36.5°; pulse 110. Moist râles appeared at base of right upper lobe. Dulness is again increased, but not so marked, and complains of cardialgia. This time there is bronchial breathing. Lupus of nose shows swelling, but not equal to first injection.

27th.—Bronchial breathing; distant and near crepitation occasionally. Dulness giving way to tympanitis.

30th.—Dulness no longer present; no râles found.

Dec. 2nd.—0.005 c. c. injected at 10 a.m. 4 p.m.—Resp. 60; expectoration renewed, slight dulness at angle of right scapula. 9 p.m.—Temp. 39.3°; resp. 68; occasional râles at right apex. No bacilli found.

3rd, 8 p.m.—Temp. normal; resp. 72. Headache; pain in larynx, which showed redness of inter-arytenoid fold. No ulceration to be seen; vocal cords normal. Exanthema, resembling measles, appeared over the whole back, with a few reddish spots on abdomen. Nose less swollen. In nostrils, little ulcerations near external opening, covered with white epidermis, appeared. Complaints of extreme lassitude.

5th.—No signs of exanthema. Pleuritic friction felt at right scapular region, reaching to side

of thorax. Has some expectoration, but in four specimens found no bacilli.

6th.—At left base of uvula a patch appeared, showing a whitish membranous covering, which was thrown off in two days, leaving an ulcer which was healed by Dec. 5th.

8th.—0.003 c. c. injected, and no rise of temp., but resp. 64. Pain in larynx; upper surface of right arytenoid body swollen more than left, but no change in color, or ulceration. Tendency to cough; no sputum. Slight constitutional disturbance.

10th.—0.003 c. c. injected. Temp. normal; resp. normal. Night sweats absent; feeling of a cold in nose. Pains renewed in right base.

12th.—0.005 c. c. injected. No reaction, and temp. pulse and resp. normal. Limbs weak.

Weight.—Before treatment, 105 lbs.; after first, second and third injections, 97 lbs.; during last ten days, with small reactions, 99 lbs. No albumen in urine; spleen always normal.

Dec. 15th.—0.005 c. c. injected. No reaction.

17th.—0.007 c. c. injected. No reaction.

REMARKS.—This patient has every indication of a permanent cure being effected.

1890. CASE II.—Painter, æt. 24. Mother died of pneumonia, tubercular; father died of consumption; one brother alive and healthy. As a child, had typhoid fever, measles, scarlet fever; never had scrofulous glands. Present trouble commenced in Sept. of this year, with cough and expectoration. At end of Sept., hæmoptysis (a cupful); end of Sept., for fourteen days, complains of night sweats, chills in evening, and fever. Present complaints are cough and pain in chest on deep inspiration. Strongly built, good muscular system, face flushed, skin brownish, and slight indication of lead line. Pulse regular, 72; appetite and thirst normal; tongue coated, liver normal size, thorax well built.

Supra and infra clavicular fossæ of left side give, on percussion, a shorter and higher note than on right side. This is also the case in supra and infra spinous fossæ on left side. Behind from body of seventh vertebra on left side, percussion note is shorter than on right side.

On auscultation, left anterior apex, bronchial respiration. Below clavicle, anteriorly on left side, soft bronchial breathing, with numerous small sized râles at height of inspiration. Behind, on left side, evident pleuritic friction, particularly

from seventh vertebra downwards. Breathing at this point is weaker than on right side. Heart normal. Vital capacity 2000 c. c. Tubercular bacilli in large numbers.

Nov. 6th.—Small ulceration on left arytenoid body, inner side.

10th.—Percussion note, left apex, shorter. Left supra spinous fossa, bronchial breathing and râles. In left supra and infra clavicular fossæ, soft bronchial inspiratory breathing, and not very numerous râles. Post. left lower lobe still shows shorter percussion note and weaker vesicular breathing than right side. During all the time observed (Oct. 13 to Nov. 18) had night sweats only twice.

18th, 8 a.m.—Injected 0.002 c. c. 6 p.m., temp. 38.6°; 7 p.m., temp. 39.3°; 8.30 p.m., temp. 39.5°; 10 p.m., 38°. During reaction, face flushed and complains of feverishness, pain in left leg. Has slight exanthemata in face, itching, sweats severely. Pulse dirotic, conjunctivæ reddish; complains of pain in left chest.

19th, 7 a.m.—Temp. 37.5°. Feels well.

20th, 9 a.m.—Temp. 36.4. 0.003 c. c. injected. Vital capacity 1800 c. c. Shows no particular reaction, except face, which in evening shows reddish spots. Sputum is increased 4 c. c. At inner side of left arytenoid body, have discoloration of mucous membrane.

22nd.—0.005 injected. Sputum is increased to 60 c. c. Bacilli found without morphological change. No temperature reaction.

23rd.—No fever; complains of pain in neck, oppression of chest. On anterior commissure, mucous membrane shows some whitish prominent patches. No distinct swelling surrounding it.

24th—0.008 injected. Temp. 38.5°. 4 p.m.—Complains of pain in neck, and this time ulceration of right arytenoid body is noticed. Both vocal cords injected. Epiglottis pale.

25th.—Temp. normal. Redness of larynx decreased. Sputum increased to 60 c. c.

26th.—0.001 injected. Temp. normal. The nummulated sputum appears mucous and is decreasing 30 c. c. Vital capacity 1700 c. c.

27th.—Exanthemata of face, very apparent. Evident ulceration of right arytenoid body and ulceration of vocal cords. Sputum 10 c. c.

28th.—0.005 c. c. injected; slight reaction. Complains of pain in back and shoulders. In six preparations, one bacillus found.

30th.—Dulness in lower apex is present. True bronchial breathing is hardly to be heard. Very occasional moist râles. Particularly evident in infra clavicular fossa. 0.020 c. c. injected; slight reaction. Vital capacity 2200 c. c. Sputum 40 c. c.

Dec. 2nd.—0.025 c. c. injected. Sputum 30 c. c. Catarrh of larynx receding and ulceration no longer evident.

3rd.—Anterior pillar very red and shows large number of whitish spots, which Gerhart considers herpetic.

4th.—0.030 c. c. injected. Temp. 38.1°. Sputum 20 c. c.

5th.—Vocal cords greatly injected and ulceration more evident.

6th.—0.040 c. c. injected. Temp. normal. In four preparations, no bacilli found. Sputum 20 c. c. Patient feels well.

10th.—0.060 c. c. injected. Sputum 20 c. c. Exanthemata of face. Vital capacity 1950 c. c.

12th.—0.070 c. c. injected. Percussion note on left side is hardly distinguishable from right. Bronchial breathing not heard; occasional râles. Sputum 20 c. c.; evident reaction. Bacilli few, in one specimen.

16th.—0.080 c. c. injected. Sputum 10 c. c. Feels very well.

Weight, Nov. 18th.—63 kilos. Dec. 16th.—66 kilos. Urine shows no albumen. Night sweats entirely gone. Sputa very scant. Small ulceration on third tracheal ring noticed.

1890. CASE III.—Seamstress, æt. 19. Entered hospital Nov. 17th. Mother died of tubercular pleurisy; father died of accident; one brother alive and healthy. Lost four members of family from phthisis—three sisters and one brother. As a child, had measles and diphtheria; never scrofulous. Menses regular since fifteen years. No abortions or childbirths; anæmia for five years. Felt well, and did general housework till two years ago, when she began to work as seamstress. For one year had pain in right chest; since then, also cough—dry and hacking—but no expectoration. About ten weeks previous to entrance, had an affection of lungs, lasting eight days, with high fever, right pneumonia. Since then cough has greatly increased, expectoration set in, and night sweats. Never had hæmoptysis, and previous to Sept., no night sweats. Appetite poor.

Complains of extreme general weakness, loss of

appetite and pains in right chest, cough and expectoration. Suffering expression of face, weakly built, small woman. Skin white, anæmic, not dry; had no exanthemata. Conjunctiva and lips anæmic; tongue coated. No infiltration of glands; slight dyspnoea. Apex of left lung, anteriorly, was two fingers' width above clavicle; right apex, anteriorly, one finger above clavicle. Dulness of right apex extending to fourth dorsal vertebra, posteriorly. Left apex had harsh vesicular breathing, with sonorous râles; right apex showed distant bronchial breathing and many moist râles, and occasional metallic click. Over left clavicle, dulness, and here, too, slight bronchial breathing. Right apex consolidated to second rib. Right side, below clavicle, shows tubular breathing and râles. Right lower limit of lung shows no movement on respiration. Heart normal, with systolic, anæmic murmur. Spleen normal. Laryngoscope shows no change. Bacilli found in large numbers.

Nov. 24th, 10 a.m.—0.002 c. c. Koch's lymph injected between shoulder blades. 5 p.m.—Chill, pain in right chest increased, nausea, headache, dizziness and vomiting. 6 p.m.—Temp. 39.5° C.; resp. 24; pulse 120. Sputum is increased, but not the cough.

25th.—Pain in chest, but feels well otherwise. Both arytenoid bodies show discoloration. Afternoon temp. 39°.

26th, 11 a.m.—0.005 c. c. injected. 12.30 to 2 p.m.—A chill. 4 to 5.30 p.m.—An intense chill; nausea, and tendency to cough; expectoration doubled, and more mucous; no sweat, feverish. Lungs—dulness increased three fingers' width. Right anterior apex very dull, and tubular breathing and consonant râles also anteriorly.

27th.—Lungs like the day before; expectoration increased.

28th, 9.30 a.m.—0.008 c. c. injected. Dulness on left side one centimetre deeper than on previous day. Tubular breathing does not extend down as far as dulness. No change in larynx. At night, retching and vomiting.

29th.—Left apex shows vesicular breathing, no consonant râles, and dulness is less extensive by several centimetres than on the 26th.

30th.—Bronchial breathing over left apex anteriorly, to-day, is not to be heard, but harsh and vesicular; no consonant râles. Dulness receding. 10 a.m.—0.001 c. c. injected. 4 p.m.—Chill and

reaction. Dulness under right clavicle, becomes marked and persists till next morning.

Dec. 2nd, 9 a.m.—0.001 c. c. injected. 3 p.m.—Reaction. 6 p.m.—Temp. 39.8°, accompanied by slight dyspnoea and vomiting.

3rd.—Feels perfectly well. p.m.—Over infiltrated right anterior portion—so-called Gerhart's sign.

4th.—0.015 c. c. injected. Lung changes, show more recession. 9 p.m.—Resp. 60. Patient weakening.

Weight, Nov. 20th.—81 lbs.; 24th, 77 lbs. = 4 lbs. lost in four days.

Dec. 3rd.—After five injections, 75 lbs. = 2 lbs. lost in nine days.

Dec. 5th.—Patient shows very high fever in evening; without injection, temp. 39.2°. Sleeps well, sweats in morning; complains of loss of appetite. Bacillus tuberculosi plentiful, but show changes in form, compared to bacilli before injection.

Dec. 6th.—0.015 c. c. injected. 6 p.m.—Temp. 39.5°. 9 p.m.—Intense dyspnoea; resp. 72. Great pain in chest; retching and vomiting.

7th.—Hardly any fever; temp. 38.2°.

8th.—0.015 injected. 6 p.m.—Temp. 39.4°; resp. 54. Can find no cause for dyspnoea. Complains of more pain in lungs.

10th.—0.015 injected. Temp. 38.6°. Hardly any dyspnoea. Pulse 140.

11th.—Out of bed again. In evening, without an injection, temp. 39.7°; sleeps little, extremely weak. At right base in axillary region, percussion note shorter than on left side; mucous râles.

15th.—No changes.

REMARKS.—In considering this case, it should be remembered that the sanitary arrangements of Charité Hospital belong to last century. There is practically no ventilation and the atmosphere of the wards is disgusting. The diet is not much better, and I append it:

Breakfast.—7 a.m.—Coffee, one small roll, one piece brown bread. 9 a.m.—Bacon (small piece), butter, one pint beer.

Dinner.—Hash (rice or beet with prunes), and in this a piece of boiled meat.

Supper.—Soup (farina or oatmeal), no meat, coffee.

VESICO-VAGINAL FISTULA, PRODUCED BY A ZWANK'S PESSARY; OPERATION AND CURE.

BY DIXON C. ALLAN, M.D., AMHERST, N.S.

During the summer of 1888 I was consulted by a prominent lady of this country supposed to be suffering from "disease of the kidneys." She was upwards of sixty years of age, the mother of six children, had been very robust and enjoyed the best of health until the commencement of her present trouble, now more than a year ago. She had, however, for some time previous to this been troubled with what she was told to be "falling of the womb," and for the relief of which she had been provided with a pessary—Zwank's. This she had worn for a number of months, and it gave a great deal of comfort, at no time producing the slightest pain or inconvenience. The present trouble commenced, to use her own words, "over one year ago, when in the act of walking across the room her water suddenly fell from her." From that day to the present time, summer and winter, day and night, her water had continued to flow from her constantly, keeping her clothing wet, producing, despite the utmost care, itching, irritation and scalding of the privates, buttocks and thighs, giving rise to a disagreeable odor, all of which combined, had made her inexpressibly wretched and disgusting to herself, her family and her friends. Moreover, she had suffered great depression of spirits, and a decided falling off in health and strength.

She had consulted medical men in reference to her condition, and for the last six months had been under the care of a local celebrity—a graduate of the University of Pennsylvania and an L.R.C.P., etc., Edinburgh—who among other things had given her a long course of "Warner's Safe Cure," for what he told her was diabetes!

An examination was proposed, but the patient "not having dreamed that such a measure would be necessary," and being a refined and modest lady, it was not until much explanation had been made that she finally submitted to the requirement.

Inspection discovered dermatitis effecting the thighs, nates and vulva, the labia being excoriated and swollen. The urethral outlet was shrivelled and firmly agglutinated, nothing having evidently

passed it for a long time. Digital examination found the vagina tender, but normal in its anatomical relations, and the cervix uteri the same, while in front and a little to the left of the latter, occupying the vaginal junction, an opening which admitted the tip of the finger was easily recognized. By the use of the speculum and sound this proved to be a vesico-vaginal fistula. The opening was about three-fourths of an inch in length, and a little less than half as much in breadth, its borders rather thin, indurated, smooth and pale. The patient was informed that an operation afforded the only hope she had of benefit; and its full consequences, possibilities and probabilities were carefully explained. After consulting with her husband and family an operation was decided upon. Some time was occupied in placing the parts and system in as good condition as possible, and when this had been accomplished, assisted by Drs. Robert Mitchell and E. H. Lowerison, I proceeded to operate.

The patient was placed upon a table, etherized and secured in the lithotomy position, Sim's speculum and retractor introduced, and a strong silk thread passed through the cervix—by which to pull the uterus down—and so bring the fistula to light. This we expected to easily accomplish from the history of prolapsus ("falling of the womb").

But in this we were only partially successful, as the uterus was very firm in its position, and from this fact and other reasons we concluded that her former difficulty had been due to cystocele and not prolapsus; and subsequent events tended to substantiate that opinion. We were consequently compelled to use the Sim's speculum and retractors; but the uterus was still held down as much as possible by means of the cord to which a weight was attached and allowed to hang over the foot of the table, thus saving the hand of an assistant for that purpose. The borders of the fistula were pared, being well levelled at the expense of the vaginal wall and underlying structures, down to the mucous membrane of the bladder. The bevelled margins of the fistula when completed, presented a denuded surface about one-third of an inch wide all round the orifice. This part of the operation was performed with a Sim's bistoury and forceps. Sponges were not used very freely, but a boro-salicylate solution was frequently played upon the wound from an irrigator arranged for

that purpose. The fistula was then closed by nine points of silk-worm gut sutures; the proper needles—curved and without cutting edges—being employed for the purpose. The patient was placed in bed, and a self-retaining catheter, to which a rubber tube was attached, leading to a vessel beneath the bed, was introduced.

