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## The Northern Lancet And Pharmacist.

*Gleans from the journals of the World all that is new in Medicine, Surgery and Pharmacy, placing monthly before its readers in a condensed form Medical, Surgical, Obstetrical and Pharmal advances in both hemispheres.*

WINNIPEG, DECEMBER, 1890.

### WINNIPEG GENERAL HOSPITAL NOTES.

BY W. S. ENGLAND, M.D.  
Medical Superintendent.

#### TUBERCULAR MENINGITIS.

CASE 1.—J.H., aged 21, foreigner, was admitted to the Winnipeg General Hospital under Dr. Blanchard, October 15th, 1890, complaining of a severe headache, anorexia and weakness. His previous health has always been good. The family history is very vague. One brother died at the age of nine from some obscure brain trouble, said to be due to over-reading.

The present illness began about October 1st, '90, the patient then experiencing a dull frontal headache. At first this was not constant but it soon became much more severe and about October 12th it became constant and he was obliged to take to his bed. A physician was called in who pronounced the patient to be suffering from a mild attack of typhoid fever, and sent him to the hospital. Previous to this his appetite has been good and his bowels regular. He has suffered slightly from vomiting and indigestion.

On admission the patient appeared very languid and indisposed, although not seriously ill. Eyes are dull and heavy, pupils normal, skin dry and hot. The tongue is heavily coated with a thick white fur, breath somewhat offensive, anorexia, bowels constipated. The abdomen is flat but otherwise apparently normal. There are no rose-colored spots and no iliac tenderness; temperature 98

to 99°F., pulse 50 to 60, respirations normal. He complained of a dull constant headache situated in the frontal and parietal regions, sometimes in the occipital region. The sleep is poor and muscular tremors are seen at times. The heart, lungs and urine were examined with a negative result. A tonic was given before meals and analgesics for the pain with very slight benefit.

Oct. 27th. Sleep was very broken last night; vomiting and epistaxis this morning. He is very irritable and complains of stiffness of the neck. An ice cap was applied to the head and sedatives given freely.

Oct. 28th. Patient is somewhat delirious to day and is very restless; temperature 100.2-5°F., previous to to-day it never going above 99°F.; face flushed; pulse slow and full. The fundus of the eye was examined, it appearing congested and the blood vessels indistinct. No tubercular nodules were discovered on the choroid. The ears were examined and reported negative. These symptoms continued until the 30th inst., when the patient became very listless and finally unconscious. The pupils were moderately contracted but even and active; temperature 102°F.; the pulse remaining slow and full; no "tache cerebrale" were elicited. A transient paresis of the right arm and leg was noticed to-day which was soon recovered from, but followed by a similar paresis of the left side; swallowing became difficult. Later, on both sides of the body became paralysed and the patient sank into a deep coma and died on the 31st, about midnight. Before death the temperature gradually rising to 105°F.; the pulse and respirations becoming rapid (140 and 60), and the chest filled with rales.

The autopsy revealed acute miliary tuberculosis affecting both lungs throughout, and the surface of the kidneys and liver. There was a moderate amount of effusion into the subarachnoid space at the base of the brain, and into the lateral ventricles. A tubercular meningitis of an advanced degree affecting the thin membranes at the base of the brain was

present; miliary tubercle also being deposited along the blood vessels of the longitudinal and other principal fissures of the brain, also along the choroid plexus and in the smaller vessels of the dura-mater. No original focus for the dissemination of tubercle was found; no enlarged or caseating glands present.

CASE 2.—Fibro-Cystic Tumor of the Uterus, Hysterectomy—Recovery.

A.B., aged 34, unmarried, was admitted to the Winnipeg General Hospital June 16, 1890, under Dr. Good, complaining of a swelling of the abdomen and weakness.

The previous health has always been good, and menstruation regular until about ten months ago, when she first noticed a lump in the abdomen, in front. Soon she began to suffer from frequent and irregular menstruation. Also menorrhagia at times. These symptoms gradually increased in severity, and the patient became very anæmic and lost flesh, but still was able to continue with her work.

Her attending physician was called in about five months ago, who considered his patient to be suffering from a uterine fibroma.

She was given a tonic and put on fl. ext. ergot, ʒi doses t.i.d.

The tumor at that time reached to within an inch of the umbilicus. Soon after that her menses ceased, but the tumor continued to grow gradually, and at present is about the size of a uterus at the seventh month of gestation, reaching about two inches above the umbilicus.

The tumor is hard and even on its surface, except for an irregular nodule at its upper and left side, no fluctuation was made out; on auscultation no bruit or foetal heart was heard. The cervix is softened and congested; the external os somewhat patulous. The cavity of the uterus measures nearly six inches.

Recently she has suffered from pressure symptoms on the rectum and bladder, but no pain. The menorrhagia began again about four weeks ago and has lasted more or less since.

June 17th. The patient was prepared and ether being given, Dr. Good proceeded

to operate. An incision about four inches long, was made in the linea alba over the centre of the tumor. The surface of the tumor being exposed an aspirating needle was introduced, but no fluid could be withdrawn.

The tumor was found to be united to the parieties and adjacent organs all around by firm adhesions, consequently it was found necessary to enlarge the original incision upwards and downwards, making it about seven inches long.

These adhesions were ligatured in parts and broken up, and the tumor reflected downwards out of the abdominal cavity. Both ovaries and fallopian tubes were found embedded in dense adhesions and a good deal of difficulty was experienced in ligaturing them. They were removed and a wire fixed around the stump of the tumor (the cervix uteri), and tightened. The stump was transfixed below the ligature by two steel supports, the ends of which were brought to rest on the abdominal parieties and then cut across above the ligature.

The abdominal cavity was washed out with a weak solution of boracic acid and the incision sutured tightly around the stump completely excluding it from the abdominal cavity, a drainage tube being inserted adjacent to the stump above.

The operation lasted two hours, after which antiseptic dressings were applied and the patient removed to a warm bed. Although the shock was severe the patient soon recovered, and looked very encouraging.

Champagne and small pieces of ice only were given for the first twenty-four hours. The wound was dressed thirty hours after the operation and was found to be looking well. There was comparatively no discharge. The drainage tube was removed and another suture tightened in its place.

The patient made an uninterrupted recovery except for an attack of diarrhoea on the 26th inst, when she became very restless and exhausted, and the temperature rose to 102°F., but fell to normal again in a few hours. She was allowed up on the 16th July, and discharged on the 24th

as cured. Since then she has been in good health and looks much improved.

The tumor was of the nature of a fibroid but small cysts were found in places, around which areas the tissue was soft and somewhat translucent in appearance.

### LINGERING LABOUR.

#### *Meeting of the British Medical Association.*

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I may begin by asking myself in what respect do my own views in 1890 differ from those I was taught as a student some thirty-five years ago. The predominant idea at that time was that interference by way of promoting a rapid labor, and easing the agonies accompanying it, was a thing to be looked on with the greatest suspicion. This teaching, which was embodied in the often-quoted axiom, that "meddlesome midwifery is bad midwifery," led to the patient being often needlessly left to linger on in many fruitless hours of suffering, wearied and exhausted by her pains, and making, therefore, a protracted convalescence which she might have readily been spared. The tendency of the day is perhaps to err in the opposite direction, but I do not hesitate to affirm that it is the bounden duty of the practitioner to avail himself of every means in his power to ensure his patient an easy and short labor, with as little suffering as possible, provided only he is satisfied that the means he adopts are such as are not in themselves likely to prove injurious.

To begin with, let us consider what may be done in a case of labour prolonged in the first stage from a rigid and undilated cervix. In this, the great lesson insisted on in my youth was that protraction is of no importance provided the membranes are unruptured, and that therefore the sufferings of the patient were of little consequence. For example, I refer to Churchill's *Midwifery*, which was the most generally used textbook when I was a student, and I find it laid down that labour is not to be considered

as even tedious, unless more than twenty-four hours have elapsed; again, we are told that no matter how long the delay, we are not justified in interfering unless we find evil resulting. I fancy that few modern obstetricians would admit these statements to be such as now guide them in practice.

