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ALCOHOLIC STIMULANTS AS REGARDS QUALITY.\*

BY ANGUS MACKINNON, ALVINSTON, ONT.

It is almost superfluous to tell an assembly of medical men that alcoholic stimulants hold a prominent place in Therapeutics. Notwithstanding much hostile criticism, both from within and without the ranks of the profession, these stimulants are still high in esteem, and stand well up in the front row of remedial agents. This perhaps is not wholly due to the force of science. The popular belief in the curative power of whisky and brandy is proverbial. There is an old proverb which runs, "like priest, like people." Should we parody this proverb, and say, like people, like doctor, might it not suggest the power of ulterior force in the matter of the importance attached to these stimulants? We must confess, whether priests or doctors, that we are all liable to be influenced by our environments. Be that as it may, the consensus of medical opinion the world over, is that alcohol is an agent of great value and power in the treatment of many diseased conditions. It is but fair to remark that a highly respectable minority firmly oppose this view, and demand the expurgation of alcohol from the Pharmacopœia, as not only worthless but absolutely injurious, under all conditions. The majority, however, although admitting certain

drawbacks, refuse to let go their hold until science discovers a substitute more innocent, but of equal virtue.

These being the views of the profession, it naturally follows that the quantity prescribed is enormous. Alcohol being a powerful agent, like a two-edged sword, is capable of cutting two ways. It is therefore clear that it should be ordered with the utmost definiteness as to dose, and frequency of repetition. Such is the rule in the case of opium, chloral and all powerful drugs. Why should alcohol be an exception? Moreover, we are usually particular about the quality of our remedies. If we have reason to believe a certain article is not up to the standard, or has been tampered with by a dishonest dealer, we reject it instantly. Why not apply the same tests to our whisky and brandy? Alcohol is good or bad according to the dose. It is quick and powerful in action, and demands the same accuracy of administration as other agents of potency. Why then, of all other drugs, should it be prescribed in the haphazard way that is too much the custom?

The readiest answer to these questions is, that accuracy of dose is impracticable, since we do not know the alcoholic strength of any of the articles used. We must admit, and emphasize, the correctness of the answer. We do not know how much alcohol is contained in any given sample of the various alcoholic stimulants in the market. The answer is full and complete, and to prove its absolute truth is the main object of this paper.

In any discussion of this question it is necessary to bear in mind that the contained alcohol is the chief ingredient in all alcoholic stimulants. The balance is the menstruum, and is made up of water, and other substances, all of which are of no value except to make the alcohol pleasing to the palate and acceptable to the stomach. That imponderable, invisible something, conjured in our imaginations as pervading the product of the still, aside from the alcohol, chemistry proves to be a myth. It is said that delusions die hard, and here is one of them.

This leads to the remark that accuracy of dose is impossible in the absence of legal standards. The manufacturers and dealers are subject to no law. The distiller pays his revenue tax on his alcohol, not on his whisky. The whisky is another affair entirely. So in regard to all other liquors. But this is only a part of the trouble. Were liquors made in the old fashioned way, we would look for greater uniformity of strength, whether the article was better or not in other respects. But as a matter of fact they are not; that is, the spirituous liquors are no longer the product of distillation, save as regards the alcohol. Wishing to obtain more information regarding a business whose secrets are kept with wonderful fidelity, I wrote a short paper sometime ago, which I had published in an American journal having a large circulation. That communication contained the substance of what is to follow. I challenged criticism. Although several replies appeared, none disputed the main points.

One word more before entering on the main question. Pure spirit, the technical name for alcohol, is the same in quality whether obtained from grain, roots, or fruit. This fact should not be lost sight of in comparing fabricated liquors with those made in the old fashioned way. I shall now proceed to describe the modern processes of distillation and liquor making in general as practiced at present.

It is not generally known that the process of making whisky has been entirely revolutionized. This change is due chiefly to the introduction of what is called the column still. The product of the mashes is now all run off into strong alcohol, that is, pure spirit. This is all distillation has to do with the production of old

rye, malt, Bourbon, Scotch and Irish whisky. The remainder of the process belongs rather to the practical chemist than the distiller. The latter, however, takes it upon himself to make two brands, rye and malt. His method is very simple and above reproach. To make old rye all the proper quantity of alcohol is run into a tub. The water is added to bring it down to twenty-five under proof, that is seventy-five (75) parts alcohol to one hundred and twenty-five (125) parts water. Next the coloring and flavoring ingredients are added. These vary somewhat with different distillers for the purpose of distinguishing the brands, more than any other purpose, and hence are not made known. There is reason however, for believing that such additions are of a harmless nature. Carmel is the principal, if not the exclusive coloring matter. To make malt a trace of creasote or similar substance is required. For this reason, so called malt whisky had better not be used, although the amount of flavoring is probably too infinitesimal to do harm. This done, the work is accomplished. It is evident that "age" can add nothing essential to modern whisky. If allowed to remain long in its oaken cask it will extract some additional color and flavor from the wood, but nothing more.

Whisky made in this way is incomparably superior to old-fashioned whisky. This statement, I am quite aware, runs counter to common belief, but it is true, nevertheless. One constantly hears the remark, whisky now-a-days is not as good as the whisky we used to have. "The old whisky would not fly to one's head like what we now get." This is purely imaginary. Old-fashioned distillation gave whisky full of impurities. In it the fusel-oil, an extremely poisonous substance, was retained. So were also ethers and extractive matter. The column still disposes of all these. Their retention made whisky more intoxicating and harder on the "head." The true explanation is found in the fact that the people who thus speak are Old Country born. On coming to this country they could drink whisky, and more of it, than they can now. It is notorious that the people of northern Europe have a great tolerance for alcohol. They can live and thrive on an amount that will kill in America. The climate here tends to develop

neuroses. Hence, in the course of time these people lose their tolerance for alcohol and blame the whisky. Of course I here speak of standard whisky and not a fabrication.

All the evidence goes to show that there is a vast amount of fabricated or spurious whisky in the market. Every considerable centre of population has its dark cellars supplied with the materials for carrying on this vile traffic. It says but little for our laws that a business so life-destroying and iniquitous, can be carried on without let or hindrance. Everybody knows that "forty-rod" whisky is extensively sold and consumed, but who has ever heard of any one being punished for the crime? The main object is cheapness. To accomplish this the quantity of alcohol must be small, but the stuff must be capable of producing some kind of intoxication or frenzy. To make up for the lack of alcohol, substances of less value are supplied. That briefly is forty-rod whisky, and we cannot always be sure we are not imposed upon. Not long since I heard an Irishman describe it as follows: "It is nather fit for man or baste; it has nather oats, barley nor whate; it is made of pure combustibles." It is but proper to add here that no respectable public house dispenses "forty-rod" to its guests. I presume it is mostly consumed in catch-penny way-side places, and in the low groggeries of the large towns and cities.

While on the article of whisky, it is worth remarking, that it is the only liquor made whose alcoholic strength is known definitely. The distillers turn it out of uniform strength. The hydrometer here is unerring. After the cask leaves the warehouse, and is out of bond, all confidence is at an end. Medical men should see that their druggist gets his whisky in bond, rather than from the cellar of a liquor dealer. Standard whisky is too strong and pungent for use without dilution. It is the custom of public houses to dilute it by adding one gallon of water to three gallons of whisky. For use as a mere beverage, the article would be improved by continuing this process *ad infinitum*.

The Scotch and Irish whiskys are made just like our own. They buy American corn-made alcohol; "fix it up," and re-ship it to us, handsomely labelled, and we are fools enough to

pay a high price for the fraud! These people find it more convenient and cheaper to import alcohol instead of corn, from which nearly all American alcohol is now made. Verily, had the poet Burns lived in these days of sharp practices, the world would never have heard of Sir John Barleycorn.

Having discovered beyond all cavil and question, the *new* way in distillation and whisky-making, we have the key which unlocks the main secrets of the liquor making business.