Although every precaution was observed to avoid injury to the vesical mucous membrane, nevertheless for the first twenty-four hours the urine was tinged with blood, and the catheter had to be twice removed during that time on account of its being stopped with clots. Furthermore, the catheter produced considerable pain and irritation in the urethra and neck of the bladder, and led to the conclusion that the constant retention of the instrument was of doubtful utility.

The patient who was much reduced and quite weak at the commencement of the operation, manifested considerable prostration for some hours afterwards, and on the second day suffered from a complete suppression of urine for the space of twelve hours. It was not retention, as not a dram of urine was secreted during that time. I could not ascribe any cause for this, other than the effects of the ether. Chemical and microscopic examinations of the urine had given no evidence of any renal affection. The patient's condition was serious during this period, but it ultimately yielded to active treatment and the urinary secretion again became established.

From this time forward there was satisfactory and progressive improvement.

On the fourth day the catheter was removed and only used as occasion required, which was for a space of about a week, during which time there was both, some retention and incontinency. After this the urine was under the patient's control, and could be held comfortably and passed at will.

On the eighth day the stitches were removed, and the fistula found to be completely closed—not a drop of urine passing from the time of its closure, so far as could be ascertained.

Warm vaginal injections of creoline, which, as a matter of course, were used from the first, were continued throughout.

A week later a few granulating spots occupying the site of the wound, were touched with nitrate of silver, and in a few days more all was

thoroughly cicatrized, and the cure complete. Two months afterwards the patient complained that the "falling of the womb" was again troubling her somewhat, and an examination showed the difficulty was due to cystocele. For this, astringents and a Skene's cystocele pessary were used, and from then until the present, the patient has been very comfortable and regained considerable flesh and strength, and her general health has greatly improved.

The main objects of reporting this case are:—The necessity is shown of making a correct diagnosis—a very easy matter truly—also that such unfortunate cases may haply be benefited by an operation under even unpromising circumstances; and that the operation does not require an expert or specialist for its successful performance; and it is also a warning-against allowing the management of pessaries to pass into the hands of patients, particularly such faulty ones as Zwank's, and others of equally bad construction.

CASE OF INVERSION OF BLADDER OF TWELVE YEARS' STANDING.

BY DR. N. E. MCKAY, M.R.C.S. ENG.,

Surgeon, Victoria General Hospital, Halifax, N. S.

C. C., æt. 13, was admitted into the Victoria General Hospital on the 9th day of August, 1890, suffering from inversion of the bladder.

Family history.—Sister has hip-joint disease. Father is now in hospital suffering from vesical calculus.

History of illness.—When patient was about 9 months old she suffered severely from prolapsus recti, which lasted off and on for a year. Having lived in a remote part of the country where the services of a medical man could not be easily obtained, she received no treatment for the trouble. From her birth her urine dribbled away constantly. When suffering from the prolapsus recti and its concomitant tenesmus, a tumor suddenly appeared at the vulva, which did not increase in size with time. It never went away until a month before patient was admitted, when, one morning as she was getting up, it suddenly disappeared, but it returned in the afternoon of the same day.

Present condition.—Patient is emaciated and pale, but otherwise is apparently in good health. On examination, a semi-elastic tumor the size of a large hen-egg, pyriform in shape, is found protruding from the vulva; its base is directed forward, and it is attached by a large pedicle to the arch and rami of the pubic bones. The tumor is very florid and is covered with a grayish gelatinous mucoid substance. There is complete absence of clitoris, meatus and urethra. On the under surface of tumor in the mesial line, near its pubic attachment, a small opening is perceptible, surrounded by a cluster of small tubercles, from which urine dribbles away constantly, and through which a size 10 female catheter-bougie is easily passed to the extent of eight or nine inches and urine withdrawn. On closer examination, a slit-like opening is discovered on left aspect of base of tumor, from which dirty-colored urine is easily drawn.

The abnormal condition of parts interfered with our obtaining urine in quality and quantity, by which we could determine the condition of her kidneys.

Treatment.—On the 13th August I returned the bladder, under an anæsthetic, by gentle digital pressure. The fingers being first well oiled with carbolized oil, the meatus was greatly dilated, large enough to admit two fingers. To lessen its calibre, I vivified the mucous membrane on either side and brought and held the freshened surfaces together with silver sutures, two on each side; then dusted pad with iodoform and applied a pad of cotton wool with a T bandage to prevent recurrence of the inversion. The wound was dressed two or three times a day *pro re nata*.

From the 13th day of August, the day of operation, till the 17th, patient's temperature ranged from 97° to 99½°; general condition fairly good. From the 18th until the 21st, temperature gradually rose to 101°, when she complained of pain in left iliac region. This did not create any undue alarm, as she had a similar pain in same place at different times before. On the 18th, the wires were removed and wound looked well. From 21st till 24th, temperature ranged between 97° and 101½°. On the 25th she fell into collapse; temp. 97½° to 96°; pulse weak and thready; in which condition she remained until the morning of the 26th, when she died.

Post-mortem examination.—Bladder *in situ* and

greatly distended and thickened; urethra and clitoris completely absent; both ureters greatly distended and their walls thickened; both kidneys completely disorganized and flattened out like a pancake. The cortical and medullary substances are completely riddled with pus cavities; each pus cavity is surrounded by a thickened adherent pyogenic membrane, and the pelvis of both kidneys is full of purulent material.

The rareness of inversion of the bladder is my only excuse for publishing a report of this case.

Correspondence.

To the Editor of the CANADA LANCET.

DEAR SIR,—Considering the universal importance of the recent discovery of Prof. Koch of the treatment of tubercular affections, it may be of interest to your readers to learn the results of experiments up to the present. Speaking generally, it may be affirmed that Prof. Koch has not over-estimated the importance of his remedy. While it remains in the experimental stage in the human patient, it must needs be crude and blurred by occasional fatalities. It is likely to be no exception to the rule that much practical knowledge is to be gained by careful investigations, before such a potent remedy can be used with impunity. Several thousand patients are at present under observation, and useful information is rapidly accumulating. In lupus it has passed the experimental stage and many cures are to be seen at the hospitals. In pulmonary consumption, the injections are given in much smaller quantities, and this necessitates a longer interval before a curative dose is arrived at. In from three to four weeks' time many cases of consumption will have undergone the course, and until then opinions must be very guarded. Yet incipient cases appear cured and many advanced ones benefited. Some forms are only slightly affected by treatment. Prof. Bergman is enthusiastic and at the polyclinic showed us numerous cases of tubercular joints and glands greatly improved and incipient ones cured. Dr. Lennox Browne, of London, a throat specialist, strenuously advocated the method, and at the Charité Hospital here we saw a typical tubercular ulcer of the larynx heal in less than a week. As a means of diagnosis it is very important, for

while an injection, say, of 0.001 c. c., gives no reaction in the non-tubercular patient, it on the other hand produces a decided impression in the tubercular, even when lying dormant. This is demonstrated in the case of a nurse in the Charité Hospital, who, when young, suffered from a tubercular disease of the bones of the hand and foot, and for the past seven years from lupus of the nose, which was apparently cured. The lungs were examined repeatedly, but found intact. At her own suggestion, 0.005 c. c. of the lymph were injected, with the result that in ten hours the nose presented the appearance as if an acute erysipelas had been implanted upon it, and next day a tubercular ulcer appeared in the trachea and signs of consolidation in the right lung, accompanied by free expectoration, fever and dyspnoea. This proved the presence of tubercle in these several places. The injections were repeated at intervals up to the present, when 0.005 c. c. produces no reaction, and the nose and throat are healed.

The importance of the discovery can be best estimated if we consider that one-half of all deaths in Great Britain, between the ages of fifteen and thirty-five, result from tubercle.

A new era has undoubtedly arrived in the practice of medicine, of which this is but the prelude to other triumphs of a similar kind. Already, indeed, immunity from diphtheria and tetanus is reported in the lower animals by inoculation, and no doubt cancer will soon succumb to treatment.

At this point the oft-mooted question forces itself upon us—whether, namely, the human race actually benefits in the long run by those artificial checks upon the operation of natural selection? Manifestly, by artificially rescuing from death those who are prone to disease, we increase the racial predisposition thereto and lower the standard of health. This artificial interference with the operation of natural selection is insignificant when compared with the workings of nature. But with regard to tubercle, it is no doubt more frequently the result of unfavorable external conditions than of inheritance, and we have abundant reason to believe that—by means of the destruction of the breeding-grounds of phthisis and by improved hygienic measures, together with proper precautions against infection—this hereditary tendency to the disease would die out in a few generations and that a healthy race would survive,

free from tubercular taint and endowed with the vivid intelligence and bright social attributes which are well known to be so common amongst those who now often succumb to the disease, and that we may look forward to its ultimate extinction as a cause of death.

FRED. WINNETT, M.D., M.R.C.S. Eng
Berlin, Jan., 1891.

Reports of Societies.

BALTIMORE GYNECOLOGICAL AND OBSTETRICAL SOCIETY.

DECEMBER MEETING.

Vice-President, Dr. Charles H. Riley, in the chair.

Dr. Wm. E. Moseby related the following case: Mrs. Maggie G., a light-colored woman, about 30 years of age, twice married, had had two children by her first husband. Had suffered much during the past twelve years from dysmenorrhœa; had been unable to do ordinary work.

Examination showed the uterus to be retroflexed and firmly bound down, but the character of the adhesion could not be definitely made out. There was an irregular-shaped elastic mass in the position of either tube, diagnosed as cystic ovaries, together with chronically inflamed tubes. All the pelvic tissues were very sensitive to pressure. There was a deep, double laceration of the cervix, and a lacerated perineum, with very lax vaginal wall, but only slight rectocele.

When the abdomen was opened the mass on either side of the pelvis was found to be composed of a cystic ovary, and the corresponding tube firmly matted together by old organized adhesions, each mass being firmly bound down to the pelvic wall by numerous old and many more recent adhesions. There were also adhesions to the omentum. The left ovary ruptured before it could be removed. The mass in the right side appeared to be a large hematosalpinx, but examination proved it to be an ovarian cyst into which blood had entered from a ruptured Graafian follicle. The adhesions behind the uterus were very broad, strong bands, and were pulled off the uterine wall. All possible care was used to secure

the patient against hæmorrhage, and the abdomen¹¹ was douched out with hot boiled water until the uterine flow was practically colorless. A glass perforated drainage tube was introduced to the bottom of the *cul de sac*, and the incision closed above it. The extreme difficulty of separating the adhesions and the douching prolonged the operation to about one and a-half hour.

Although stimulants and artificial heat were pushed, no reaction could be obtained, the temperature never reaching 95°, and the patient died about six hours after the operation, apparently from shock.

At no time was there any discharge of blood from, or even bloody fluid from, the drainage tube. Dr. W. G. Keirle, however, kindly examined the pelvic cavity post-mortem, and reported that death was due to hæmorrhage, the exact source of which could not be made out.

Dr. J. Whitridge Williams, kindly furnished the pathological report, which will be given below.

Dr. Thomas Opie exhibited a placenta that he had gotten a few hours before the meeting, from a case of placenta prævia.

The patient was 35 years of age, and had borne one child previously. When he saw her first she was blanched and exsanguinated. The blood-flow began three days before, with a loss of a quart, and continued with more or less rapidity up to the time of operation. Her confinement was not expected for two months. When first seen by him there were some rhythmical pains, and some dilatation. The cervix was dilated with the fingers and cone of the hand; the placenta was detached with a sweep of the forefinger around the cervix; the bag of waters was artificially ruptured and traction forceps applied. The child was delivered in fifteen minutes without further loss of blood, the placenta coming away simultaneously with the birth of the child. Though the position was occiput posterior, there was no laceration of the perineum, and the child was unscathed. Both mother and child were left doing well.

Dr. Opie also exhibited a specimen of an ovarian tumor which he had recently removed. The tumor had developed into the epigastric region, and the abdomen was about as large as it would have been at the full term of pregnancy. It took two hours to break up the adhesions, which were

very dense between the tumor and the intestines, and between the tumor and the omentum. The second tumor was taken from the pelvis. It was ovoidal in form, about seven inches in length, by five inches wide and four inches thick. It was removed entire, and upon section it proved to be a dermoid growth. There was no history of peritonitis to account for the extensive adhesions. The patient had never had a day's discomfort other than from the size of the cyst. She did not know until four weeks ago that she had a tumor. The material in the large cyst was colloid. Notwithstanding the extensive adhesions, the length of time consumed in breaking them up, and the injury resulting from the operation, the patient has made a good recovery, this being the seventeenth day after the operation.

Dr. Howard A. Kelly: The term colloid is often used in two senses. An incorrect use, describing the yellowish, more or less opalescent, thick, viscid materials, often found in ovarian cysts; it is employed in such cases, as more or less synonymous with gluey. The other use of the term is to describe a rare condition, in which the contents of the cyst are more like calf's-foot jelly, and have a vitreous fracture; they are with great difficulty removed, clinging to everything. This latter is true colloid, and when found such tumors are of a suspiciously malignant character. We should limit the use of the word to the latter condition.

I wish to refer to two minor matters of interest supported by this specimen of placenta prævia. The position which the placenta has occupied in the uterus can accordingly be determined by the position of the opening in the membrane made by the passage of the child, inasmuch as the fundus uteri must of necessity be just opposite to this perforation; we can, therefore, by re-constructing the membranes see just in what part of the uterus the placenta lay. In one of my placenta prævia cases there was no hole at all in the membranes, as I had extracted the dead child through a perforation in the placenta. We can do still more than this in the way of a diagnosis with the membranes. By allowing them to be expelled untouched into the bed and carefully observing their exact position, we can tell as well on which side of the uterus the placenta was attached.

The second point is, that we may have placenta

prævia hæmorrhage without being able to detect a placental margin, owing to a low attachment of part of the placenta, near the internal os, below the contraction ring, but not over the hole of the cervical canal. The lower part of a placenta thus attached 'is separated by the opening up of the lower uterine segment.

Dr. L. E. Neale said: although Dr. Kelly had alluded to a point of some interest, it is of far more practical importance to recognize placenta prævia prior to its expulsion and as far as he knew this could only be done with certainty by digital examination; partial placental separation and rupture of the membranes during labor in cases of placenta prævia was outlined by Mariceau as early as 1668, but was fully described by Puzos in 1759; he saw nothing in the history of the present case as related by Dr. Opie that contra-indicated the method of Broxton Hicks, a method that up to the present time had given by far the best results—viz., $4\frac{1}{2}\%$ maternal mortality. If this method when practicable could be performed earlier than delivery by any other method, and was not difficult, and gave the best results, why not have applied it in the present case?

Dr. Wilmer Brinton asked why Dr. Opie objected to the tampon in cases of placenta prævia; he thought no arbitrary law could be applied.

Dr. Opie said in closing the discussion that results of operative procedure depended largely upon the skill and familiarity of the operator with the special operation resorted to; in his first case of placenta prævia he had attended, he had turned and lost both mother and child. With rapid dilatation and forceps he feels that he has command of the situation, and having resorted to that method repeatedly, has gained greater skill and does better work. While Dr. Neale might do better by some other method, he is fully satisfied that he does best himself with the forceps; he is opposed to the use of the tampon because it conceals what is going on; it is not best to wait for pains. He is in favor of rapid dilatation and delivery in placenta prævia, in puerperal eclampsia and in abortion; to put in a tampon and go away is hazardous; the tampon is of very little help in hæmorrhage.

Dr. Kelly read a paper upon, "The Examination of the Normal Pelvic Viscera"; describing various new dimanual and trimanual methods of palpating the normal ovary.