The mere wear and wear of a labour lasting more than twenty-four hours seems to me to be in itself a serious thing, nor do I admit that it is right to wait with our hands folded, doing nothing, until symptoms of mischief have actually arisen. I shall not consider here at all cases in which rigidity of the cervix is due to structural causes, such as cicatrices, inflammatory or malignant indurations, and the like, all of which are exceedingly rare. I refer simply to the frequently met with difficulty arising from non-dilatation caused by inertia, or by irregular and cramplike pains, premature rupture of the membranes, adhesions of the membranes, and over-distension of the uterus from excess of liquor amnii.

It is in such cases that our predecessors recommended an energy of practice very much at variance with their theory that delay was of little consequence. Blood-letting was the first resource, fourteen to fifteen ounces being recommended by Churchill as a very moderate quantity; then came tartar emetic in nauseating doses, large hot baths, and other such means, all of which may be placed in the limbo of obsolete remedies, and none of which are probably ever thought of in the present day. Opium was advised occasionally, and no doubt is useful in certain cases, but has the disadvantage, no matter in what form it is administered, when given in sufficient quantity to be really useful, of temporarily arresting the pains altogether. It is to be noted that in the vast majority of such cases there is no real obstacle in the cervix. It may be said that this will always dilate readily enough provided the expulsive powers be properly acting, and in dealing with this our first object will be to ascertain, and if possible remove, the cause which is interfering with the normal progress of the case. Fortunately, we have most useful agents at our disposal which were

altogether unknown to our predecessors. Of course, I do not consider the obvious resource of seeing to such conditions as the state of the bowels, the bladder, the normal axis of the uterus, and the like. The relief of the acute pain, the calming of the excitement attending it, the lessening of spasmodic uterine action which is one of the chief causes of non-dilatation of the cervix, and the relaxation of tissues are all promoted in a most marked degree by the use of anæsthetic drugs, which were entirely unknown to our predecessors. I do not here refer to the administration of anæsthetics by inhalation. The value of this at the proper time, which in my judgment is during the expulsive stage, is very great; but chloroform, especially when given over-freely, has, in my experience, the disadvantage of distinctly retarding labour by lessening uterine action, and thereby causing inertia. It is too strong an agent, I believe, for the first stage, and not sufficiently prolonged in its action. In chloral, however, we have a remedy of almost incalculable value in prolonged first stage, and which practically supersedes all other methods of dealing with this troublesome complication.

In 1874, in a paper on this subject, I directed the attention of the profession to the value of this drug in labour, and ever since I have been constantly using it with the best results. Since that time I have practically never had any trouble from the thin rigid cervix, which formerly used to give so much worry. Under the use of this agent the pains become longer, steadier, and more efficient; the patient falls into a somnolent condition, dozing quietly between the pains, which are not lessened or annulled, as is the case when chloroform is inhaled freely; and, above all, the wild state of excitement, which is so frequent in this class of labour, is calmed and soothed, to the infinite relief both of the patient and practitioner. Nor is it necessary to administer doses of any unsafe amount. Fifteen grains, repeated in twenty minutes, either by mouth or rectum, is generally sufficient to produce an effect lasting over several hours. Possibly a third dose may occasionally be required, but never more.

Another great good following this practice is that, when the expulsive stage is reached, the patient being already in a state of semianæsthesia, very much smaller quantities of chloroform or of the A C E mixture are required than would otherwise be the case. Since using chloral in this way I have never had occasion to give opiates either by the mouth, rectum, or hypodermically, and I believe them to have the disadvantages of tending to arrest uterine action altogether, instead of steadying or even increasing it, as is the case with chloral.

A subsidiary drug, of recent introduction into midwifery practice, is often decidedly useful at this stage of labour, and that is quinine. It is, perhaps, hardly to be called an oxytocic, since it is said to act rather as a general stimulant and promotor of vital energy than as a direct exciter of uterine action, although it has recently been pointed out by Dr. Doyle that in Trinidad quinine, given in malarial fevers, constantly produces uterine contraction and abortion. Be this as it may, it is, I believe, the case that in labour with feeble ineffective pains in the first stage, one or two doses of 15 grains have often a markedly beneficial effect in strengthening and altering the character of the pains; nor have I ever had reason to think that it has any of the dangerous properties of ergot.

Amongst mechanical means used in undilated os, manual dilatation with the finger long held a prominent place, and was formerly, as you will remember, the subject of much acrimonious discussion, having been recommended by Smellie, Burn, Gooch, and other prominent obstetricians, and strongly reprobated by others, such as Denman, who calls it "an abominable practice." In recent times Dr. Trenholme, of Montreal, has pointed out—and I am convinced that it is a sound practical observation—that separation of the membranes by sweeping the finger round the inner surface of the os, frequently remarkably promotes dilatation. Whether his theory that this acts by separating adhesions which retard dilatation be correct or not I cannot say, but of the fact I have no doubt, and this mechanical expedient can at least do no harm.

When the head is pushed low down into the pelvis, the os being soft and relaxed, and the membranes ruptured, my belief is that gentle manual dilatation, pushing, as it were, the os over the head, is frequently extremely useful, and may very materially expedite the progress of the case. It requires, however, some judgment and practical experience as to the proper cases in which it is to be used. I have myself never seen any thing but good follow in the cases in which I have adopted this expedient, but I hesitate to recommend it, for I can well understand that when rashly or roughly practiced it may do much harm. Pushing up the swollen anterior lip, when impacted between the head and the pubes, is not only legitimate, but essential, in my opinion, to save injury to the os. The gentle pressure of the finger is obviously much less likely to be hurtful than the long-continued bruising to which the uterine structures would otherwise be subjected. Lastly, the mechanical dilatation of the os by caoutchouc dilators may occasionally, but I think very rarely, be of service.

We may now proceed to discuss the modern practice in prolonged second stages, the head being in the pelvic cavity, and the labour simply delayed from want of expulsive pains. In this most common class of lingering labours the two most prominent changes are the almost entire disuse of oxytocic drugs, such as ergot of rye, and the more frequent use of the forceps. In every textbook of thirty or forty years ago a large amount of space is given to the indications for the administration of ergot. No practitioner went to a labour without it, and although it was admitted to be not quite free from some risk to both mother and child, no doubt was expressed as to its great utility. Its tendency to produce tonic and tetanic uterine contraction, and, therefore, seriously to imperil the life of the child, is now universally admitted; and this property, invaluable in the third stage of labour after the birth of the placenta, has of late years been almost universally admitted to be an absolute contraindication to its use in the second stage.

We may safely take the rules now in force in the chief lying-in hospitals to be a good guide to the prevalent practice of the day, and I find on inquiry that the administration of ergot is now absolutely prohibited before the expulsion of the placenta at the Rotunda Hospital in Dublin, the Edinburgh Maternity Hospital, and the chief lying-in hospitals in London—the General Lying-in, the British Lying-in, and Queen Charlotte's. We may, therefore, fairly conclude that ergot is no longer used as an oxytocic in good midwifery practice. Whether its use should be entirely given up is a question on which there may be some difference of opinion. My own is that the drug is an unsafe agent, and that its effects are too much beyond our control, and that, therefore, its disuse is a distinct scientific gain.

An entirely modern oxytocic, first brought prominently into notice by Kristeller under the name of "expressio factus," is manual pressure applied directly to the uterus to increase the force of feeble pains, or even to take their place when they are entirely absent. The idea, however, is a very old one. Thus it was certainly known to the ancients, for Albucasis says: "Cum ergo vides ista signa, tunc oportet ut comprimatur uterus ejus, ut descendat embryo volociter." That pressure applied to the uterus is of great utility in labour may be inferred from the fact that in some form or another it is almost universally found to take a part in the obstetric customs of savage tribes. Thus among the Kalmucks a woman sits behind the patient, and, passing her arms round her, squeezes the uterus during the pains. Very similar expedients are commonly used among the North American Indians, the Mexicans, the natives of various parts of Africa, India, Siam, and the Sandwich Islands. In some cases the pressure is applied by an assistant seated in front of the patient, with the hands spread out on either side of the uterus, in others the uterus is clasped from behind, whilst in some cases pressure is applied by bandages passed round the abdomen. A practice so wide-

ly spread must have in it an element of utility, and we shall do well to study how far it may with propriety be adopted in scientific midwifery.