Brandy one dollar, to one dollar and fifty cents per bottle; good (!) port wine about the same. Let us see. The books say it takes from five to ten gallons of wine to make one of brandy. What, and selling for about the same price? That is what they say. Nothing more need be said. The Hennessy and Martel brands are frauds; so is all brandy sold at so slight an advance on wine. It is not, and cannot be real brandy, as claimed. High price is no proof of genuineness, it is true. Marking up the price to inspire confidence is a common trick of the trade. But a low price in this case carries with it the clear evidence of deception. This much, however, can be said in extenuation, that the deception which leads to the payment of an unnecessarily high price, constitutes the major part of the crime. It is dishonest to label a thing that which it is not, under any circumstances. Let the whole truth be widely known, and imported brandy will gradually be discovered. We know well, that there is not a bottle of old-fashioned brandy made. Now what is it? It is a solution of alcohol, stronger than whisky, with added ingredients to give it taste and boquet, as nearly as may be to genuine brandy. That is all. Some years ago the Dominion Government ordered an investigation. Brandy was purchased at different points and submitted to Professor Croft for analysis. All the samples proved to be about equal. Once some sample *known* to be fabricated was found to be as good as the French brandys. This proved of course, what must have been known before, namely; that the French brandys themselves were fabrications. What is to hinder, let me ask, a Canadian constructing as good a formula as a Frenchman? The French produce a large quantity of alcohol from the beet root. They

are also heavy importers. If their wine and brandy are all pure, what becomes of all this alcohol?

Gin is made after the same manner. The process is essentially identical with the making of spirit of juniper. The Dutch buy our alcohol, add to it oil of juniper and dirty canal water, and send it back as the purest gin. Holland, Rotterdam, De Kuyper, Booth, are magic words to the purchaser of gin. All a delusion and a snare! I remember reading about fifteen years ago, an account of a gin trial in the city of Montreal. A man by the name of Monsell, decided to put some gin on the market. Finding he could not sell it under his own name, it occurred to him to put De Kuyper's name on the label. It sold so well that De Kuyper's agents had the man arrested, and very properly punished. But there was no complaint about the article sold. Counterfeiting gin was not the offence; counterfeiting the great name, De Kuyper, was the punishable crime.

Here I wish to draw special attention to these two liquors, brandy and gin. I do not know what the yearly importation of these French and Dutch mixtures is, but it is enormous. The cost to our people is great, and millions of dollars are annually diverted from the industries of the country and poured into coffers of bloated foreigners. As these liquors, no matter how well compounded, have no special medicinal merit over whisky and spirit of juniper, medical men should discountenance their use in every possible way.

Rum I have not investigated, partly because it is seldom prescribed as a medicine, nor used as a beverage to any considerable extent. Whether the sugar planters have abandoned the *old* way and adopted the *new*, I cannot say. The chances are that they have.

Wine is in extensive use both as a medicine and beverage. Our country has been found well adapted to the growth of the grape. South-western Ontario yields per acre more than double that produced in France. Wines, equal in all respects, to the best French and Californian wines can be made, and are made, in our own country. I would be unwilling to say anything calculated to injure this home industry. Apart from this, there is good reason for the belief that our native wines, for purity

and reliability, are far in advance of imported wines. It may be that the delicate processes of the vintage are not always carried to the letter; but that is true of the foreign products as well. The vintage, seen at its best, has come more or less under the influence of modern methods. Not many, perhaps, are aware, that for generations it was the regular and right practice to add brandy freely to the vats in process of fermentation. Alcohol, pure and simple, of course, now takes the place of brandy. Alcohol is also frequently added at subsequent stages. A druggist got a cask of native wine. When it was opened it was found to be in a state of active fermentation. The druggist complained to the maker. In reply he was requested to add a stated quantity of alcohol, and assured that would make the wine all right; at the same time, informing him that he (the maker) always found alcohol effective. This little instance goes to show how extensively ready-made alcohol enters into the production of all alcoholic stimulants. This practice of adding alcohol to cut short the fermentive process, is probably the worst than can be said of our native wines, and that much, and a great deal more, can be said against the imported article. It must be remembered that wine, rich in the blood of grape, and poor in alcohol, will not keep in our climate. It will sour in summer and freeze in winter. By far the most villainous and extensive adulteration practiced in the liquor business obtains in wine, "forty-rod" whisky excepted, and that not excepted but as regards quality.

There is probably more "doctored wine" used than there is of forty-rod whisky. Very little, if any, of the imported article bears any real resemblance to the genuine article. Not long since, the German Government was honest enough to confiscate a large quantity of fabricated wine lying on the Rhine, just awaiting shipment abroad, to England, I believe. The production of port wine was always small; over fifty years ago it sold as high as eighty-five dollars the gallon. (*Vide* Chambers' Encyclopedia.) At present its native valley produces but a small quantity. Yet port wine can be found in oceans in any part of the world, and to keep up appearances, is sold at a high price. No one need be told that there is not a

single bottle of genuine port wine in all America.

Not long since, I read a very able clinic by a justly celebrated New York physician. One of these recommended by him in the case was, "Sound Port." Verily, delusions do die hard.

The brand in our markets known as port wine is a fabricated wine containing twenty per cent. or over of alcohol. Of all wine adulteration this article is the worst. As a medicine it should receive a wide berth. As in the case of brandy and gin, it would be a wise and commendable policy to discourage the use of imported wines by us altogether. The home article is more reliable, and in every way superior. The question of the home production of wine as a substitute for the foreign counterfeit, is one bearing very intimately on the health and life of our people, having also an economic side, involving millions of hard earned money.

Beer, including under that name all malt liquors, is the last article to be brought under notice. We constantly hear the remark, beer is not as good as it used to be. I believe the statement is correct. How much fabricated beer is made I am not prepared to say. We do know for a fact that a vast amount of beer

distributed, in country places especially, which is but beer in name. The difference between it and genuine beer is too great to be due to accidental causes. It is designedly poor, and as such is made by and sent out by the great breweries. The manner of the manufacture of this slush should be made a matter of investigation by the Provincial Board of Health, as an enormous quantity of it is consumed, especially during the thirsty summer season. Keen competition has led to the study of cheap methods of production, and that explains the trouble. But the public have a right to know all about it. We know that corn is largely used in place of barley; we know that cheap (and perhaps dangerous) substitutes are used for hops; we know resin is freely used; we know also that a cheap and poisonous quality of salicylic acid is used to prevent souring; we know all this, but we have a right to know a good deal more.

There should be no secrets regarding the making of beer, or any other liquor, any more

than there is about any other staple article of consumption.

Prof. E. H. Bartley, of Brooklyn, New York, has made the adulteration of beer by salicylic acid, a matter of long investigation. He informs us that the quantity used averages from twelve to fifteen grains per gallon. The effect on large beer drinkers he considers most injurious. Whatever may be said of rheumatism, between resin and salicylic acid the kidneys are pretty well corned. It is time the delusion vanished that beer contains food. Long ago Liebig told us that there was more nutriment in a loaf of bread than there was in a whole hogshead of beer. Especially is this true of the beer of our time, unless it be London (England) beer. Some wicked critic has suggested that the peculiar richness of London beer and porter is due to the water, that of the Thames, noted for its abundant richness in city sewerage. This reminds me of a trial about which I read a short account not long since. In the long ago, Albany beer was celebrated all over the Union, and long defied all competition. One day a man named Delevan published to American beer drinkers some nasty facts. He discovered that the famous breweries were all built on the brink of a pond; that the water supply was obtained from this pond, and that the said pond was pregnant with dead dogs, cats, and other rottenness. The result was a law suit in which the brewers were signally beaten. Instantly Albany beer went down, and never recovered the blow, much to the joy of all other brewers.

I would not say that honest beer (ale) is not made. Brewers do still brew, but the trouble is that we never can know what we are buying. Honest beer no doubt is made, but where can we be sure of getting it? This is a general inquiry, but no one vouchsafes an answer.

This concludes a short review of alcoholic stimulants as regards quality. It is not all that could be said, but time forbids more. The facts in the case are in no way honorable to the average liquor manufacturer, nor do they reflect credit on the business shrewdness and watchfulness of our profession. The distillers, brewers, and compounders command us in this wise: "Shut your eyes, open your mouths, and see what you will get." We have been most obedi-

ent and docile. Along with the public in general we have been long-suffering beyond all praise. We have suffered ourselves, our patients, and the public to be robbed, that a rapacious horde of swindlers, at home and abroad, might grow opulent, powerful, and haughty. We have aided and abetted the greatest swindle the world has ever known, before which the South Sea Bubble, the Holland Roses, and all the other frauds ever perpetrated on a credulous people, pale into insignificance. This monstrous fraud ceases not its work of ruin. By day and night its murderous shafts are driven hither and thither into the bodies and souls of men. Alcoholic stimulants, pure and simple, are dangerous enough and ruinous enough, but this gigantic fraud intensifies the evil. Medical men are the supposed guardians of health and life. In regard to this matter, verily the watchmen have been asleep. It is now high time to awake to a true realization of the situation, and call on the whole people to open their eyes, shut their mouths, and behold this monster. I cannot but believe it is in the power of the medical profession to stamp out this evil in a large measure. I shall suggest only two or three things. First, the Government should be asked to prohibit the importation of all liquors. Canada is able to produce all that is needed in this way, for all purposes. Commissions should be appointed to investigate and report on the whole liquor business. A business of such vast proportions should surely be the subject of careful inquiry. Medical authority should construct formulæ, and have them published and authorized, for the making of whisky, brandy, and gin. As all these are now but dilutions of alcohol, it is much better every way that they should be made by certain uniform standards. The adoption of these suggestions would go a long way towards purifying the liquor business, save millions of money, and in numerous ways promote the happiness and well-being of our people.

