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No. 11.

PRESIDENTIAL ADDRESS ONTARIO MEDICAL ASSOCIATION.

THE GENERAL PUBLIC AND THE MEDICAL PROFESSION.

BY ADAM H. WRIGHT, M.D.

According to the constitution of this Association, I am now called on to deliver an address, setting forth the conditions of the profession in this province, with such suggestions as I deem it proper to make. In referring especially to the relations existing between the profession and the public in Ontario, I may say, in a general way, that they are pleasant and satisfactory. Our efforts, in a private way, and in a public way, are at least fairly well appreciated. The public are frequently kinder to our profession than we are to each other. In this respect history is simply repeating itself.

If we consider some of the triumphs of medicine during the century now closing, we will find that some of our heroes got but little or no support from their professional brethren. One of the most important features of the early years of the century was the complete triumph of vaccination. Edward Jenner had perfect confidence in vaccination in 1770; but, after that, he labored quietly and persistently for thirty long years before he published his first treatise on the subject in 1800. We were told by Dr. Ward Cousins last year, that, although the new method spread rapidly over the whole civilized world, the acceptance of vaccination was due to the efforts of public-spirited men rather than to those of the members of the medical profession. Many of the doctors of that time considered vaccination as pure quackery, and even charged the vaccinator with flying in the face of heaven.

About the middle of the century Semmelweis made a great discovery in midwifery. In 1847 he enunciated the view that puerperal fever was caused by the introduction of putrescent substances from without, and used chlorine as a disinfectant. By his new method he reduced the mortality in one of the lying-in hospitals from 11.4 to 1.27 per cent. Notwithstanding the proof he adduced, his views were bitterly opposed by

the great mass of the profession. We have been told by Cullingworth, that he was ridiculed and despised, and finally died insane, the victim of continued persecution.

It is much more satisfactory to consider the work of another hero in the latter half of the century—that grand man of our own time—Lister, who has reached so high a niche in the temple of Fame. It is pleasant to think of those “gifts of nature which gave him a happy combination,

The patient thought, the steadfast will,
Resolve and foresight, strength and skill,

which he has laid upon the altar of suffering humanity” (Mr John Wood), and through them the great work he has accomplished. We all rejoice that Lord Lister has received his reward; that all people of all nations of the civilized world have united to do him honor.

We have heard much in recent years about the advances made in medicine, and the greatly improved status of the profession; and yet it is difficult for the student of to-day to fully realize the truth of such statements. The following advertisement taken from a newspaper of Shakespeare's time will give us an idea of the position, social and otherwise, of a physician of that era:

WANTED.

In a family who have had bad health, a sober, steady person in the capacity of doctor, surgeon and man-midwife. He must occasionally act as butler and dress hair and wigs. He will be required sometimes to read prayers and preach a sermon every Sunday. A good salary will be given.

In those days the physician was generally depicted by writers (dramatists and others) as a cunning knave or an ignorant charlatan. What a contrast is presented in considering the position of our profession to-day. The painter makes the physician a hero. For instance, take Mr. Luke Fildes' picture, “The Doctor,” which you have probably all seen. Mr. Mitchell Banks speaks about the original painting as follows: “Of the hundreds of medical men who must have stood before that picture I am sure there was not one whose pulses it did not quicken with pleasurable pride, or who left it without thinking that it already had been, and again would be, his privilege to fight against pain and suffering and death like his colleague on the canvas. For to us he is a real living man like ourselves. We have acted like him and felt like him.

“Note where the scene of the picture is laid; not in some rich man's mansion, where the doctor might reasonably expect a handsome fee for his trouble, but in the workingman's cottage, where, most likely, the gratitude of the people and a consciousness of having done his duty by the poor will be his sole honorarium. With admirable skill the painter has pitched on the early hour of morning for the time. The light of the lamp in the room and the light of the dawn coming through the casement are struggling with each other. It is the cold, sad hour when human vitality is the lowest, and when statistics tell us most men die. The sick child, worn with the raging fever, that commonly burns from eight in the evening till one or two in the morning, lies spent and exhausted. Till then the parents have been fighting on with their nursing, soothing and caressing, encouraging their little one. But now

they too are exhausted and depressed, and hoping against hope seems all that is left to them. And there sits their friend—the gentle doctor—watching with them, and still puzzling his brains to think what more he can devise to stay the lamp of life from flickering out. He is no courtly physician; no London specialist, that man, thank God. He is only a country doctor. But his somewhat rugged face tells of honesty and common-sense, self-reliance and gentleness. What more do you want? The men that look like that man, whatever be their business, or trade, or profession, whatever be their wealth or their social position, I say, of such men is the kingdom of heaven.”

Mr. Gladstone, some years before his death, spoke as follows about our profession: “And speaking of the body of the profession it is impossible for us not to notice the change, it is impossible for us not to see how far more strongly now than of old the medical man of to-day conforms to those general laws of common sense and prudence which are, after all, universal laws of human life in every one of its departments. It is impossible not to see his greater and more sustained earnestness of purpose, that elevated sense of the professional dignity, that desire to make it subservient to humanity, that general exaltation of his aim in the exercise of his profession.”

This is a generous tribute to our profession from a personal point of view. From another distinguished British statesman we get kindly words as to the scientific side of the profession. Mr. Mitchell Banks tells us that a few years ago the Marquis of Salisbury went down to Oxford to plead for the Radcliffe Infirmary, and said, “I believe that if you respond munificently to the appeal that is made to you, you will do something more than place this Infirmary in a position of which it need not be ashamed; you will be taking a long step towards introducing more closely the cultivation of one of the greatest of sciences—the science of medicine—in this ancient university. I always think that science has scarcely received among us all the tribute it ought to receive among the sciences which rest upon observation. It is the most sober, the most absolute, the most positive among all the sciences. Again, there is no other science—which is but another name for a work of mercy—there is no other science that is so closely linked with the relief of human suffering as a remedy for human calamity in its most overwhelming form.”

This, coming from a man who in his younger days was distinguished as a scientist, who in latter years kept himself fully in touch with every advancement in science, whose chief relaxation to-day is working in his chemical laboratory, is a magnificent tribute to our profession. Tell your parson, tell your lawyer, tell your funny friend when he gets off that old joke about doctors differing, that one of the most distinguished statesmen, who is at the same time one of the greatest scientists of the world, says positively that the science of medicine “is the most sober, the most absolute, the most positive among all the sciences”

The modern novelist delights to describe the doctor as Fildes has painted him. We all love such noble specimens of our order as George Ohnet's *Le Docteur Rameau* and Ian Maclaren's *Doctor MacLure*. I need go no further in this direction as I have given sufficient evidence to prove that

where the doctor was despised two hundred years ago, he is respected and honored to-day.

If it be admitted that the public are, as a rule, well disposed to our profession, it may be well to consider what return we make to this same public for their kindly consideration. I will refer very briefly to this aspect of the question, but I may say that we try to replace the gross quackery and charlatanism of past ages by careful methods of investigation and general honesty of purpose. We are earnestly trying to place medicine on a scientific basis. We are endeavoring to do our duty both to our patients and the general public. We are not all heroes; but, as far as my experience and observation has served me, I have known very few physicians who have not done some kindly and generous acts in their professional career, and I have known many who have done numerous, generous and noble acts in a very quiet and unostentatious way. In fact, some good souls appear to form a habit of doing such things without knowing it.

How do members of the profession treat each other? Frequently, not very well, sometimes very ill—I am sorry to say. There is altogether too much mutual distrust and small minded jealousy in our ranks. I often think that we are apt to become big in great things, and small in little things. Let me refer first to the town only containing two doctors—Smith and Jones. The two physicians, working together in a profession that we are pleased to designate as a noble one, should be on the most friendly terms. It is in the interest of themselves, their patients, and their profession that such should be the case. And yet how frequently do we find that they are deadly enemies. Such enmity in such is really a calamity for both Smith and Jones, and also for the science of medicine in that town. Sometimes, instead of open enmity, there is an armed neutrality; that is a little more respectable, but scarcely less objectionable.

This sad condition of things is so common that it appears to me that we ought to continue to put forth some strenuous efforts to improve matters. What are the causes? Smith and Jones are both good and honest practitioners, we will suppose. The success of each must depend largely on his reputation. This is a truism which both fully appreciate and concerning which both are duly or unduly sensitive. The public are apt to put a relative valuation on our services. Smith and Jones may be equally good doctors, but a large portion of the community will refuse to think so, and a section will praise Smith at the expense of Jones. This is very unpleasant for Jones and he resents it. He hears that Smith has said something of an unfriendly nature about him. Some simple remark made by Smith is so terribly twisted and grossly exaggerated in the report given to Jones that the latter becomes very angry. If Jones asked Smith about the matter in nine cases out of ten the trouble would probably be settled amicably. I have only to say professional jealousy is not confined to small towns. In this city—Good Toronto—we have quite a sufficiency of the commodity.

I have not time to discuss in detail the means we should adopt to banish jealousy from our ranks, but I may say, in a general way, that we

should endeavor to see more of each other. There is no better way to do this than by attending the annual meetings of our Provincial and Dominion Medical Associations. A man like our able and genial friend, Dr. Harrison, of Selkirk, who always attends these meetings, is a broader and more generous man than Dr. Jones, of Selkirk (if there be such a man there) who never attends them. When we meet in groups of two or more we might be a little more charitable in speaking of absent ones. I heard, a short time ago, a friend of mine speak to a small group of doctors in Toronto who were talking about a physician, whom I will call Jones, in terms not altogether complimentary, as follows: "Why is it that you fellows never have anything nice to say about Jones? He has at least nine good points for one bad. Why can't you sometimes refer to some of the nine instead of eternally harping about the one?" I think it would be well for us to act on my friend's advice and cultivate more than we do that greatest of all virtues, charity, in criticising the characters and acts of our professional brethren. I have but little to say about our ethical codes which are intended to promote peace and brotherly love between us. They are well enough in a way and accomplish much good, but we must not rely too much on them because there never was and never will be devised a code which will make a crooked man straight.

I do not wish, however, to be considered a pessimist in this connection. As a matter of fact I am not. I love and respect my profession and my friends in that profession. As I have frequently said to my student classes, our profession is a great and noble one in the sense that it gives us grand opportunities for good work in the interests of suffering humanity. If we work honestly and conscientiously, having regard to our duties to God and man, we will make the profession of medicine good, great and noble in the best sense of the words.

This country has produced many specimens of the better and higher type of physician. I will refer simply to one, James Elliot Graham, whom we hoped to have as our presiding officer at this meeting. He was the father of our Association in a sense, as he first conceived the idea of its establishment, and was one of the chief promoters of its organization. Dr. Graham was one of the greatest men and one of the most high-minded physicians that this country has produced. I think I can speak for the whole profession of Canada when I say that through his death this province and this medical Association have suffered an irreparable loss.

There has been, I think, no time in the history of this Association when its members were doing more in the interests of the public than now. Our Public Health Committee had an interview with the Hon. G. W. Ross and the Hon. J. R. Stratton during the last session, and asked the government to make some provision for the treatment of inebriates and dipsomaniacs. The Government had before that declined to do anything because of the expense, but when it was suggested that the probation system, as carried out in Massachusetts, was not expensive, the interviewing committee was asked to draft a bill to be introduced into Parliament. This was done, and the proposed bill was presented to the Premier. The bill did not, however, come before the House, although

I understand the members of the Government are favorably disposed towards an inexpensive scheme for benefiting this class of unfortunates. Dr. A. M. Rosebrugh, of Toronto, has for years taken a very active interest in the matter, and in his good work has been greatly assisted by Dr. Wm. Oldright. These gentlemen are very anxious to get all the help possible from members of this Association in the promotion of their good work.