Dr. Wm. Church: When speaking of what should be found or can be found at an examination, it is necessary to consider the circumstances under which the examination is made. Office examinations are the most usual, and all the facilities are not usually at our command, and this circumstance should be specified and taken into account. Certain advantages in methods give certain advantages in results. Of course when the woman has no ovaries, or when the ovaries are not in the pelvis cavity, they cannot be palpated.

Dr. Hunter Robb: I thoroughly agree with Dr. Kelly that the normal ovary can always be palpated under an anæsthetic, and also that in a large number of patients the ovary can be outlined without anæsthesia. Four years ago Dr. Kelly taught me the method of examining the ovary by invaginating the perineum, and I can testify to its utility. This lengthens out the examiner's finger and thus enables the practitioner who has a short finger to accomplish it with almost the same facility as a longer one. The corrugated tenaculum devised by Dr. Kelly may be used to advantage with nulliparous patients to define the uterus and its appendages still further. No one, of course, would think of using it in inflammatory conditions of the pelvic cavity.

Dr. B. B. Browne said that he had listened with much pleasure to Dr. Kelly's paper, and congratulated him upon the admirable manner in which he had systematized these valuable methods of pelvic examination,—methods which most of us had been using in our gynecological practice for several years. He generally preferred the use of two fingers in the vagina, as he could thus make a more satisfactory examination of the tubes and ovaries than with one finger. In many cases a more accurate idea of the adhesion can be had by getting the fingers about the ovary and fixing it between the fingers and the spinal column; pulling down the uterus aids diagnosis very much.

Dr. Opie said that there were few objections to Dr. Kelly's paper, but it seems that the elbow on the hip is incompatible with delicacy of touch. The law, as expressed by Martin, being—"The more lightly the parts are touched the easier the goal is reached, and the less the force that is employed, the more distinctly things are felt." He thinks it is a cruel sort of thing to drag an organ out of its position, and would like to know how much displacement can be made with the tenaculum without producing dangerous trouble; for example, cellulitis, metritis and injuries to the peri-uterine tissue; he had met a number of cases in which he had not been able to make out the

ovaries. Dr. Martin says he can palpate normal tubes, but Dr. Opie has never been able to reach that degree of perfection.

Dr. Neale referred to the possibility of tracing out the uterus through the anterior vaginal wall, as had been demonstrated to him by Dr. Kelly, at the Hopkins Hospital clinic; he had no doubt that in a large majority of cases the normal ovary could be displaced out of its normal position and palpated or touched with ease through the vaginal walls. He believed that a great deal of difficulty in an ordinary gynecological examination was due to the fact of neglecting to empty the bladder, or to employ the rectal touch.

Dr. H. P. C. Wilson said, he thought there were a large number of women in whom he was sure he could not palpate the ovaries, and he was doubtful if any one could do so. The cause is often found fixed in the pelvis as in a mass of putty, and no definite outlines can be made out; in other cases the abdominal walls are from two to four inches thick with fat, and in such cases he had failed to find the ovaries.

Dr. J. Whitridge Williams said, that he could certainly feel the ovaries in four cases out of five, and that he had succeeded occasionally in finding the ureter.

Dr. Moseby: The old teaching is that the ovaries can not be palpated in their normal position. When an ovary can be found by an ordinary examination, its location may fairly be considered as abnormal. If Dr. Kelly's idea, that all men who cannot make out normal ovaries should be thrown out of the specialty, should be enforced, a large number of experienced and thoroughly informed specialists would be excluded from practice. It is practically impossible to examine every patient thoroughly enough to make out the normal ovaries in office examinations. In dispensary, and more especially in hospital practice the case is very different.

Dr. Browne thinks that the cases in which the ovaries cannot be felt are the abnormal cases. If the symptoms point to an examination of the ovaries they can be made out, but if necessary an anæsthetic should be given.

Dr. Kelly, in closing the discussion, said that he examines every case coming to him, vulva to ovaries, making a special note of every important organ.

When the patient complains of persistent pelvic pain the examination is never considered complete or the diagnosis sure without a special note as to the condition of the ovaries. I have been asked about examining the ureters by palpation. They can be felt in almost all cases, being distinctly traced from the anterior part of the pelvis back to the side of the uterus. Pressing upon a diseased nerve causes a desire to pass water, often irresistible. I prove that this structura is a

ureter by catheterizing it. The catheter can be felt through the vaginal wall outside the bladder in the ureter, and the urine collected as it comes down from the kidney, drop by drop. The Fallopian tube can often, but not always, be made out.

The amount of displacement of the uterus which can be made without injury is considerable. In normal cases it can easily, and without harm or pain, be brought down to the vaginal outlet. When there is fixation, gentle traction can be made until pain is felt. In these cases I use traction with the corrugated tenaculum, and then pushing up the fundus with the finger, practise massage, stretching the adhesions. I am sure that the downward traction to the valva without pain never does any harm.

Dr. J. Whitridge Williams' remarks upon the pathological specimens submitted to him by Dr. Moseby, Dr. Wilson and Dr. Opie :

The specimens submitted by Dr. Moseby are of considerable interest, and consist of the uterine appendages from both sides. The specimen from the left side consists of the Fallopian tube, ovary and part of the broad ligament. The tube was completely occluded at its fimbriated end, but otherwise presenting nothing abnormal, except numerous small adhesions. It contained a very small amount of dirty, yellow fluid, consisting of columnar ciliated epithelial cells and numerous disintegrated cells. The ovary was considerably torn and covered by very dense adhesions, while the broad ligament presented nothing of note. The specimen from the right side was an irregular mass of tissue about $5 \times 4 \times 1\frac{1}{2}$ cm., consisting of the tube and ovary imbedded in dense adhesions. At first glance the mass appeared to be composed of two parts, a large solid anterior portion covered by dense adhesions, and posterior to it a cystic structure about $4 \times 1\frac{1}{2}$ cm. in size. This had a bluish color, thin wall, and was intimately connected with the rest of the mass. Imbedded in adhesions, a piece of the ampullar end of the tube was found, which could be traced for about 4 cm. and then lost itself in the mass, and appeared to have no connection with the above-mentioned cystic portion. The main portion of the mass on section was shown to be composed of ovarian tissue, which was covered and completely hidden from view by very dense adhesions. It contained two tolerably fresh corpora lutea about $1\frac{1}{2}$ cm. in diameter. The larger of these corpora lutea communicated by a small opening with the cystic portion above mentioned, which contained a thin reddish, watery fluid containing blood cells. On cutting open this cystic portion its walls were found perfectly smooth with several smaller cysts projecting into it. These varied in size up to 2 cm. in diameter, and were filled with a clear watery fluid, and arose directly from the ovarian tissues. On examining the scrapings from the walls of these

cysts I found that they were lined by a layer of almost flat cuboidal cells, which were distinctly ciliated. These cysts could not have originated in the tube, as was readily demonstrated by their arrangement in relation to the larger cyst, and by the lining epithelia, which was totally different from that of the tube. Their smooth interior precluded the idea of a ciliated papillary cystoma, and the only probable thing for them to be were dropsical Graafian follicles, which had been prevented from rupturing by the dense adhesions covering them, and so attained their large sized. The fact that they were lined by ciliated epithelium is not at all opposed to this supposition, for cilia have previously been found in the dropsical Graafian follicle, as was shown by Von Velits, of Budapest, about a year ago, and as I found, altogether independently of him, last spring. But as yet I have not made a sufficient number of observations to assert that all dropsical follicles are lined by ciliated epithelium. The blood in the large cyst in all probability came from the corpus luteum, with which it was connected. The adhesions about the ovary were particularly dense and resisting. The diagnosis from the specimen is pelvic peritonitis, with adhesions binding down the adnexa on both sides, particularly the right side, with several very large dropsical Graafian follicles.

The specimen submitted by Dr. H. P. C. Wilson was a small myoma about 3 cm. in diameter, and bore on the surface a piece of vaginal membrane the size of a two cent piece. The tumor was submitted to me to decide whether its origin was from the anterior fornix or from the uterus itself. Sections made through the tumor and the vaginal mucous membrane readily showed it to be a myoma, which was separated from the submucous tissue and epithelium by numerous bands of non-striated muscular tissue. From the presence of muscular fibres between the tumor and epithelium, I think we are justified in concluding that it was not of vaginal origin. Were it of vaginal origin it should arise from the submucous tissue and be immediately adjacent to the epithelium and not separated from it, as was in this case, by muscular tissues. Force is lent to this conclusion by the fact that vaginal fibroids are very rare indeed, and many of the reported cases, especially fibroids, from the anterior fornix had their origin in the anterior wall of the uterus instead of the vagina.

The specimen submitted by Dr. Opie was a greatly hypertrophied posterior lip of the cervix, which measured 5 cm. in length and 2 cm. at its broadest part. Microscopically it was found to consist of almost normal cervical tissue, with only a very slight increase of the connective tissue. Except at its cut surface the entire mass was covered with the usual stratified epithelium.

Generally speaking, we may distinguish two forms of hypertrophy of the portio-vaginalis—falicular and diffuse or simple hypertrophy. The first form is due to increase in number and size of the cervical glands, with frequent retention of their contents, and is quite frequent, but never attains a very great size, and is readily distinguished by its nodular appearance. The diffuse or simple form of hypertrophy is far more important. In this there is a general increase in all the elements that compose the cervix, though there may be a slight increase in the amount of connective tissue, as there was in this case.

WILLIAM S. GARDNER, M.D.,
Secretary.

Selected Articles.

WHAT I HAVE LEARNED TO UNLEARN IN GYNECOLOGY.

BY WILLIAM GOODELL, M.D.

Every earnest worker in any field of the inexact sciences finds himself compelled to unlearn as well as to learn. The errors which he discovers and weeds out will usually be traditional teachings—the legacies of our forefathers—for we get many of our opinions, as well as many of our diseases, by heredity. What I have thus learned to unlearn in the treatment of women's diseases will be the burden of this paper.

To begin, then, I have learned to unlearn the grandmotherly belief that the climateric is in itself an entity, and that, as such, it is responsible for most of the ills of matronhood, and especially for that of menorrhagia. True, it must be conceded, that as an entity it does seem to disturb the vasomotor system, and through it to cause many severe perturbations, such as tinglings and numbness, and sweating of the skin, flushes of heat and shivers of cold, emotional explosions, and a large group of hysterical symptoms. It can also lay claim to being an important factor in the causation of insanity. Yet, contrary to the prevalent lay and professional belief, how rarely can true uterine hæmorrhages, or other uterine discharges be traced to the climateric as a cause in itself. Yet many a poor woman has lost her health, her life, indeed, by her own and her physician's traditional belief, that her hæmorrhages or other vaginal discharges are critical and due to the "change-of-life," as it is popularly called—a misnomer which too often leads to indolent diagnosis and slovenly therapeutics.

What physician of any practice has not been called in to see some wretched sufferer, whose health has been crippled for months, or even for

years, by hæmorrhages or by other discharges from the sexual organs, which have been attributed to the "change-of-life" by her friends, or—what is more inexcusable—by the successive physicians whom she has consulted? To the shame of the latter, they may not have made even a digital examination; yet a polypus or a fungoid degeneration of the endometrium, or a uterine fibroid, or a cancer of the cervix has been found by a more alert man, who does not believe in climateric omnipotency. Never can I forget a case—not the only one—of a beautiful woman, beloved by a large circle of friends and surrounded by every luxury that wealth could furnish, who was allowed by her physician to bleed almost literally to death. Why? Because a polypus, being at first intra-uterine, was not recognized, and because her age justified, in his opinion, the diagnosis of "change-of-life." This diagnosis having been made, no other vaginal examination was ever thought of by this physician. But when he was discharged and another one was called in, the latter found the polypus dangling in the vagina. She was bedridden and as translucent as alabaster when I twisted off the growth. Hæmorrhages did not return, but neither did her health, and she died a few months later quite suddenly and very unexpectedly.

In other cases, by the careless indolence of the physicians, begotten by this traditional belief in climateric influences, I have been compelled to undeceive some poor women and break as gently as possible to her, that the flow which she had joyfully accepted as a return of her monthly periods, and which she has mistaken for rejuvenescence, is the sure token of an incurable and far advanced cancer of the cervix.

I have learned to unlearn the teaching that woman must not be subjected to a surgical operation during her monthly flux. Our forefathers, from time immemorial, have thought and taught that the presence of a menstruating woman would pollute solemn religious rites, would sour milk, spoil the fermentation in wine-vats, and do much other mischief in a general way. Influenced by hoary tradition, modern physicians very generally postpone all operative treatment until the flow has ceased. But why this delay, if time is precious and it enters as an important factor in the case? I have found menstruation to be the very best time to curette away fungous vegetations of the endometrium, for, being swollen, then, by the afflux of blood, they are larger than at any other time, and can be more readily removed. There is, indeed, no surer way of checking a menorrhagia or of stopping a metrorrhagia than by curetting the womb during the very flow. While I do not select this period for the removal of ovarian cysts, or for other abdominal work, such as the extirpation of the ovaries, of a kidney, of

breaking up intestinal adhesions, etc., yet I have not hesitated to perform these operations at such a time, and I have never had reason to regret the course. The only operations that I should dislike to perform during menstruation would be those involving the womb itself—such as the removal of a uterine fibroid, or a partial or a complete hysterectomy, and the various operations for uterine cancer, etc. This exception is based upon the danger of hæmorrhage arising from the increased vascular tension and pelvic hyperæmia, which exist during menstruation. This is well shown in fibroid tumor of the womb, in which this increased vascularity causes a corresponding increase in the size of the tumor itself. For obvious mechanical reasons it would also hardly be wise to sew up the torn cervix of a menstruating womb.

I have learned to unlearn that antelexion and anteversion in themselves—that is to say, as displacements merely, and without narrowing of the uterine canal—are necessarily pathological conditions of the womb. Text-books speak of them as such, and exhibit many ingenious forms of pessaries devised to rectify these so-called displacements. But very rarely indeed do I have to resort to them, and then only to a stem-pessary in antelexions; for I find in almost every virgin or every barren woman that the womb in varying degrees is either bent forward or is tilted forward, and is apparently resting on the bladder. The mistake made, as I have more elaborately shown in my *Lectures in Gynecology* is in attributing to this natural position of the womb the various forms of pelvic trouble, especially that of irritability of the bladder, to which women are so liable. But the sympathy between the brain and the bladder is a remarkably close one—so close, indeed, that some physiologists contend that “every mental act in man is accompanied by a contraction of the bladder.” The irritability of the bladder thus becomes one of the first symptoms of nervousness, to which everyone is liable. Many a lawyer before pleading an important case, and many a clergyman before delivering a discourse, is compelled from sheer nervousness to empty his bladder. So it is with the lower animals, which, when frightened, micturate involuntarily. A nervous bladder is then one of the earliest phenomena of a nervous brain—for nervousness means a deficient control of the higher nerve-centres over the lower ones—a lack of brain-control. Now a hysterical girl, or a woman whose nervous system has given way under the strain of domestic cares, consults the physician for such ordinary symptoms of nerve-exhaustion as wakefulness, utter weariness, a bearing-down feeling, backache, and, perhaps, above all, an irritable bladder. Upon making a digital examination, he usually finds the fundus of the womb resting on the bladder where it naturally should rest. At once he

jumps to the conclusion that the whole trouble is due to the pressure of the womb on the bladder—viz., to the existing natural anteversion or to the antelexion, as the case may be. Enticed away by the vesical lapwing from the bottom factor—the shattered nerves—he now makes local applications, and racks his brain to adapt or to devise some pessary capable of overcoming the supposed difficulty, heedless of the dilemma that the upward, or shoring, pressure of the pessary on the bladder must be greater than the counter, or downward, pressure of the womb, to which he attributes the vesical irritability.