For many years past I have used uterine expression regularly whenever I found it necessary to intensify feeble uterine action, and I am satisfied that with proper limitations we have in it a most valuable addition to our resources, which is as yet not sufficiently appreciated, and which is destined to take a recognised place as an oxytocic agent in every way safer and more manageable than ergot. The best way of using it is, I think, for the practitioner to stand by the side of the patient (who is in her usual position on her left side), and to spread his left hand over the fundus. When the pain comes on strong downward pressure is made in the direction of the axis of the brim. If the finger of the right hand be placed simultaneously on the head *per saginam*, it will be felt to be pushed down in a very marked way. I have often in this manner pushed the head through the brim, where it had been long delayed, and right on to the perineum in two or three pains; and on more than one occasion when called to a tedious labour with the view of delivering by forceps, I have avoided the use of the instrument by this means, and rapidly terminated the case.

A mechanical oxytocic of this kind is entirely within the control of the practitioner, and can be used exactly as he thinks best to assist feeble pains, or intermitted when the pains are stronger, and it has, therefore, none of the disadvantages of ergot, the effects of which when once given are entirely beyond our control. I have never seen anything which led me to think that pressure on the uterus, used with due care, has had any sort of injurious effect. It is, in fact, merely a means of supplementing the deficient *vis a tergo*, which is so essential for the proper progress of labour. It is needless to say that this expedient is only applicable in the second stage, after the rupture of the membranes, and when it is known that the pelvis is of full size, and that there is no resistance from the soft parts.

The one characteristic of modern midwifery practice which most distinguishes it from the practice of half a century ago is the frequency with which labour is terminated by the forceps.

Strongly convinced as I am that it is unwise to allow patients to drag on unnecessarily in labour for an indefinite time, and satisfied though I be that the modern practice is far better in this respect than that of our immediate predecessors, I am by no means sure that the pendulum may not have swung too far in the opposite direction. When I hear of men who put on the forceps in every fourth or fifth labour, I cannot help fearing that they may have been tempted to their use, perhaps unconsciously, with the view of saving their own time, rather than because they considered them essential for the welfare of the patient. It is very difficult in practice, and the remark applies to many other things besides the use of the forceps, to walk in the safe and judicious *via mediæ*.

It is surely needless to insist that the convenience of the practitioner can never be a reason for expediting labour. Before, however, considering the practice of to-day, let us see what was that of the past. Within the memory of many of the senior members of the profession the use of the forceps was the rarest of events, and it was so held *in terrorem* that many conducted a large midwifery practice without hardly ever using them. Even since I began practice in London it came to my knowledge that in one of the largest metropolitan suburbs there was not a single practitioner who possessed a pair of long forceps. As an example of the kind of practice which was prevalent, let me give you two instances culled from published histories.

One is the historical case of the Princess Charlotte of Wales, which I have elsewhere described in this connection, but which will bear referring to again because of its interest and importance. It may be fairly assumed that the heiress to the Crown had the best attendance that could be procured, and that her labour was conducted on the principles then recognised as correct. In this case the membranes ruptured at 7 p.m. on a Mon-

day evening. The head must have been on the perineum early on the Tuesday morning, because Baron Stockmar tells us in his *Memoirs* that at that time delivery was momentarily expected. At 6 p.m. on the Tuesday evening the discharges are stated "to have become of a green colour." Even then Dr. Sims, who describes the case, says: "There never was room to entertain a question about the use of instruments;" and this luckless patient was actually not delivered until 9 p.m. on the Wednesday, and was allowed to exhaust herself with feeble ineffective pains for fifty hours after the rupture of the membranes, and not much less after the head was on the perineum. Naturally this case gave rise to much discussion at the time, but no one seems to have suggested that the physicians were to blame in allowing their patient to linger on so long in a labour that probably could have been terminated with the greatest ease on the Tuesday morning. It is a strange thought that but for this atrociously bad midwifery the whole destinies of the nation would probably have been altered, and our present Sovereign might never have succeeded to the throne she has so long and so admirably occupied.

The second case I take, almost at random, from Gooch's *Compendium of Midwifery*, and I select that book because its author was *facile princeps* amongst the obstetricians of the day, and was a man of the greatest shrewdness and practical skill. He tells us "if the labour has been a long time stationary, and you believe that it cannot safely be accomplished by the powers of Nature, your best practice will then be to apply the forceps." This is sound practical teaching, far above that which was prevalent at the time; but even he is so imbued with the dread of the forceps that this is how he illustrates it:

"I was sent for by an accoucheur," he says, "who had been detained at a labour for two days and a half. The head had been fixed in the pelvis and touching the perineum for fourteen hours. I said I would wait three hours longer, and, if she was not then delivered, I would apply the forceps and deliver her in ten minutes—which I was obliged to do after the head

had been retained low in the pelvis for seventeen hours" I venture to affirm that if any student of the present day were to tell the Conjoint Board of Examiners that it was an admissible thing to leave the head on the perineum between forty and fifty hours, as in one of these cases, or even seventeen, as in the other, he would infallibly be remitted to his studies for a very considerable period.

It will thus be seen that the practice of the practitioner as regards the use of the forceps was essentially bad and quite indefensible. It was, indeed, one of the most curious examples I know of the way in which practice is apt to run in a groove, and in opposition to what now seems to us the plainest principles of common sense. It appears to us altogether incomprehensible that men who could make such a fuss about so safe and simple a procedure as the application of the forceps when the head is on the perineum should at the same time proceed to perforation and the destruction of the fetus, then so common, with amazing lightheartedness, as if it were a matter of no moment at all. When we learn that in so great a school of midwifery as the Rotunda Hospital in Dublin, between the years 1815 and 1821, out of 21,867 deliveries the forceps were never once used, no record being even made of the number of craniotomies, and between the years 1826 and 1833, out of 16,654 births, they were only applied twenty-seven times, craniotomy being performed 118 times in the same number of cases, we cannot but reflect with horror on the number of infants—to say nothing of the mothers—whose lives must have been needlessly sacrificed. Contrast this with the present practice of the same institution, in which the forceps are applied on an average of 1 in 16.5 cases, and the striking change which has taken place will be very apparent.

I think it will now be very generally admitted that the long train of evils which we were taught were likely to follow the use of the forceps, and which have hindered many a man from using them when they were obviously indicated, really arose from pressure on the soft parts, and from the exhaustion incident



to a long labour, and were strictly preventable accidents.

Few, I think, will deny that unnecessary delay, after the head is in the pelvic cavity, is not only useless, but pernicious, and that by timely interference we lessen the risk both to the mother and the child. It is quite impossible, however, to lay down any precise rules as to when the forceps should be used in lingering labour. Every case must be treated on its own merit, after careful examination of the effects of the pains.

Perhaps I may be allowed to conclude these imperfect notes by quoting what I have said on this point in my work on the *Science and Practice of Midwifery*, as I do not think I could put it more concisely in fresh words:

"What has to be done, I conceive, is to watch the progress of the case anxiously after the second stage has fairly commenced, and to be guided by an estimate of the advance that is being made and the character of the pains, bearing in mind that the risk to the mother, and still more to the child, increases seriously with each hour that elapses. If we find the progress slow and unsatisfactory, the pains flagging and inefficient, and incapable of being intensified by the means indicated, then, provided the head be low in the pelvis, it is better to assist at once by the forceps, rather than to wait until we are driven to do so by the state of the patient."

#### POSTHUMOUS LABOUR.

A correspondent writes:—"At Moglia, in the province of Mantua, occurred a case of post-mortem delivery in some respects unique. A woman, Lavinia Merli by name, subject to chronic epilepsy, had suddenly lapsed into the cataleptic state when in the eighth month of pregnancy. So death-like was the trance that she was certified as dead and ordered to be buried. The coffin containing the unfortunate woman was closed and deposited in the mortuary chapel pending the gravedigger's work, when next morning it was found with the lid raised up. The woman's body—now a corpse—was horribly con-

tracted, and, closely pressed between the knees, lay a new-born child, quite dead. The gravedigger and his men, for reasons of their own, kept their discovery a secret and buried the two corpses. The facts, however, leaked out, and the judicial authorities, aided by physicians from Mantua, at once proceeded to exhume the coffin and examine its contents. A very minute and prolonged inspection was made, with the result that the physicians declared themselves satisfied that the mother was already dead when the child was expelled from the womb. From the position of the bodies and the commencing decomposition in which they were found, taken in connexion with other considerations set out at length in the official report, the conclusion was arrived at that the gases, disengaged by the putrefactive process, and seeking an exit, had forced out the fœtus; that, in short, the case was one undoubtedly very rare, but by no means unprecedented, in obstetric experience, of "posthumous labour." The incident, however, has attracted notice beyond the Mantuan province, and medico-legal discussion on its details is yet far from being exhausted. It is asked, not unnaturally, if the woman Merli had really ceased to live, how the coffin lid came to be even partially raised? She is not by any means the only patient, in catalepsy or "nona," who in quite recent Italian experience has been certified as dead and treated accordingly; and the anti-cremationists, making the most of such cases, are warning the public how still more slender, in "apparent death," would be the chances of escape for Merli and her like, if, instead of the coffin, she had been consigned to the crematorium.