Dr. Agnew says that riding a bicycle will cause spinal complaint.

There are about one hundred and forty writers on the editorial staff of the *British Medical Journal*.

## Selections.

### TREATMENT OF CHRONIC CYSTITIS IN WOMEN.

BY HUNTER MCGUIRE, M.D., RICHMOND, VIRGINIA.

The successful treatment of chronic cystitis in women requires an unusual amount of patience, skill and tact on the part of the surgeon.

In the first place, functional bladder trouble has to be eliminated from true cystitis. Pain about the pubic region and pelvis generally, frequent and painful micturition, tenesmus, the sensation that the bladder is never emptied, going on day and night for weeks, producing emaciation, exhaustion, and a life of wretchedness, may be due to a great variety of causes. It may be purely functional; piles, fissure of the anus, an ulcer of the rectum, or thread-worms in this organ may cause reflex bladder symptoms. Malaria may provoke vesical irritability; sometimes this happens without serious disturbance of the organs of digestion and alterations in the character of the urine; under such circumstances the only explanation that can be given is the effect of malaria on the nervous system.

We cannot help believing that true vesical irritability is occasionally a pure neurosis, certainly there are cases which can be explained in no other way. As our knowledge of pathology, however, increases, these cases of neuroses of the bladder as well as of other organs, will become less frequent; improvement in our knowledge of the pathological changes which take place in the female urethra will surely contribute to this end. Masturbation is another source of vesical disorders; congestion of all the pelvic organs and irritation of the meatus urinarius follow its prolonged practice. Diseases of the uterus, especially of the cervix uteri, and displacements of the womb are common sources of functional vesical disorders. Pelvic abscesses and tumors frequently provoke this trouble. One of the most persistent and painful cases of functional vesical trouble that I have ever seen was in a woman, who still menstruated regularly at forty-seven years of age. She had constant but not very severe pain until the monthly period came on, when the pain became very severe, and morphine was freely given to

relieve it. I removed, in this case, the left ovary and tube, finding upon the latter a neuromatous growth, about as big as a marble; she went home in a month entirely well.

It is pretty safe to conclude, when the urine is normal or nearly so, that the disorder is functional, and not true cystitis; again, as a rule, with, of course, exceptions, when a woman has to void her urine frequently, and suffers pain in the act, but is relieved when the viscus is empty; or, if she attempt to hold the water too long, spasm of the bladder comes on and the urine is involuntarily ejected in spurts, then the trouble is functional; but when there is great and prolonged tenesmus, with pain and straining after the water has all come away, as a rule there is real disease of the bladder or urethra.

The only way to treat functional bladder trouble is of course to correct, if possible, the cause. A displaced womb must be replaced and retained in its proper position; a diseased womb must be cured, rectal trouble relieved, a foreign body in the bladder removed, etc. It is of the treatment of true cystitis, chronic in character, uncomplicated by other disorders, that I wish to speak.

Generally, in chronic cystitis, the urine is loaded with phosphates, and muco-purulent matter; it is also more or less alkaline. Before any operative interference is undertaken, the urine should be made normally acid; this can generally be accomplished by the free use of citric acid in the shape of lemonade, or lemon juice and water; the mineral acids act more slowly, and benzoic acid is not well borne by the stomach, if administered for too long a period of time. I have seen the use of citric acid in one day remove a thick phosphatic crust on the edges of a vesico-vaginal fistula, or on the wound through the perineum in lateral lithotomy.

The first step in the surgical procedure is to dilate the urethra far enough to temporarily paralyze the sphincter muscle. This should be done while the patient is under the influence of an anæsthetic. I use for dilatation a three bladed urethral speculum, and after the expansion has been continued far enough, the speculum is removed, and the finger introduced into the bladder. The dilatation should be done slowly, twenty or thirty minutes being required before the process is complete; after this a short piece

of drainage tube is introduced into the bladder, and the urine allowed to drip into a cup between the legs of the patient, if she lies on her back, or close to the hip if she is lying on her side. The latter is preferable, as in that position the tube is more easily retained. The tube should be introduced into the bladder only far enough to drain the organ, and the free end should be just long enough to drip the water into the cup. If too long, it will be pulled out of the bladder by its own weight. The object of the treatment is to give the bladder complete rest. The tube should be kept clean by occasionally washing or changing it. It is a good plan to wash the bladder out through the tube once or twice a day with hot water. I published an account of the treatment of obstinate chronic cystitis by drainage in 1874. Since that time I have repeatedly resorted to it, and with great success. For the last three or four years I have added dilatation of the urethra to the drainage, in this way making physiological rest of the organ more complete. If the paralysis of the canal and sphincter pass off before the cure is effected, dilatation must be repeated.—*University Med. Magazine.*

#### OPEN-AIR TREATMENT OF PHTHISIS.

Among the many changes which have taken place in the treatment of phthisis in the last forty years, none is more marked than the substitution of a system of bracing and hardening the patient for one of "coddling," and foremost in this plan is the principle of open air, or exposure of the patient as much as possible by day and by night to the influence of the atmosphere. The great object of change of climate is to afford greater facilities for this process, and it appears from the testimony of most authorities that the meteorological phenomena which interfere with the success of the system in England are not the coldness of the climate, but its humidity and the prevalence of fog and mist, and the fear of exposure to these elements prevents its being completely carried out here.

There is no question now that cases not only of non pyrexial, but also of pyrexial phthisis are favorably influenced by open-air treatment, which produces a diminution of the troublesome



symptoms such as high temperature and night-sweats. The plan, though adopted at several places on the Continent, is perhaps most completely carried out at Dr. Dettweiler's large establishment at Falkenstein, in the Taunus Mountains, at an elevation of 400 metres above sea level, and it may be well to quote M. Pouzet's description of a recent visit to Falkenstein.

The consumptives are placed on open balconies, sheltered from wind and exposed to the sun. Here, on mattresses or bamboo couches, they recline in loose but warm clothing, with tables alongside for books, letters, etc., and the inevitable glass of milk; or they sit in shelters movable on pivots to protect them from wind, or in kiosks with open sides, but, whatever the form of protection, the invalids live all day in the open air, independent of the state of the weather.

Dr. Dettweiler appears to be a rigid disciplinarian, and to enforce early rising, with fines and the pain of dismissal, and the patient commences the day with a friction to the skin in the form of a dry rub, or with a towel moistened with water or alcohol, but the stronger patients are submitted to the action of the douche.

After a rather simple breakfast, which would not satisfy all English patients, they betake themselves to their couches, from which they occasionally rise to take short walks, generally up a gentle slope, at the same time throwing back the shoulders, and each quarter of an hour drawing at least ten full deep inspirations through the nose, and thus emptying and filling completely the organs of respiration. The more hardy take long walks in the neighboring forest.

The dinner and supper are both substantial meals, washed down by red or white wine, and milk is taken between times. Expectoration into handkerchiefs or on the ground is forbidden, and patients are furnished with ordinary spittoons or portable ones on the pattern described in the *British Medical Journal* of October 12th, 1889.

The patients sleep with the windows of their bedrooms open at the top, and all curtains, carpets, or hangings are carefully removed. Stoves appear only to be allowed to be lit during dressing in the morning, and never at night, but sleeping in woollen underclothing, and the

avoidance of too many coverings to the bed, is advised.

The French physicians appear to be likewise advocating the open air treatment of phthisis, and especially sleeping with windows open, but some of them object to the common-sense practice of sleeping in flannel, for fear of promoting perspiration, which they say is so tiresome a complication of phthisis—confounding this it seems, with the characteristic night-sweats which it is well known are a form of watery flux quite independent of clothing or of pyrexia.

The system of open-air treatment pursued at Davos and St. Moritz differs from that pursued by Dr. Dettweiler at Falkenstein in the larger amount of lung gymnastics it includes, and far surpasses it in results, but these must be largely credited to the effect of the mountain climate.

The douches to the chest, which were formerly largely used at Davos as a means of promoting deep inspirations, have lately been, for the most part, abandoned, probably owing to the great dislike of English and other patients to their use in winter, and to the same results being pleasantly arrived at by the more agreeable exercises of mountain ascents, tobogganing, etc.