In the lying-in chamber the fear of septicæmia will ever haunt me, but I have long since abandoned the idea cherished by that class of waistless and witless nurses, now happily obsolescent, that the parturient woman is to be swathed like a mummy and to be kept as immovable. What earthly harm can accrue to a woman after a natural labor if she turns over from side to side, sits up in bed, or even gets up to use the commode, if she feels like it, I cannot see. Natural labor is a physiological process, not a pathological one, but tradition has thrown around the lying-in bed a glamor of mischievous sentiment.

In relation to this let me express my disbelief that mammary abscess comes from “caked” breasts, or from breasts over-distended from a secretion of milk too great for the infant’s needs. Mammary abscess, in the suckling woman comes, in my opinion, from cracked nipples, and from cracked nipples alone. In proof of this let me ask my readers if any of them has ever had a case of mastitis after a miscarriage, or one of gathered breast following a stillbirth—always provided the breasts were let pretty much alone so far as pumping and sucking are concerned. Under these circumstances the unsucked and unpumped breast will swell up and grow painfully hard, but it will not inflame or suppurate. Let me not be understood as saying that an overdistended breast should not be relieved by sucking or by pumping; but the means employed for this relief must be so sparingly used, and at such long intervals, as not to crack the nipples. This immunity from mammary abscess after miscarriages and stillbirths is attributed by the physician to his local applications of belladonna, or of other milk-drying drugs. But it comes from the absence of the exciting cause of cracked nipples—the sucking child.

Long ago I came to the conclusion, that the womb, like the nose, has its own secretions; and that, because the cervical canal is stopped up with mucus, it is not to be treated any more harshly than a stopped-up nose. I was led to this belief from seeing very many cervical canals wholly closed up, even destroyed by the remedies applied to get rid of this mucus. Then again I found that, just as the nose secretes abundantly under

the stimulus of the emotions, so the womb secretes more actively under a stimulus conveyed to impressionable nerves—so much so, indeed, that leucorrhœa is a common adjunct to nerve-prostration, and is then cured by the cure of its cause. This nasal analogy led me soon to think that even uterine catarrhs are not of such paramount importance as to merit heroic treatment, and that metritis and endometritis, in so far as symptoms are concerned, are often idle words. The mucus of a uterine catarrh is in quality very much the same as the mucus of a nasal catarrh, and its secretion is in itself no more weakening. It is not a disease in itself, but is merely the symptom of a disease. It is not, therefore, that highly vitalized fluid, the loss of which, according to the traditional belief of the great majority of physicians, and of all women, saps the very citadel of life, brings on decrepit and premature old age, and hastens its victim to an untimely grave. This widespread error is a relic of mediæval ignorance, which believed in the existence of two seeds—the male and the female semen—and their admixture to insure conception. Hence leucorrhœa has erroneously come to mean pretty much the same thing as spermatorrhœa—a belief fostered by cunning quacks, who know how largely sex and sexuality make up our being and influence our credulity.

As a corollary to this, let me add, that I have wholly freed myself from the belief that cellulitis is at the bottom of most female ailments, and that the hot-water douche is its cure-all. My experience teaches me that, save in some case of active congestion or of acute inflammation of the pelvic organs, the hot douche is of questionable utility, and that its indiscriminate employment has done far more harm than good, especially when continued for any length of time. I cannot withhold the opinion that from its use both ovaritis, salpingitis, and peri-uterine inflammation have actually been set up by the overheating and the subsequent chilling of the pelvic organs. The crucial test of surgical research which cannot be gainsaid has shown that cellulitis is almost a myth, that what have long been deemed exudation tumors and inflammatory deposits in the areolar tissue, are tubal and ovarian lesions.

I have learned to unlearn the idea—and this was the hardest task of all—that uterine symptoms are not always present in cases of uterine disease: or that, when present, they necessarily come from the uterine disease. The nerves are mighty mimics, the greatest of mimics, and they cheat us by their realistic personations of organic disease, and especially of uterine disease. Hence it is that even seemingly urgent uterine symptoms may be merely nerve-counterfeits of uterine disease. I have, therefore, long since given up the belief, which with many amounts to a creed, that the

womb is at the bottom of nearly all female ailment. Nerve-strain, or nerve-exhaustion, comes largely from the frets, the griefs, the worries, the cares and the cares of life. Yet, although the imagination undoubtedly affects it, it is not a mere whim or an imaginary disease, as all healthy women and most physicians think; but it is the veriest of realities. When some flippant talker or some slipshod thinker scoffs at nervousness as a sham disorder, I say to him: "Can the bribe of a principality" keep you from blushing when you are ashamed, or from blanching when you are afraid? Under the fitting sense of shame or of fear these vasomotor disturbances are momentarily beyond your control; and so they are in the nervous woman, whose vital organs are, as it were—not transiently, but—perpetually blushing and blanching under deficient brain-control over the lower nerve-centres."

Strangely enough, the most common symptoms of nerve-disorder in women are the very ones which lay tradition and dogmatic empiricism attribute to womb disease. They are, in the order of their frequency, great weariness, and more or less of nervousness and of wakefulness; inability to walk any distance and a bearing-down feeling; headache, nape-ache, and backache; scant, or painful, or delayed, or suppressed menstruation; cold feet, and an irritable bladder; general spinal and pelvic soreness, and pain in one ovary, usually the left, or in both ovaries. The sense of exhaustion is a remarkable one; the woman is always tired, she passes the day tired, she goes to bed tired, and she wakes up tired, often, indeed, more tired than when she fell asleep. She sighs a great deal, she has low spirits, and her arms and legs become numb so frequently that she fears palsy or paralysis. There are many other symptoms of nerve-strain, but since they are not so distinctively uterine, and, therefore, not so misleading, I shall not enumerate them.

Now, let a nervous woman, with some of the foregoing group of symptoms recount them to a female friend, and she will be told that she has womb-disease. Let her consult a physician, and ten to one he will think the same thing and diligently hunt for some uterine lesion. If one be found, no matter how trifling, he will attach to it undue importance, and treat it heroically as the peccant organ. If no visible disease of the sexual organs be discoverable, he will lay the blame on the invisible endometrium or on the unseeable ovaries, and continue the local treatment. In any event, whatever the inlook or the outlook, a local treatment is bound to be the issue.

Until my eyes were opened to the harlequin tricks of the nerves, I have repeatedly made the same mistake, and I now see it made over and over again by other physicians. To give but two recent instances out of very many:

Not long ago a lady was sent to me by a very intelligent physician to have a cervical tear repaired. She had been seen by several physicians, all of whom had treated her locally, and all had concurred in the opinion expressed by my friend. Her most pronounced symptoms were insomnia, unending weariness, excessive nervousness, great dread of being alone, severe bearing down, painful locomotion, constant backache, and an extremely irritable bladder which gave her no peace day or night. She had in addition most of the canonical uterine symptoms. Being sure that a comparatively trifling tear of the cervix could not give rise to so many exacting symptoms although she herself attributed them to this cause, I closely cross-questioned her, and soon discovered the source of the mischief. After a rather difficult labor—her sole one—she had given birth to a still child. This was a great disappointment, yet she was convalescing naturally, when a great conflagration broke out in her city. After destroying most of this city it swept onward toward her house. Her valuables were hastily packed up, and she was bundled up ready to be carried away at a moment's notice. Fortunately the fire was put out at the second house from hers. Since then she has never been well.

It was not the cervical tear that had wrecked her health, but disappointed motherhood, and the noise, the tumult, the fear, the long-drawn-out agony of suspense.

The second case gave the following history :

She was aged forty-two years, and was the mother of one child, now twelve years old. She had sharp pain in the right ovary, burning aches in the left one, and difficult locomotion. A sensation of tingling, prickling, and stinging heat pervaded her whole left side. Her left eye had wavering vision, as if she were looking through heated air. The catamenia, formerly scant and painful, were replaced by an abundant leucorrhœa. Her bladder was irritable and needed emptying day and night. She was tired all the time, lay awake most of the night, and her sleep was troubled by distressing dreams. A well-known oculist had cut the muscles of her eyes, several physicians had treated her locally off and on for many years, and she was now sent to me to decide the question of the removal of her ovaries. The womb lay in the first stage of retroversion, there was some endometritis, and the left ovary was tender and reachable. Finding, as in the foregoing case, that her symptoms were out of all proportion to the local lesions, I suspected nerve-trouble, which her history confirmed. Ten years ago, while sailing with her husband across a lake, a storm overtook them. The boat filled with water and, after a desperate struggle, they barely reached the shore. Two years later her nerves, still much shaken by this narrow escape from drowning, received another

shock. A burglar broke into her home, and her husband had, in her hearing, a fierce and noisy hand-to-hand fight with him. One more year passed, and she met with a railroad accident, in which twelve persons were killed, but she was uninjured. This final shock completely shattered her nervous system; and she was plainly suffering from a sore brain, and not from sore ovaries. In one word, it was the old, old story of wounded nerves countefeiting a wounded womb.

I have learned yet another trick of the nerves : that when riotous from being under-fed, from over-work, or from lack of discipline, they billet themselves, like an insolent soldiery, on some maimed organ and hold high revel there. For instance, a woman, hitherto in perfect health, may have an adherent or a dislocated ovary, or a torn cervix, or a narrow cervical canal, or a slight displacement of the womb—lesions which may have given her no appreciable trouble whatever. But let her nervous system become unstrung, and at once, through disturbances in the circulation both of the nerve-fluid and of the blood-fluid, there set in vesical, uterine, or ovarian symptoms, which may indeed reach so exacting a pitch as to demand a local treatment. Nor are the sexual organs the only ones thus affected. Every weakened organ in the body is liable to such functional outbreaks. The stomach rejects its food, the bowels either refuse to act or else they are very loose, the heart loses its rhythm and beats irregularly, the vocal cords relax and the voice cannot be raised above a whisper, and almost every sphincter muscle in the body behaves as if it were insane. I have known a woman in her nervous attacks to become as jaundiced as if she had the liver of a Strasburg goose. The yellow color was fugitive, but it lasted longer than the emotion that caused it. Even the eyes, which before may have exhibited to their owner no visual defect, now blink painfully at the light or may cause violent headaches, which glasses alone can allay. In the following case various organs were thus affected :

An unmarried lady in splendid health and with a magnificent physique, had unusual muscular strength, which she was fond of testing. One day, while wrestling with her brother, which she often did, she felt something give way in the pelvis, and shortly after this her health began to fail. Her monthly periods, hitherto painless, now gave her acute suffering, and a persistent leucorrhœa soiled her linen. The left ovary throbbed with a constant ache, walking became painful, the bladder grew irritable, and the stomach began to reject its food. From sluggish circulation, local congestions took place, particularly in the head and in the pelvis. Thus when she stood up, the pelvic organs seemed to fill up with blood and painful pelvic throbs beat time with her pulse.

From these she got relief by sitting with her knees raised up, or by lying with her feet higher than her head. Soon insomnia, photophobia, and dreadful headaches set in. These were followed by illusions when her eyes were closed, which vanished when she opened them. She heard imaginary conversations and saw unpleasant sights. She became morose and irascible, and kept much by herself; in one word her mind hovered on that ill-defined borderland between sanity and insanity.

The wrestling episode and her many orthodox uterine symptoms misled every one, including herself, her family, and several physicians, who attributed everything to uterine disease and treated her accordingly. She had much local treatment of the usual kind, and more for supposed ante-flexion. Getting no better, she travelled many miles to consult me. My examination of her revealed merely glairy mucus in the cervical canal, some tenderness over the left ovary, which was slightly displaced, and the natural ante-flexion of a virginal womb. These lesions were too trivial to account for her lamentable condition, and I looked to her history for an explanation. This clearly satisfied me that she was suffering from nerve-breakdown. This diagnosis was a great surprise to her and to her mother, who accompanied her; but, notwithstanding her contrary convictions, she entered my private hospital. With the exception of a few douches of corrosive sublimate for the leucorrhœa, her uterine organs were let severely alone, and she was treated merely for her nerves. Her friends were greatly dissatisfied with this treatment, and at their instance a near medical relative wrote me a letter in which, after criticising my treatment, he urged upon my attention the wrestling match and the uterine character of the symptoms. At the end of six weeks she left me very greatly improved in every respect, but as her headaches still troubled her more or less, I asked Dr. de Schweinitz to examine her eyes. He found some astigmatism in one eye, and "the highest degree of hypermetropia which he had ever seen, excepting in two other cases." Suitable glasses remedied these defects, and she afterward progressively improved—so much so, that eight months later I received from her a most grateful letter of thanks. Further, the physician himself who had criticised my treatment of her, wrote me quite recently, that he was about to send me a patient with analogous symptoms, who had been unrelieved by a long course of uterine treatment.

Just as headache does not necessarily mean brain disease, so ovary-ache does not necessarily mean ovarian disease. Yet time and again—and I say this deliberately—have ladies been sent to my private hospital to have their ovaries taken out, when the whole mischief had started from

some mental worry. Their ovaries were sound, but their nerves were not, and no operation was needed for their cure. So misleading, indeed, are the symptoms of a jaded brain or of other nerve-strain, under the uterine livery in which they are often clad, that I have recently known a jilted maiden to be treated by a cup-and-stem pessary, and a bereaved mother to be douched and tamponed and cauterized for a twelvemonth. Such cases, even when accompanied by actual uterine disease, are not bettered by merely local treatment. Nor are medicines by themselves of much avail. What they need is massage, perhaps electricity, and that freedom from care which strict seclusion gives. Hope should be infused into every case, and, above all, there must be imported into it the personality of the physician. It was not the staff of the prophet that awakened the dead child; but death was quickened into life when the prophet threw himself upon its body and breathed into it of his own intense vitality.

As the outcome of much that I have learned to unlearn, I have arrived at this very short gynecological creed: I believe that the physician who recognizes the complexity of woman's nervous organization and appreciates its tyranny, will touch her well-being at more points and with a keener perception of its wants, than the one who holds the opinion that woman is woman because she has a womb.—*Med. News.*

THE ANTI-FERMENTATIVE TREATMENT OF INFANTILE DIARRHŒA.

Infantile diarrhœa may be a symptom of many diseases, such as dietetic, parasitic, tubercular, syphilitic, miasmatic, and local diseases, or it may result from diseases of defective nutrition. I propose in this communication to discuss only the causation and the treatment of that variety of acute infantile diarrhœa that is caused by irritative products resulting from fermentations produced in milk either previously to or after ingestion. The majority of the cases of this kind occur in infants who are being reared on cow's milk, and, although they occur at all seasons of the year they are far more common during the summer. The infant is restless and irritable; the tongue is generally coated with a white fur; the diarrhœa is severe, and is frequently accompanied with vomiting and signs of abdominal pain; the motions are watery, usually greenish at first, with lumps or flocculi of curd in them; later they may become lighter in color, or even may resemble the rice-water stools of cholera or of arsenical poisoning. In some of the cases marked nervous prostration is present. The causation of this variety of acute infantile diarrhœa has been attributed by various

authors to indigested caseine, to the action of bacteria, to acid fermentation, to alkaline fermentation, to poisonous ptomaines, or to catarrh of the intestinal mucosa, set up by the above-mentioned or other irritants. Bednar was one of the earliest writers who put forward the theory that primary abnormal decomposition of food was a cause of diarrhœa in children. Escherich found by the aid of Koch's method of cultivation that the bacterium lactis determined strong lactic acid fermentation in carbohydrates, and especially in milk sugar, but that this bacterium does not split up albumen. On the other hand, according to Bagninsky, in a paper read before the Berlin Medical Society in 1888, the bacterium produces only very small quantities of lactic acid; moreover cultivation experiments show that the formation of acetic acid, when it exceeds a certain limit, destroys this bacterium, so that if the bacterium be sufficiently active it dies, so to speak, by its own hands, killed by its own products. Experimentally, it is found that a trace of calomel in the gelatine prevents almost entirely the growth of this bacterium, and this may explain the undoubted usefulness of calomel in sudden diarrhœa in the children, due apparently to fermentation of milk sugar in the milk-supply.