#### CURE FOR CONSUMPTION.

THE EMPEROR AND DR. KOCH.

Dalziel's agent at Berlin telegraphs:—Every one at the Charity Hospital is under promise not to divulge anything respecting the experiments carried on by Professor Koch for the cure of consumption. The private patients under Dr. Koch's care belong to the highest aristocracy.

crazy, and they have pledged their word of honour to observe silence with regard to their treatment until such time as the professor releases them from the pledge of secrecy. I learn from a private source that a consumptive youth, the son of an official at the Berlin Hygienic Institute, of which Professor Koch is president, has already been cured by his method. In the cases now under treatment a change for the better is observed after five or six injections of the lymph, which are made within a fortnight. In one case of long standing, however, it took a month to effect any improvement. All the patients are seen daily by Dr. Koch, their sputa is preserved and examined, their temperature noted, etc. Before another six weeks have elapsed all the patients under treatment will have passed through the period of observation, and Professor Koch will then be ready to place the results of his experiments before the world. He thinks that from four to eight weeks will be necessary to complete the cure, but slight cases may occupy less time. If a foreigner should arrive here within the next 11 days and be willing to place himself entirely under the rules at the Charity Hospital, as indicated in yesterday's despatch, he might succeed in coming under Dr. Koch's present experimental cure. He would have to bring with him a doctor's certificate that he is suffering with the tuberculosis bacillus, otherwise he would not be admitted. It would be of no use applying to the professor personally; the hospital authorities are competent to decide on the admission of a patient.

The intelligence telegraphed relative to Dr. Koch's audience with the Emperor is confirmed by the *Berliner Politische Nachrichten*, a semi-official organ supported by the Minister of Finance. No further particulars are obtainable in regard to what passed at the interview, but a Bill is being prepared for presentation to the Reichstag, empowering the Government to appropriate a large sum of money in order to place the professor in a position to devote himself entirely to educating a staff of Government and army doctors in the method of preparing the lymph and treating consumptive patients. It is proposed to give the system a complete or-

ganisation by creating a central depot for the lymph in every province, such depot to be connected with a hospital where the poor can be treated gratuitously—that is to say, at the cost of the Government. The Emperor regards Dr. Koch's discovery as a matter of national pride, and he considers it his duty to confer the benefit not only on his own people, but on the whole world. As one half of all the sickness prevalent in the German army is of a consumptive character, the Emperor is interested in the invention from military motives. Dr. Koch had an audience yesterday with the Emperor on the subject of the Professor's treatment for the cure of consumption. His Majesty proposes that the Government shall buy the invention outright, and shall erect special hospitals for the cure of consumption. Dr. Koch will receive a large annuity besides a title. It is stated as an assured fact that slight cases of consumption have been cured by Dr. Koch's method, and in older cases, where parts of the lungs have gone, life has been lengthened and the growth and progress of the bacillus checked, if not actually destroyed.

#### ASEPSIS AND ANTISEPSIS,

As Practiced in the Obstetrical Department of the Royal Hospital for Women in Dresden.

TRANS. BY H. J. SCHERCK, M.D.

In N. O. Med and Surg. Jour.

As soon as a patient is admitted she is given a full bath, and clothed in a simple hospital outfit; if she is in labor, she is removed to one of the two large rooms which are used only during labor, and are employed alternately once every other week, so that in the mean time they can be carefully fumigated and disinfected. Should she not be in labor, she is placed in a wing in the building kept for those cases before delivery.

As soon as the labor is terminated, the patient is put in a fresh bed and carried to another ward reserved for the "puerperium."

Most careful attention is given to the exact and full histories from admission until discharge; the measurement of the pelvis, abdomen, etc., as well as the

weight, growth, and measurement of the child. In fact, these histories could not be more complete and satisfactory.

As my idea is to give the most important antiseptic rules in as short a space as possible, I have translated some of the rules, which will convey the idea of how the institution is managed.

*General Considerations.* I. Pregnant women, those in labor and others passing through the puerperium, can very easily be fatally infected through a digital examination.

II. The most frequent and dangerous agent for carrying infection is the examiner's finger.

III. As the hands are the most useful and best instrument that the obstetrician possesses, it is desirous above all things to keep his hands and nails surgically clean.

IV. The external examination of pregnant women (i. e. the palpation of the abdomen) as well as during and after labor, reveals all that can be desired in the vast majority of cases, viz., the position, presentation, and progress.

Therefore the physician should refrain as much as possible from internal or vaginal examinations, and only make one when it is demanded by the welfare of the mother or child.

The fetal heart should be the guide, and should be listened to often and carefully, etc.

*Rules for the Antiseptic Management of Labor.*—These rules are also in force for operations, examinations, etc.

The physician on duty is not allowed, for forty-eight hours before entering upon his duty-day, to attend autopsies, septic cases, especially the vaginal examination of such cases as cancers; neither is he allowed to do microscopical work during that time.

On the morning of his duty-day he must take a full bath, and an entire change of clothing.

Clothes (woollen) that have been worn at autopsies must never be worn while on duty.

While on duty it is not permissible to examine pregnant women other than those in labor, and under no circumstances patients in the "puerperium;" for this

purpose a physician not on duty is to be summoned.

Before entering the "birth room" the physician must remove his coat and bare both arms beyond the elbow, and put on a long cotton mantle previously made aseptic. (These mantles cover the entire person and have short sleeves.)

The nails of the assistants must be worn short, and should he have any cuts, abscesses, sores, etc., he is not to examine. No rings are to be worn.

Before each digital examination the hand and arms of the examiner must be cleansed in the following manner: 1. All suspicion of dirt must be removed from under the nails, with a knife or point of scissors. 2. The hands and arms must be scrubbed with a brush in warm water and soap for a least five minutes. 3. After the above he is supplied by the nurse with a basin of 1—2000 sublimate solution, 1 part solution 1—1000 and 1 part water, using again the brush and soap for three to four minutes. 4. Finally for one minute the careful washing of the hands in a 1—1000 sublimate solution, the hands and arms not to be dried, but kept damp.

The lubricant used is a 2 per cent. carbolic vaseline, kept in a porcelain jar submerged in a 5 per cent. carbolic solution.

The external genitalia of the patient are first washed and scrubbed with soap and warm water, and afterward with a 5 per cent. carbolic solution. This is done by the nurse, who has previously washed her hands in the same manner.

The internal examination is made in the following manner:

With the thumb and forefinger of the left hand the labia minora are separated from one another, and the forefinger *alone* of the right hand guided along the posterior vaginal wall to the os uteri.

Only two fingers are to be used in exceptional cases. Examinations are to be done in as short a time as is possible, and care should be exercised not to rupture the "sac" or to bore in the os with the finger.

The hands must be disinfected in the same manner after an examination as before, so as to avoid carrying infection from one patient to another.

No vaginal douche is employed, excepting in instrumental labor or septic births.

In cases of instrumental interference the vagina is to be irrigated with a 1—4000 sublimate solution, or 5 per cent. carbolic solution—depending on circumstances.

Instruments are all first scrubbed with soap and water, boiled and kept in 5 per cent. carbolic solution. After the labor is completed the vagina and the uterine cavity in cases of septic births is cleaned with a solution of 2 to 5 per cent. carbolic solution, kept at a temperature of 40 deg. C.

Such are the most important rules in vogue here, and with the exact practice of those rules naught save good results can possibly follow.