Another extremely important matter is that relating to the prevention and cure of consumption and other forms of tuberculosis. The results at the Gravenhurst sanatorium, and at the sanatoria in various parts of the world, have been very gratifying. Largely through the exertions of Dr. E. G. Barrick, of Toronto, an association has been formed with the object of bringing proper facilities for the treatment of the poor who are suffering from this disease in Ontario. Through the efforts of this committee an admirable Act was passed at the last session of the Ontario Legislature providing for the establishment of sanatoria for consumptives by municipalities. I earnestly hope that fruition from Dr. Barrick's association will appear in the near future. I hope the profession of Ontario will make some extra exertion to get the public interested in this subject. If the wealthy of our province can get some adequate conception of the enormous amount of good that can be accomplished by this crusade against the most terrible disease of civilization, they will not long withhold substantial assistance to Dr. Barrick and his noble band of co-workers, including, I am glad to say, a goodly number of charitable women. I can speak for you all, I think, when I wish them God speed.

We will have this afternoon a discussion on the most important question that has ever come before the profession of Canada, *i.e.*, Inter-Provincial Medical Legislation. Dr. Roddick has done a vast amount of good work in connection with the matter, as you know. I am very glad to be able to say that the profession in Ontario has commenced to realize the great importance of the new movement. I am very glad that Dr. Williams, and many other members, if not all the members of our Medical Council, are taking a very active interest in the matter. The largest of the provinces in our Dominion will have a great influence for good or evil in the settlement of the question. May I venture to hope that the representatives of Ontario will be broad and generous as well as just while carrying on negotiations with the representatives of the other provinces and the territories.

It is not a part of my duty to make the slightest reference to any debatable points in connection with the question; but, I may, perhaps, be allowed to refer to one phase respecting which there will be no difference of opinion. We all appreciate, now better than before, the fact that while we are physicians of Ontario we are citizens of Greater Britain, and we would like to have our professional status as broad as our citizenship. The little Englander of Canada is dead. We have buried him, and we are glad to have been at his funeral. *R. I. P.* These three letters represent Latin words. I don't give the words in full because I do not wish to put too much Latin into one address. Something—call it imperialism if you like—has heated our blood. We feel bigger than we

did a few months ago. We are sometimes seized with a delirium which is very peculiar from a psychological point of view. Take, for instance, that cyclone of good-natured lunacy which struck Toronto last Wednesday night and raged furiously for something like thirty hours.

In connection with these remarkable phenomena we, the profession of Ontario, feel that we are getting too large to be bounded by the Ottawa River on the east and the Lake of the Woods on the West. We want our Medical Parliament to do all in its power to set in motion the machinery to give our graduates a Dominion degree which will carry with it a license to practise in any part of the great empire of Greater Britain.

ELECTRICITY AND BRAIN POWER.

BY SIR JAMES GRANT, M.D., F.R.C.P. (LOND).

Consulting Physician General Hospital, Water St., and St. Lukes Hospital, Ottawa.

Professor Heger, of Brussels, in a paper presented at the International Congress of Physiology held at Cambridge, England, in August, 1899, stated that, "an important property of the cerebral nerve cell, is its variability in reaction, as regards its cell body, its processes and its epidendritic granules. Changes in all three portions may co-exist, or occur separately under different conditions, the further significance of which is important, *and demands investigation.*"†

The evolution of mental power being closely associated with healthy brain cell action and the activity of the neurons of the cerebral ganglionic centres, the following facts may be of interest, as evidence that defective mental activity unassociated with structural change, may be very materially improved, by the transmission through the brain of modified electric currents by the application of a neurotone

CASE No. 1.—(J.B.), aged 75 years, small stature, pulse and temperature normal, well formed and generally enjoys excellent health, until 1890, when after excessive horse exercise, in the mountains of British Columbia, he experienced a feeling of weariness and fatigue, followed gradually by weakness in his limbs, and considerable loss of power, in ordinary locomotion. Within the past four years, the steps became shorter and shorter, until he walked with considerable difficulty and uncertainty. No loss whatever of complete sensation in any part of the body, or evidence of paralysis, only defective muscular power, and a disposition to occasional slight involuntary escape of urine. Feby. 5th, 1900, placed under neurotone treatment every second day, consisting of applications to the spine, abdomen, limbs and sides of neck (parotid regions) and the free use of Parishes' food with general tonics. At present there is a marked change for the better in the entire system, of a progressive and gradual character. The face, which until recently was pale and exsanguine, has a much healthier appearance, the minute vessels having filled up, through increased assimilative action, in the alimentary canal, the result of electrical action and general muscular power so far improved, that he steps out with considerable ease and comfort. The patellar tendon reflex is perfect in the right leg, but slightly lessened in the left, no trouble from escape of urine. During the past year memory has been defective, so much so that usual business was conducted imperfectly. Within the past week memory was so far restored, could conduct usual official duties with comfort, facts, figures and general data causing little inconvenience, in fact the whole mental condition giving evidence of marked improvement.

The improvement in mental power under such circumstances is an

*Read before the Ottawa Medical Society, March 23, 1900.

†British Med. Journal, Sept. 2, 1899.

attractive feature which opens up a wide field for research, particularly when not dependent on any serious disease of the central nervous system. No indication of touch paralysis, such as first recorded by Wernicke of Germany. In the neurotone examination of the body I observed that the entire left side had a moderate diminution of sensation, compared with the right side, but as to muscular development and tonicity, no appreciable difference. When first seen he could not stand on either leg which he now does with ease. Vision in both eyes perfect, and the other senses normal, and no history whatever of syphilis.

Within the past year I have been much impressed with the diagnostic importance of conditions in the line of anæsthesia, long anterior to loss of power, or the outcrop of paralysis. This is the period for active treatment, to ward off change of structure, and paralytic conditions, otherwise, almost certain to follow. With respect to anæsthesia such may be, either cerebral or spinal in its origin, and as Williamson of Owens College has pointed out, when there is loss of sensation, in cerebral disease, in a portion of a limb only, the boundary line of the anæsthesia, is more or less at right angles to the long axis of the limb, but in spinal diseases, when anæsthesia is in a portion of a limb only, the boundary line of anæsthesia runs more or less parallel with the long axis of the limb. Hemi-anæsthesia has been known to end abruptly in one limb, and by post-mortem examination found to be produced by lesions of the internal capsule at the *posterior third* of its *posterior segment*. The most remarkable result is the sudden termination of hemi-anæsthesia in hysteria, which is of exceptional character. In those cases where a patient feels generally out of sorts without being able to define any particular symptom, it is prudent to make a careful neurotone examination of the different regions as to anæsthesia, as I have found such to exist without any apparent systemic indication, and to prove most instructive, as to the line of treatment that should be followed.

CASE NO. 2.—THERMO-ANÆSTHESIA, OF FOUR MONTHS' DURATION.

A. P. at 44 years—married and two of family, a farmer, well developed, weight 165 lbs., uniform and no particular change in years. Has usually enjoyed excellent health. Never used alcohol or tobacco, except an occasional chew. Never experienced any accident, or injury to spine or head. No consumption in family. No indications of syphilis. Parents lived to a good old age, and father died of paralysis. Rests well at night and enjoys his food. Knee jerk, plantar reflex, and abdominal reflex perfect, also the superficial or skin reflexes generally normal. No evidence of the slightest loss of power in the affected parts, and sensation, as a whole perfect. No affection of the cranial nerves. Precisely the same reduction of temperature, fully one degree in left foot, as in the left hand. The grasp and other movements of the arms, are uniform, and in parts are equal in both sides. The optic discs are normal, co-ordinating power uniform. About four months ago experienced partial occasional numbness and coldness in left hand, and a sense of prickling in the same arm, also the same feeling of numbness and coldness in the left foot,

particularly the toes, ordered a "black draught," and Parishes' food with ferruginous tonics, saline sponging to spine and the body generally, and the free application of the neurotone to the chief ganglionic centres. Here is a case of well defined *thermo-anaesthesia*, without loss of sensation to tactile or painful impressions. It has been noted that in cases of lesion of the pons, there has been anæsthesia, to pain and temperature, on the side opposite to the lesion, while tactile sensation has been unaffected. In the present case, the existence of any cerebral disease, is not defined, even although there is evident localized reduction of temperature and tactile sensation retained. What the precise condition of the system which induces this evident local reduction of the temperature, is difficult to define. The recent remarkable discoveries regarding the structure of the nervous system, may doubtless throw new light, on many nervous phenomena, of health and diseases. M. Capitan of Paris, (*La Nature*, Nov. 25, 1899), states, that the nerve cell, once regarded as a small, polygonal mass, with prolongations at the angles, through the able investigations of Nissl, von Lenhossek, Ramon-y-Cajal, Golgi and Prof. Mathias Duval, as well as other active observers, have demonstrated, that this *actual simple nerve cell*, is complicated in other ways. In its structure, an *amorphous substance*, called *chromatin* in packed grains, and in which are distributed bundles of fibres, forming a net work of considerable regularity in the meshes of which are packed, the grains of this peculiar and interesting substance. From the cell arise a large number of prolongations in all directions, compared with the rootlets of a plant. These cell prolongations are not continuous, but simply approach each other, and possess contiguity, but not continuity. Thus we observe how recent histologic and biologic investigations, as to nervous structure, have made quite a revolution in our ideas, of this portion of the system. As to this particular case, in arriving at a diagnosis of the entire condition, it is well to bear in remembrance, that it is still a disputed point with physiologists, whether the so called motor area, has any sensory function, as great destruction of the motor cortex has been known to exist, without any sensory symptoms being produced, Dr. Williamson of Owens College, states in the *Medical Chronicle*, February, 1899. "I have seen cases of extensive destruction of the motor area of the cortex by tumour growths, (verified by autopsy) in which during life, I have not been able to detect any anæsthesia, and I have also found sensation normal, when the autopsy has revealed extensive softening of the motor area, of the cortex. Under such circumstances it is prudent to observe cautiously, treat carefully, and await practical results.

May 26th. This case has so far made a good recovery, temperature now being normal throughout.

150 Elgin St., March 23, 1900.

REMOVAL OF SEPTAL SPURS.—A NOTE UPON THE USE OF CARMALT-JONES SPOKESHAVE.*

BY D. J. GIBB WISHART.

Prof. of Laryngology and Rhinology, Trinity Medical College and Ontario Medical College for Women.

For the past two years, I have largely abandoned the use of the Bosworth nasal saw in the removal of those projections springing from the nasal septum, which present (a) the appearance of horns, such as occur usually far back in the nasal cavity, are bony in character, and impinge against a small area of the mucous covering of the inferior or middle turbinated surfaces; or (b) the appearance of shelves, usually more anterior in situation, partly cartilaginous and partly bony in character, and in length any where from one-quarter to one inch, and lying parallel or almost parallel to the floor of the inferior meatus.

I do not include here those spurs whose sides incline towards each other at an angle obtuse, or only slightly acute; nor again those spurs which are really deflections of the septum, the angle of the said deflection being sharply acute; nor, except in rare instances, any spur associated with the deflection of the septum. These call frequently for the saw operation.

In the classes of cases, a and b, however, the spurs lend themselves readily to the operation which I am about to describe, and after their removal, there is left a clean, flat, straight wound, which heals readily.

The modus operandi is as follows:

The parts are prepared by spraying with alkaline and antiseptic solution, preferably Nasal Plasma Solution; followed by the packing around the spur in its entire length of pledgets of aseptic cotton moistened with a solution containing cocaine 4 per cent.; extract of supra-renal capsule, 10 per cent., and trikresol, 12 per cent. Care must be exercised that the under and posterior surfaces of the spur be treated, as well as those more easily reached. These pledgets are left in position for ten minutes, and removed, and if the parts are not sufficiently anaesthetised, renewed and replaced.