Now, although I do not for a moment deny that several irritating substances resulting from the fermentation of milk may be factors in the production of this form of acute infantile diarrhœa, yet my contention in this paper will be that the principal share of the blame rests with the milk or cheese ptomaine, tyrotoxinon, produced during the fermentation of milk under certain conditions. I will, therefore, here give a brief description of this body. In 1883-84, 300, cases of cheese poisoning were reported to the Michigan State Board of Health. The symptoms were vomiting, diarrhœa with watery stools, occasional pain in the region of the stomach, tongue at first white, red and dry later on, pulse feeble and irregular, countenance pale with marked cyanosis; dryness and constriction of the throat were complained of by all, and in a few cases the diarrhœa was followed by marked nervous prostration. In the majority of the cases no fatal termination occurred. From the symptoms many of the cases were at first diagnosed as arsenical poisoning. In all these cases the cheese was apparently in good condition, and there was nothing in the taste or odor of it to excite suspicion. From some of this cheese Victor Vaughan extracted a crystalline ptomaine which he named "tyrotoxinon," and which he found was capable of producing the symptoms described above as characteristic of poisonous cheese. He later on extracted tyrotoxinon from milk that had stood in stoppered bottles from three to six months. He found that tyrotoxinon administered to a cat produced vomiting and watery

stools, with subsequent immediate retching and vomiting whenever it lapped a little milk. This condition continued for three days, when the animal was placed under ether and its abdominal organs examined. The stomach and intestines contained a frothy, serous fluid, such as had formed the vomited matter, and the mucous membrane was very white and soft; there was not the slightest redness anywhere along the alimentary canal. Similar results in several other experiments on lower animals were obtained by the same observer. It may be mentioned here that the chemical constitution of tyrotoxinon is known; it has been shown by Victor Vaughan to be identical with diazobenzol ($C_6H_5N_2$).

Many remedies have been employed in the treatment of infantile diarrhœa with the view of arresting the abnormal intestinal fermentation. Carbolic acid, creasote, resorcin, salicylate of soda, salicylic acid, naphthol, and salol have been given as antiseptic remedies in the hopes of checking the abnormal fermentative changes going on in the bowels. Ringer recommends a weak solution of bichloride of mercury in acute or chronic diarrhœa of children with very slimy stools, and accompanied by pain and straining; the salient indication, according to him, for employing the bichloride of mercury, is the slimy character of the motions. In some forms of infantile diarrhœa, characterized by watery, very offensive, muddy looking or green colored stools, Ringer recommends small doses of grey powder. Illingworth uses for infantile diarrhœa a mixture containing perchloride of mercury, iodide of potassium, carbolic acid, sal volatile, and paregoric. This is a most useful combination, and it was the employment of it that first directed my attention to the treatment about to be described in this paper. Dr. Angel Money has recently drawn attention to the temporary value of naphthaline as an antiseptic in cases of infantile diarrhœa and of fetid urine. Dr. Edward P. Davis of Philadelphia, in a recent clinical lecture on the treatment of infantile diarrhœa, points out that it is of prime importance that the milk should be sterilized, and also advocated in cases of pronounced gastric irritation the washing out of the stomach with water containing either bicarbonate of soda or salicylate of soda; as an intestinal antiseptic he recommends small doses of calomel, or as a final resort, intestinal irrigation with water made alkaline with bicarbonate of soda, or with thymol solution (1 in 1000), or with salicylate of soda solution (20 gr. to 20 oz of water). Dr. Koblasenko, in a Russian medical journal, states that he has found great advantage from the use of zinc oxide in the summer diarrhœa of children; he gave the zinc oxide in a mixture with ether and tincture of rhatany.

The treatment that I have lately employed in

these cases consists of (1) drug treatment and (2) diet treatment.

1. If the view that I entertain be the correct one—viz., that the milk ptomaine tyrotoxin is one of the main factors in the causation of the diarrhoea—then the rational treatment will be to destroy or to render insoluble, and therefore inert this substance, and at the same time to stop the abnormal fermentative changes occurring in the stomach and intestines, and so arrest further production of this and other irritating chemical bodies. Now, can any one drug combine these two functions? Yes, in the soluble biniodide of mercury we have a drug which renders the milk ptomaine insoluble and inert, and which at the same time is one of the most powerful, if not the most powerful, of antiseptics. But, it may be asked, what advantages: (a) The soluble biniodide of mercury precipitates the milk ptomaine tyrotoxin by forming an insoluble double iodide with it; bichloride of mercury is powerless to precipitate the milk ptomaine. (b) The soluble biniodide of mercury is a much more powerful antiseptic than the bichloride of mercury. (c) The soluble biniodide of mercury is a safer drug than the bichloride of mercury, in that it is more rapidly eliminated from the system than the latter preparation. This is explained by the facts that the bichloride of mercury after it has passed into the circulation becomes converted into insoluble or partially insoluble compounds, both by the albumen and by the carbonate of soda of the blood (an albumate of mercury and a carbonate of mercury being respectively formed), and that in consequence the mercury becomes deposited in the various tissues, and so by not being speedily eliminated from the system, may produce toxic effects. This disadvantage is not possessed by the soluble biniodide of mercury, which is not precipitated either by the albumen or by the carbonate of soda of the blood, so that there is consequently no danger of its being deposited in any of the tissues; and, as a matter of fact, after absorption into the circulation, it is rapidly eliminated by the kidneys. This rapid diffusibility through the system and elimination of the soluble biniodide of mercury in the urine I have been able to prove in the following manner. A male adult, who had not previously taken mercury, came under my friend Mr. Hastings Stewart to be treated for secondary syphilis. A subcutaneous injection of three quarters of a grain of the soluble double iodide of mercury and potassium was administered, and within two hours of the injection I was able, after careful analytical search, to find a small quantity of mercury in the urine. It was on account of its property of precipitating the milk-ptomaine tyrotoxin, and so rendering it insoluble and inert, and on account also of its powerful germicidal action, that I was first led to employ the soluble

biniodide of mercury in the treatment of infantile diarrhoea. I have always prescribed it together with chloral hydrate, the latter being employed as a sedative to the irritated and possibly inflamed mucous membrane of the stomach and intestines, and also on account of its action on the muscular walls of the intestine in diminishing exaggerated peristaltic action. The form in which I prescribe it is as follows: R.—Liq. hydrarg. perchlor., ℥xii; potass. iodid., gr. $\frac{3}{4}$; chloral hydrat., gr. j.; aquam ad $\bar{3}$ j. This forms the teaspoonful dose, which in case of infants up to six months of age may be given every four hours, and for infants from six to twelve months of age every three hours; children more than one year old may take two teaspoonful doses. This mixture contains the biniodide of mercury dissolved in the excess of iodide of potassium as a soluble double iodide of mercury and potassium; every teaspoonful of the mixture contains one-fiftieth of a grain of biniodide of mercury. Taking into account the irritant action of most of the persalts of mercury, it might be imagined that the biniodide of mercury itself would possibly act as an intestinal irritant. I have, however, never found this to occur in any one of the cases in which I have employed it, and this I attribute to its extreme solubility and diffusibility, and to its rapid elimination by the kidneys I have by me the records of eighty cases of acute infantile diarrhoea that I have treated by the biniodide of mercury method. In all the cases the diarrhoea was severe, and in many of them was accompanied by vomiting with signs of abdominal pain, and in a few of the cases by marked nervous prostration; the ages of the infants varied from three weeks to eighteen months. The results, briefly stated, are as follows:—In seventy-two of the eighty cases the diarrhoea ceased within two or three days; in five of the remaining eight cases it ceased within four days; and in no case did it last over seven days.

2. As regards the diet treatment, if milk is to be given I always direct that it should be previously boiled; and here let me remark that boiling the milk not only destroys germs but also rapidly decomposes any of the milk-ptomaine tyrotoxin that may have been formed, the tyrotoxin splitting up on boiling into carbolic acid and nitrogen. In the majority of cases during the continuance of the diarrhoea I order one part of boiled cow's milk to be mixed with three parts of barley water, sweetened with milk sugar or with saccharine. I advise the mothers that the various parts of the feeding bottle when not in use should be kept in a weak solution of permanganate of potash, which is not only a powerful germicide, but since all ptomaines are rapid reducing agents, they become speedily destroyed by the oxidizing powers of the permanganate. I also endeavour to get the mothers to use the old-fashioned torpedo-shaped

feeding bottle, in which no india-rubber tubing: the favorite lurking place of germs and other abominations, is employed.—Arthur P. Luff, in *Lancet*.

THE DIARRHŒA OF CONSTIPATION.

In the course of his remarks on a case that was presented for treatment at the Medical Department of the Polyclinic, Prof. Solomon Solis Cohen, alluded to the frequency of the condition, which has been called "the diarrhœa of constipation." The patients, as in the case before the class, frequently state that they have had chronic looseness of the bowels for many years. The immediate cause for seeking advice is usually paroxysmal pain, which may simulate hepatic colic, or as in a case recently seen in private practice, may simulate renal colic. The so-called diarrhœic stools should be carefully examined, and the history carefully inquired into, with the minuteness of a legal cross-examination. The true facts will then be found at variance with the patient's statements. There will be much desire to go to stool rather than frequent passages; and the amount of fecal matter passed will be found to be very small. The passages are small, thin, serous, foul-smelling, sometimes bloody, usually containing much mucus. Scybala will occasionally be passed, usually with much pain and difficulty. They are commonly glazed with a glairy mucus, and often faintly blood-stained. In other words there is a condition of irritation of the bowel, with insufficient evacuation of the contents. Frequent attempts at defæcation, but little result. The paroxysmal pains are due to distension, traction and pressure. When the patient has been in the habit of taking opium mixtures to relieve the supposed diarrhœa, the abdomen may be found greatly distended from paralysis of the intestinal muscular-layer. The percussion phenomena will be mingled tympany and dullness, the distribution of the sounds depending on the location of masses of feces in the bowel. Usually the ascending and transverse colon will be found filled, and the transverse colon may be seen to be much dragged down. Pains in the chest may be caused by traction upon the diaphragm. Enlargement of the liver, or ascites, may be mistakenly diagnosticated, unless care is taken to map out the dullness accurately, and not to be misled by the apparent fluctuation of the relaxed intestines. Headache, vertigo, languor, anorexia (sometimes bulimia), nausea, vomiting, are among the chronic or recurring symptoms, other than those already mentioned. The first thing in treatment is to thoroughly wash out the bowel. This may require several irrigations, supplemented by massage of the abdomen. When there is no absolute impaction, calomel may be given in single

daily doses of five grains, with soda or aromatic powder, continued for two, three, or four days. Olive oil in large doses and castor oil may also be given by the mouth; or warmed and thrown as high as possible into the bowel an hour or two before the irrigation. After the bowel has been emptied a tonic-laxative pill should be prescribed for continuous use for long periods, with occasional resort to calomel, oil, and salines.

A good formula is as follows:

R.—Euonymin gr. ij.
Ext. ignatiæ gr. ss.
Ext. belladonna gr. $\frac{1}{2}$.
Piperini gr. j.

M.—S: One pill three times a day, after meals.

The number of pills daily, or the size of the doses, may gradually be reduced as improvement is manifested. Resin of podophyllum, leptandrin, iridin, and the like may be used with, or instead of, the euonymin. Extract of cascara sagrada is very often useful. The dose is from two to five grains. The ignatia may be replaced by strychnine or nux vomica, the belladonna by hyoscyamus. The commonly used pill containing aloin or aloes is not often useful, and the hemorrhoidal condition present often contra-indicates it. Ipecacuanha is often usefully combined with the other agents.

The diet should be carefully regulated. At first it should be restricted to milk (peptonized, or with digestive agents added), beef-tea as a stimulant, thin soups, coffee, and the like. After a little while, when the intestinal irritation and catarrh have subsided, meats and vegetables may be added. Bran bread and other substances intended to assist peristalsis by irritation should not be given. Laxative fruits may be eaten in moderation. Pastry, sweets and other indigestibles are to be avoided. Plenty of water, preferably hot water, should be drunk. Enemata may be required from time to time, to wash out accumulations, and at first should be given daily, then on alternate days, then weekly as a routine practice. Abdominal massage and faradization of the intestines are of great service.

It is quite evident that treatment of the apparent diarrhœa by astringents and opiates is a mistake, and yet this practice is so common as to render it worth while to caution against the error, and to insist on careful examination of the patients. There are other cases of apparent diarrhœa and colic which may turn out to be something quite different on examination. "Walking typhoid fever" is familiar to all; but it is not as generally known as it ought to be, that serious and even fatal results have occurred in cases of perforating appendicitis and other inflammations in the neighborhood of the cæcum, as a consequence of neglect, due to insufficient inquiry into the case. We should never accept a patient's

diagnosis, until our own investigations have proved it to be correct.—*Times and Reg.*

MEDICAL NOTES.

Prof. DaCosta recommends the use of hydrobromate of hyosine in doses of $\frac{1}{2}$ gr. for the tremor of *paralysis agitans*.

In a case of *spinal epilepsy*, Prof. DaCosta prescribed :

R—Tinct. belladonnæ, gtt. iij.
Sodii bromidi, gr. xv.—M.
Sig.—Use t. d.

Prof. DaCosta advises as a prophylactic for those exposed to *scarlatina*, acidum carboicum, gtt. j., three or four times a day, in addition to antiseptic gargles for the throat and antiseptic baths for the whole body.

The following was given to a woman who was troubled with *habitual constipation* :

R—Aloin, gr. $\frac{1}{8}$.
Ext. hyoscyami, gr. j.
Ext. rhei, gr. ij.
Olei cajeput, gtt. j.—M.
Ft. pil. Sig.—Such a pill every night at bedtime.

For the *itching of jaundice*, Prof. DaCosta advised sodii bromidum with antipyrin internally, with the following ointment externally :

R—Menthol, gr. xx.
Alcohol, $\frac{5}{8}$ ij.—M.
Sig.—For local use.

A man who presented himself at the clinic suffering from *rheumatoid arthritis*, was ordered this ointment for local use, after blisters and massage of the joints had been first used :

R—Iodi, gr. xx.
Ung. belladonnæ,
Petrolati, āā $\frac{3}{4}$ j.—M.

A man suffering from *rheumatism*, in whom the acute stage had just been passed, was given—

R—Potassii iodidi, gr. v.
Potassii acetat., gr. x.
Tinct. colchici sem., gtt. x.
Elix. simplic.,
Aquæ, āā q. s. ad. f $\frac{3}{4}$ j.—M.

Sig.—Use every four hours, with Dover's powder at night.

Prof. Parvin said that in the *extirpation of the vulvo-vaginal gland*, in Paris, the operators melted paraffine over a water-bath and injected it into the gland, immediately placing a small piece of ice over it. This fills the sac, making the extirpation, otherwise difficult comparatively easy.

In cases of *alopecia* resulting from some continued fever, Prof. Bartholow advised the use of the following as a local tonic :

R—Ext. jaborandi fluid,
Tinct. cantharidis, āā $\frac{3}{4}$ ss.
Glycerini,
Olei vaselini, āā $\frac{3}{4}$ j.—M.
Sig.—Apply locally with a sponge at night.

In a case of *catarrhal jaundice*, Prof. DaCosta prescribed small doses of calomel with bicarbonate of soda frequently repeated. In the mornings the patient was to take a half ounce of Rochelle salts and drink some of the mineral waters. Saccharine and starchy substances were to be avoided, and a blister was placed over the enlarged gall-bladder.

Prof. Roberts Bartholow recommended in cases of *impotence* the following :

R—Zinci phosphidi, gr. ij.
Confect. rosæ, $\frac{3}{4}$ j.—M.
Ft. massa et div. in pil. xxiv.
Sig.—One to three pills thrice daily.