#### REMOVAL OF THE GASSERIAN GANGLION FOR SEVERE NEURALGIA.

BY WILLIAM ROSE, M.B., F.R.C.S.,

Professor of Surgery at King's College and Surgeon to King's College Hospital etc.

Paper read before the Medical Society of London.

F. M.—, aged sixty, was first seen by me on Aug. 19th, 1888, in consultation with Mr. Padman. At that time she was suffering from severe neuralgia, affecting chiefly the inferior divisions of the fifth nerve on the right side of the face. This had resisted ordinary local and constitutional treatment. Stretching of the inferior dental nerve was decided on, and this was done on the following day, the patient being anaesthetised. The nerve was stretched just above its entrance into the dental foramen; it was also divided at its exit at the mental foramen, both steps being effected inside the mouth. This was followed by considerable relief until March, 1889, when the pain returned with great severity. On March 19th the lower jaw was trephined and a disc of the outer bony plate removed, thus exposing the nerve in the dental canal. Half an inch of the trunk was excised. Partial relief followed this, and it was not until March, 1890, that I was again consulted, the pain being more severe in the original situations, and in addition the right side of the tongue had

become excessively painful, indicating an extension of the mischief to the lingual nerve. On March 18th, the inferior dental and lingual trunks were cut down upon in the pterygoid region through an incision parallel with the zygoma, dividing the masseter, and then deepening and enlarging the sigmoid notch with the trephine and cutting pliers—an operation which I have performed on several previous occasions, and one originally suggested to me and practised by Mr. Victor Horsley. Portions of both lingual and dental nerves were thus excised. The result of this was to produce numbness and loss of sensation in the right side of the tongue and in the integument covering the right half of the lower jaw; but unfortunately the pain which had occasionally manifested itself in the upper jaw and cheek became greatly intensified. It implicated the alveolar border of the right upper maxilla, where the agony was greatest, and extended up into the temporal region to the top of the head. The slightest touch upon the gum produced a shock of agony that was terrible to witness, and the sudden approach of anyone or the banging of a door was sufficient to induce a paroxysm. Opiates and other sedatives had practically no effect. It was quite evident that the superior maxillary nerve as involved, and the patient's sufferings were so great that some serious mental derangement appeared imminent. Taking into consideration the previous relapses after partial nerve excision, I decided to make an attempt to remove the Gasserian ganglion, as nothing short of its destruction seemed to hold out any prospect of relief. I also decided to remove the superior maxilla at the same time, for the following reasons: First, on account of the extensive disease which probably existed in the nerves contained in it (and this was amply borne out by subsequent investigation); secondly, the increased facility thus given for opening the base of the skull; and thirdly, in deference to the express desire of the patient that, whatever else was done, the side of the jaw where the pain was greatest should be removed. Accordingly on April 2nd, fifteen days after the last operation, assisted by Mr. Cheatele, the surgical

registrar, and Mr. Penny, the house surgeon, the ordinary operation for removal of the superior maxilla was in the first place performed, and when the bleeding had been arrested and the foramen oval exposed to view, the pia of a half-inch trephine was passed into the foramen, which acted as a centre, and the ring of bone surrounding it was carefully sawn and lifted out. The Gasserian ganglion could then be seen lying upon the apex of the petrous portion of the temporal bone, a small Schall electric illuminator being of great help at this stage of the operation. The ganglion was loosened by gently passing an aneurysm needle beneath it, and removed in three or four pieces by the aid of a narrow probe-pointed bistoury and fine-hooked forceps, the dura being uninjured. The bleeding was slight. The incisions in the cheek were brought together in the usual way with interrupted sutures of wire and catgut, cyanide gauze was applied, and the eye carefully protected with a soft pad. The patient suffered somewhat from shock, but her general condition on the following day was satisfactory. She, however, complained of heat and pain at the back of the right eyeball, which, on examination, showed considerable conjunctival congestion and chemosis. Next day this had increased, and was accompanied by haziness of the cornea, which subsequently ulcerated and eventually necessitated excision. In all other respects steady progress was made. The old pain ceased from the day of operation and has not since returned. She expresses herself as being in better health than she has been for years past. On Oct. 25th she was carefully examined by Dr. Ferrier, and it was interesting to observe that although sensation and taste are practically absent from the right anterior half of the tongue, it is distinctly present posteriorly. There is circumscribed anæsthesia of the right cheek and obvious wasting of the temporal, buccal, and other muscles on that side. The movements of the lower jaw are limited, probably on account of the operation in the pterygoid region. There is no paralysis of the facial nerve. The patient was shown to the

Fellows of the Society, and also the ring of bone which was removed from the base of the great sphenoidal wing, together with the superior maxilla, the infra-orbital canal of which was laid open, in order to demonstrate the thickened state of the nerves. Microscopic sections of the excised ganglion were also exhibited, together with diagrams showing the anatomy of the parts dealt with.

As far as I have been able to learn, this is the first instance in which the Gasserian ganglion has been successfully removed in the human subject. It is undoubtedly an operation of considerable danger and difficulty; at the same time I feel convinced that the severity of the symptoms and the hopelessness of being able to effect relief in any other way justified such a procedure. The loss of the eye is greatly to be regretted, and, it is to be hoped, need not necessarily occur in future cases. In the present instance the patient is more than contented with the immunity from pain which she now enjoys, and thankful to have gained it, even at the sacrifice of an eye. In any future case of the kind, I should be inclined to stitch the eyelids together as an additional protection.

**BROMIDE OF GOLD IN EPILEPSY**—The manobromide of gold has been employed in Russia, Germany and Belgium as a nervine and anti-epileptic. Dr. Goubart, of Brussels, has reported that the initial dose for adults should be one eighth of a grain, to be increased to one fifth; for children, from one-twentieth to one-tenth of a grain. The drug is a yellowish gray friable mass, insoluble in water.—*Jour. Am. Med. Association.*

**"A SECOND SARAH."**—A woman living in the mountains near Fort Smith, Ark., named Sarah Gates, aged seventy-one years, proved herself almost a second Sarah by giving birth to a well formed and healthy male child. Two years ago, Mrs. Gates, then a widow, married William Gates, a young hired hand on her farm. The case is exciting a good deal of interest among physicians.—*Medical World.*

## THE NORTHERN LANCET AND PHARMACIST.

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WHILE wishing all our readers the kindly greetings of the coming season, we must ask them to consider the following:—Some four years ago, when this journal was established, it was calculated that owing to the great expense of printing and publishing in Winnipeg, in comparison with other places, that under the most favorable circumstances, a strictly professional paper would not be remunerative for some years to come, and such loss would have been cheerfully born by the proprietor, but it was not anticipated that a large number of professional men would receive the journal, year after year, and never pay a single subscription. We regret to say that such is the case, while others are in arrears for one, two and three years. The paper has been entirely devoted to the interests of the profession in the districts in which it circulates, a very large extent of territory. We are reluctantly compelled to announce that, if the present appeal is not generously responded to and arrears of subscribers forwarded before the time arrives for the next issue, the publication of THE NORTHERN LANCET will cease. All communications should be addressed: EDITOR NORTHERN LANCET, Winnipeg.