The patient is seated in the usual position for examination, the head supported firmly against the head rest by an assistant, and the parts are brought as fully into view as possible. I prefer at this stage to use Palmer's speculum, as it allows of a good view of the parts with a maximum of room for the handling of the instrument. The surgeon stands in front and to the right of his patient, and inserts the Spokeshave with the level of the cutting edge always turned towards the septum, passing it gently back over the spur, until it drops into the slot, and then pressing the blade as closely up to the septum as possible, by this means engaging the whole of the spur.

* Read before the Ontario Medical Association June 7th 1900.

If the anaesthesia is efficient the above can be done leisurely, and a careful examination made to see that the blade is in place. This being ascertained, the surgeon places the left hand upon the forehead of the patient, and with the right hand draws the blade rapidly and directly, and firmly forwards, with sufficient force to overcome whatever resistance may be afforded by the bone or cartilage, and keeping the blade always parallel with and close to the septum. The blade must be drawn through with one sweep, otherwise a jagged surface will be left, and when it is disengaged the spur will probably be found adhering to the mucous membrane of the septum by a small strip, just in front of its original situation. This must be snipped with scissors, and the spur removed.

The parts are then sprayed with an antiseptic, and dusted with xeriform, and the cavity filled with a narrow strip of alambroth gauze dipped in 5 per cent. solution of camphor-menthol and albolene. Healing results in a few days.

The bleeding is never extensive, owing to the action of the suprarenal extract, the wound is clean cut, and the surface if anything flatter than that obtained by the saw. In the saw operation, the hemorrhage frequently obstructs the view, and during the delay thus caused, the anaesthesia has time to pass off, thus causing a further delay, which is trying to the courage of the patient.

In the introduction of the blade, difficulty will arise in two directions, first, in keeping the parts full in view, and, second, in passing it between the outer wall and the spur. To overcome this, the parts must be fully illuminated, and every endeavor made to keep the blade immediately under the eye of the operator, until it is finally placed in position. A thorough knowledge of the position and shape of the spur, and its relation to the outer wall must be obtained beforehand by the free use of cocaine and a probe, and this accomplished, the sense of touch will be a careful guide. The operator may then carefully force the blade over the apex of the obstruction without doing damage to the outer wall, but usually dexterity rather than force is required, to insinuate the blade along the winding path. The narrower the blade, the more easily will this be done, but even when the force used has been sufficient to fracture some part of the outer wall, the mucous membrane was not injured and no evil sequelae resulted.

The instrument used has been that manufactured by Stearns Bros. of London, and with the large square shaped fenestra.

The advantages which I would claim for this method of operation are:

1. Absence of bleeding till the operation is accomplished, with the advantage of non-obstruction to the vision.
2. Great saving of time in operating.
3. The almost entire absence of pain or fear to the patient.
4. The satisfactory course pursued in healing.

47 Grosvenor Street.

SELECTED ARTICLES.

THE INDICATIONS FOR SURGICAL INTERVENTION IN CASES OF APPENDICITIS.

I. *Given a case of appendicitis: What are absolute indications for operation?*

II. *Given another case of appendicitis: How do you recognize the favorable moment for surgical intervention?*

ROBERT ABBE, M.D., New York:

I. A first attack: If symptoms ameliorate after the initial vomiting, the pain is well localized over the appendix and the temperature does not rise after the first twenty-four hours, put on ice and delay operation until convalescence, provided the patient can be kept under close observation and within immediate reach of surgery.

If the case grows progressively worse for twenty-four hours operate promptly.

If the onset is severe, the pain in the abdomen intense and tenderness to touch marked, with vomiting, irritable ("snappy") pulse, and coated tongue, operate immediately, inasmuch as many of this class represent the gangrenous type from internal pressure by appendiceal concretions and retained putrid contents, and may by instant operation be caught before rupture, which usually follows twenty four hours after distention.

II. Any case which has passed the acute septic stage may be operated on in the interval, *i. e.*, before another attack. Delay of at least a week is usually wise, but three days will, as a rule, be ample.

G. E. ARMSTRONG, M.D., Montreal:

I. *a.* In acute appendicitis, when the pain, tenderness, vomiting, elevation of temperature, acceleration of pulse and the facial expression indicate clearly the nature of the disease and that the lesion is localized, operation is absolutely indicated unless improvement results from twelve to twenty-four hours of rest, with ice or hot fomentations locally.

b. If during a mild attack or in convalescence there is a sudden accession of pain and tenderness, particularly if the latter tends to become more widespread.

c. In a probably gangrenous appendicitis.

d. In perforating appendicitis.

e. When a persistent tender tumor mass is present.

f. When fluctuation indicates a pericecal abscess.

g. When chills and sweats indicate that absorption is going on, or that a septic pylephlebitis is developing, which may end an abscess of liver or spleen.

EDITORIAL NOTE.—In the following article the views of an equal number of clinicians and of surgeons are brought to bear upon those points in the management of appendicitis concerning which it is most important that clinicians and surgeons shall be agreed. The two questions submitted are printed immediately below.

- h.* Drainage in general septic peritonitis.
- II. *a.* Localized appendicitis not readily yielding to other treatment.
- b.* A history of two or more attacks.
- c.* Persistence of soreness or a sense of something pulling after recovery.

REGINALD H. FITZ, M.D., Boston, Mass.:

My experience with acute appendicitis leads me to recognize, from the therapeutic point of view, two principal classes of cases. In the one, immediate operation is demanded as a life-saving measure; in the other, delay is advisable until it becomes obvious that the patient's condition calls for an operation to check the progress of the disease or to promote the healing of an abscess.

Immediate operation is called for the sudden onset of intense abdominal pain, and exquisite tenderness, in the region of the appendix is associated in the course of a few hours with a rapid pulse, elevated temperature, and retracted abdominal wall. The condition is indicative of a certain degree of shock, and the operation is likely to reveal a perforated appendix, or one whose wall is so gangrenous as to threaten early perforation.

In the second class of cases the initial pain and tenderness, though marked, are not intense. The pulse and temperature are elevated, the latter, perhaps, for a short time as high even as 103° F., or 104° F., and the abdomen is moderately distended and tympanitic. There is a certain degree of deep-seated, circumscribed resistance in the region of the appendix. Such cases form the large majority of those seen by the physician, and tend towards resolution, spreading peritonitis, or abscess formation. Surgical intervention is inadvisable in this group of cases until the progress of the disease indicates which of these directions is to be taken.

In the course of three or four days the symptoms fade away if resolution is to follow, and no operation is then expedient.

A spreading peritonitis is indicated by persistent elevation of the pulse and temperature, by increasing abdominal enlargement, and by an extension of the initial pain and tenderness from the region of the appendix towards the median line of the abdomen, the liver, or into the pelvis. Surgical intervention is then desirable to accelerate recovery and to diminish the risk of a sudden change for the worse.

If the inflammatory signs remain sharply defined in the region of the appendix, perhaps to be determined only by pelvic examination, and the symptoms are so mild as not to call for an operation on the third or fourth day, an abscess is to be suspected, especially when there is a sharply-defined and tender tumor in the right iliac fossa, slowly increasing, it may be, in size. An operation is then demanded to drain the abscess likely to be found, and to prevent its rupture into the intestine, bladder, peritoneal cavity, or through the abdominal wall. A more remote contingency in such cases, when an operation is too long delayed, although the pus may largely be absorbed, is that a pylephlebitis, with hepatic abscess may ensue.

If the patient readily recovers from the first attack of appendicitis without the necessity of an operation, a second attack is likely to occur

only in about one-half of the cases. An operation to prevent this possibility is therefore unnecessary in the above proportion. In about four-fifths of the cases in which a second attack is suffered it occurs within a year from the original illness. To avoid an unnecessary operation in one-half of the patients, therefore, it seems desirable to wait and see if a second attack is to be suffered. If so, it is to be treated as in the first instance.

If successive mild attacks continue, the appendix should be removed when the patient is so long freed from symptoms as to indicate a quiescent state of the pathological structure.

There are conditions which make expedient an early operation even in mild cases of appendicitis. These are, first, remoteness of the patient from the easy and rapid access of skilled surgical aid; second, such occupation as exposes him to unusual violence or requires him to take long journeys, especially to distant parts; third, exceptional timidity of the part of the patient which makes life burdensome through undue anxiety as to his future welfare.

These are offered as general considerations, covering the large majority of cases, realizing, however, that there is no rule without its exceptions, and that each group of cases may contain such as to make an immediate operation expedient or inexpedient.

The physician should give each patient a chance to recover from the immediate attack without an operation, since the great majority of attacks are mild, and since the least risk from operation, if it is to be performed, is taken when the appendix is removed while there are no symptoms of appendicitis. At the same time his patient should be repeatedly seen at short intervals during the progress of an attack, lest a change for the worse, which may occur within a few hours, is allowed to continue.

DR. R. KOCHER, Berne, Switzerland:

I. I have no doubt that most lives would be saved if a radical operation were performed in every case of appendicitis in the first hours or on the first day of the appearance of symptoms.

Given the fact that for most cases of appendicitis surgical intervention is *only called for* after two or three days, I find absolute indications for operation (1) when, after that time, fever presents still a continuous or only slightly remittent type, or when the pulse is quickening and symptoms of general intoxication begin to set in; (2) when an abscess has formed which is increasing and is combined with progressing local inflammation.

II. The most favorable moment for surgical interference in acute appendicitis is when a circumscribed abscess has formed, and the interference which has proved the best for me in recent years is the opening of the abscess at the point where we can get into it without opening the free peritoneal cavity. But then, according to a note which has just been sent for publication in the *Correspondenzblatt für Schweizer Aerzte*, we have found it best to perform the radical operation *after a few days*, sometimes even after twenty-four hours, by typical incision at the place of election, with opening the peritoneal cavity and performing resection of the appendix, without touching the wound opening in the abscess cavity, which

is left to heal by granulation as in other abscesses, whilst the wound opening the peritoneum is closed at once

For patients who have gone through the acute stage with or without opening of abscess the best moment for surgical interference has arrived when every symptom of local inflammation and of general reaction is over and when the radical operation can be done in the form called by Roux and Lausanne "*Resection au froid*." We find the indications for this operation in every case where a local induration or sensitiveness of the appendix is left after a perityphlitis, and think it wise to do it whenever a patient wishes to be guaranteed against relapse.

ROBERT T. MORRIS, M.D., New York, N. Y. :

I. Given a case of *progressing* appendicitis, the absolute indications for operation are any symptoms which ensure the correctness of the diagnosis.

This opinion assumes that the patient is within reach of a surgeon whose records prove his ability to operate at any stage in the progress of the disease, and to make the death-rate, the suffering-rate and the loss-of-time-rate less than can reasonably be expected under other forms of treatment.

This opinion further assumes that the case is within natural surgical limitations. For instance, if the patient has far advanced diabetes mellitus or post-compensatory dilatation of the heart in association with an attack of appendicitis, I would forsake my rule to "operate as soon as the diagnosis of appendicitis has been made," and would resort to consultation with authorities who were competent to estimate the comparative danger between operation, on the one hand, and, on the other hand, neglect of the focus of infection.

II. Given a case of *retrogressing* appendicitis, I would again recognize the favorable moment for operation as the moment when the diagnosis was made.

This opinion assumes that the patient is within reach of a surgeon who has proven his ability to make the operative death-rate, suffering-rate and loss-of-time-rate less than it would be from mesenteric thrombosis, portal embolism, pylephlebitis, iliac phlebitis, dangerous peritoneal adhesions, and other late sequelae of infective appendicitis.

This opinion also assumes that the case is otherwise within natural surgical limitations.