Or—

R—Ferri arsenitis, gr. v.
Ergotini (aq. ext.), $\frac{3}{4}$ ss.—M.
Sig.—One night and morning.

Prof. Parvin, in his clinic at the hospital, suggested a new mode of suture to be used in *colporrhaphy*. Instead of tying each suture as it is inserted, he thinks it a very good idea to place a needle on each end of a long catgut suture, and after inserting at one end of the denuded part and drawing through to the middle of the catgut suture, to tie. Then, without cutting, begin to sew from each side, tying at each insertion of the two needles. In this way you take a "cobblers' stitch," which not only holds the parts thoroughly in apposition, but is quite strong.

In a case of *parenchymatous nephritis*, in a boy six years of age who had been taking Basham's mixture, followed by infusion of digitalis and acetate of potash with no result (the accumulation of fluid becoming so great that his abdominal cavity had to be tapped, and his scrotum pricked with a fine needle), Prof. DaCosta prescribed tinct. strophanthus, gtt. j, increased to gtt. iij, three times in a day, and in addition the following formula :

R—Caffeini citrat., gr. j.
Sodii benzoat., gr. iij.
Syrupi limonis,
Aquæ, āā q. s. ad. f $\frac{3}{4}$ j.

Sig.—Such a dose three times daily.

—*Coll. and Clin. Rec.*

THE TREATMENT OF CHRONIC RHEUMATISM.

Chronic rheumatism, including chronic articular rheumatism, and all varieties of muscular rheumatism under that heading, is a very troublesome complaint, but a very important one, owing to the large number of people, especially amongst the poorer classes, who suffer from it. The treatment is, therefore, one to be carefully considered; and in this short article I propose to give a brief *resumé* of the methods of treatment I have found most beneficial.

The clothing of the patient must be attended to. It is essential that flannel should be worn next to the skin. The Jæger underclothing is very good. The diet should be nourishing, and, if stimulants are required, a little whiskey is, perhaps, the best. The internal treatment adopted is very various. I have found the following prescriptions most useful:—

R.—Pot. bicarb.	gr. xv.
Pot. iod.	gr. iij.
Tr. hyoscam.	℥ x.
Spt. chlorof.	℥ v.
Inf. gentian.	ʒ ss.

Ft. haustus, ter in die.

In strong adults, a few drops of vin. colchicid is beneficial. I have seen good results from three grain doses of salicylate of soda three times daily. Guaiacum is useful in some cases.

As the patient progresses a mixture like the following may be given:—

R.—Ferri et ammon. cit.	gr. x.
Pot. iod.	gr. iij.
Pot. bicarb.	gr. xij.
Spt. chlorof.	℥ v.
Aqua pimentæ	ʒj.

Ter in die.

The syrup ferri iodidi answers well in some cases. If there be much pain opiates, especially given subcutaneously, are often of marvellous efficacy. If the patient is debilitated, cod-liver oil is useful.

Local Treatment—This is a most essential part of the treatment, and here we have a large variety of means.

1. *Counter irritation by blisters and liniments.*
2. *Baths* (hot-air, vapour, hot-water, and Turkish baths). Massage is useful in some cases. If much pain, hot fomentations will often relieve it.

Counter irritation: *blisters* are of more use in acute cases but sometimes are useful in the chronic form. Amongst *liniments* may be mentioned: camphor; belladonna; aconite; oil of Eucalyptus is a most useful application, especially when continued with the belladonna; oil of wintergreen mixed with equal parts of olive oil is very efficacious. I have now used this formula for several years, and have already reported its use in *The*

Hospital Gazette, British Medical Journal, Lancet, and my notes have been quoted in the *Philadelphia Medical Review*, and in Martindale's and Wescott's *Extra Pharmacopœia* for 1890. Its use is particularly beneficial in chronic cases attended with much pain, and if this liniment be well rubbed into the affected parts the pain generally stops for five or six hours after application. It has only failed to relieve the pain in an extremely limited number of cases.

The liniment composed with equal parts of olive oil and the ætherial tincture of capsicum is an old remedy recently revived by Sir James Sawyer. I have now used this application in about fifty cases, and in only two did the patients fail to derive any benefit. It is also a most useful topical application for neuralgia. It must be used with care, the patient being told to use it in very small quantities, to protect his hands when so doing—gloves are generally recommended—and the patient must be warned that none of the liniment gets into his eyes.

The treatment of chronic rheumatism is, however, at the best, not entirely satisfactory, and our patient will always have to be careful about exposing himself to wind and weather, and that he is warmly clad. We must also always remember that in these chronic cases of rheumatism we often discover cardiac murmurs on auscultation, even when there has been no previous symptom of cardiac mischief.—*Hosp. Gaz.*

MEDICAL EDUCATION.

The Minister of Education for Ontario took occasion in the recent address in connection with the Medical Department of the Provincial University, to defend the expenditure of public money for purposes of medical education, by pointing out that some of the most important discoveries in modern medical science have been made in institutions connected with the State. The argument is worthless for several reasons. In the first place, in order to estimate its value we should require to know the relative number of great scientific institutions of the kind referred to which are supported by the State, as compared with the number supported on the voluntary principle. If it should appear that nearly or quite all the great English and European medical colleges and laboratories are connected with State Universities there is manifestly no basis for comparison. The argument is merely equivalent to saying that these discoveries are generally made in connection with such institutions as really exist and not in connection with such as are non-existent. Nor does the fact that most of the great existing institutions on the other side of the Atlantic are aided or supported by the State prove anything with regard

to the possibility or otherwise of the existence of equally efficient institutions on voluntary foundations, since it is obvious that so long as the Government undertakes to do any specific work, whether belonging to its proper sphere or not, there is a little inducement for private individuals or societies to undertake the work. The Minister complained that objections were being made to the recent action of the Government to which he belongs in restoring a Medical Faculty to the University of Toronto. Having referred to the objectors it would have been but fair had he gone on to meet and answer their objections. This he scarcely attempted to do. The objections taken to the action of the Government in this matter are, if we understand them, of two kinds—general and specific. On general principles, a considerable class of objectors claim that a Government steps beyond its proper sphere and misappropriates the funds which belong to all its citizens, when it undertakes to provide for the education of those preparing for any one lucrative profession. The very fact that the medical profession is lucrative affords, it is forcibly urged, a sufficient guarantee that adequate provision will be made for furnishing the training necessary to enter it. If it be said that the medical profession is peculiar, in that the health and lives of citizens are involved in its practice, and that the Government is bound to protect these by guarding the entrance to the profession against incompetent practitioners, the answer is—admitting for argument's sake the doubtful assumption that the State institution does or can effect this result—that all that is necessary to the end in view is for the State University to perform the functions of an examining body, in accordance with the original intention of the University of Toronto. The specific objection is, in this case, a very strong one, and the Minister should lose no time in answering it. It is to the effect that the Government is guilty of grave inconsistency and injustice, in that, after chartering several medical colleges, and receiving some of them into affiliation with the Provincial University, it actually erects one of those colleges into the Medical Department of that University, thereby, not only exhibiting unbecoming and unfair partiality to one of the several competing colleges in respect to which it was bound to observe the strictest impartiality, but itself entering into competition, at the public expense, with all the voluntary Colleges, some of which were in affiliation with its own University. The objection seems well taken, and it surely behoves the Minister to show that a course, seemingly so unfair and inconsistent, and so well adapted to discourage, instead of encouraging, private liberality, was justified by some urgent public necessity.—*The Week.*

CROTON-CHLORAL IN NEURALGIA.

The use of butyl-chloral hydrate in the treatment of insomnia due to neuralgic pain is resorted to, in my belief, so rarely in this country that I have thought it worth while to call attention to its interesting action and relative value and safety.

Physiological experiment coupled with practical experience has convinced us all that chloral, while it is the best hypnotic for the majority of cases, is not one which will give sleep in painful affections or relieve neuralgia unless it is given in full doses, so full as to be dangerous. At the same time it is very desirable that we should have some preparation at hand which will both produce sleep and relieve pain. At present we use chloral and morphine together—the first for its somnifacient effects; the second to relieve the pain, and also to cause sleep. A very great advantage of butyl-chloral hydrate is its safety. The active dose for many cases of neuralgia is only 5 grains, given in pill-form, yet as much as 40 grains may be used without producing any more noteworthy effects than 20 grains of ordinary chloral so far as the heart and respiration are concerned.

The following case is of interest, as showing its advantages :

M. G., aged thirty-five years, has had, for over two years, a severe supra-orbital neuralgia, varying in intensity, and accompanied by roaring in the ears and loss of appetite and sleep. The cause of the neuralgia rests in the presence of middle-ear disease, with varying amounts of discharge. The Eustachian tubes are widely dilated and relaxed. The neuralgia is always worse when the discharge becomes in any way suppressed, and the branches of the entire trifacial nerve become involved in the painful neuralgic shootings. At this time it is impossible for the patient to go to the front door, as the noise of the street hurts her head so much as to make the pain unbearable. The loss of strength and flesh was considerable, owing to the decrease in appetite and loss of sleep. Five grains of butyl chloral hydrate were ordered every two hours in pill-form. Six pills were taken, with entire relief of all the symptoms and the attaining of good sleep and a better appetite. The effects of each dose lasted twenty-four hours, and then the pain required another six pills. She had no attacks for some weeks after this, although the ear was not discharging.

Functional insomnia resting upon no known cause also yields to this drug very well, but insomnia due to any advanced systemic lesion, as in phthisis, is not relieved in every instance under its use. The history of cases of phthisis who use the drug is that they sleep well the first night, and lie awake the second night to cough the lungs clear

of mucus which has accumulated during sleep and while the nerves are obtunded by the drug. This second sleepless night can be quieted by a large dose, 20 grains, if desired, but I have never wished to run the risk of choking up the lung by preventing expectoration. In the neuralgia of phthisis and anæmia the drug is very servicable.

Neuralgias of other nerves than the cranial are rarely benefitted by *baryt-chloral*; but it is worthy of note that it may sometimes give relief in such cases by using with it 10 or 15 drops of the tincture of gelsemium.

In migraine, sick headache, and bilous headache, Ringer has recommended it, and in true migraine with hemianopsia it is certainly one of the most useful remedies along with antipyrine and caffeine, cannabis indica and gelsemium.

Curiously enough, while it cures the neuralgia due to a carious tooth, it does not cure toothache.

A great advantage possessed by croton-chloral is the applicability of moderate doses in cases of heart disease.—Dr. Hare, in *Med. News*.

THE CURE OF ANEURISM BY INDUCING THE FORMATION OF WHITE THROMBI WITHIN THE SAC.—Dr. William Macewen in a paper on this subject (*Brit. Med. Jour.*), thoroughly explains his method of introducing a fine, highly-polished needle through the wall of the sac, and irritating the lining membrane at a point opposite that of introduction. Not only may this be done, but without removal of the instrument the wall may be irritated at various points. The pin should never be used for more than 48 hours, and its introduction should be guarded by great antiseptic care. By this procedure the white corpuscles are segregated from the stream, and there is as well a proliferation of the cells of the walls of the vessel. The irritation must be of the slightest nature. The clot which forms at the point of irritation differs from the red clot which follows electrolysis, introduction of wire, slowing the stream, etc., from the fact that it becomes organized, which Dr. Macewen believes rarely occurs in red thrombi. The organization of the white thrombus is due to its getting a blood supply from the vasa vasorum. The principle is applicable to any aneurism which can be defined and only requires extreme cleanliness. Care not to injure the coats of the vessel by too much scratching, or too many punctures, and an avoidance of important structures which may lie on or near the sac. In support of this treatment the following cases are given: (1) Aortic aneurism seen at advanced period when threatened with impending death from dyspnea, treated by induction of white thrombi within the sac. Death one month after. *Post-mortem* examination showed the interior of the aneurism to be filled to two-thirds of its extent

by firm white thrombi. (2) Aneurism of the upper part of the right femoral, involving external iliac, measuring five inches in diameter, cured by induction of white thrombi. Patient died thirteen months subsequently from carcinoma of the tongue. *Post-mortem* examination showed the aneurism was obliterated; a mass of vascularized connective tissue represented the sac and its contents. (3) Aneurism of abdominal aorta treated by induction of white thrombi in interior of vessel; cure interrupted by patient feeling so well that he determined to resume work after about a month's treatment, though tumor not consolidated. Patient still alive two years and a half after. (4) Intrathoracic aneurism. Subclavian of left side, accompanied by great swelling, pain, numbness, and loss of power in the left arm. Treated by induction of white thrombi within sac; complete consolidation of aneurism and restoration of function of arm. No anesthetics were used during the operations, and very little pain was felt. In conclusion, Dr. Macewen trusts that his method will not be used in hopeless cases, or indiscriminately, as such a course will only bring it into discredit. He considers this caution necessary on account of the extreme ease of the operation, and the lack of any necessity for particular anatomical knowledge for its performance.—*Occidental Med. Times*.

THE BLOOD-SUPPLY OF NERVES.—At a recent meeting of the Academy of Sciences an interesting communication was made by MM. Quénu and Lejars on some new points in the vascular distribution in nerves. Having hit upon a novel and special method of injection, they were able to recognize in the circulatory apparatus of certain nerve trunks a series of constant dispositions hitherto little, if at all, noticed. So far their investigations have been concerned with the cervical portions of the vagus and parts of the great sympathetic. They show that the recurrent laryngeals, together with the adjacent cervical portions of the pneumogastric and sympathetic, have their blood-supply from the thyroid arteries exclusively, and the authors suggest that herein may be found a ready explanation of the aphonia as well as the respiratory and vaso-motor modifications which are observed sometimes to follow thyroidectomy and ligature of the common carotid or thyroid arteries, and they deem it not unlikely that this fact of common blood-supply may be an element in the pathology of certain forms of Graves' disease. The veins of these nerves are more abundant than the arteries, and do not always play the part of satellites to these latter, but after forming a plexus on the ganglia of the sympathetic and pneumogastric, they empty themselves into either the network of the vasa vasorum of the common and internal carotids, creating thus an intimate

connection between the wall of the artery and the nerve trunks which accompany it, or they join the thyroid veins, and especially a network of veins which covers the lateral wall of the pharynx; while others open into the veins in front of the vertebræ and into those of the pre-vertebral muscles. This connection of the veins of the nerve vascular system with muscular veins was found also to exist in the case of the limbs, and the authors submit that if it be allowed that muscular contraction is a factor in the circulation in small peripheral veins, it is evident that the anatomical peculiarity observed is calculated to aid favorably the expulsion of venous blood from the nerve trunks. The writers finally suggest that the abundant blood distribution in nerves may readily conduce to congestion, and that this, in its turn, may not be without importance in the pathology—as yet but little known—of neuralgia.—*Lancet*.

GUAIAIC AS A LAXATIVE.—Murrell (*Med. Press and Circular*) thinks that guaiac is a valuable laxative. His attention was drawn to the subject, two years ago, by casually prescribing guaiac lozenges made up with black-currant paste, for a man suffering from rheumatism. The man continued taking the lozenges long after the pain had ceased, and in explanation said that they did him good by acting on the liver and bowels, and said that one or two of the lozenges taken in the morning before breakfast, produced a stool promptly, and without inconvenience. The author ordered the lozenges for others of his patients suffering from constipation, and what is conventionally called "billiousness," and the results were equally satisfactory. The lozenges not being available for hospital use, he had a confection prepared containing ten grains of guaiac resin to one drachm of honey. This, for the last two years, he has used extensively, not only as a purgative, but in the treatment of chronic rheumatism, sciatica, tonsillitis, dysmenorrhœa, and allied affections. He gives from one to two drachms three times daily. The purgative effect is very pronounced, and in one case the patient had fifty-six evacuations in one week. In another case it produced a well-marked rash, covering the arms and legs with an eruption which forcibly reminded one of a copaiba rash. It was accompanied by intense itching which disappeared on discontinuing the drug. The guaiac not infrequently gives rise to a burning sensation in the throat, and to obviate this he prescribes ten grains of the resin in half an ounce of extract of malt. He believes that a trial of guaiac, either as a laxative or purgative, according to the dose employed, will be found satisfactory. It is possible that if the drug were triturated with cream of tartar, or with some inert substance, such as sugar of milk, its efficacy would be increased, and that it would produce the

desired effect in smaller doses.—*London Medical Recorder*.