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THE Manitoba Students Medical Association gave their eighth annual dinner at the Clarendon Hotel on the evening of the 18th ult. It was with much pleasure we noticed the comparatively large number of students assembled around the festive board. Some fifty students are now graduating, and this in a college established seven or eight years ago and in a country almost unknown twenty years since. The progress of the country

and the vitality of the Manitoba Medical College was abundantly proven by the large and representative gathering assembled in the dining room of the Clarendon; and the post prandial part of the programme was both instructive and amusing—instructive inasmuch as it elicited the opinion of those present, who have the interests of higher education at heart, as to the fairest, readiest and most satisfactory method of attaining their ends. Rev. Dr. Bryce, while deservedly eulogizing the founders and laborers in the Colleges and University of Manitoba, bid them remember that though much has been done in the past, much remains to be accomplished in the future; progress must be their motto, and any one interested in the subject must heartily endorse those views. Glaring anomalies at present exist, a usual concomitant at the inception of all great schemes, and the time is come to correct them, which the peculiar condition of affairs existing renders a matter of no little difficulty. That personal grievance will arise if the foreshadowed scheme be accomplished there can be little doubt, but this, though to be regretted, cannot be allowed to weigh in the balance. We, however, have only one part of the scheme to consider, and it is one which every member of the Medical Profession in this Province should seriously contemplate. We have a College of Physicians and Surgeons in Manitoba, effete and moribund though it is, notwithstanding its tender years. Still it exists, and has certain corporate powers. Some of its powers it has ceded to the University, and they follow a course unique in the history of European Universities, namely, that of conferring degrees in Medicine and Surgery without the recipient having an Arts degree having merely passed the

matriculation exam. While this continues reciprocity from Universities can never be reasonably looked for. No University degree should be conferred until the Arts degree is obtained, except for *honoris causi*, and if as advocated by many, ourselves among the number, the College of Physicians and Surgeons be quietly interred, and all powers and privileges pertaining to that corporation be handed over to the University of Manitoba, the profession place themselves completely under the control of the governing body of the University, which will be probably composed almost exclusively of the ecclesiastical element. It may be urged, and very possibly with great truth, that the Medical Profession have nothing to fear in such an arrangement; but the step is too important a one to take without very serious consideration. There are two courses open to us—either to surrender all our rights, privileges, etc., to the University, or to resuscitate the comatose College of Physicians and Surgeons of Manitoba, incorporate the faculty with it, let it be a teaching, examining and licensing body—and when the University also becomes a teaching body let those who desire to take a University degree proceed to graduate in Arts and Medicine concurrent at the University of Manitoba. The College of Physicians and Surgeons will then be in a position to seek reciprocity or ad eundem privileges with the various colleges of Great Britain, and the University of Manitoba would equally be in a position to seek the same privileges for their graduates with sister Universities. The subject requires much and careful thought, and the expression of opinion given at the students' banquet proves that it is receiving that attention it so imperatively demands.

## PHARMACY.

### TEST FOR LIQUID CARBOLIC ACID.

Loof (*Apoth. Zeitung*) recommends the following very simple method of determining whether liquid carbolic acid is of the strength required for prescriptions (1 to 10): When the acid is mixed with an equal volume of chloroform and shaken, the mixture will remain clear if its strength is 1 to 11. If only 1 to 12 or below this, the liquid will be turbid, and after some time the water will separate and rise to the surface.

### GUAIACOL.

Salhi, of Berne, Switzerland, was probably the first to use guaiacol in pulmonary affections, being led to adopt it from the good results which attended the use of creasote. His first experience was quite favorable, although in a number of cases of phthisis with high temperature, it failed owing to the gastric irritation set up by its ingestion. It has been used in phthisis by Fraentzel in the Charity Hospital, Berlin, in the place of creasote with very satisfactory results, and he estimates from his observations in four or five hundred cases, that about 4 per cent. will be cured by the drug. Hornor has employed it for four years at the General Hospital at Zwickau, in the treatment of tuberculosis, and along with careful attention to diet and hygiene, he believes that cases not far advanced have been cured, and some of long standing have been improved, although occasionally no perceptible effect was noticeable.

The method introduced by Bourget is known as the "intensive treatment," and he claims by uniting pure guaiacol with pure beech-wood creasote, very considerable doses can be taken without causing gastric disturbance. The following is his formula for summer:

R. Guaiacol. . . . . f.  $\frac{3}{4}$  ii  
Tr. cinchona. . . . . f.  $\frac{3}{4}$  vi  
Malaga wice. . . . . f.  $\frac{3}{4}$  xxxv

M. Sig. Take one teaspoonful with

meals, gradually increasing to two or three times the quantity.

For winter treatment the following is recommended:

R Guaiacol.....min. xl  
Cod-liver oil.....fl.  $\frac{3}{8}$  viii

M. Sig. Take a tablespoonful with meals

Along with this treatment, a guaiacol inunction is advised, and the patient is required to wear constantly a nasal respirator containing a small quantity of guaiacol.

R Guaiacol.....fl.  $\frac{3}{8}$  v  
Cod-liver oil.....fl.  $\frac{3}{8}$  viii

M. Sig. Use as an inunction; apply to the chest, back and armpits at bed-hour.

In case the stomach becomes deranged, guaiacol, prepared as an emulsion, can be given by enema.

R Guaiacol.....gr. xxx  
Sweet almond oil.....fl.  $\frac{3}{8}$  vi  
Gum acacia.....fl.  $\frac{3}{8}$  iiss  
Distilled water.....fl. O ii

M. Sig. Make an emulsion, and give one-fourth part three times daily.

Guaiacol is eulogized by Nobili as "the true therapeutic agent in tuberculosis," as he believes it augments the power of organic resistance against tuberculosis infection, and has a destructive action upon the tubercle-bacilli. In his cases, the appetite improved, night-cough decreased, but the fever and night-sweats were not always reduced, although the subjective symptoms were decidedly improved. Arnold Schetelig (*Deutsche med. Zeit.*, 1889) substantially confirms the statements of Nobili, and asserts that those most susceptible to the influence of the remedy, are what would be termed in this country, "flabby people." He is of the opinion that the good results are due indirectly to the improvement in the condition of the blood, rather than to the contact of the remedy with the mucous membrane of the stomach and intestine, and probably, for this reason, he uses the drug hypodermatically, giving a single daily dose of pure, unmixed guaiacol of from seven to fifteen grains, the drug being deposited in the nates. He says the effects are most striking in the case of acute exacerbations occurring in

chronic consumptives.—*Dr. Aulde in Notes on New Remedies.*

### NEW DRUGS.

During a recent meeting of the British Medical Association at Birmingham, Mr. Lawson Tait in the course of an address on surgery made the following remarks:

No sooner, he said, is a new drug placed on the market than everybody rushes to try it (Laughter.) At first all is well, and "rubbishin" is good for everything. Then comes a few isolated hint about the "toxic effects of "rubbishin." and finally "rubbishin" gets dropped altogether, and we hear no more about it. (Laughter.) It is positively awful to think of what some of these new drugs — say chloral, for instance — may have done before they got settled. For the mischief that is done in this way the public are largely to blame, if, indeed, they are not wholly to blame; they like the idea of a new discovery, especially the upper classes, and he was told by men practising near the dwellings of the princes of the land, and at fashionable watering-places, that the great burden of their lives is to keep up with the new drugs and the new dodges. (Laughter.) People who live in such houses and such places always have a smattering of such things, and they judge a man harshly who is ignorant of them. He instinctively distrusted men who were always going in for new drugs, and for himself he would have none of them. (Hear, hear.)

### INCOMPATIBILITY OF MERCURIC CHLORIDE WITH VEGETABLE MATTER.—

R. Strych. sulph.....grs. ij.  
Hydrarg. bichloridi....grs. ii j.  
Ext. cascara sag. fl..... $\frac{3}{8}$  ii j.  
Rad. jalap..... $\frac{3}{8}$  ss.  
Cascara cordial..... $\frac{3}{8}$  v j.

This is a very unscientific mixture. In the first place on mixing solutions of strychnine sulphate and mercuric chloride a precipitate is formed, slowly if the solution is dilute. This indicates the probable conversion of a portion of the mercuric chloride into the comparatively inert sulphate, and there possibly may



be an entanglement of some strychnine in the precipitate. Next, if all the ingredients minus the jalap are mixed and allowed to stand a precipitate appears which from its grayish color indicates that the mercuric salt has been reduced either to a mercurous salt or more likely a mixture of the latter with finely divided metallic mercury. The character of the prescription is thus somewhat changed therapeutically, and in addition a "shake mixture" is formed which is more or less dangerous from the presence of the precipitate, and this danger is enhanced by the addition of the jalap which by its resinous nature, would tend to further prevent the proper distribution of the dose.

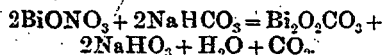
It has long been known that mercuric chloride is decomposed by compound syrup of sarsaparilla, and that is should be similarly affected by other vegetable preparations may be expected.—*Druggists' Circular*.

#### BISMUTH SUBNITRATE AND A BICARBONATE.

The *Druggists Circular* publishes the following prescription sent by a correspondent who states that it exploded three hours after it was compounded:

R. Tinct. strophanthi..... f. ʒ. iss.  
 Bismuth trisnitrat. [?]..... ʒ ij.  
 Sodii bicarb..... ʒ ij.  
 Mucilag. tragacanthi.... f. ʒ ss.  
 Syrupi..... f. ʒ ss.  
 Aquæ..... ad. f. ʒ iv.