Both of the opinions given in answer to questions I and II assume that the surgeon intends to work for the best interests of the patient, and not for the protection of his own reputation, or for the speculative effect of his action upon the sentiments of the community.

HERMAN MYNTER, M.D., Buffalo, N. Y. :

I. I look upon appendicitis as an exclusively surgical lesion. I do not deny that numerous cases recover under so-called medical treatment, but I maintain that they recover in spite of medical treatment, by the

healing power of nature. Twenty per cent. of all cases are serious, and the mortality under any kind of medical treatment is about 20 per cent., which means that almost all the serious cases die. It is, however, the height of absurdity to compute the mortality in appendicitis from all cases. It is as absurd as if we would compute the mortality of the radical operation for hernia from all operations for hernia. If in 100 operations for hernia, all performed after Basini's method, there were twenty with gangrene from strangulation, and these twenty died, then nobody would state that Basini's operation had a mortality of 20 per cent. But that is just what is done in appendicitis, particularly by physicians. They state that under medical treatment there is a mortality of 15 or 20 per cent. in all cases, while the truth is that the 80 per cent. which recover are the light cases, which would recover under any treatment, or without any other treatment than rest in bed and diet. The 20 per cent. of fatal cases are the serious cases with perforation, gangrene, and peritonitis, local or diffuse.

In Denmark, all cases of appendicitis are still treated almost exclusively with opium, and their statistics are convincing of the utter worthlessness of that treatment. In the diffuse cases Professor With had a mortality of 100 per cent., Floystrup 100 per cent. in the diffuse cases and 37 per cent. in cases with local abscess, and Mcnrad had 100 per cent. mortality.

We must classify our cases, and we will find that operations performed inside twenty-four or thirty-six hours have a very low mortality, as low as in interval cases, and that whether they are localized, gangrenous or perforating, while the mortality in the diffuse cases increase gradually with every day's delay in operating, till it reaches 67 per cent. on tenth day.

The pathological changes in a slowly-progressing appendicitis are similar to those in other tubes (such as urethra, Fallopian tubes, gall ducts): shedding of epithelium, formation of granulation tissue, cicatricial retraction, *stricture*, stasis with dilatation, hydrops, empyema, coprolites, necrosis, gangrene, perforation, peritonitis. Infection with the colon bacillus, however, may at any time and at any point lead to total gangrene, with rapidly fatal peritonitis. Perfect recovery after a serious attack occurs only after destruction of the appendix during a local abscess, and then independent of any known medical treatment, or else by the formation of an appendicitis obliterans. This form, however, may keep the patient in a state of chronic invalidism, with symptoms of nervous dyspepsia.

In cases of septic lymphangitis the appendix may macroscopically appear normal, but the microscope will show colonies of bacilli in the wall. This form is accompanied with symptoms of septic infection, such as somnolence, profuse perspiration, general malaise, high temperature, small, rapid pulse, pain in ilio-cecal region, followed by rapidly fatal peritonitis.

What, then, are absolute indications for operation?

1. All cases which are from the onset acute, with pain, vomiting, increased temperature, frequent pulse, muscular retraction, and in which

no improvement occurs inside twenty-four or thirty six hours. If the pulse increases to 110 and 120, and keeps there, or goes higher, operate at once.

2. In cases of septic lymphangitis, operate at once.
3. In cases of localized, circumscribed abscesses, make laparotomy, and extirpate if seen before fifth day. Incise and drain if seen from fifth day till tenth day, or later, but leave the appendix alone, unless easily found and removed.
4. In cases of diffuse peritonitis, with costal respiration, meteorism, fecal vomiting, and rapid, weak pulse, operate, unless patient is in extremis; drain both flanks and pelvic cavity. Operation offers the only chance, even though a poor one.

5. In chronic and tuberculous cases, with invalidism.

II. I do not recognize any moment as being more favorable for surgical intervention than any other, save the early one.

An operation performed inside twenty-four hours or thirty-six hours is as devoid of danger as an operation in the interval, but in cases of septic lymphangitis and sudden gangrene even this moment may be too late. The more severe the pain and the constitutional symptoms the more urgent is immediate operation, provided the patient is not in a state of profound shock. Surgery ought not to be held responsible for those cases which come too late to operation, with well-developed diffuse peritonitis.

FREDERICK A. PACKARD, M.D., Philadelphia, Pa.:

I. Persistent pain and tenderness in the right iliac fossa after the application of an ice bag, and thorough evacuation of the bowels. Local signs more marked than slight pain (spontaneous), and tenderness on deep pressure in the region of the appendix. The existence of increased resistance (not rectus rigidity), fullness or dullness means that the case has passed from the realm of medicine to that of surgery, and requires constant surgical supervision, if not immediate operation.

II. I consider that the favorable moment for surgical intervention occurs when it is evident that the case is not one of those that can be relieved permanently by the local application of ice to the right iliac fossa, and free purgation, with divided doses of calomel. Where amelioration does not promptly follow these measures (or even with a false improvement from the use of narcotics, but increasing physical signs), I believe that the sooner the appendix is removed the better. I would recognize it by persisting pain or tenderness in the iliac fossa, or by bulging, dullness, or superficial edema in that region. After these are present I see nothing but danger in delay.

ROSWELL PARK, M.D., Buffalo, N. Y.:

I. Rising pulse-rate, rising temperature or subnormal temperature, increasing tumor or abdominal rigidity, intense pain, septic appearance (sordese, typhoid tongue, etc.), leucocytosis, symptoms of obstruction of the bowels, peritonitis, or increasing distension; these are the principal indications for operation, not one of which the surgeon can afford to disregard.

II. To recognize the favorable moment for operation is not always possible, nor for the surgeon even frequently so, since he is often called in after this moment has long passed. *The* favorable time is either the earliest possible, after recognition of the features previously mentioned, or else after a fairly well walled-off abscess has permitted one to feel that he may content himself with simple incision, evacuation of pus, and resting there till the time has come for an interval operation.

NICHOLAS SENN, M.D., Chicago, Ill.:

I. Absolute indications for operation are perforation and gangrene. In acute cases an early operation, that is, within forty-eight hours, is imperative, when the symptoms point to progressive peritonitis.

II. In relapsing appendicitis the time of choice for operation is during the interval between the second and third, or later attacks. In acute cases, after abscess formation has taken place, the operation is directed largely toward the treatment of the abscess, and the appendix is only removed when such a procedure does not add to the danger of the operation.—*Maryland Medical Journal*.

WHEN SHALL THE UTERUS BE DOUCHED AND HOW SHALL IT BE DONE.

By EDWARD P. DAVIS, A.M., M.D.,

Professor of Obstetrics, Jefferson Medical College, Professor of Obstetrics and Diseases of Infancy, Philadelphia Polyclinic; Visiting Obstetrician to the Jefferson, Philadelphia and Polyclinic Hospitals, etc.

Two important considerations warn us against interfering with the uterine cavity during or after labor. The first is the danger that by so doing we may infect the tissues, and the second is our desire to avoid hæmorrhage, either through the detachment of the placenta or after labor through interference with the thrombi which close the sinuses of the womb. There must be a definite indication and a danger greater than the risks of interference to justify the invasion of the uterine cavity.

As regards the risk of infection, it would seem a simple matter to so sterilize a douche-tube or other instrument that it would do the uterine cavity no harm. The difficulty does not lie with the douche-tube or instrument; it is with the circumstances under which it may be introduced. In many obstetric cases, the attending physician has no sterilizing apparatus at hand and depends upon boiling his instruments in domestic utensils to secure asepsis. The vagina is a cavity so situated as to be readily contaminated and made sterile with the greatest difficulty, and a douche-tube or instrument must first pass through this channel to reach the uterus. In obstetric cases in private house, insufficient help and the lack of aseptic appliances make the practice of asepsis difficult. It is not then strange that careful practitioners avoid the invasion of the uterine cavity during and after labor so far as possible.

The risk of hæmorrhage following the use of the douche-tube or instrument exists principally in those cases in which the uterus is empty and in which uterine contractions are deficient and the womb remains enlarged and flabby after labor. In highly nervous patients with such conditions, any interference with the uterus occurring after labor may be followed by hæmorrhage. In some septic cases, intra-uterine manipulation may be followed by severe bleeding, occasioned by relaxation of the womb and by disturbance of its thrombi. With these considerations, we may appreciate the fact that careful precautions must be taken to render the introduction of a douche-tube or instrument within the parturient uterus a safe procedure.

The indications of an intra-uterine douche are precisely those conditions which are at the same time its dangers, namely, septic infection and hæmorrhage.

In the former, it seems rational to remove from the uterus retained and decomposing blood-clot, placental tissue, membranes or purulent secretion and bacteria. In cases which proceed normally, the uterus drains itself after labor by its intermittent contractions, and its cavity being aseptic, the lochial discharge is removed with sufficient thoroughness.

When, however, infection is present, the contractions of the womb are less active, its walls are relaxed, the lochial discharge is retained and partially absorbed, and the patient undergoes a gradual auto-intoxication. When the womb is infected, as shown by an abnormal lochial discharge or a lack of the normal discharge with fever and rapid pulse, the indication is clear to thoroughly cleanse the interior of the womb.

This may be done by the use of a stream of sterile fluid or by the use of dilute antiseptic solutions. In all cases in which the patient is profoundly depressed and has suffered from loss of blood, it is well to employ normal salt solution rather than one of the carbolic derivatives. Mercurial solutions should not be used within the uterus. The danger of absorption of mercurial poison is sufficient to warn us against their employment. For the first cleansing of the uterus a thorough exploration of its cavity is necessary, as well as a douche. The finger may be employed for this purpose, although it will rarely be sufficiently long to accomplish the result thoroughly. In our experience it is much better to employ a douche curette, thoroughly but gently exploring the uterine cavity and douching it at the same time. This procedure rarely requires the use of an anæsthetic. It is but little painful, and is seldom followed by much disturbance. The external parts and the vagina must be made aseptic before the uterine cavity is entered, and the patient may be conveniently placed across her bed, her hips projecting slightly over its edge. By attaching a fountain syringe to the curette a copious douche may be given. From one to two gallons of fluid may be used to advantage. In septic cases, we prefer not to employ a sharp-edged instrument, nor to use forcible curetting, as we wish to interfere as little as possible with the zone of resistance in the uterine tissue and with the thrombi closing its sinuses.

In septic cases, after the womb has been curetted as described, the physician may desire to give intra-uterine douching a further trial, and then he may employ a douch tube. This instrument should be as simple as possible in its construction, capable of being thoroughly sterilized, and large enough to give a free flow of fluid and a prompt and ready return. To fulfill these indications, we have long since abandoned the use of all forms of douche-tubes except the glass tube, and occasionally a hard-rubber tube. For our use, we have had made a tube of specially strong glass, having a groove along the distal portion of its under surface. There is no aperture in the tip of the tube, and it possesses but a single curve along which are holes, which permit the passage of the fluid. The groove serves sufficiently as a channel for the return flow. This tube may readily be boiled, and has given uniform satisfaction. For sterilizing it and also the curettes employed, we use pans of simple construction and convenient size.

Intra-uterine douching has long been considered an efficient means of treatment in post partum hæmorrhage. In this emergency it is not always easy to maintain aseptic precautions. It is better to be prepared for hæmorrhage before it occurs than to run the risk of infecting the uterine cavity through a lack of preparation. It is our practice in all cases of labor to sterilize the glass douche-tube and to have ready a sufficient supply of sterile or antiseptic fluid to enable us to thoroughly douche the uterus should bleeding occur during labor or soon after its completion. The question naturally arises, by douching the uterus, which is relaxed

after the delivery of the child, shall we not remove clots which have formed as plugs to close the sinuses of the uterus? The old teaching was to turn out the large clot, and this we believe to have been correct. A stream of hot fluid will not remove the clots within the sinuses of the uterus, while a considerable mass of coagulum must be removed if the uterus is to contract properly. Intra-uterine douching for hæmorrhage is most successful when followed by an intra uterine tampon of iodiform or sterile gauze. The two in combination empty the womb and make it impossible for a large clot again to form, while stimulating the uterus to contraction.