It is doubtful whether in England we are sufficiently alive to the advantages of the open-air treatment in phthisis, for though in our palatial hospitals the systems of ventilation and warming have been carried to a high state of perfection, and the atmosphere is changed frequently and without draught, the exposure of a consumptive patient on a terrace or balcony to the sun's rays and free breezes of heaven would probably be far more beneficial, provided the effects of chill and damp were guarded against. Even in pyrexial phthisis the removal of the consumptive's bed from the hot ward to a cool covered terrace is often accompanied by beneficial results, and we commend this treatment to the medical men who have charge of consumptive patients.—*Brit. Med. Jour.*

#### TREATMENT OF PROLAPSUS OF THE RECTUM IN CHILDREN.

During my service at the Children's Hospital, I have seen a number of cases of prolapsus of the rectum which present many points of clinical

interest, both as regards their causation and treatment.

In persistent cases of this affection in children, in which the various palliative measures of the treatment have failed, I have found that the safest and most satisfactory method is that recommended by Allingham, which consists in the application of nitric acid to the mucous membrane of the prolapsed gut. It is applied as follows:—The child's bowels are moved by the administration of a dose of castor oil, or by the use of an enema, the patient is then anæsthetized, and the surface of the prolapsed bowel carefully dried and cleansed of mucus by wiping it gently with absorbent cotton. The whole of the mucous surface of the exposed gut is next painted with nitric acid, applied by means of a camel's hair brush or a swab of cotton, care being taken not to allow the acid to come in contact to the skin adjacent to the verge of the anus. A pledget of oiled cotton or lint is now introduced into the central depression of the prolapsed mass, and by pressing it upwards with the finger the bowel is reduced. A compress of lint is then placed over the anus and held in position by bringing the buttocks together by broad strips of adhesive plaster. The bowels are kept quiet for two or three days and then opened by the administration of a small dose of castor oil. The use of the pledget of oiled lint I have not found necessary in practice, as it is apt to be passed when the patient recovers from the anæsthetic, so that I generally omit its use and merely coat the surface of the cauterized mucous membrane with olive oil or vaseline.

A recurrence of the prolapsus may take place with the first few passages, but a permanent cure is generally effected by one application of the acid; should this not be the case the cauterization may be repeated at the end of a few weeks, and even in the most aggravated cases I have never failed to see a second or third application followed by a satisfactory result.

The *palliative* treatment consists first in reducing the prolapsed bowel or mucous membrane as soon as possible, and this can generally be accomplished without difficulty by placing the child across the knees and making gentle pressure with the fingers over the whole mass of the tumor for a few minutes. In recent cases little difficulty is experienced, but in cases in

which the bowel has been down for some time and inflammatory effusion has taken place, there may be great trouble in returning the mass, and it may be necessary to administer an anæsthetic.

The *preventive* treatment should consist in not allowing the child to have the bowels moved in the sitting posture, and prolonged straining at stool should be prevented. The child should only be allowed to have an evacuation when in the recumbent posture, or while lying on the side, or in the standing position. The mother or nurse should support the perineum and anus by two fingers placed upon either side of the anus, or should forcibly draw the skin of the buttock to one side when the child is passing the stool.

If examination of the patient shows that there is present either a vesical calculus, a contracted prepuce, a rectal polypus, or parasites in the rectum, all tending to produce great straining efforts, the removal of the cause will promptly effect a cure. The importance of looking carefully after the child's diet which, as before mentioned, may be an important factor in the production of this affection, should not be overlooked.

The use of enemata of cold water or of astringent solutions, such as decoction of oak bark, or a solution of alum, may be employed with good results in mild cases, and of these I think the enemata of cold water will be found to be the most satisfactory.—*H. R. Wharton, M.D., University Med. Magazine.*

DEATH FROM ETHER.—A death under ether is reported to have occurred at Bellevue Hospital on November 5th. The operation was for abscess in the cervical region. Ten minutes after anæsthetization was begun asphyxia took place. The kidneys were found, at the autopsy, to be the seat of cystic degeneration.

TO ABORT A FELON.—Dr. Gaucher, says the *Therapeutic Analyst*. in writing on the abortive treatment of felon, states that to effect this object it is sufficient to moisten slightly the painful part with a little water, and to pass over this surface a stick of nitrate of silver. In a few hours after the skin becomes black, all pain disappears and the inflammation is arrested. No dressing is required, and the black color disappears in six days.—*Cin. Med. News.*

THE TREATMENT OF PHLEGMASIA DOLENS.—The *Union Médicale* attributes to Delore and Poulet the following sketch of the proper treatment of phlegmasia alba dolens: Absolute rest in the dorsal decubitus, the affected member placed in an attitude of forced extension, and a mixture of oil and chloroform applied; then cotton batting is placed around the limb, which is to be kept warm at an even temperature. Movement and repeated examinations are to be avoided. To combat pain, narcotics by the mouth, subcutaneous injections of morphine, and laxatives are in order. When pain begins to subside, alkaline and diuretic drinks may be given to hasten resolution of the œdema. If there is much œdema, the fluid may be allowed to ooze out through small incisions, or through a drainage-tube. The patient should be kept in bed for thirty days after the cessation of pain and until the œdema has almost completely disappeared.—*N. Y. Med. Jour.*

ABDOMINAL DROPSY IN A YOUNG SUBJECT.—Some time ago, I was invited by Dr. Burwell, of this city, to see the following case: A boy, eleven months old, with acute general dropsy. The scalp, hands, arms, legs, and ankles all pitted on pressure. The abdomen was greatly distended with fluid. There was no history of previous ill-health. The bowels moved naturally every day. There was no suppression of urine. There had been no cutaneous trouble. Small powders of jalap and cream of tartar were prescribed. These operated freely, and reduced the œdema of the extremities to a marked extent. The ascites, however, was undiminished, and we accordingly decided to tap. We drew off one pint of fluid, which was straw-colored, and did not differ from the usual ascitic fluid. The child made a complete recovery. I report this case, as I believe it unusual to find dropsy in children under a year old.—*James Wright Putnam, M.D., in Buffalo Med. and Surg. Jour.*

TREATMENT OF PARTURIENT RUPTURED UTERUS.—The conclusions to which my brief studies and limited experience force me are as follows, viz.:

1. In cases of rupture of the uterus, with the head presenting, delivery by forceps should be attempted, but should be abandoned if not found

easily practicable. Turning should not be undertaken, but the case should be at once recognized as one for either the Cæsarean or Porro operation.

2. In cases of ascertained incomplete rupture, treatment should be by antiseptic irrigations and rest.

3. All cases of ascertained complete rupture should be submitted to abdominal section so soon as the condition of the patient with reference to shock will admit, for the following purposes—viz., (1) to explore the abdomen, (2) to remove all foreign bodies, (3) to cleanse the peritonæum, (4) to close the rent if the labor has been short and the uterus not seriously damaged, and (5) to remove the uterus if the labor has been long and the uterus seriously damaged.—*Reed in N. Y. Med. Jour.*

ANTIFEBRIN IN QUINSY.—In the *Wiener Medizinische Blätter* for August 8, 1889, Dr. W. Sahli writes that on the second day of a violent attack of quinsy he took seven grains of antifebrin, and within a quarter of an hour all headache and pain on swallowing or in mastication had completely disappeared. On the next day there was a slight return of pain, which was almost immediately subdued by the repetition of the dose of antifebrin, and this treatment was continued on each reappearance of pain with the same results, until the disease had run its course. Dr. Sahli refers to twelve cases of quinsy in which four grains of antifebrin likewise produced satisfactory results. The same effect was also observed by the writer in the relief of pain in angina of an epidemic of scarlet fever and diphtheria. It relieves pain in all movements of the throat, and, by rendering the operation painless, is a great assistance to gargling the throat, especially in children, while, of course, it also assists in the administration of food. Dr. Sahli does not, however, claim that antifebrin is a specific for angina or diphtheria, since the pathological processes are not influenced by its administration. He administers it shaken up in a little spirits and syrup.—*Therapeutic Gazette.*

IODOFORM GAUZE IN POST-PARTUM HÆMORRHAGE.—Dr. O. Piering, assistant in Prof. Schauta's obstetric clinic in Prague, has published his experience in the employment of Dührssen's

plan of plugging the uterus with iodoform gauze for post-partum hæmorrhage due to an atonic condition of the organ. Dührssen recommends that, when post-partum hæmorrhage comes on, the bladder should be emptied, and forcible friction and intra-uterine irrigation of hot or cold water, along with ergotin in hypodermic injections employed; that if the hæmorrhage still continues, the cavity of the uterus should be filled with iodoform gauze, the irritation produced by this setting up active and permanent contraction. The method has, according to Dührssen, the advantages of great certainty, complete harmlessness, and facility in its performance. Olshausen, Viet, and Tehling, however, say that the contraction set up is not always permanent, and that the method is not so free from danger as Dührssen believes. In consequence of these conflicting views, Dr. Piering resolved to give the method a trial, and he details several cases in which he employed it with complete success. In no case was any harm done by it. He advises that resort to the plug should not be too long delayed, and he prophesies an important future for the plug of iodoform gauze in post-partum hæmorrhage.—*Lancet*.