The prescriber probably did not want trisnitrate of bismuth, but wanted the subnitrate. The former is the crystalline acid salt, is not official, and is seldom if ever used save as a source for some other salt. We suppose that our correspondent dispensed the subnitrate, though either salt would decompose the bicarbonate. The reaction with the subnitrate is said to be as follows:



As in the case of our correspondent, the reaction is generally slow of occur-

rence, and thus frequently escapes the notice of the dispenser who only learns of the result when the liberated gas bursts the bottle. Some dispensers in this case would substitute the subcarbonate for the subnitrate of bismuth, but each material variation from the prescription should not be made without consultation with the prescriber.

It is probably advisable to pursue the course recommended by the author of "The Art of Dispensing," in a similar prescription, which is to mix the subnitrate and bicarbonate in a mortar and pour a little boiling water on them when effervescence takes place immediately, after which the prescription can be dispensed without fear of explosion.

#### EXPLOSIVE TABLETS.

Charles Bulloch reports (*Amer. Journ. Pharm.*) that a mixture of potassium chlorate and ammonium chloride a popular preparation for throat troubles, has been noticed after a few weeks to give off chlorine compounds. A lot of tablets containing this mixture which were more than a year old, were removed by him from the small bottles in which they are usually put up, and 4 ounces of them placed in one bottle for delivery. While standing undisturbed, a loud explosion occurred, and the bottle containing the tablets was almost pulverized—the concussion breaking several other bottles in proximity, although they were protected by pasteboard. The cause of the detonation may be looked for in the formation of chloride of nitrogen as one of the resultants of decomposition between the salts. Mr. Bulloch remarks that if the quantity of the tablets were large, sufficient heat might be generated by the decomposition to cause spontaneous combustion, should circumstances favor it.

SCENE: An Old Pharmacy. Enter Old Celt.—"I'm wanting a character the day, Mr. —." Chemist: A character! A character for what? Celt (with emphasis): "A character for taking the water off a man." Catheter supplied.

## MISCELLANEOUS.

**PREGNANCY AFTER REMOVAL OF BOTH OVARIES.**—Dr. J. Anderson Robertson reports (*Brit. Med. Jour.*, Sept. 27, 1890) the case of a woman, age 23, who menstruated regularly and became pregnant nine months after removal of both ovaries.

**ANOTHER ANTISEPTIC: Lysol.**—Dr. Gerlach, of Wiesbaden, has described the antiseptic power and advantages of lysol, which he has recently used with much success in Wiesbaden. As a bactericide it is more powerful than carbolic acid or creolin; it is less poisonous than either of these two; and, finally it is much cheaper than either. The active principle in lysol is the cresote.—*Pharmaceutical Record.*

**SULPHONAL IN DIABETES.**—Dr. Casaroli, of Pisa, mentions the favourable action of sulphonal in diabetes. This drug diminishes the quantity of sugar in the urine, also reducing the polyuria and the thirst. These results were obtained by doses of from 5 to 30 grains per diem, but not to so marked a degree as with doses of 45 grains continued for several days. The 30-grain doses could be administered for some time without any ill effects; but although the 40-grain doses at first caused no disturbance, it was found that, when they were continued for any lengthened period, they caused giddiness and excessive sleepiness, which disappeared when the drug was discontinued. Sulphonal was used with good results in conjunction with both a mixed diet and a strictly meat diet; in the latter case a large quantity of sugar appeared in the urine as soon as the sulphonal was stopped. In the only case in which antipyrin had been previously used it was found to exert less influence than sulphonal.

**IMPURE SALICYLIC ACID.**—At the instance of the Sanitary Inspector of Glasgow, a Glasgow chemist was charged at the Sheriff Court with selling one ounce of salicylic acid which contained 2½ percent of cresotic acid. Professor Charteris was called, and gave evidence regarding the injurious effects he had found arising from the use of the artificial salicylic acid, and regard-

ing his experimental researches as to the action on animals of the impurities frequently present in the artificial acid. Other evidence (that of the city analyst) was also offered to show that cresotic acid was not a necessary impurity in the salicylic acid manufactured from carbolic acid, but depended upon impurity in the carbolic acid. The case was then withdrawn, the prosecutor stating that the object of the sanitary authorities was not to press for a penalty, nor even for a conviction, but to let the public know what they were getting, while the Sheriff said it had been "a most useful prosecution, as it showed to the profession and the public the results of Professor Charteris's valuable discovery."

**THE LEGAL RESPONSIBILITIES OF ABDOMINAL SURGEONS.**—The legal obligations of the surgeon with regard to the operation of abdominal section would appear to have been defined by law courts in the United States in a manner which places the practitioner in a rather awkward dilemma. If a surgeon, we are told, "for the welfare of a patient, deems it best for him or her to perform abdominal section, and death ensues, malice can, under subdivision 3 of section 193 of the Penal Code, have him indicted for manslaughter in the second degree," and further, "if a surgeon neglects to perform abdominal section, when, in the estimation of another, it should have been performed, and the patient dies in consequence of pelvic conditions, that surgeon, under subdivision 3 of section 193 of the Penal Code, can be found guilty of culpable neglect, and indicted for manslaughter in the second degree." Dr. Van der Veer, who has discussed this question, considers these rulings just and necessary; he laments the kind of expert testimony often given, but adds that the judges have heretofore treated the profession with fairness and have clearly indicated their opinion that the public good is not subserved by undue and wilful persecution of a conscientious surgeon who has shown a proper amount of intelligence in his profession.

**THE DRY METHOD OF TREATING WOUNDS.**—Dr. Hal C. Wyman, of Detroit, calls attention to this valuable

method of treating wounds. The treatment consists in drying the wound with hot, dry towels taken from an oven where they have been heated to 212° F. (100° C.). No water is allowed to touch the wound or the adjacent parts, from first dressing to final healing. Loose fragments are removed; all tissues bruised beyond repair are cut away with scissors; blood and dirt are scraped away with hot, dry towels. All lacerated parts are approximated and held with sutures which have been freshly sterilized by dry heat. Then a dry mixture of Wyeth's impalpable powder of boracic acid (7 parts) and iodoform (1 part) is rubbed into the wound along the lines of approximation. Over this are laid strips of dry iodoform gauze. Over them oakum freshly sterilized by heat, and over the oakum freshly sterilized cotton, held in place by a roller bandage fresh from the oven. The dressings are allowed to remain undisturbed until healed, unless pain, rise of temperature, or soiling of the dressing by discharges, indicates that fresh dressings are needed. This method, he claims, favors the cleansing of the wound, favors the control of hæmorrhage, diminishes the tendency to fermentation and putrefaction, hastens the repair of wounds, and insures the healing of flaps and ragged pieces which by the wet method would slough.—*The Dixie Doctor*, September, 1890, p. 172.

**HYPNAL OR MONO-CHLORAL ANTIPYRIN.**  
— At the meeting of the Société de Biologie, held July 5, 1890, Drs. Quinquaud and Schmidt stated, as the result of their investigations, they had found that the mono-chloral antipyrin possessed the advantages over chloral of more ready administration and more marked hypnotic effects, with less marked action on the circulation. They were not, however, prepared to make any definite statements as to the analgesic properties of this compound.

On the other hand, they state that the bi-chloral antipyrin possesses no advantages over the mono-chloral antipyrin or the chloral hydrate. The authors thus serve to confirm the investigations of Dr. Gley on the subject.

Hypnal is nearly tasteless and quite odorless, and is devoid of all irritating action on the mouth or stomach; it is easier to administer than chloral, especially when treating children or delicate patients. As it possesses both hypnotic and analgesic properties, it is an unrivalled soporific, especially when sleeplessness proceeds from physical pain. Owing to its sparing solubility hypnal is to be given either suspended in a mucilaginous potion or dissolved in a spirituous elixir. It may also be administered in capsules, or even cachets. The usual dose for an adult is 1.0 gramme (15 grains), but as much as 1.5 grammes (24 grains), or even 2.0 grammes (30 grains), may, without danger, be given, when pain and sleeplessness are intense.—*The Therapeutic Gazette*, September, 15, 1890, pp. 640, 648.