If a suspicion arises that a portion of placenta or membranes has been retained within the uterus, and that hæmorrhage results from this cause, the douche-curette should be employed. An exuberant endometrium and decidua may give rise to hæmorrhage, which is best controlled by curetting and douching. The disturbance which follows this slight operation is more than compensated for by the stimulating effects of the hot intra-uterine fluid and by the pressure which the gauze makes if it is found necessary to apply it.

Cases are occasionally seen where sepsis and hæmorrhage are combined. In these patients, the infection has proceeded to such an extent that the blood is profoundly altered, and its coagulating power greatly reduced. Cases of incomplete abortion complicated by septic infection are sometimes among this class. In these patients, prolonged douching and intra-uterine manipulation must be avoided. The use of an anæsthetic is dangerous. While it is proper to douche and cleanse the uterus, this should be done as rapidly and gently as possible, the cavity firmly packed with gauze, and the patient stimulated in the most active manner. Such cases are occasionally lost through failure to rapidly perform the necessary manipulations.

When labor must be terminated by the introduction of the hand or of an instrument within the uterine cavity, and when the patient is to some extent exhausted, so that the contractile force of the uterus is lessened, we believe it to be safest and best to expedite the removal of the placenta by expression, to thoroughly douche the uterine cavity with sterile water, normal salt solution, or 1 per cent. lysol at 110° F., and should a tendency to relaxation of the uterus be feared, to conclude the douching by an intra-uterine tamponade of iodoform gauze. When this is removed the uterus should again be thoroughly flushed with one of the liquids named. No further intra-uterine or vaginal douches in our experience have been required after this treatment.

In hæmorrhage, we have seen excellent results follow an intra-uterine douche given as already described. In septic infection we have seen the best results from thoroughly curetting and douching the uterus so soon as the patient has foul lochia and evidences of uterine infection. In a few cases, a second uterine douche has seemed advantageous. We do not believe it wise to give repeated intra-uterine douches.

At each case of confinement there should be used a simple sterilizer in which the instruments of the obstetrician may be boiled. A suitable tube for douching the uterus should be in readiness at each case. Its use, however should be very carefully limited in our judgment to the indications given.—*Journal of Obstetrics and Gynecology.*

THE PAST YEAR'S ADVANCES IN MEDICINE AND SURGERY.

The *Medical News* says editorially under this caption that one of the striking features of the past year is the position that surgery has taken in the treatment of diseases of the gall-bladder and gall-ducts. These affections have been wont to run a most uncertain and unsatisfactory course under medicinal management, and it has now become clear that early operative intervention is destined to take them out of the physicians hands. Expectant treatment for gall stones, once it has become manifest that the attacks of pain are recurring, will soon be a thing of the past. In the treatment of intestinal obstruction and intussusception surgery has also asserted itself, and operation within the first twenty-four hours after diagnosis, or as soon as it is clear that medical measures fail to give relief, is henceforth to be the indication. In cases of typhoid perforation, operative interference as soon as the diagnosis is established has been emphasized, during the past year as the only justifiable rule of procedure. Two successful methods of treatment seem worthy of particular mention in the review of the year. Pagenstecher reported a case of stab wound of the left ventricle of the heart, in which, twenty-four hours after its infliction, he successfully inserted four sutures. The three deep sutures penetrated the entire thickness of the heart muscle, leaving only the endocardium intact. It was with the greatest difficulty that the uppermost suture could be inserted, because its site was not visible except when the heart raised itself up and twisted on its axis during systole. The manipulations necessary for the insertion of the sutures did not perceptibly disturb the heart's rhythm or action. This is the tenth case of active surgical interference in wounds of the heart, and six of them have been successful. The mortality of these cases under expectant treatment was from eighty to ninety per cent. The second notable success was the cure of volvulus, with all the classical symptoms of that affection, by the simple method of having the patient, while maintaining as near as possible a horizontal position, roll over in bed. The attempt to turn, if made in the direction of the twist in the intestine, is followed by immediate increase of pain, while even a partial turn in the opposite direction brings relief, and several turns untwist the ileus completely, with absolute cessation of symptoms.

In medicine the notable event of the year has been the definite determination that a special form of mosquito is the host and the carrier of malarial infection. It is evident that the discoveries in this line are soon to bear abundant fruit in the prophylaxis against the disease and its ultimate eradication from infected regions. In general the advance of civilized nations into the tropics has led to a great increase of knowledge of tropical diseases. England and Germany, as well as our own country, have taken a commendable interest in this work, and it is

evident that the question of the habitability of the tropics by white men is soon to be settled in the affirmative. Progress in general medicine has been more along the line of better appreciation of details than distinguished by any single noteworthy advance. Improvements even in such old-fashioned diagnostic methods as inspection and palpation are not wanting.

The shadow that the diaphragm makes on the chest wall of thin people and the corresponding shadow of the abdomen made by a dilated and partially filled stomach, under similar conditions, have become significant features of physical diagnosis. The percussion of the vertebral spine is now made to convey valuable information for the solution of such difficult diagnostic problems as aneurisms, enlargement of the intrathoracic glands, and mediastinal tumors. The vertebræ act excellently as pleximeters. The use of certain organs, as the spleen and liver, as pleximeters in percussion, to elicit information from beneath them, has also developed, and promises to be of value.

In some directions physicians have been undoing the work of too hasty conclusions. The resistive vitality of the individual rather than the virulence of microbes is now recognized as the determining factor in the course of disease. The claims of discoverers of the specific germ of rheumatism have brought out more clearly than ever that in even simple acute rheumatism there is present not a single entity, but a series of pathological conditions due to many causes. The fact that contributions of the great body of the profession, rather than that of a single genius, have influenced medicine during the past year is a matter for congratulation. It is well known that gradual progress made all along the line is more effective in permanent advance than sudden bounds, which are apt to overleap the mark, leaving the future to discount unwarranted assumptions.—*Therapeutic Gazette.*

DIFFUSE SEPTIC PERITONTIIS.

A very valuable article on this important subject by Dr. George R. Fowler (*New York Medical Record*, April 14th, 1900), deserves to be widely read. It is written with special reference to treatment by elevating the patient's head and trunk, so as to facilitate drainage into the pelvis. The author points out that the peritoneum is virtually an enormous lymph sac, and therefore peritonitis is lymphangitis. The absorbents of the peritoneum are represented by the lymphatics, and the protection which these afford against infecting agents by exudative material thrown out (thrombo-lymphangitis) to act as a defensive barrier by blocking the lymph channels serves to preserve the life of the subject, on the one hand; while a failure in this respect, either because of the enormous and overwhelmingly rapid increase of septic material and the large size and number of channels necessary to destroy or obstruct, on the other hand, permits the destruction of the organism.

The region of the peritoneum possessed of the highest physiological power of absorption is that of the diaphragm, where large lymph trunks are present, the open mouths or stomata of which stand ready to take up and transport to the system at large whatever fluid with its contained pus, blood, bacteria, or toxic products of the latter may present itself.

The region in which the anatomical conditions favoring rapid absorption exist in the next highest degree is the intestinal. Here there likewise exist large lymph trunks and stomata, but not to the same extent as are found in the region of the diaphragm. These are, however, sufficiently numerous to render this region a dangerous area of absorption.

In the remaining region, namely, the pelvic, the non-absorptive character of the peritoneum is apparent. Microscopical study of this portion of the peritoneum reveals the fact that, while it is rich in capillary lymphatics, large lymph trunks and stomata are comparatively absent. The smaller lymph vessels of this region become much more rapidly obstructed, and hence absorption from this region proceeds very slowly, and finally ceases altogether, the arrest being coincident with plugging of the capillary lymph vessels with lymph thrombi, the result of infection and consequent inflammation of the lymph vessels themselves, aided by pressure from without, the latter resulting from peri- and paralympangitis. This cessation exists until the toxic properties of the contents of the pelvic cavity are either destroyed or neutralized, when absorption is resumed through some, but not all, of the vessels. Many of the latter remain permanently closed. The latter circumstances correspond to the clinical fact that in some patients many attacks of pelvic peritonitis result in the formation of chronic exudates, due to the inability on the part of the absorbents to remove the latter, at least for a long time.

As a practical clinical fact, it has long been noted by surgeons that

septic inflammatory processes, when confined to the most dependent portion of the peritoneal cavity, remain quiescent and without urgent symptoms for a long time, as compared with a like condition of affairs existing in that portion of the peritoneal cavity situated above the pelvis. In other words, the peritoneum in this region is possessed of qualities which enable it, first, to resist infection; second, to limit the infection within its own area when it does occur, and third, either so to modify the virulence of the infection or to resist the absorption of its toxic products as to prevent, in the great majority of cases, the grave constitutional symptoms characteristic of an equally extensive infection of the peritoneum above the pelvis.

The author reasoned, therefore, that in cases of septic peritonitis, from whatever cause this might arise, it ought to be advantageous to so raise the patient's trunk that all peritoneal exudations might drain downwards into the pelvis; in other words that the absorption of these exudations might be prevented as far as possible.

In practice he has found that it is needful to insist that the elevation of the bed from the horizontal shall be at least from twelve to fifteen inches. In order to prevent the patient from sliding down in the bed, a large pillow is placed folded beneath the flexed knees, and upon this the buttocks rest. The pillow is prevented from sliding by a piece of stout bandage passed through at the folded portion and secured to the sides of the bedstead.

The author quotes nine cases in which this treatment was followed by recovery. Of these, the following is typical and highly instructive:—

October 23rd, 1899, Brooklyn Hospital. The patient presented the typical clinical picture of diffuse septic peritonitis, with a history pointing to perforative appendicitis as the cause. No hope was held out for recovery, and I hesitated about operating at all. The operation revealed a perforated appendix lying free in the peritoneal cavity and a large quantity of foul-smelling sero-pus. The abdominal cavity was flushed with the peroxide of hydrogen and bicarbonate of sodium solutions, finally washed away with decinormal saline solution. The abdominal cavity was dried out, and combined glass and wicking drains were placed in the pelvis.

The patient steadily improved and recovered.

[It would be difficult to exaggerate the value of this method, based as it is on a common-sense adaptation of physiological facts. But it may be pointed out that it would be equally valuable in all cases of peritonitis, and especially after all cases of abdominal section. In the latter cases, however, I should regard it as advisable to lower the bed to the floor on the second, or at most on the third day, because of the undoubted liability of some patients to the occurrence of phlebitis of the lower limbs after an abdominal operation.]—*The Medical Times and Hospital Gazette*.

THE TREATMENT OF ANEURISM BY SUBCUTANEOUS GELATIN INJECTIONS.

FUTCHER (*Journal of the American Medical Association*, Jan. 27, 1900), in an article on the treatment and cure of aneurisms, states that the credit of having introduced this method to the medical profession is due to Lancereaux, of Paris, who gives the following directions for the making of gelatin solution and the giving of the injections: The solution is made by dissolving four or five grammes of white gelatin in 200 cubic centimeters of 0.7-per-cent. sodium chloride solution, and sterilizing thoroughly at 120° C. The flasks are kept for several days at a temperature of 38° C., and any in which the gelatin becomes turbid or fails to harden in the cold are discarded.