GLYCERINE OF BORAX IN THE DIARRHŒA OF INFANTS.—If we regard infantile diarrhœa as due to the excessive fermentation of food in the intestinal canal causing irritation and a catarrhal condition of the intestinal mucous membrane, it seems reasonable to look for a remedy to act both on the cause and effect. Glycerine itself is an antiseptic of no mean order, and relieves the congestion and pain of inflamed piles, chiefly mucous surfaces, while every mother knows the virtues of glycerine of borax when applied to the mucous membrane of the mouth. So it was no great step to introduce it further into the alimentary canal. Whether fed from the breast or brought up by hand, the motions of patients with diarrhœa infantum were like curds of milk, suggesting that the irritated intestine had hurried its contents on as quickly as possible. Again, they were very foul-smelling, suggesting great fermentation. Therefore the glycerine of borax has to do two things: to act as an antiseptic to prevent excess of fermentation in the stomach and intes-

tines, and to soothe the mucous membrane thereof in passing over it. I have found it answer capitably; the children like it, it lessens the griping pains, it renders sweet the offensive motions, and it stops the diarrhœa. One case died while under this treatment; the child was seven months old, had had diarrhœa two days, and was utterly worn out when I saw it. But I suppose there always will be cases which come under our notice too late for cure. I give it as follows: Glycerine of borax, twenty minims; tincture of orange, three minims; distilled water to one drachm. To be given every one, two, or three hours, according to the severity of the cure or the age of the patient.—*Dr. E. M. Simpson in Lancet*, Oct. 12.

LEAD IN DRINKING WATER.—*The Pharmaceutical Journal and Transactions*, October 12th, 1889, (Allen & Reynolds).

An interesting discussion occurred on this subject at the British Pharmaceutical Conference at Newcastle-on-Tyne, in September last, in which Allen, of Sheffield, Reynolds, Branson, Linford, Thirsch, Kinnimont and Chaplin took part.

Mr. Allen finds that filtration through animal charcoal effectually removes lead which has passed into solution. The charcoal must be animal, and a bone ash filter answers the same purpose. It is, in fact, the phosphates which are the active agents in removing lead. The sign that the filter has ceased to be effectual is its getting coated with a white precipitate—phosphate of lead. By this means he was able to cure the water used by his own family, which had contained large amounts of lead. To his surprise, however, the symptoms of lead poisoning persisted, and it was only after some time that he discovered and removed the cause. The fact was that the tea-kettle crust contained a very large amount of lead, which had gradually got deposited. The only remedy was to get a new kettle.

Mr. Reynolds calls attention to the special danger of hot water supplies which have been in contact with lead pipes. I am in a position to confirm that. He sounds a much-needed note of warning to servants not to fill their tea-kettles from the hot water supply. Some outstanding points of importance in these researches may be

recapitulated for the benefit of householders in towns, where the water supply is moorland.

(1) The danger of lead poisoning may be averted by filtration of the water through charcoal, before it reaches the lead pipe.

(2) Lead may be removed by filtration of the water, after it has passed through the lead pipe, through animal charcoal.

(3) The water should be allowed to run some time in the morning before it is used for such purposes as making tea, porridge, etc.—*Medical Chronicle*.

SIMS ON THE RELIEF OF INCONTINENCE OF URINE IN WOMEN.—Dr. Sims has had under his care a number of cases of young girls unable to retain urine for over a very short period, and constantly liable to involuntary micturition during sleep. He has treated similar symptoms in elderly subjects who had previously suffered from cystitis, all inflammation having subsided. In all such cases, in the young and in the old (cystitis and morbid growths being entirely excluded) Dr. Sims found contraction of the walls of the bladder due to a hypertrophy of the muscular coat. The holding capacity of the bladder was consequently much reduced. He examined, eight years since, the bladder of a young lady, aged 17, suffering from a very severe form of the affection in question. The bladder measured but  $2\frac{3}{4}$  inches from the meatus to its posterior wall. A silver catheter was introduced into the bladder, and warm water was injected by means of a Davidson's (much resembling a Higginson's) syringe. The bladder only held  $1\frac{3}{4}$  oz. at the first sitting. This treatment, which gave considerable pain, was continued daily, a little more water being injected every day. At the end of two months' treatment the bladder could hold 12 oz. of water, and for the first time in her life, the patient awoke in a dry bed. At the end of three months, 18 oz. could be held without severe pain. The patient, as the capacity of bladder increased, would only have occasional attacks of incontinence of urine during sleep. At the end of the three months she was cured, and has remained well ever since. Dr. H. Marion Sims treated in a similar manner a case where the patient was 50, and had suffered from cystitis several years previously. A saturated solu-

tion of boracic acid in water was employed for distension of the bladder. At the first sitting only 1 oz. could be held; at the end of three months the bladder could retain 22 oz. The patient, before treatment, could not hold her urine for many minutes, and had to empty her bladder about thirty times at night. After treatment she could retain her urine for six hours. The cure appears to have been perfect.—*Lond. Med. Recorder*.

RAILWAY SPINE.—A Berlin telegram with the above heading, which appeared in the *Standard* of November 20th, contained an account of the case of a Berlin engine-driver who was said to be suffering from a disease of rare occurrence known to German physicians only under the English name of "railway spine." With the greatest bravery and presence of mind the man had been the means of averting a fearful collision, and we read that a terrible excitement had taken possession of him, and that all the feelings of excitement, terror, and responsibility were compressed into the space of a few moments—in the moments which elapsed between his first consciousness of the impending danger and his successful and heroic prevention of the accident. He had no further immediate effects than a violent trembling in his legs; and after continuing at his work for five days, the symptoms of this railway spine showed themselves in full development. So far, in the account there is no evidence of spinal injury, and the symptoms named are as little suggestive of it. We read that the man is completely prostrated, incapable of exertion, and quite lost to his calling. He has become lean, his gait is slouching and toilsome, and his speech slow and stammering. Digestion, memory, and sleep are seriously affected; there is diminution of nervous sensibility (*sic*) over the whole body, so that he can scarcely feel the prick of a pin which draws blood. The legs, moreover, are benumbed, and, as it were, palsied up to the knee. The only apparent reason, therefore, for calling this a case of railway spine is that his present condition is the result of something which happened to him on a railway, together with the notion, long exploded in this country, that railway injuries are of necessity spinal. The explanation of

the case is, in reality, very simple. It is a not very uncommon or extraordinary example of a functional neurosis; in other words, of traumatic hysteria originated by profound psychological disturbance. And associated with and underlying this in its present stage is a considerable amount of general nervous depression, such as is often termed neurasthenia. A recognition of these conditions is essential if treatment in the case is to be of any avail. It is, we think, a matter of regret that paragraphs, more or less of a sensational kind, such as that from which we have quoted, should appear in the lay press where no comment can be made upon them, or explanation be given to them, by those who are competent to do so. They are fraught with grievous harm. They increase the apprehension, anxiety, and nervousness of those who have been recently in railway accidents, and who may happen to read them, and indirectly they are in this way likely to cost the railway companies many thousands of pounds. This is no idle statement, but is a fact within our own knowledge on more occasions than one.—*Brit. Med. Jour.*