**SETTING A BROKEN JAW.**—A white man, in company with some friends went to a negro meeting ostensibly to hear them sing; but the negroes did not want them around, and attempted to drive them off. In the melee one of the white men received a blow with a club which broke his lower jaw in two places—on the left side between the first bicuspid and cuspid, and on the right side between the first and second molars—both of the fractures being complete, thus dividing the bone into three distinct pieces. Three physicians were called in so set it; but after laboring two days with ligatures and every conceivable appliance within their reach, gave it up. After consultation they determined to call in a dentist, when I was sent for. When I arrived, the parts were suppurating, and the patient was suffering exceedingly. My first act was to obtain an impression of the lower jaw and teeth, the different pieces being held in their normal position while the impression was being taken; (fortunately the patient had a good set of teeth in his lower jaw). This I effected by the use of gutta-percha in a mouth cup, prepared for the purpose, and made a very correct plaster model of the normal position of the lower jaw, on which I vulcanized a rubber splint. This I put over the teeth, extending to the right and left beyond the fractures,

making it in front sufficiently thick to cut a space large enough to insert the point of a spoon, through which opening the patient was fed on soup and gruel until the fracture united. This splint was applied, and the mouth closed on it. The fractures were immediately set, and bandages were applied under the chin to the top of the head. In ten days the bone had completely united, leaving no trace visible of the fractures.—John L. Doggott, Bedford City, V.A.

**THE DURATION OF PREGNANCY.**—Issmer (*Archiv für Gynäk*, vol. xxxv, Part 2) publishes certain researches on the question of the duration of pregnancy. According to clinical observation, it appears that the date of birth is an event independent of menstrual congestion. Dr. Issmer noted the history of 22 ovariectomies and 2 operations for removal of the appendages, and inferred therefrom that typical menstrual hæmorrhage is a direct result of changes in the ovaries. In most cases that hæmorrhage is the outward visible indication of expulsion of an ovum. It is important, if possible, to ascertain the date of conception, and to determine from which menstrual period the fertilised ovum arises. Dr. Issmer collected 1,220 cases where the date of the last period was authenticated, 628 where the date of conception could be fixed, and 471 where both were known. The date of the last menstrual period is certainly the surest for beginning the reckoning of pregnancy under ordinary circumstances, as it is an event which the patient can correctly observe. Close inquiries in cases where the date of conception can be fixed show that the probability of impregnation during the first fourteen days after menstruation compared with its probability during the remainder of the menstrual cycle is as 2.68 to 1. One-third of all impregnations occur between the eighth and twelfth days, counting from the beginning of the last period. Pregnancies arising from conception during the first half of the cycle are the shortest. The chances appear to be as 3.67 to 1 that impregnation followed the last period rather than the last but one. The be-

ginning of labour represents a reaction to the sum of certain internal and external stimuli, dependent upon the amount of the stimuli and on the power of resistance which the uterus can offer. A male foetus is expelled, on an average, 1.5 day earlier than a female. The normal duration of pregnancy is 280.1 days. The range is from 260 to 304 days, only reckoning cases where the foetus is well developed.

**RECENT HYPNOTICS.**—Dr. H. Dehio (*Petersburg. med. Wochenschr.*, No. 33, 1890) gives the result of trials of various hypnotics in the Dorpat Clinic for Nervous and Mental Diseases. Hypnone in doses of 10 to 15 drops was useless, and methylal and chloralamide were found of little use in the few cases in which they were tried. Paraldehyde was and remains the most reliable hypnotic used in the clinic. In severe cases a dose of 5 to 6 grammes was followed by another of 3 to 4 grammes; this was found sufficient to give a night's rest. As a rule the drug acted well, but sometimes only slight sleep followed, and in other cases tolerance was soon established. But these occasional disadvantages are counterbalanced by the fact that the drug, even in large doses, does not influence the heart or respiration. Paraldehyde may upset the digestion, causing diarrhoea. The medicine must be pure, it must not redden litmus paper. If kept exposed to daylight or in badly-stoppered bottles it soon becomes acid. After the prolonged use of paraldehyde the following symptoms may appear: loss of appetite, grey coloration of the face, dryness of the skin, and loss of body weight; at the same time the drug does not produce somnolence. These symptoms soon disappear on discontinuance of the drug. Paraldehyde, however, is the sheet anchor in the Dorpat Nerve Clinic. Amylene hydrate was also found of use, and has the advantage of not affecting the digestive tract, although it may produce headache and depression. Urethan is of service in doses of 45 to 90 grains in mild cases of insomnia. Sulphonal was given in doses of 15 to 60 grains. It was not found so useful as paraldehyde and amylen hydrate. Drowsiness, weakness, and

inco-ordination of gait were noticed after its administration. In mania it acts only slightly, also in progressive paralysis. In many cases of excessive motor disturbance such as occurs in mania and delirium tremens, all these hypnotics are practically useless. Hydrochlorate of hyosine (1.70 of a grain) is the best remedy in these conditions. Dr. Dehio's conclusions do not quite agree with those of the Therapeutic Committee (see report in the *British Medical Journal*, 1890).

**CEREBRAL ABSCESS FOLLOWING EAR DISEASE.**—Otto Korner (*Arch. f. Ohrenheilk.*, xxix., Abstr. in *Fortscher. d. Med.*, Oct. 15th) gives some interesting statistics upon the subject of cerebral abscess following upon disease of the ear, based on 100 cases which he had personally observed. Of these, 91 were examined after death, and in 9 the abscess was opened during life. He finds that the frequency of such abscesses in the cerebellum is nearly twice as great as in the cerebrum; and that in children below ten years of age their frequency is three times that of adults. The explanation of this difference is held to be the greater distance of the tympanum from the cerebellum in children. The liability of males is twice that of females, and the generally admitted fact of the disease being more common on the right than on the left side is borne out by these statistics. As regards the extension to the brain from the diseased temporal bone, Korner finds (1) the cerebral abscess most often occurs where the dura is implicated, in cases of disease of the petrous or mastoid; (2) the dura and brain substance between the diseased bone and the abscess are generally diseased; in only six out of ninety cases was the intermediate brain substance normal. He thinks that more careful observation may show more cases of direct extension of the suppuration from the diseased bone than is now thought to be the case. The abscess is nearly always in the temporo-sphenoidal lobe or in the lateral lobe of the cerebellum in the vicinity of the diseased ear. The few exceptions which he met with were, he thinks, possibly examples of metastasis or

of generalised tubercle. As a rule, the abscess is solitary; in six of his cases it occurred in the temporo-sphenoidal lobe, as well as in the cerebellum, but in four out of thirty-two cerebellar cases, and in five out of sixty-two cerebral, there was more than one abscess in close contiguity. The most frequent complication was thrombosis of the lateral sinus. Purulent meningitis, in some cases by extension from the bone disease, in others from rupture of the abscess, occurred seventeen times. In ten cases the abscess burst into the lateral ventricle, and in one case into the fourth ventricle. In one case death was preceded by the bursting of a cerebellar abscess into the ear. Disease of the middle ear and mastoid is more likely to lead to temporo-sphenoidal abscess, of the labyrinth to cerebellar abscess. This fact may aid in localising the seat of the abscess, for diagnosis is not much aided by the seat of pain, and but little by that of tenderness on percussion. Vertigo and optic neuritis may occur in either form, but disorder of speech, with hemiplegia and hemiparesis, may point to implication of the cerebrum rather than of the cerebellum. Two cerebral cases exhibited crossed facial paralysis, which, however, also occurred in one case of cerebellar abscess.

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#### LIBRARY TABLE.

The Physician's Visiting List for 1891, P. Blakiston, Son & Co., Philadelphia. The fortieth issue of this very complete and useful visiting list has reached us. The preliminary matter contains the list of new preparations introduced during the year '90. Price for 25 patients, \$1.

Walsham's Surgery.—P. Blakiston, Son & Co.—continues to be a favorite student's book. The increasing range of subjects, a knowledge of which is demanded from candidates presenting themselves for examination for degrees and diplomas in medicine and surgery, necessitates the abbreviation of all text-books, and Walsham's work is in this respect a model of its kind. Price, \$3.