For giving the injections he uses a 500 cubic centimeter sterilized flask, with a tight-fitting rubber stopper through which two glass tubes pass. One of the glass tubes extends to the bottom of the flask, and is connected by rubber tubing with a proper sized needle. To the other short glass tube a stiff rubber inflating bulb is attached. In order to purify the air a glass bulb filled with absorbent cotton is interposed between the rubber bulb and the flask. The temperature of the gelatin solution must be 37.6°. According to Lancereaux no pain should be produced by the injections. With proper asepsis and antisepsis there should be no general or local reaction. After the injection the patient should have absolute rest, and palpation of the aneurism must be avoided. The injections are made at intervals varying from two to fifteen days. Lancereaux thinks that best results are obtained by giving them every sixth to eighth day. He states that, generally speaking, ten, fifteen or twenty injections are necessary to effect a cure. He advises injecting the gelatin solution into the subcutaneous tissue of the thigh, and never into or in the vicinity of the aneurismal sac.

Huchard emphasized the importance of aneurism patients taking the proper sort of diet. An essential point in the treatment is the lessening of the arterial tension. For this reason all sorts of food which tend to produce toxins which have a vasoconstrictor action must be avoided. Bouillon, fat soups, meat, fish, particularly sea fish, and cheese must not form a part of the patient's dietary. Alcohol, tea, coffee, and tobacco are also forbidden. A strict milk diet is preferable, but fruits and leguminous foods may also be permitted. Drugs which cause a dilatation of the blood-vessels, such as iodides and nitrites, are also useful.

Futcher states that the following conclusions may be drawn from his experience with the gelatin treatment:

1. In not a single instance has the aneurism been cured, although in one case the abdominal aneurism has diminished considerably in size and the case is still under treatment.

2. In seven of his nine cases there was an appreciable diminution in the subjective symptoms referable to the pressure of the aneurism.

3. It seems quite certain that the subcutaneous injection of gelatin solution does materially increase the coagulability of the blood.

4. Contrary to the statement of Lancereaux, we have found that the gelatin injections are frequently very painful to the patient, the pain lasting and being most intense often as late as six hours after the injection.

5. Although Lancereaux states that with strict antiseptic and aseptic precautions there should be no elevation of temperature we have found the contrary. In several instances the injections were followed, two to four hours later, by a distinct chill, with an elevation of temperature reaching at times as high as 103° F. In no case was there any local sup-puration, and in only one case was there any local reaction.

6. Notwithstanding the fact that there is not yet a case which can be reported as cured, there is some merit in the treatment, and it deserves a further trial.—*Therapeutic Gazette*.

THE SYSTEMATIC TREATMENT OF ECLAMPSIA BY CHLOROFORM AND CHLORAL.

Taken as a whole, the literature of eclampsia forms one of the most unsatisfactory chapters in the history of obstetrics. Conflicting ideas as to etiology and pathology lead, naturally, to the present conflicting ideas as to treatment, and to contradictory and bewildering statistics as to result. Perhaps, after all, the practical obstetrician need not feel that he is worthy of too great reproach for his inability to find a satisfactory treatment for a condition whose every-day phenomena are still unsolved riddles to the physiologist and the pathologist. When our laboratory scholars have agreed upon a theory as to the origin and life history of urea, perhaps we shall approach the solution of this perplexing problem. It is not our purpose, however, to discuss here the treatment of eclampsia in general, but rather to refer to one phase of the subject with reference to which there is substantial agreement among recent writers. In the treatment of eclampsia, as elsewhere, it should be the aim of the physician, if he can not always do good, at least to avoid doing harm. And it is safe to assert that in the treatment of eclampsia in the past this rule has been honored in the breach rather than in the observance.

Which one of us, even it strong and in good health, would like to be subjected to the prolonged chloral and chloroform narcosis, happily not practiced as much as formerly, but still too much in vogue. If there is one thing in connection with the treatment of eclampsia, about which modern authorities are beginning to agree, it is the folly and danger of this kind of treatment.

It is significant enough that Ohlshausen and Veit, in the last editions of their work, while strongly advocating the use of morphia, and not advising the use of either chloroform or ether (except, of course, in operative procedures), admit the superior safety of ether.

Still more striking is the fact that such keen observers as Ahlfeld while holding diametrically opposite views as to the induction of labor and the operative treatment, unite in proclaiming the danger of prolonged chloroform narcosis. "It increases the tendency to death," says Smyly, as the result of many years observation at the Rotunda. Fritsch, too, in a recent summary concludes that many deaths have been caused by this kind of treatment in cases which might otherwise have recovered.

The employment of anesthesia in the various obstetrical operations which may form part of the treatment of eclampsia is, of course, indispensable, but its long continued use, simply for the purpose of suppressing the convulsions, is a source of danger both to mother and child.

Even in operative procedures we should not relax our vigilance. Dührssen has called attention to the occasional occurrence of sudden death at the very beginning of chloroform narcosis in cases of eclampsia with much uterine distension. In such cases it would seem to be a wise precaution to rupture the membranes before beginning the administration of the anesthetic.—*Obstetrics.*

ACCIDENTAL HAEMORRHAGE: THE HAND BETTER THAN THE BAG.

FIEUX (*Annales de Gynec. et d'Obstét.*, March, 1900) insists that in accidental hæmorrhage from detached placenta the obstetrician's hand is safer from the first as the delivery agent than Barnes's and Champetier de Ribes's bags. He relates a bad case, where the bleeding set in early in the eighth month. The patient was aged 35, she had already been pregnant twice, bearing the children to term, but both died during labour. Fieux found the patient dying from hæmorrhage. The uterus reached to the epigastrium, it felt as hard as wood all over; neither any tender nor any soft spot could be felt. Dark blood flowed from the vulva through a tampon. This plug being removed, the os internum was found impermeable, the cervix and os externum had undergone none of the changes characteristic of labour. Fieux injected saline solution (500 grams) under the skin. The patient was placed in obstetric position, then two fingers were introduced after a little manipulation through the os internum, the membranes were ruptured, and the dilating bag, introduced. But after twenty minutes' application according to the usual method the bag proved useless for dilatation. Fieux therefore passed his hand, finger by finger, into the uterus. The breech presented, the anterior foot was drawn down, and the child delivered; the head gave trouble for a moment when passing the outlet. The placenta immediately followed. Behind it a big black clot over half a pound in weight came away, followed by much blood. Half an hour after the beginning of this obstetric operation the uterus was perfectly empty. The *post-partum* hæmorrhage, which was but slight, was entirely stopped by introduction of the hand combined with a hot injection. The patient soon got well. Fieux considers that manual dilatation is much superior to the bag in any case similar to this, where the patient has already lost much blood and the parts around the cervix are rigid. The uterus must be emptied by the quickest method, and the hand is quicker than the bag.—*Brit. Med. Jours.*

DIET IN NEPHRITIS.

In a paper read at a recent meeting of the Chicago Medical Society on the effect of diet in nephritis, Dr. N. I. Davis, Jr., says (*Philadelphia Medical Journal*) that when a case of acute nephritis first comes under treatment it is best to enjoin rest in bed, to withhold all food for twenty-four or thirty-six hours, to give water freely and to empty the alimentary canal. Milk should then be given, at first in small quantities, at intervals of two hours; the quantity must be increased gradually until two quarts are taken daily. The exclusive use of milk is especially useful to those who have acute nephritis, because it meets the demands of the system more perfectly than that of any other single article of food. Intolerance of milk is often lessened or removed if, when a milk diet is begun, it is given in very small amounts, one or two ounces at a time, for example, and if the amount is slowly increased. Milk, moreover, is less likely to produce gastric distress if it is sipped instead of being drunk rapidly. All things considered, it is the universal judgment of the profession that there is in this disease no substitute for a milk diet.

When the urine becomes copious and the amount of nitrogenous matter voided in twenty four hours all that can be expected, farinaceous foods may be prescribed in addition to milk. In a few days some of the sweet fruits and simple vegetables can be given. When albumen disappears from the urine an egg can be tried. During the time that albuminous foods are being added to the patient's dietary, close watch must be kept upon the effect of it, the quantity of urine, the amount of daily nitrogenous excretion and the amount of albumin and number of tubercasts, if any, are found in the urine. When an egg can be taken without harm, white meats can be tried, such as the breast of squab and chicken, a little of boiled ham, or perfectly fresh fish. Red meats, rich in extractives, should not be eaten until recovery is established.

In chronic diffuse nephritis there is the same indications for a milk diet as in acute nephritis. It is, however, so prolonged a malady that an exclusive milk diet cannot be maintained continuously. A diet for this form was given. Interstitial nephritis is so chronic a malady that an exclusive milk diet, even if it were necessary, could be maintained only for a small portion of its entire course. The observation of Zasiadko, of St. Petersburg, are suggestive of the value of different diets in chronic nephritis. This gentleman administered to ten patients suffering from chronic nephritis, a vegetable diet for ten days, for a like period an animal diet (with a little bread added), and for another equal period of time a mixed diet. While upon a vegetable diet the amount of albumin in the urine lessened, arterial tension diminished, dropsy increased, the pulse became slower, weaker and softer, appetite failed, the patients became weaker and more apathetic. While upon animal food, the albumin increased in the urine, arterial tension rose, edema lessened, the pulse quickened and grew fuller, the patients became stronger and more cheerful. The effects of a mixed diet were midway between these. Alcoholics are looked upon as contraindicated in renal affections by the majority of clinicians. They are renal irritants.—*The Dietetic and Hygienic Gazette.*

THE TREATMENT OF EPILEPSY;

Furstner (*Centrabl. f. Nerven u. Psychiat.*, Coblenz u. Leipzig, December, 1899, S. 708) discusses at length the different forms of epilepsy and their amenability to treatment by the bromide salts. He is a thorough believer in the efficacy of bromides in true epilepsy, and agrees with Biswanger that the evil results of their continued administration is greatly exaggerated both by the profession and by the lay public. One of the reasons of their failure in private practice he states to be this fear, the want of realization of the continued and continuous effect of the drug, as well as a want of patience and perseverance on the part of patients and their relatives. Beyond the passing and occasional first symptoms of bromism, he has never in his experience seen any bad results when the drug was administered in doses of from three to four grms. per day to children, and from five to six grms. per day to adults. Except occasionally, when ordinary doses lost their influence, he has never prescribed the drug in larger quantity.

He next proceeds to deal with the very important question of mistakes in diagnosis, whereby other affections are confounded with genuine epilepsy.

The first group of cases in which errors in diagnosis are apt to be made are met with chiefly in private practice and in young persons, although not a few cases have been observed among adults. The relatives are always sure that epilepsy exists, and many of the symptoms are identical with those of true epilepsy. The seizures occur most always in the daytime, and the tongue, sometimes the lips, are bitten. Sometimes as many as four or five attacks occur in a day. The seizures are often due to physical disturbances, *e.g.*, constipation, and often to occurrences in the surroundings, such as family quarrels, whippings, etc. After the attacks there is usually drowsiness, irritability, or paræsthesia; such objective symptoms as pupillary anomalies or heightened patellar reflex may also be observed. When in such cases bromide is prescribed in doses according to the age of the patient, the only result is an increase in the severity and frequency of the fits. If the doses are increased, mental apathy, obtuseness, and urinary troubles and acne result. The writer looks upon such cases as hysterical manifestations. A complete change in their surroundings, such as isolating them or placing them in an asylum, lessens the frequency of the seizures or often stops them altogether. The sudden cessation of the bromides is followed by no bad effects. In some cases of this kind he is of opinion that the exhibition of the bromides is useful for purposes of different diagnosis. Next he discusses a group of cases, almost wholly confined to children, where organic changes in the brain are either congenital or acquired at a very early age. Their only point of resemblance to true epilepsy is in the character of the convulsions. When bromides are given to such cases, the results are inconstant. Any improvement is temporary, and at intervals the fits return in spite of bigger

doses. In such cases a regular bromide course is not justified. Furstner next proceeds to discuss what is known as "epilepsia tarda," and will only admit into the group those cases in which there is no gross brain lesion present. In some cases of epilepsia tarda the bromide treatment successfully removed the fits; in other cases the results were less satisfactory, and after apparent recovery the attacks returned. In the last group he is of opinion that organic brain lesions were present, either congenital or of early occurrence (infantile paralysis), or, more probably still, that the cerebral arteries were atheromatous.