#### ALCOHOL TREATMENT OF PUERPERAL FEVER.

—Dr. A. Martin delivered a lecture, on June 28th, before the Berlin Society of Obstetrics and Gynæcology, in which he mentioned anew the favorable influence of alcohol upon the course of puerperal fever. The administration of alcohol in puerperal sepsis was first recommended by Breisky, and eleven years later was again taken up by Runge, and thoroughly discussed in several communications. Dr. Martin, whose cases were for the most part in private practice, complains that most of the cases of puerperal sepsis in private practice are brought to the physician's knowledge for the first time when the infection has already become general, and when the prospects of a local treatment are least favorable. He communicates an account of 18 of the cases in which the administration of alcohol had been possible. Five of these 18 died. The cases were of extraordinary severity, in which treatment with alcohol was begun for the first time when the fever had raged for a week and the patients had been weakened by severe complications. Thus, there existed in several cases, which finally

ended in recovery, purulent parametritis, ichorous decomposition of the ovum, pyemia in one case with panophthalmitis and purulent destruction of a hip-joint; three of the cases were reckoned as of pyemia and fifteen as of septiemia. Four of the 18 patients were taken sick in connection with an abortion, which was criminal in three cases; the other fourteen patients had given birth at the normal end of pregnancy, in three cases by artificial aid. In four cases local treatment was employed in addition to the use of alcohol, while in the other cases no advantage was to be expected from local treatment, except as disinfecting washes. The alcohol was given in the form of cognac, rum, Burgundy, Bordeaux, and southern wines, for the most part mixed with champagne; the most concentrated food possible was also given. It frequently required, however, energetic persuasion on the part of the physician and of the attendants to induce the patients to take the drinks, which often had to be changed. Diarrhœa occurred at times in nearly all the patients, and when it did the drink was changed, champagne being stopped, and mucilaginous drinks being given. In one of the cases, which is given in detail, the patient took within a period of six weeks the following: 17 bottles of cognac, 13 of Burgundy, 37 one-half bottles of champagne, 4½ bottles of other heavy wine, and 6 bottles of porter. Martin does not think, as Breisky did, that the favorable action of alcohol consists in its influence in reducing fever, but rather in a strengthening of the heart's action, and in the increase of resisting power of the individual against the ravaging action of the infection.—*Deutsche med. Wochenschrift, Med. and Surg. Reporter.*

RENAL SURGERY.—Mr. Kendal Franks, in a discussion on Renal Surgery at the last meeting of the British Medical Association, as reported in the *British Medical Journal*, called attention to a class of cases which were not uncommon, namely, those in which the diagnosis of renal calculus was almost certain, and in which the symptoms clearly indicated the affected side, and yet in which, when the kidney was exposed, the most careful digital manipulation and the most systematic exploration with a long needle failed to detect the presence of a stone. Now,

in such cases the practice had most frequently been to take one of two courses. The first course—and perhaps that most usually adopted—was to close up the wound and to trust to relief being afforded by the division of the nerves which necessarily resulted from the exploratory incision. Such temporary relief often followed, but it was very rare to find it lasting, and he ventured to look upon such a proceeding as surgically unsound. The second course which had been adopted was to excise the offending organ, as had been done by Mr. Henry Morris. But this was too severe a remedy, and one which Mr. Morris himself condemned, suggesting that it might be wiser to incise the kidney *in situ* and to search for the stone systematically. This was a proceeding Mr. Franks had himself adopted with marked success. He did not consider that incision into the kidney substance was a formidable proceeding, and as an exploratory measure was much to be preferred to excision. Should the stone be found, it was better to find it in a kidney which, otherwise healthy, still formed part of the patient's body, than in a kidney on the dissecting table. In the case he alluded to the symptoms of stone were tenderness on pressure over the right kidney, with intense paroxysmal pain, beginning in the right renal region, and shooting down the right side into the hip and groin. There was a well-marked deposit of oxalates in the urine, but no blood or pus. When the kidney was exposed, no stone could be felt anywhere, and a needle passed systematically through the renal substance failed to detect it. Mr. Franks then incised the kidney for a length of about two inches from the convex border right through to the pelvis, and after some careful search, reached a small abscess cavity containing a small stone and some crystalline particles. The incision in the kidney had to be enlarged to the extent of three inches in order to clear out the cavity thoroughly. The patient made a complete recovery, and had not since been troubled with any of her former symptoms.

Mr. Franks also laid stress upon the importance of leaving the wound in the kidney to granulate without using any means to close it. A case he mentioned showed the aggravated symptoms of renal colic which might be caused

by a foreign body such as a gauze plug inserted into the renal wound. He also thought that by leaving it gaping all blood-clots and *débris* would be gradually washed out, and thus the danger of their forming later the nuclei of stones would be avoided.

In cases of tubercular diseases of the kidney, he thought with Dr. Newman that excision of one of the kidneys should be performed, if the case could be got sufficiently early before the second one was involved. It was not easy to diagnose a scrofulous kidney from a case of stone, but an exploratory incision would clear away all doubt. The difficulty was to know whether the second kidney was involved.

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THE  
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TORONTO, DECEMBER 16, 1889.

PLACENTA PRÆVIA.

One of the most serious of the numerous emergencies of midwifery practice is hæmorrhage caused by placenta prævia. At the recent meeting of the British Medical Association, Dr. Braxton Hicks opened a discussion on this subject with a very interesting address. With reference to treatment, he thinks, with almost all obstetricians, that there is no positive safety to the patient until pregnancy is terminated. In certain cases one may temporize until the child becomes viable; but in adopting such a course an obstetrician assumes a serious responsibility which is frequently unjustifiable. The expectant plan of treatment may result in a fatal hæmorrhage during the absence of the medical attendant, and such an occurrence is one of the saddest catastrophes in obstetric practice.

When the induction of labor has been decided on, we have to consider two conditions.

The os may or may not be dilated. When there is alarming hæmorrhage with no dilatation of the os the case is frequently very perplexing. Shall we use a vaginal tampon or Barnes' dilators which will act as a cervical tampon? Dr. Hicks thinks the general consensus in British midwifery is against the use of the vaginal tampon. We are not sure that this statement is quite correct, and find that, in the discussion that followed his address, so high an authority as Dr. More Madden states that after trying various plans he has found nothing superior to the tampon, "the introduction of which is followed by labor, and then effecting delivery by version." Probably most will agree that there is nothing safer and more effectual than Barnes' dilators, but every practitioner does not have them at hand when the emergency arises, or if he does they very easily get out of order and will then be useless. In a fair proportion of cases we believe the vaginal tampon when properly introduced has an excellent effect, and we would be sorry to see it get into unmerited disgrace.

When the os is wholly or partially dilated the treatment will depend on a variety of circumstances. It is difficult to give a definite rule. What we want, however, is to get pressure on the bleeding surface. Sometimes a mere puncture of membranes will suffice to bring the head down to act as a plug. Sometimes the forceps may be slipped past one edge of the placenta over the head of the child which may then be brought down. In the majority of cases probably the best plan is to turn, preferably by the combined external and internal methods, as so well described by Hicks, and bring down the breech to act as a plug. When we thus have our plug, whether it be head or neck, in position to prevent further hæmorrhage, it is well as a rule to leave the delivery to nature unless some interference appear necessary.

#### DIDACTIC LECTURES.

So much has been written, and so much has been said about the subject of an excessive number of purely didactic lectures now required in this Province, that the matter must be very carefully considered by the Medical Council in the near future. It seems not to be generally understood that in Ontario we are in this respect

quite out of touch with modern ideas on the best methods of teaching. We still require our students to attend didactic courses a second year, *i.e.*, to attend courses in medicine, surgery, medical jurisprudence, etc., in their third year, and to attend the same courses again in their fourth year. A similar condition exists in the primary branches. These lectures may possibly be superior to the ordinary text-books—Flint, Ashhurst, etc., but unfortunately they interfere with practical work in laboratories, dissecting rooms, and hospitals. In no other part of the world does such a system obtain. Of course, from a medical school point of view it may be cheaper, easier and simpler to lecture than to teach practically, but the tendency of the age is to get past such narrow ideas, and Ontario cannot long afford to ignore a question of such vast importance.

We are probably justified in saying that the curriculum of the University of Toronto, as recently amended, is altogether the most modern in Canada, and comes closely into sympathy with the requirements of the most advanced medical colleges of Europe and the United States. According to it, no student is required to attend any purely didactic course a second time, but all are asked to spend more time in practical work in all departments. Whether the Council will accept the students who have faithfully done the work prescribed in this curriculum remains to be seen; but, if not, the time-table will be so arranged that all can fulfil their requirements, but in doing so they will be compelled to omit some of the practical work. In such a case the onus of such an impediment in the way of the students must fall on the Council.