THE Polish count who was brought into court for sequestering four children, and rearing them as animals, has been acquitted. It is reported that they had been confined each in a large, well-lighted and heated and ventilated room, well fed, and occasionally washed by a deaf mute; that they were unclad, never punished or restrained in any act; that two of the children have been confined thus, three, one four, and one four and a half years. The defence of the count was, that he was conducting a scientific experiment to learn what were the natural instincts and the intuitions really innate in the human species. The age of the children is not reported. They did not speak, and made barking, growling noises, and precipitated themselves upon their food like animals.—*Boston Med. and Surg. Jour.*

RESORCINE IN THE TREATMENT OF WOUNDS INFECTED AT POST-MORTEM EXAMINATIONS.—The deaths recently of several young practitioners in Germany, in consequence of blood poisoning following the receipt of slight wounds while making post-mortem examinations, has, according to a foreign contemporary, drawn attention to the question of the best means of treating these lesions. In this connection, Audeer, of Munich, has had good success with resorcine. Of all the antiseptics resorcine is, in his opinion, the most efficacious when used in these cases of blood poisoning. It is applied in the form of an ointment to the infected wound in a strength varying from five to fifty per cent. Vaseline is usually the excipient employed, but any other will do as well. Strong ointments of resorcine have a caustic action upon the tissues, and this being so, it is best to begin with the milder forms, say a half per cent., in order to obtain some anæsthesia of the wound. Then some hours afterwards a strength of from twenty to fifty per cent. may be applied, and the part may be covered with cotton wool. By this plan recovery rapidly ensues without pain, some desquamation of the part subsequently following.—*Med. Press and Circular*.

URINE OF OPIUM EATERS.—A statement has gone the round of the medical press, to some extent, that tincture of the chloride of iron added to the urine of an opium habitué will give a blue tint, as evidence of the presence of morphia. Dr. Mattison, of Brooklyn, whose experience makes authoritative what he says on the subject, states that this is not true.

Never be ashamed to own you have been in the wrong; it is but saying in other words that you are wiser to-day than you were yesterday.

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ERICHSEN'S DISEASE.

An attempt is being made in certain American professional circles to give the above patronymic title to the disease, or better the group of symptoms, first described by Mr. Erichsen, and otherwise known as "Railway Spine." The motives in this attempt are two-fold, one set of its promoters conceiving that they are doing the eminent surgeon an honor, the other, apparently most of them heads of the Medical Departments of some of the great American Railway Corporations, from desire to injure him, wishing, as one of them puts it, "not only to fix the name more accurately, but because a large amount of obloquy attends the subject which Erichsen ought to bear. His book is said to have cost English railways fifty million dollars, and American railways as much more."

Signs are not wanting in various quarters of a tendency towards the isolation of a separate branch of the medical profession, the Railway Surgical Staff, as distinct from their brethren as the Army Staff of any country is from the body of practitioners in civil life. Railway surgeons of course are only human, even those high up in the service of wealthy corporations; so one need not be surprised at finding *ex parte* views taken of Mr. Erichsen's work, and unfair imputation of motives to the sufferers from the carelessness or ill-fortune of railway employees. In the *Journal of the American Medical Association*, Nov. 1, '90, a paper is published, entitled, "Legal Aspects of

Spinal Concussion," read before the American Medical Association at its annual meeting in May last, by Dr. Clevenger, of Chicago. In the discussion that followed, a Dr. Judd, of Galesburg, Ill., is reported as saying, that "after twenty-two years' active practice, he had seen no spinal concussion cases recover until after the damages were recovered, and then speedily, except such cases as had no suspicion of a suit for damages attaching to them." To the credit of the Association, his ungenerous imputation of motives did not go by unchallenged, though others joined him in attributing to Mr. Erichsen's work the growth of a large amount of malingering and humbug. A few words on the subject may be not without interest, though it can by no means be exhausted in a paper such as this.

In pp. 743-763, vol. 1 of Erichsen's 8th edition, the subject is dealt with, and the most cursory reader will be struck with the vast preponderance of subjective over objective symptoms, so that it has been said that the suit for damages turns mainly upon the credibility of the plaintiff. Careful examination will show that objective symptoms of great value are also urged: loss of electrical irritability, paralysis, epilepsy, insanity even, and obscure neuroses which, though really diseases, may count as symptoms of the reality of the lesion, and can be shown to be distinctly pathological.

A short discussion of Shock in general will pave the way to a better understanding of the question. The symptoms of Collapse are too well known to need repetition at length: the pinched and changed expression, paleness and clammy sweat, sighing, irregular and shallow respiration, muscular relaxation; lustreless, half-open, unmoving eyes, with wide-open pupils and dark rings beneath them; blunted sensibility, both special and cutaneous, with no loss of rationality if only the sensorium be strongly enough appealed to; the small, slow, irregular, almost imperceptible pulse, and marked diminution of temperature; these are some of the chief. They indicate absolute loss of control, for a longer or shorter period, of the vascular system by the vaso-motor nerves, so that the patient is "bleeding into his own veins"; and by anæmia and nervous jar all the organs are rendered, for the time being, incapable of performing their functions. A workable theory

as to the causation of "railway spine" may be mentioned in this connection, that "the functional disturbance of the cord without demonstrable cord lesions, can be best accounted for by supposing that the spinal sympathetic system has been deranged, secondarily interfering with the blood supply of the cord and its membranes." This interference may or may not go on to cause chronic myelitis, or one or other form of sclerosis.

Shock in all its forms may be classified, as to causation, under the three heads: 1. *Corporeal* or traumatic, one variety of which is surgical shock, and which is usually either transient or speedily fatal. 2. *Psychic* or emotional, which may be instantly fatal, as in the classic tale of the execution of the janitor of King's College, Aberdeen, by the students, who with elaborate detail tried, sentenced and blindfolded him, then, instead of the axe which he had seen, struck him across the neck with a wet towel, causing instant death. Cases of death from sudden emotion will suggest themselves as within the experience of many of us. Another and not infrequent result of psychic shock is a condition of "chronic shock," often very persistent, but seen more frequently as the result of — 3. *Combined corporeal and psychic shock*. This variety is more frequently seen as the result of railway accidents than from any other cause, so much so, that it has been given the special name of "railway shock." All degrees of severity are seen: the mangling of the body which either causes speedy death, or, by the corporeal shock, blunts the nerves, so that the secondary shock due to the horrors of the scene can make no impression upon the obtunded sensorium. Or if the body escape with a scratch or a trivial bruise, the emotional element in the shock sustained is received in full force by the nervous system, the severity of the impression being usually in direct proportion to the absence of physical injury, and frequently ending in a condition which has been named "traumatic neurasthenia," the chief symptoms of which are, among various neuroses, emotionalism, flushing, hyperidrosis, tachycardia, sleeplessness, headache, epilepsy, even insanity.

The symptoms and sequæ of this combined variety of shock vary according to—1, the region injured; 2, the emotional state of the patient both by temperament and at the time of the accident; and, 3, the age of the patient, a child usually suf-

fering little from psychic shock. The force of the shock may be expended mainly on the heart and vascular system (traumatic shock), or the brain and cord (psychic shock and neurasthenia).

The position assumed then by such special pleaders for railways as Herbert Page, with his assertions about "litigation symptoms" and "quick-cure-by-settlement" cases, is that psychic shock cannot produce organic cord changes, and the public in this day of the *sauve-qui-peut* chase after the nimble dollar, in which might makes right as much as ever it did in the palmiest days of Feudalism, are surely indebted to Mr. Erichsen for putting on a recognized footing the disease we have been discussing, collating its symptoms and putting them as it were in concrete form. Grant that humbugs and malingerers, have in some cases profited by his labors, just damages have doubtless in many more cases been awarded, for "we find many instances, in and out of the books, of fatal issues among patients accused of malingering. We occasionally find a conscientious railway surgeon who acknowledges that railway accidents do not always improve health, and that a few dollars' settlement will not resurrect the dead."

Cases of railway shock are usually such as demand entire absence of bias, "the scientific mind" for their true diagnosis, lying as they do in the dim borderland in which mind and matter meet, which neither the physiologist nor the psychologist will ever fully understand. And surely it is only serious bias which can deny that psychic shock can, apart from organic lesion, produce damage by which the nervous system is incapacitated from performing its functions, and the unfortunate patient caused such suffering as no mere physical maiming could produce.

THE KOCH TREATMENT.

The world generally and the medical profession in particular have, during the last few weeks, been excited by the marvellous discoveries of Dr. Koch. The treatment of tuberculous lesions of various kinds has been taken up by the ablest and most scientific men of the world, with the result that to-day we have before us sufficient data to outline the usefulness, and some of the dangers, of this wonderful agent. In the presence of the facts as stated by various observers, and modified in some

instances by the varying interest and enthusiasm which attaches to every new discovery, we can recognize in Dr. Koch's anti-tuberculine a remedy which, when injected even in the small dose of one milligramme, excites marked change, in all deposits of a tuberculous nature. That these changes are, in the very great majority of cases curative, it is not possible for even the most ardent advocate of the treatment to assert. In lupus it does cause a most wonderful series of changes, these being mainly of the character of "œdema" of the lupus patch—the scar tissue softens, and the part of the lupus patch not cicatrized becomes acutely inflamed and afterwards tends to heal. But lupus is probably the most insidious and unsatisfactory of all diseases to deal with, owing to its great tendency to relapse; and it has been found, even already, to have evinced this same tendency after the Koch treatment, and in subsequent relapses the injection has not been followed by results the same as at first.

That certain substances of a septic character will excite acute inflammation in a part previously inflamed, or will lead to changes in old scar tissue, has long been known to the profession, and a glycerine extract of tubercle bacilli is essentially a similar substance. When the reports of Koch's treatment of tuberculosis of the lungs, at present to hand from all parts of the world, are carefully reviewed, it is not possible to regard the treatment of pulmonary cases with much hope; a few cases have been reported cured, but such form a very small percentage of the total number treated. It has been proven beyond doubt, that in advanced cases where cavities exist, or in which there is any extensive involvement of the pleural covering, the injection is in the highest degree dangerous.

It is to be regretted that the lay press has given such great publicity to this matter; the harm done is everywhere apparent, not only in the number of those who, unsuited for treatment, have been led to travel long distances in the vain hope of being speedily cured; but in the incorrect and sensational reports it has given of the views held by many eminent members of the profession, it has led the public generally to believe that the medical profession everywhere regarded it as a permanently established cure for pulmonary phthisis, and the fact that such is not at all likely to be the case will rebound to the injury of the profession.

In addition, the manner in which those who have handled the lymph have been advertised and reported has been most injurious in its tendencies, and while some may have favored the publicity which the daily papers gave them, we are of the opinion that such are very few.

PALPATION OF THE NORMAL UTERINE APPENDAGES.

Dr. Howard A. Kelly read a paper upon the "Palpation of the Normal Uterine Appendages" (published in full in the Feb. number of the *Am. Jour. of Obst.*) He stated that the normal uterine appendages could always be palpated. There are two avenues of approach, by the vagina and by the rectum, and three ways of utilizing these avenues. First, with one hand; second, with two hands employed bi-manually, either by vagina or rectum, and third, the tri-manual method, by vagina and by rectum.

First, the examination with one hand is unsatisfactory and the ovary cannot even be felt, unless abnormally displaced downward into the recto-uterine pouch. Second, the success of the bi-manual examination depends upon the downward pressure with the external hand displacing the abdominal walls in the direction of the ovary to be palpated, and thus affording a resistant plane against which the ovary can be felt by the internal hand. The internal hand must be used to invaginate the perineum, which is thus displaced upward into the pelvis. This invagination gives the examining finger, even though it be a short one, the necessary length. One, often even two inches, are thus gained in the palpating finger. Care must be taken in making the pressure necessary to produce this invagination, not to stiffen all the muscles of the forearm, thus impairing the tactile sense.

The rectum is, of all others, the best avenue for approaching the structures lateral to the uterus, affording as it does a wide open channel throughout the whole length of the pelvis. Where the structures cannot be reached at once through the rectum, they are brought within easy touch by bringing the uterus and ovaries into an *artificial retroposed* anteflexion, the mechanism of which was carefully described, by diagrams.

Dr. Kelly had, in this way, palpated fibroid

tumors on the posterior surface of the uterus near the fundus, not as large as a pea.

Third, the tri-manual examination is conducted either by the vagina or by the rectum and vagina, assisted with the hand above. The peculiarity of this method is an *artificial descensus uteri*. The uterus is grasped with a pair of bullet forceps and drawn downward until the cervix is seen at the vaginal outlet, and while an assistant holds it in this position, the gynæcologist uses his hands bi-manually. To obviate the employment of an assistant, Dr. Kelly has invented an instrument, which he calls the corrugated tenaculum, flattened and roughened so that it can be readily held between the last phalanges of the third and fourth fingers and the ball of the thumb, while the index finger of the same hand, assisted by the abdominal hand above, is engaged in making a vaginal or rectal examination.

By one or the other of these methods, the uterus, broad ligaments and ovaries and tubes are within reach of a most thorough and searching examination, revealing at once the smallest abnormalities.

SIMPLE REMEDY FOR PALPITATION.—Dr. Gingeot (*Rev. Gen. et de Chir. et de Ther.*) recommends (*Jour. Am. Med. Assoc.*) as a valuable remedy for palpitation—one that has proved serviceable to him—the application of cold to the precordial region. Attention must be paid to the method of applying cold. The simplest plan of all is to apply a wet sponge over the heart in the morning before dressing. At night, when in bed, the patient or an assistant may put a cold compress over the heart, well covered with dry bandages, to retain moisture, and prevent any wetting of the clothing. When this compress is warm, the patient will remove it, and will probably fall asleep. There are objections to the ice-bag, one being the condensation of insensible perspiration upon the surface of the skin. The ether-spray is a simple and convenient method of refrigeration. With proper instruction as to necessary precaution in the use of ether, the patient can apply cold in this way at any hour of the day or night. Palpitation of purely nervous origin seldom fails to be greatly benefited by the application of cold; and a certain success often follows its use in cases of palpitation due to organic dis-

eases. Equalizing the heart's action will often prevent an increase in its size. It is also useful in aneurism and passive dilation.

TURPENTINE IN ENTERIC FEVER.—Prof. H. C. Wood (*Med. News*) fears that the value of turpentine in typhoid fever is in danger of being overlooked at the present day. There are two stages of the disease in which it is particularly useful. The first stage is at the end of the second week, when the tongue becomes dry and glazed and the abdomen very distinctly tympanitic, with or without diarrhoea. The second period is during convalescence, when perpetually recurring diarrhoea indicates failure of some of the ulcers to heal. Professor Wood states that it is his routine practice to give turpentine in every case of typhoid fever, beginning about the twelfth or fifteenth day; and he believes that if its use were habitual, there should be fewer cases of intestinal hæmorrhage or other severe symptoms due to local lesion. It may be given with glycerin and a volatile oil made into an emulsion, in doses of ten to fifteen drops every two hours during the day time, the patient being allowed to rest at night. The following formula is used by him:

R.—Ol. carophylli, gtt. vj.
 Ol. terebinthinae, ʒ jss.
 Glycerinae, ʒ ss.
 Mucil. acaciae, ʒ ss.
 Syrupi, ʒ iij.
 Aquae, āā ad. ʒ iij.
 M. Sig.—Deserts spoonful as directed.