Before pronouncing any opinion based on statistics, as to the value of bromides in true epilepsy, it is necessary and desirable to have more knowledge regarding the convulsions and fits of infancy. Whether these stand in any relation to epilepsy or not, they certainly tend to create a predisposition towards the occurrence of that disease in later life. Out of 141 cases where epilepsy occurred prior to the eighteenth year, the writer found that convulsions had occurred in childhood in ninety-two cases; and where epilepsy first appeared in fifty-two cases, at the age of twenty to thirty years, convulsions in childhood were ascertained in nineteen of them.

Fits in children should be systematically treated with bromides, and the treatment should be continued long after the cessation of the fits. The writer had his best results where the treatment begun in childhood was continued over the age of puberty.—*Edinburgh Medical Journal*, April, 1900.

NERVOUS AND MENTAL DISEASES.

OBSTETRICAL PARAPLEGIAS.—Ballet and Bernard (*Revue Neurologique*, November 30th, 1899) refer to the pioneer work of Bianchi, in 1867, upon this subject. Before his day, obstetrical paralyses were thought to be reflex in nature, and he was the first to show that the condition is due purely to compression by the fetal head or forceps of the sacral nerves.

Since Bianchi's study, material of this sort has rapidly accumulated, and some of the standard works on obstetrics now devote a separate chapter to obstetrical paralyses.

Within the past few years, however, a reaction has set in, due to the prevalent ideas as to the autotoxic nature of pregnancy. Instead of compression paralysis we hear nowadays more about infectious polyneuritis as one feature of a general autointoxication. It is claimed that polyneuritis from intoxications of all sorts shows a marked tendency to involve the domain of the sciatic nerve; so that while some of these obstetrical paralyses may be purely traumatic, others are of toxic or mixed nature. The present authors report a case exhaustively and then analyze the entire subject of obstetrical paralyses; as a result of their labors they come to the conclusion that the subject is much more complex than has heretofore been thought. In fact they make no less than four categories, well differentiated, of these lesions, viz.:

1. Paraplegia symptomatic of an infectious or toxic polyneuritis, occurring in puerperal women with sepsis or albumenuria.

2. Purely traumatic paraplegia, due to no other cause than compression of the nerves. The case described by the authors appears to be typical of this class.

3. Associated cases, in which a trauma (compression) and a coincident infection or intoxication are both present as factors. A case reported by Lamy, in the *Revue Neurologique* for August 30th, 1896, serves to well illustrate this category.

4. Finally, we may have hysterical paraplegias in connection with childbirth. Charpentier, and more recently Leeson (*Edinburgh Medical Journal*, 1897, p. 411), have made contributions to this subject.—*Med. Review of Reviews*.

SOCIETY REPORTS.

TORONTO MEDICAL SOCIETY.

Stated Meeting, April 19th, 1900.

The President, Dr. Gilbert Gordon, in the chair.

Dr. Duncan exhibited a patient. Case reported in June Number of THE CANADA LANCET.

Dr. Gordon exhibited Mr. T. electrician, six months ago exposed to severe changes of temperature in Edmonton ; was a moderate drinker ; had considerable domestic worry. In September he noticed weakness in hands, arms and shoulders. Was unable to dress himself. In Montreal a diagnosis of multiple neuritis had been made. There was no history of syphilis. A doctor in New York diagnosed muscular atrophy.

Dr. Graham Chambers exhibited two patients, 1st, case of iodide rash. Eight years ago had syphilis, three weeks ago an ulcer had appeared on the lip. Pot.iodid. was given. When the rash appeared, also after the treatment was begun, balinitis developed. Dr. Chambers said the rash was not an affection of the sebaceous glands but of the blood vessels, as the rash was produced often where there were no sebaceous glands. Case 2, Pityriasis Rosea, the rash came out first in bright red spots on the chest, arms and elbows. There were two lesions, one scaly macular, the other circinate, red edged and centre clearing. It was a typical case of the maculate and circinate form.

Dr. Webster opened the discussion on the use of oxygen gas in pneumonia. He reported a case seen at the Western Hospital on the 7th day of the disease. Patient was perfectly helpless, cyanosed and apparently dying. The cold gas was used for fifteen minutes but the supply became exhausted. Then heated oxygen was used. The patient in a very few minutes was evidently much relieved and became a nice color. When the cyanosis recurred the gas was again administered and the patient lived from Friday until Tuesday. On Monday afternoon the effect of the hypodermic injections of strychnia seemed to become worn out before the time for the next injection arrived, and the heart was found to respond less and less to the stimulant. The patient died without cyanosis. The case was one of double pneumonia.

Dr. H. B. Anderson said he had seen oxygen used in two cases, first in a case of Dr. Guinane's in St. Michaels, in an emergency he had been asked to advise the house surgeon. The pulse was 200, temp. 104, respirations 100, extreme cyanosis. He could not tell the extent of lung involvement in the pneumonia as he saw the case only on this occasion. Gas was administered by an ordinary inhaler, improvement was immediate, in less than ten minutes. On the same day a recurrence was relieved by oxygen and the patient made a good recovery. Second case: Child four months old, suffering with broncho pneumonia, pulse above 200, temp. 104 1-5, respiration 100. Heated oxygen was used, and

the child made a rapid recovery. He quoted Dr. A. H. Smith, N. Y., who introduced oxygen in 1860. He found by obstructing the wind-pipe of animals that they could be kept alive by the administration of oxygen gas, showing that although the volume of air admitted was reduced, the excessive supply of oxygen sustained life. Dr. Smith's conclusions were that little benefit could be expected in complete consolidation of the lungs, but very good results in such cases as diphtheria, croup, bronchitis, broncho pneumonia and croupus pneumonia, where there was obstruction and little or no consolidation.

Dr. McIlwraith had had two cases which he reported. He had noticed that the cold gas used in the first case had acted as a cardiac stimulant, but the heated oxygen used in the second acted as a nerve stimulant.

Discussion. Dr. Wilson said that in 1877 he had used oxygen gas in a case of bronchitis with weak heart. He had obtained a splendid result, manufacturing the gas himself from manganese dioxide. He could not find out at what degree of heat the gas heated in Underwood's respirator was when it reached the patient.

Dr. McPhedrn said in consultation he had seen little benefit in serious cases of pneumonia. He agreed with the paper quoted by Dr. Anderson.

Dr. Anderson said in reply that the gas was a heart stimulant and was advised in Dr. Smith's paper to be given early when respirations reached 35, to relieve the right heart.

Dr. Rudolph described some experiments with chlorotone, 1st, as a local anæsthetic. After free bathing for 15 minutes the parts were still sensitive. 2. As a general anæsthetic, it was a perfect anæsthetic for physiological work. 1.5 gm. given to a dog, the chart of cardiac tracings, was exhibited and began 55 minutes after the dose. The blood pressure improved and continued so for 3 hours and 9 min. The dog died from heart failure. Respiration continued for a few minutes after the pulse stopped. 2. A small dog was given .24 gm. per kilo weight more than enough to produce anæsthesia according to the statement of the company pushing the drug. The dog became intoxicated but not anæsthetized. The temperature fell and he took three days to recover. 2.75 gm. per kilo produced complete anæsthesia, but also death. Here the anæsthesia was perfect, blood pressure is not affected by the dose until the last when death occurs. The temperature shows an enormous fall which is not described in the literature of the drug. With guinea pigs .2 gm. per kilo administered produced a gradual death without anæsthesia, the temperature falling from 101° F. normal to 80° F. Dose of .1 gm. per kilo produced a slight fall in temperature, dose .15 gm. produced marked fall in temperature, no insensibility, intoxication and very slow recovery. The effect produced by the drug was, 1. great fall in temperature, 2. intoxication, and 3. if the dose was large enough, insensibility and death. His conclusions were: 1. No use as a general anæsthetic. 2. Narrow margin between no effect and fatal or profound effect. 3. No antidote.

Discussion. Dr. J. Ferguson said he had found it a perfect failure as a hypnotic. Dr. Dickson thanked Dr. Rudolf, and said it was a step in the right direction. Dr. Chambers said from its chemical structure it

should be better than chlorol. The fall in temperature was common to all the phenic series. He had had good results in two cases. Drs. McPhedran and Webster had had no good results. Dr. Rudolf in replying said that the first guinea pig which had died had had suppression of the urine.

(STATED MEETING, MAY 17TH.)

The President, Dr. Gilbert Gordon, in the chair.

Dr. F. N. G. Starr reported a case of malignant (?) disease of the gall-bladder, simulating hydro-nephrosis; feeding through the gall-bladder for three days. A female, aged 51, first seen March 22nd, 1899, was complaining of pain in the right renal region extending to Poupart's ligament and across to the left side. On examination, a mass, the size of a duck's egg, three fingers breadth below the costal margin, not continuous with the liver, movable on palpitation and respiration, very tender, resonance over the mass, and between it and the liver margin. She described a sensation of something slipping up under the ribs on sitting up. She gave no history of gall stones or discolored stools, but of pain in the side, associated with a diminution in the quantity of the urine, lasting a day or two; then a large quantity would be evacuated and the pain relieved. Examination of the urine shewed neither sugar nor albumen. A few dumbbell crystals sp. gv. 1022, amber color. An offensive discharge from the vagina, but on examination no growth or malposition. There had been no menstruation for five months. A provisional diagnosis was made of floating kidney. On April 9th she had after three days of great pain, passed half a chamber pot full of urine, and was then comfortable for a time, but was again suffering. Very little urine had been passed—each day 8 oz. being withdrawn by catheter. In the next 15 hours she passed 4 oz. The mass had increased greatly in size and now extended to the left of the umbilicus and was less freely movable. She was vomiting a great deal. Nothing relieved her not even lavage. It seemed that the ureter had become kinked. On April 12th an incision was made over the right kidney which was found normal in size and appearance. The ureter was however greatly distended because of some intra-peritoneal tumor, the wound was closed and an opening made over the mass which was found to be a greatly distended gall-bladder.

On aspirating, a considerable quantity of dark brown grumous fluid was drawn off, which, microscopically, was made up of cholesterine crystals and disintegrated blood. The general peritoneal cavity was protected by sponges and the bladder opened. The wall was very thick, from $\frac{1}{4}$ to $\frac{1}{2}$ an inch. The patency of the common bile duct was made out, and believing the case malignant, the opening into the gall-bladder was sutured to the abdominal wound and a drainage tube put in the remainder of the wound was closed. For days the tube drained away the dark brown fluid which gradually became clearer until clear bile was discharged. As soon as the patient began to recover from the anæsthetic, the vomiting recurred. For 36 hours she lived on nutrient enemata, then the bowel refused to retain them. The evening of the third day found the patient sinking. She was restless, face drawn and pinched, eyes sunken, temperature subnormal, pulse 140, irregular and barely perceptible. Mr.

Cameron came in at this time, and while discussing the advisability of giving a subcutaneous injection of normal saline solution, it occurred that through the gall-bladder was a direct opening into the duodenum. Three pints of solution were put into an irrigator, the nozzle into the drainage tube which was packed to prevent leakage, and the injection began at an elevation of 18 in. and raised to 3 ft. There was some leakage but the patient got about one quart. Inside of half an hour the effect was marvellous. She became restful, pulse full, temperature slightly elevated, vomiting ceased and she had her first undisturbed sleep. These injections were repeated twice during the night, and in the morning it had proved so successful that 3 oz. of peptonized milk was given and continued every two hours for three days. She was then fed by the mouth. Recovery good. She continues in good health, though she still wears the drainage tube because on two occasions it had become blocked with mucous, and she complained of the old pain under the ribs; hence, fearing that the closing of the opening would lead to a recurrence of her old symptoms, she was advised to put up with the inconvenience. Dr. Starr wished to call the attention of the members to the unusual method of feeding a patient when the condition had become hopeless. He had been unable to discover that this method had ever been tried before.