We are pleased to know that McGill University agrees with Toronto. Dr. MacDonnell, a member of McGill Faculty, in his very able introductory address for the present session, speaks as follows: "The days have long since gone by when didactic lectures were regarded as forming the principal part of a medical education. A century ago medical students were apprenticed to practitioners, and everything they learnt was of a strictly practical character. Jenner was apprenticed to a country surgeon near Bristol, and Sir Astley Cooper began professional life at the age of fifteen, as an apprentice at Yarmouth. In those days the didactic



lectures served a useful purpose in supplementing the strictly practical instruction which the pupil received from the master. The school system gradually replaced the apprentice system, and made the student, we won't say scientific, but it made him a man of books and opinions, and cultivated his memory to the neglect of his powers of observation. A double course of lectures on all the more important branches of study was thought necessary, and the number of lectures in each course was fixed at one hundred. Opinions have changed, and improved methods are beginning to prevail. It was found that lectures failed to replace practical instruction. The professor has now to give way to the teacher. Students were over-lectured and under-taught. Your Faculty would wish to replace a large proportion of the didactic lectures by practical laboratory work and instructive demonstrations, but the boards will not let them. They exact the pound of flesh; they must have the one hundred lectures twice told. For my part, I see no hope of a change until such time as the affairs of our profession are controlled by more enlightened men. . . . The excessive time devoted to didactic lectures is the worst in our Canadian system of medical education. There is no country in the world where so many lectures have to be attended. When your brain is weary with much listening, your fingers cramped with note taking, your ischial tuberosities worn away from much sitting, do not entertain hard feelings against the Faculty, but remember the provincial boards." We may say that the board specially referred to by Dr. MacDonnell is that of the Ontario Medical Council.

#### NOTES.

NEW YORK POST-GRADUATE HOSPITAL.—An abstract of the fifth annual report shows that this hospital is in a flourishing condition. During the last eighteen months 486 house patients have been treated. In the dispensary connected with it 8,000 new patients have been treated, 32,000 visits having been made. All the facilities connected with this hospital are at the disposal of those practitioners who take the regular course in the Post-Graduate School.

A bacillus peculiar to warts has been discovered by Dr. Kühemann.

## Meeting of Medical Societies.

### THE PATHOLOGICAL SOCIETY OF TORONTO.

[Specially reported for THE CANADIAN PRACTITIONER.]

#### SARCOMA OF THE BRAIN.

Dr. H. W. Aikins presented a specimen of sarcoma of the brain.

J. L., a healthy boy of 9, on August 13th, 1888, struck his head on a toboggan slide. He was unconscious for a moment, then dizzy. He was seen two weeks after the accident, and had during that time been suffering with headache and left internal strabismus.

Ophthalmoscopic examination by Dr. Reeve showed double optic neuritis. During the next two months incoordination of muscles came on and increased so that when brought to my office he kept falling all over the sidewalk.

On 29th of December he was unable to walk the full length of the room, falling to one or other side, more usually backwards. No pyrexia. Patellar reflex exaggerated.

Early in January, 1889, incontinence of urine came on, although the sphincter ani remained intact. Fixed mydriasis on both sides. Spasmodic hyper-extension of extensor muscles from the hip down. Fearful screeching during sleep, but no pain complained of when he was awakened. He had now become quite helpless.

In February he had become apathetic, wandering, sleeping or dozing. Pupils wildly dilated, no reaction to light. Morning vomiting.

The head now began to increase in size. Slight protrusion of the left eyeball, with some swelling of left upper eyelid. Early morning muscular spasms, in which limbs are flexed, followed by wild screaming. Incessant rolling of the head from side to side while dozing. Tâche cérébrale well marked.

Later on both eyeballs protruded somewhat, and there was a generally diffused swelling of the forehead and eyelids. There was a slightly developed Cheyne-Stokes respiration. His power to memorise was now completely gone. In his wanderings he used expressions which he had not employed for over 4 years. As he dozed there would appear here and there small irregular patches of skin, now hyperæmic, now anæmic.

Hearing is apparently unaffected, but he speaks in a whisper.

During the night and early morning there were strong tonic spasms. In these spasms while the left side of the face was dry and very pale, the right side was almost crimson and transpiring very freely. There was little change in the symptoms for the last few months of his life, save that the spasms were followed by vomiting. He died on May 7th.

Post mortem examination showed the usual evidences of hydrocephalus. In the front part of the anterior portion of the left cerebellar hemisphere and partially imbedded in and connected with it was a soft, somewhat greyish, semi-diffuent tumor, rather larger than a man's thumb. Microscopic examination showed this to be a round cell sarcoma.

*Discussion.*—Dr. J. E. Graham said that the presence of a tumor was shown by the falling backwards, the staggering gait, and the vertigo. These generally indicate a lesion in the centre of the cerebellum. Although the tumor was not in that position it may have pressed upon the centre. The strabismus was important, because there is said to be a connection, as yet unexplained, between the visual centres and the cerebellar. There is said to be a similar relation between the auditory centres and the cerebellum, but in this case no auditory symptoms were noticed. The strabismus also shows that there must be some connection between co-ordination of the ocular muscles and the cerebellum.

Dr. Reeve had suspected a coarse lesion at the base of the brain, because of the development so soon after the trauma, of the evident paresis of the muscles, and the double optic neuritis. In this, as in many other cases, in spite of the double optic neuritis the vision was normal. Might not the sarcoma have been forming prior to the trauma? We know that we have cases of cerebral abscess in which the abscess was present before the trauma.

Dr. Peters asked why so small a tumor, situated on the outside of the brain, exerting but little pressure on the cerebellum had produced such marked symptoms. The pressure must have been both slight, gradual, and exerted on the whole brain.

Dr. W. P. Caven thought that the vomiting,

nausea, optic neuritis and other symptoms were due not to the pressure of the tumor, but to its location.

Dr. Graham believed that the tumor produced such marked symptoms because it was outside the brain substance.

#### TYPHOID ULCERS.

Dr. McPhedran showed a specimen of typhoid ulceration, in which in the large intestine the solitary follicles were ulcerated from the cæcum down to the rectum. The ulcers were elevated and hard, admitting the tip of the little finger into the hole scooped out by loss of substance. In the cæcum and small intestine were elevated Peyer's patches and solitary follicles. In none had the gland substance been completely destroyed, but portions were gone here and there giving to its surface an irregular worm-eaten appearance.

The vermiform appendix, of a whitish mottled color, was coiled up like a snail. These coils were held together by lymph, evidently old. The appendix was very much thickened, being fully the size of one's little finger. The mucous membrane of the appendix was ulcerated and of a worm-eaten appearance. One of the mesentric glands was caseating. In the right lung were two small pea-sized calcareous masses.

The girl, aged 18, had been sick for a week before coming to the Hospital. The temperature chart resembles that of tuberculosis in the great morning falls.

Dr. Osler, of Baltimore, who had seen the specimen, considered it to be typhoid, but in an earlier stage than is usually seen in the dead house.

He was in doubt whether the case was one of typhoid alone, of tuberculosis, or of typhoid with an acute tuberculosis just being super-added. The condition of the mucous membrane of the appendix and the caseating mesentric gland tend to the view of a tubercular element being present.

#### EPITHELIOMATOUS STRUCTURES.

A. B. Macallum, M.D.: The epitheliomatous structures referred to were observed four years ago in all the epitheliomatous growths studied. They may be arranged in three classes: (a) small leucocyte-like bodies, which lie either within or between the epithelial cells of the new

growth; (*b*) cellular elements of the same size as, or slightly larger than, the epithelial cells themselves and possessing special reactions to dyes; (*c*) round or oval bodies usually several times larger than the epithelial cells, possessing a refracting membrane or capsule and containing a large number of spore-like elements slightly smaller than the cells of class *a*.

These spore-like bodies have apparently a nucleus, a certain amount of cell plasma, but no cell membrane. They have been seen in certain cases leaving the capsules by diapedesis, and at points in a section one can determine the presence of a number of similar elements differing in varying degrees from the elements in the capsule. It has been found that there are forms intermediate between the cells of the class (*a*) and those of the class (*b*), and that there are forms apparently in various stages of transition between (*b*) and (*c*). In other words all the structures are merely different stages in the development of the spore-like body found in the capsule. The organism is probably one of the germs, coccidium belonging to those parasitic protozoa, gregarinæ.

From studies of the origin of the "cell nests," it would seem that the latter are produced or caused by the organisms in question, the spore-like bodies penetrating a group of neighbouring cells, setting up gradual decay and cornification in these. A cell nest ultimately becomes filled with the leucocyte-like structures which apparently eat up the cornified epithelial cells.

These peculiar structures have been noticed by two other observers quite recently in cancer of the stomach, intestine, and of the breast.

Whether they are the irritating elements in epitheliomata cannot as yet be determined. The fact that coccidia cause carcinomatous growths in parrots and in the œsophagus of sheep points definitely to an affirmative answer in this matter. Paget's disease has been determined by some to be due to coccidia.

#### ABSCESS OF BRAIN.

Dr. McPhedran: The patient had been struck on the head with an axe. The wound was dressed by a druggist as a mere skin wound. On the sixth day after the injury he was seen by Dr. McPhedran. The wound was stinking. The skull was trephined twice, removing bone and giving exit to pus. The

patient died on the 13th day after the injury, the only noteworthy symptom being free hæmoptysis which occurred twice.