CHRYSAROBIN IN HÆMORRHOIDS.—A Paris correspondent of the *Pharm. Rec.* states (*Coll. and Clin. Rec.*) that extraordinary success has been reported with chrysarobin in the treatment of hæmorrhoids. For the external variety he prescribes the following ointment to be applied several times daily after a washing in a 1 to 50 solution of phenic acid, or a 1 to 100 solution of creolin: Chrysarobin, 80 ctgr.; vaselin, 25 gm.; for external use. For internal use the formula is as follows: Chrysarobin, 8 ctgr.; iodoform, 2 ctgr.; cacao butter, 2 gm.; make one suppository. In three or four days, pain and hæmorrhage are said to disappear, and it rarely happens that the most obstinate cases are not cured within two or three months.

TEA DRINKING AND COLD FEET.—Mr. Jonathan Hutchinson says in the *Arch. of Surg.*, that he once advised a lady to drink more tea. "I cannot touch it," was her reply. "It makes my feet icy cold, and wet with cold perspiration." On further inquiry, she assured Mr. Hutchinson that she was quite certain of her facts, and had often tested them. She thought that the perspiration was usually of the soles chiefly. Her hands were, she thought, also made cold, but not so definitely as her feet. Mr. Hutchinson says he had long been familiar with the facts that tea made the feet cold, but did not know that cold perspiration attended it.

SALOL IN ACUTE TONSILITIS AND PHARYNGITIS.—Dr. Jonathan Wright speaks highly of this drug in the above conditions, in doses of from 60 to 120 grains daily. It is given best in powder form, or as an emulsion. The author appends Dr. Gongenheim's summary:

(1) Salol acts beneficially in acute angina of whatever cause. (2) It quiets pain and dysphagia with the greatest rapidity. (3) It may shorten the duration of quinsy. (4) It lowers the temperature. (5) In nearly all cases it diminishes the duration of the angina. (6) Sixty grains at least should be given daily.

GRANULAR CONJUNCTIVITIS.—The following treatment is recommended by Tenlon (*Med. Progress*) in cases of granular conjunctivitis of a persistent type, with much photophobia. He orders one drop of the following collyrium to be instilled into the eye morning and night:

R—Distilled water, ʒ ss.
Neutral sulphate of atropine, . . . gr jss.

In the evening he introduces into the eye a very small piece of the following ointment:

R—Calomel, pure and thoroughly pulv., ʒ ij.
Vaseline, ʒ j.

He also finds it of service during the day to apply fomentations for as long periods as possible, consisting of the decoction of chamomile as hot as can be borne. At the same time it is well to administer internally cod-liver oil, syrup of the iodide of iron, and general tonics.

TREATMENT OF SWEATING FEET.—Dr. Legoux says (*Internat. klin. Rundschau*) that liq. ferri sesqui-

chlorati is the best drug for this condition, and he uses the following mixture:

R—Liq. ferri sesquichlor., . . . ʒ viiss.
Glycerini, ʒ iiss.
Ol. Bergamotti, ʒ v.—M.

Sig.—To be applied either with a camel's hair brush, or a feather, on the soles and between the toes. In a few days the sweating and the stench disappear.

THE DRY TREATMENT OF CHANCROIDS.—The following treatment in use in the surgical divisions of Bellevue Hospital, New York, is recommended: After the prepuce has been retracted a small quantity of absorbent cotton is made to surround the penis just behind the corona, and is held in place by a rubber thread-band. The sulcus behind the glans is thus obliterated, and no longer forms a receptacle for secretions. The ulcerated glans is free from irritation, the prepuce being held back, and the cotton absorbs the exudation almost as soon as formed. The dressing can be changed as often as is necessary to keep the parts dry.

INFANTILE CONSTIPATION WITH GASTRIC IRRITABILITY.—Dr. Woodbury, of Philadelphia, says, in *The Dietetic Gazette*, that this may be relieved by a quarter of a grain of calomel with two grains of saccharated pepsin every hour or two till the bowels are evacuated. For simple constipation, he recommends Carlsbad water in tablespoonful doses, four or five times a day. This has a most happy effect, partly from the quantity of water, but more especially from the increase of secretion along the intestinal tract, caused by the action of this water.

THE TREATMENT OF BURNS.—Dr. Bradeleben, of Berlin (*Lyon Med.*) treats burns by washing with a 2% solution of carbolic acid, or a 3-1000 solution of salicylic acid. The blisters are then opened and the whole surface covered with subnitrate of bismuth, over which cotton wool is placed in a thin layer. This dressing is removed when necessary; if the burns are very extensive bismuth in ointment is used instead of the powder. It is said that symptoms of bismuth intoxication never follow, and that recovery is more rapid, and suffering less than with any other method of treatment.

TREPHINING FOR EPILEPSY.—Says Dr. Minor (*Boston Med. and Surg. Jour.*):—There are three main indications for trephining in epilepsy that hold good, provided medical treatment or the removal of peripheral irritation by other methods fails to cure or relieve.

1. In the distinctly traumatic epilepsies following depressed fractures and other lesions of the skull.

2. In the traumatic epilepsies in which the only visible lesion consists of a scalp wound that is sensitive or tender, and upon which pressure develops either an aura, vertigo, or an epileptic seizure.

3. In all epilepsies, whether traumatic or not, in which the character and development of the seizures is such as to indicate a definite motor area as the seat of a cortical lesion.

The contra-indications, he went on to say, were, in brief, those that might be applied to cases of such long duration as to lead to marked mental degradation; to cases in which from the first the seizures had been general and sudden; to cases where the general symptoms indicated an extensive cerebral degeneration, and to cases where, in addition to any or all of these conditions, there was nothing in the symptoms or history of the case to indicate a definite or circumscribed lesion of the cortex that could be reached or removed.

TREATMENT BY SUSPENSION.—Little seems now to be written or said, says *The Lancet*, regarding this method of treatment in this country. On the Continent, however, it is still used, but apparently its sphere is being gradually narrowed. In the *Deutsche Med. Wochenschrift*, 1890, No. 37, Rosenbaum gives the results observed in a series of cases seen at Mendel's clinic in Berlin. Of sixty cases which had a full course of treatment, there were twenty-five which improved. The improvement was most marked as regarded ability to stand and walk; the pains were lessened in frequency, but not abolished; incontinence of urine was temporarily improved in some cases, but it is not claimed to have been cured in any. As to improvement in the acuteness of vision in cases where the sight was affected, nothing very definite seems to have been experienced. It is to be noted that the cases in which improvement is said to have taken place are all cases of locomotor ataxy. The author is not enthusiastic as to the efficacy of

suspension, but thinks it might be tried, and is of opinion that in estimating its value from the therapeutic point of view, allowance must be made for the very considerable mental effect produced on the patient.

IMPORTANCE OF EXAMINATION OF THE TEETH IN EPILEPSY.—Dr. Bakowski mentions in the *Przeglad Lekarski (Lancet)* an instructive case of epilepsy occurring in a young Jewess. It had been going on for nine months, and latterly the fits had become more frequent, there being several every day. Bromide of potassium, quinine, arsenic, and asafoetida had been given without any effect. Finally, although there was no complaint of toothache, it was decided to examine the mouth. Two teeth were found to be carious—the first upper molar on the right and the first lower molar on the left side. These were extracted, with the result that the fits entirely ceased and did not return, though the patient was under observation for six months subsequently. Upon being closely questioned the girl remembered that before the fits commenced she had had some unpleasant sensations in the affected teeth, but nothing that could be described as pain.

EHRlich's TEST FOR TYPHOID FEVER.—The difficulty of the early diagnosis of typhoid is recognized by every practising physician, and any aid in that direction should be very thankfully received. The following is said to be certain: Make two solutions, one consisting of seventy-two minims hydrochloric acid and ten grains of sulphilic acid in three ounces distilled water; the other, a freshly-prepared one-half per cent. solution of sodic nitrite in distilled water. To twenty-six parts of urine from a typhoid fever patient, add twenty-five parts solution one, and one part of solution two, and the mixture is rendered alkaline by addition of ammonia. A bright orange-red color appears.

SAYS the *Hospital Gazette*:—We understand that Dr. Duke, of Dublin, has designed, or will shortly publish an illustration or description of a new form of chloroform inhaler, the advantage claimed being that the valves are made to sound on the slightest inspiration or expiration of the subject under chloroform, and so give immediate notice of any change in the respiration. When

we consider the large number of deaths from chloroform published week after week, any means for contributing to the safety of chloroform administration should be gladly welcomed.

THE Hamilton Medical and Surgical Society held their seventh annual dinner in Newport's Dining Hall, on Thursday the 16th ult., at which all the members thoroughly enjoyed themselves. The toast list of the evening embraced:—The Queen and her Representatives, The Hamilton Medical and Surgical Society, Our President, Our Guests, The Ontario Medical Council, Our Absent Friends, The Army, Navy and Volunteers, and The Ladies.

ETHER INJECTION FOR NEURALGIA.—Dr. Kunes, of Antwerp, has conceived the plan of using subcutaneous injections of ether in the treatment of neuralgia. He prefers to use Hoffman's anodyne, containing equal parts of ether and alcohol. He injects as near the seat of pain as possible, a quantity equal to what an ordinary Paravaz syringe will hold. Often a single injection has sufficed, but in a certain number of instances, two or three have been found necessary.

PUERPERAL FEVER.—At a recent meeting of the Obstetrical Society of London, in a discussion regarding fever in childbed, opened by Boxall, it was concluded that bi-chloride of mercury remained the best antiseptic known, but that its routine use in douches was not necessary. In several hospitals of London, salufer had been tried as an antiseptic, but found inferior to corrosive sublimate.

A SOLUTION FOR NASAL CATARRH.—According to *L'Union Médicale*, the following solution is used successfully in the London Hospital:

R.—Ammon. muriatis, ʒ j.
Sodii chloratis, ʒ iiss.—M.

Sig.—Add a teaspoonful to a glass of water, to be used twice daily as a nasal douche in post-nasal catarrh combined with deafness.

PUNCTURE AND COLLODION IN HYDROCELE.—Leroy recommends that one-third, or one-fourth of the fluid be withdrawn by means of an aspirator, after which the whole scrotum is painted with a thick layer of collodion, which is to be re-

newed every twenty-four hours. A cure results in from 12 to 15 days. M. Broquet has also employed this treatment with success in three cases.

COMEDONES.—McCaskey (*Weekly Med. Review*), uses the following application in the treatment of comedones:—

R.—Ether sulphuris, ʒ viij.
Ammon. carb., ʒ i.
Boric acid, gr. xx.
Aque. ad. ʒ ii.—M.

Sig.—Apply locally, twice daily.

NITRO-GLYCERINE IN ASTHMA.—Dr. Hofman has recommended subcutaneous injections of nitro-glycerine in doses of $\frac{1}{16}$ to $\frac{1}{8}$ of a grain. In angina pectoris and severe asthma he claims that the effects of these injections are remarkable. No objectionable after-effects have yet been observed.

TANNIN IN BURNS.—Mikasky, in *Rev. de Therap.*, recommends tannin in superficial burns, as follows:

R.—Tannin,
Alcohol, āā ʒ j.
Etheris sulph., ʒ i.

WE learn from Dr. Powell that Dr. Nicholas Seine has signified his intention to read a paper at the next meeting of the Ontario Medical Association. Dr. Howard Kelly, of Baltimore, will also be one of the American guests who will read a paper.

BY an error in our December issue, the name of Dr. W. E. Almas was included in the list of those who recently took the triple diploma, Ed. Dr. Almas took the L.R.C.P. Lond. examination and holds that diploma.

SALOL-COLLODION.—Dissolve four parts of salol in four parts of ether, and then add thirty parts of collodion, and apply it to the affected parts in acute rheumatism and it will be found to give rapid relief from pain.

DR. J. H. PARSONS, late of Meaford, Ont., has returned from Europe, where he has been devoting himself to the special study of the eye, ear, throat, and nose. He will soon begin the practice of his specialty in the city.

It is said that one of the patients suffering from leprosy, treated by Prof. Neumann, of Vienna, shows some signs of improvement. There is said to be a flattening of the nodules and some desquamation.

SCABIES.—The London *Med. Rec.* says the following is an efficient application for scabies :

R—Creolin, 1 part.
Balsam of Peru, 20 parts.

INK AND RUST STAINS are easily removed (*Med. World*), by a solution containing ten parts each of tartaric acid, alum and distilled water.

Books and Pamphlets.

COMPEND OF DISEASES OF CHILDREN, by Marcus P. Hatfield, M.A., M.D., Professor of Diseases of Children, Chicago Medical College; Physician to Wesley Hospital, etc.

Having read this compend, we are fully convinced that it will merit the approval of the medical student. As there are no lectures given solely on children's care and diseases, this little volume will be of great service to him, until he commences practice, when the use of a more lengthy discourse on this subject will be found necessary.

As the first few years of child-life are the most critical, and likewise most difficult to manage when disease sets in, the young physician should be well acquainted with the management and treatment of children, and as a preparatory course, while a student, Dr. Hatfield's compend will be sufficient.

COMPEND OF HUMAN ANATOMY, by Samuel O. L. Potter, M.A., M.D., Professor of Theory and Practice of Medicine in the Cooper Medical College, San Francisco. Author of "A Handbook of *Materia Medica*, Pharmacy and Therapeutics," etc. Late Ass't.-Surgeon U. S. Army.

Of all the studies in a medical course, anatomy is the most important. To wade through a "Gray," for review, is very irksome, and by having an Anatomy in an epitomized form and thoroughly reliable, both time and labor will be saved. Dr. Potter has thus conferred a boon on the student and practitioner alike, by publishing his compend of Anatomy. The tables and plates of the nerves and

arteries are excellent; these constitute the Appendix, and by their aid one can review this important part of the work in a short space of time.

A PRACTICAL TREATISE ON IMPOTENCE, STERILITY and allied disorders of the Male Sexual Organs, by Samuel W. Gross, A.M., M.D., LL.D., Professor of Surgery and Clinical Surgery, Jefferson Medical College, Philadelphia, etc. Fourth edition, revised by F. R. Sturgies, M.D. Philadelphia: Lea Bros. & Co. 1890. Toronto: Vannevar & Co. Pp. 169, cloth.

The author lays great stress upon the fact that impotence and sterility depend upon reflex disturbances of the genito-spinal system, which are almost always induced or maintained by appreciable lesions of the prostatic urethra. He makes this very clear by the narration of a number of well selected cases. The work supplies, in a compact form, sufficient practical and strictly scientific information for the general practitioner. We commend the book as a very suggestive and useful one, and believe it will do much to enlighten the rank and file of the profession in those subjects; for while the uterus and ovaries with their various disorders are constantly kept before the minds of the profession, information relating to the male sexual system is much more difficult to find.

THE PHYSICIAN'S RECORD, for the use of Physicians and Nurses, compiled by Agnes S. Brennan. New York: G. P. Putnam's Sons. Toronto: Williamson & Co. 1890.

This will be a useful blank-book for nurses having charge of cases in private families. It is ruled for date, time, temperature, respiration, pulse, medicine, nourishment, stimulants, remarks and urine, with an interleaved slip for the doctor's orders,—at the end one charts for the physician. The book contains 100 pages, and is neatly and strongly bound.

Births, Marriages and Deaths.

At Christ Church, Willard, N. Y., on Jan. 7th, '91, Edwin R. Bishop, Esq., M.D., of the Willard State Hospital, to Miss Bessie E. Gilbert, daughter of Morris J. Gilbert, Esq., of Willard, N. Y.

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