Post mortem examination showed nothing in the arachnoid space. Diffuse suppurative inflammation of the pia mater. A large abscess in the right anterior lobe of cerebrum opening into the lateral ventricle.

Dr. John Caven said that the hæmoptysis was not due to pyæmia nor to disease of the lung. In a series of cases of diseases of the brain we often find pulmonary hæmorrhage, usually in the form of apoplexy, not of hæmoptysis. As yet no explanation had been given.

#### MULTIPLE ABSCESS OF BRAIN.

Dr. H. W. Aikins: The notes of this case have been supplied by Dr. Stark, at whose request I made a post mortem examination.

T. B., æt. 38.

First seen by Dr. Stark on 17th of August last, had been attended by another medical man, and was supposed to be recovering from a somewhat serious attack of bowel colic. His temperature at that time was 100, his pulse 95. He was comparatively comfortable, and was then anticipating an early recovery.

Next seen on Sept. 3rd; was found in pretty much same condition, though considerably reduced in strength. His skin was hot and dry, although he transpired freely at night time. Tongue slightly coated, and bowels somewhat constipated. Was very nervous and excitable, very restless at night, and what sleep he procured was almost altogether in the day. Appetite poor. Pain in epigastrium. Pupils about normal, no vomiting, no cerebral symptom.

He remained in this condition until about a couple of weeks before he died, sometimes feeling much better, and again worse, but well enough to be able to go out for a drive once or twice.

On Sept. 20th he became somewhat more nervous and excitable, and very much depressed. On the 25th was still very nervous, excitable, and sleepless, and toward evening, while reclining on a lounge, called to his wife to say that a very strange feeling had passed over him; this lasted only a moment, however. On the next day, the 26th, he was exceedingly drowsy, but could be roused from his lethargy to answer questions with a "yes" or "no." Incontinence

of urine. On the 27th, his pupils became slightly dilated, and he was very much more drowsy, semi-comatose. On the 28th, he was seen by Dr. H. H. Wright in consultation; he was completely comatose, pupils widely dilated, left arm paralysed, but irritation of the sole of his left foot was followed by drawing up of the member. On the 29th, there was complete left hemiplegia, with continued incontinence of urine, though the feces were retained. There was full paralysis on both sides on the 30th, and he died during the course of the day.

Throughout his illness his pulse ranged from 90 to 109, and his temperature varied from 98½ to 100, his bowels were slightly constipated, he did not vomit, and throughout his whole illness he did not complain of headache.

The abdominal and cranial cavities alone were opened at the post mortem examination.

All the organs examined in the abdomen, with the single exception of the liver, were found in an apparently healthy condition.

The liver was riddled with very recently formed abscesses.

During the removal of the brain, quite a quantity of pus was found welling up in the front part of the longitudinal fissure. It was also found freely distributed over the pia mater at the base of the brain. Also a small superficial abscess in the right cerebellum on its under surface.

Upon section, a number of abscesses (12 or 13) were found in different parts of the cerebrum, for the most part small, and containing the usual greenish-coloured pus. The walls of the right ventricle were soft, with pus in the cavity itself. The cerebral substance otherwise firm and healthy.

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## Correspondence.

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### MEDICAL STUDENTS' MISSIONARY MOVEMENT.

*Editors of CANADIAN PRACTITIONER.*

SIRS,—It may be of interest to many of the readers of the CANADIAN PRACTITIONER to know that there has existed for the past five years among the medical students of Toronto, a Young Men's Christian Association.

The object of the association has been to

promote growth in grace and Christian fellowship among its members, and to engage in aggressive Christian work among the students.

The growth of this good work has been very encouraging to those engaged in it, and the influence of the association for good has steadily increased from year to year.

Encouraged by the success of the work at home, the association has now determined to take its part in the great foreign missionary movement to which Christ's Church everywhere is being stirred up, and in obedience to His command, "Go ye into all the world and preach the Gospel to every creature," to place its representative in the foreign field.

Doubtless it is not generally known how the missionary movement seems to have taken special hold on the colleges of our land, so that students of all classes are now volunteering for missionary work.

Within the last four years nearly four thousand students have offered themselves for this work from colleges in the United States and Canada.

The Medical Students' Y.M.C.A. in Toronto is now seeking to do its share, and already ten of its members have signified their intention of devoting their lives to foreign missionary work.

Mr. Hardie, a fourth year student, has been unanimously chosen by the association as its first missionary, and efforts are now being made to raise the necessary funds to thoroughly equip him, and place him in the field ready for the work of a medical missionary, early in the coming spring.

It is estimated that \$1,000 will be required for Mr. Hardie's outfit, and a further sum of \$750 a year for the support of himself and family.

The question of the field to which Mr. Hardie should be sent was discussed and decided by a committee appointed for the purpose.

The claims of Corea, the land of the hermit nation, were urged very strongly, and after careful discussion and seeking the guidance of Him whose work the mission cause is, it was finally unanimously decided that Mr. Hardie should be sent to co-operate with Mr. Gale, who is now working in the south of Corea.

Mr. Gale is a graduate in Arts of University College, Toronto, and was sent to Corea by the

Y.M.C.A. in connection with that institution in 1888. He is much in need of assistance, being the only missionary working outside the capital, Seoul.

Corea indeed seems to be a very promising field, more especially for the medical missionary.

Protestant missionary effort in that land was begun in 1882 by Gutzlaff, and the subsequent work of Dr. Allen is more or less familiar so all who have followed the modern missionary movement.

It seems to be the testimony of all that no class of missionary obtains such ready access to the heathen as the thoroughly equipped medical man, who, by carrying healing to the body, wins the heart, and is then gladly listened to while he points to the great Physician of the soul.

The Medical Students' Young Men's Christian Association feels confident of success in this its undertaking, and it is hoped that medical men throughout the land will give it their hearty support and sympathy, remembering the work in prayer, and thus aid in the effort to fulfil our Divine Master's command to preach the Gospel of the Kingdom, and to heal the sick.

W. W. BALDWIN,

*Vice-President of Med. Students' Y.M.C.A.*  
22 Carlton St., Dec. 10th, 1889.

## Book Notices.

*Laparo-hystéropexie contre le prolapsus utérin. (Nouveau traitement chirurgical de la chute de l'utérus).* Par Paul Dumoret. Volume in-8o. de 168 pages, avec 8 figures dans le texte.—Prix, 3f.50. Publications du Progrès Médical. Paris, 14, Rus des Carmes.

*Wood's Medical and Surgical Monographs.* Vol. 4. No. 1. William Wood & Co., 56 Lafayette Place, New York.

This volume contains three monographs:—1. "The influence of the male element upon the female organism," by Dr. John Brown. In this chapter especial reference is made to the influence manifest in plants and animals. 2. "The internal and external temperature of the human body as modified by muscle-kneading," by Dr. A. S. Eccles. This is a short chapter, and describes the modes of conducting experiments and results obtained. 3. "The Diseases of the Breast," by Thomas Bryant, F.R.C.S., Senior Surgeon and Lecturer on Surgery, Guy's Hospital,

etc. This article occupies practically the body of the volume as the first two are very short. Mr. Bryant treats the abnormalities and diseases of the breast from a clinical rather than from a pathological standpoint. The deservedly high reputation of the author, both as a practical surgeon and a teacher of surgery will be a sufficient guarantee of the excellence of the article.

## Miscellaneous.

Typhoid fever of a mild type has been unusually prevalent in Dublin this fall.

FEMALE PHYSICIANS IN LONDON.—England is said to have but 73 female physicians, of whom the leading one is Dr. Scharlieb. She was the first woman to receive a medical diploma from the University of London. After residing in India for a time she returned to London where she soon acquired a very large practice. Dr. Carett-Anderson, a Paris diplomée, is another of the leading female practitioners in London. She was instrumental in establishing the woman's hospital in London, and is dean of the school attached to the hospital, and also holds the chair of medicine. This hospital is managed entirely by women, the apothecary and attending physicians being women, the consultants only being of the opposite sex.—*Weekly Med. Review.*

JOURNALISTIC GALL.—In a late number of the *Western Medical Reporter*, a Missouri editor gets the knife in this style:

Of all the examples of gall ever exhibited in America, the most brilliant hails from St. Joseph, Mo. A fellow out there conceived that he was a long-felt want, and started a new journal (sic); as he had no brains to invent a title for his penny-a-liner, he must needs steal a well known journal's thunder, and the abortion was dubbed "*The Western Medical and Surgical Reporter.*" Now it was unnecessary for the engineer of the dirty little tramp sheet to appropriate our name. Had he stated his condition of intellectual bankruptcy, we would have invented a name for him, as we want no journalistic bastards sworn upon us."

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