Drs. Primrose, Oakley, Rudolf and McMahon discussed the case.

Dr. A. Small reported a case of an alcoholic treated by the "Bromide sleep." A man, aged 40, was given on the first day, 9 dr.; on the 2nd, 8dr.; on the 3rd, 10dr.; on the 4th, 8dr.; was drowsy all afternoon; then 15 gr. sulphanol were given and he slept. Since then he has not returned to the alcohol. The temperature ranged through from 96.2° to 98° F.

In discussion, Dr. Rudolf said he had failed to produce sleep, but that the results were good. There was no Bromide rash. Dr. McLeod, the originator of the treatment, had reported nine cases with two deaths, one from pneumonia, one from septicæmia from caries of the teeth. One case also had had bronchitis and recovered. No fatal dose has been recorded. Brunton, on theory, gave sodium chloride as an antidote, but as bromine repels chlorine, the theory is unsound.

Dr. Powell said the treatment was old. He had, in 1878, treated a morpho-maniac, giving potas. brom. dr. 6 to 8 a day until the staggering gait was produced. The treatment lasted six weeks; the patient lived 15 years and died of pneumonia, without having returned to the use of morphia, though given it twice during that time. Pot. brom. is much more of a tissue poison than the soda salt. Strychnine is antagonistic.

Drs. Machell, A. R. Gordon, Carveth and Hunter also discussed the treatment.

The reports of the officers shewed that the society was in a better condition than it had been for ten years. The average attendance was 35. Addresses were given during the season by Dr. Rotch of Boston, on "Infant Feeding," Judge Macdougall and Mr. B. B. Osler on "Expert Testimony," and Prof. McLennan on "The X Ray."

The following officers were elected: Pres., A. Primrose; 1st Vice-Pres., F. N. G. Starr; 2nd Vice-Pres., R. D. Rudolf; Cor. Sec., Porter; Rec. Sec., A. G. Ashton-Fletcher; Treas., G. H. Carveth; Council, Gilbert, Gordon, McMahon and Machell.

MISCELLANEOUS.

SPASM OF THE LARYNX DUE TO AUTO-INTOXICATION
FROM RENAL INSUFFICIENCY FOLLOWING GENERAL
ARTERIO-SCLEROSIS.

Dr. Valink, *J'Union Medicale du Canada*, April, 1900, contributes an exhaustive report of a case in practice under his close observation for an entire year. On March 14th, 1898, the doctor was called to relieve A. L., a carpenter, aged 55 years, suffering from a severe attack of suffocation. The crisis had been short, and upon his arrival the patient had recovered entirely and was standing at his shop door. Inquiry proved that this was not the first attack, and that the patient had been treated for asthma as a possible cause of the spasm. The patient was submitted to a thorough examination, with the following result. The nasal fossæ and the larynx were healthy, the respiratory murmur deficient in the left lung, with a history of several attacks of pulmonary inflammation upon the same side, hacking cough, with mucous expectoration free from tubercle bacilli. There was dyspnoea on exertion, but none following the suffocative attack. Pulse 85, hard, intermittent, general arterial sclerosis, with coldness of the extremities, cardiac hypertrophy. Reflexes normal, epigastric pains, furred tongue, gastro intestinal fermentation and constipation. Urine pale, sp. gr. 1010, amounting to 400 c.c. in 24 hours, slightly albuminous, urea diminished, alkaline with phosphates, urobilin, and indican. Skin dry and itchy in the lower extremities. The patient was nervous, a hard worker, without any history of syphilis and subject to chronic rheumatism.

The author here enters into a somewhat detailed explanation of the effect of arterial sclerosis, in modifying the functions of the body organs, causing phenomena connected with nutritive changes, and saturating the system with toxins from deficient elimination, the organs themselves being affected, the nervous centres and especially the medulla oblongata sharing in this. The differential diagnosis is also discussed in detail, which led to the doctor making a diagnosis of "laryngeal spasm, combined perhaps with spasm of the trachea and bronchi, from intoxication of the bulb, due to renal and hepatic insufficiency, in an individual with general arterio-sclerosis."

The patient was put upon a milk diet, with abstinence from meats, and calomel and beta-naphthol used to clear and purify the digestive tract. After five days the albumen, indican and urobilin disappeared and the urine increased in amount to 800 c.c. with a density of 1015. At the end of three months, an attack of bronchitis intervening, the urine was maintained at 1000 c.c., with traces of albumen. There was no attack of spasm during the bronchitis. Sodium iodide and trinitrine were administered and the former diet maintained. For four months the urine con-

tinued satisfactory, amounting to from 1200 to 1500 c.c. in the day with a density of 1015 to 1022, slightly acid, urea 22 grammes, no albumen or indican.

In the autumn, as the result of exposure and hard work, and the resumption of a meat diet, there was an attack of laryngeal spasm. On examination the urine was found to have diminished to 350 c.c. in the day, the urea to 7 grammes, sp. grav. 1010, with a trace of albumen, some blood corpuscles and leucocytes. Three weeks rest in bed, with a milk diet, restored the patient. Several similar relapses followed, each preceded by carelessness in diet. In the following March the patient changed physicians, his new attendant making a diagnosis of laryngeal phthisis and general tuberculosis, entirely traversing the former line of treatment, and adopting over-feeding, creosote, etc. The auto-intoxication thus produced caused a diminution of the urine to 200 c.c. with abundance of albumen followed by severe attacks of laryngeal spasm in which condition his former physician found him on his arrival. The patient's face was blue and anxious, the mouth agape, the thoracic wall immobile with no vesicular murmur, the skin clammy. After the spasms relaxed, the patient was exhausted, but respiration became normal and there was no laryngeal bruit. Morphia was administered, followed by some hours sleep. Another laryngeal spasm then occurred, and the patient succumbed.

The author concludes this interesting report by drawing attention to recent observations of Lancereaux tracing the laryngismus stridulus of infants to auto-intoxication from intestinal fermentation.—WISHART.

Obstetric Aphorisms.

C. A. Van Ramdohr in Post Graduate for April has the following aphorism for the obstetrician's guidance and compact enough to be easily remembered.

1. Never rupture membrane unless you are prepared to finish delivery at once, if necessary, or unless you intend to confine the patient artificially within a limited period of time.
2. External measurement of pelvis has to be practised to yield trustworthy results.
3. The external (Baudelocque's) diameter is never reliable.
4. The distance between the crests should be about an inch greater than the distance between the spines. Equal distances or a larger interspine indicate a deformed pelvis.
5. Contraction at the outlet is extremely rare, and if it occurs, is usually the result of an ankylosed coccyx.
6. If the index finger can touch the promontory there is always a reduced conjugate diameter.
7. If, on the introduction of two fingers, the middle one does not reach the promontory, the conjugate is normal or more than normal.
8. Whenever the whole hand can be passed through the superior strait, there is a possibility of withdrawing the child through the natural passages.
9. If the hand cannot be passed, there is an absolute indication for Cesarean section.—*Med. Record.*

Intestinal Antisepsis in Typhoid Fever.

The season for the annual discussion on the treatment of typhoid fever is close at hand and we may expect the current literature from now until December to be filled with such names as Woodbridge, salol, Osler, calomel, cold water, salts, turpentine, opium and silver, and such like.

The International Medical Magazine for April leads off with a symposium on this very seasonable subject. The opening article is by James M. Anders, who says that intestinal antiseptics are valuable in this condition, but they are by no means a specific, as he considers the disease one of the general system and not altogether confined to the intestinal canal.

The Woodbridge treatment he gives a black eye in passing and in fact only mentions it to condemn it as illogical and unscientific, which it undoubtedly is beyond and peradventure.

He recommends intestinal antiseptics for a rational purpose that is to control in some measure the meteorism which is often due to some undigested matter in the canal and in such cases a laxative will have a good effect. Salol he has used for a number of years with good results.

Intestinal irrigation is recommended in appropriate cases as where the ulcerative process is in the colon as well as in the small intestine.—*Charlotte Med. Jour.*

Nutrient Enemata.

C. A. Ewald (*Archiv. f. Anat. und Physiol.*, Supp. Bd., 1899, p. 160).—Careful experiments on the extent to which nitrogen is absorbed from the rectum were made. The enemata employed consisted of milk and eggs, with the addition of a little salt and red wine, each being of the value of about 400 calories. Three such enemata were given in the day.

The nitrogen eliminated by the urine and that contained in the material washed out of the bowel were carefully estimated, and in that way the degree of absorption ascertained.

Details of 5 cases are given and in these the degree of absorption varied from 30 to 95 per cent. of the nitrogen contained in the enemata. The writer is unable to explain the great individual differences in the absorptive power of the rectum but the same variations are observed in its degree of tolerance. Thus, in some of his patients rectal feeding was carried on for a month, whereas in others pain and intolerance supervened after 3 or 4 days. The addition of opium to the enema was not always sufficient to allay the rectal irritability.

The amount of nutriment which can be administered by the rectum is bound to be insufficient for the patients needs. An individual even when absolutely confined to bed must be supplied with at least 1,500 calories of potential energy daily, while the enemata given, even supposing them to be fully absorbed, did not contain more than 1,200 calories. Unfortunately it is impossible to increase the strength of the enema or to give it more frequently for both courses result in producing irritation of the rectum. He concludes "Our researches and clinical experience show beyond doubt that, under favorable conditions, a very considerable

proportion of nitrogen given per rectum can be absorbed, although an actual storage of it in the body was not attained. Further research must endeavor to find a method of giving larger or more concentrated quantities of proteid without producing intolerance."—*The Medical Review*.

Gonorrhœal Endocarditis

By Dr. Loeb (*Deutsch. Arch. f. Klin. Med.*; Ref. *Bost. Med. & Surg. Jour.*, CXLII, No. 12, p. 303).

The author make the occurrence of a case of ulcerative endocarditis, in which gonococci were demonstrated in the valvular lesions, an excuse for a short review of the subject with reference to previously reported cases, and draws the following conclusions:

1. Amongst gonorrhœal patients there develops in certain instances an endocarditis, either in direct association with the acute catarrhal stage, or, as is more common, as an accompaniment of a joint manifestation.

2. Apart from occasional observations in which bacteriological examination demonstrated streptococci, and the endocarditis accordingly is to be considered part of a pyemic infection, gonorrhœal endocarditis is a genuine metastasis caused by gonococci.

3. It occurs in two forms; endocarditis verrucosa and endocarditis ulcerosa. In the former it is generally the mitral valve which is affected, resulting in permanent valvular defect or in *restitutio ad integrum*. The ulcerative form almost always attacks the aortic valve and relatively often the pulmonary.

4. Endocarditis ulcerosa of gonorrhœal origin occasionally attacks normal valves, but generally develops in valves that have been the seat of former disease.

5. As in the ulcerative form of endocarditis in general, so also in the gonorrhœal form the female, in proportion to total number of infections in that sex, is relatively often attacked.—*The Post Graduate*.

THE MERRY MICROBE.

They say there's microbes all around, huntin' for their prey ;
There's nothin' pure tew eat or drink, and no safe place to stay ;
There's miasmy in the dew-fall and malarly in the sun ;
'Tain' safe to be out doors at noon or when the day is done.

There's bacteery in the water and tricheeny in the meat,
Ameeby in the atmosphere, calory in the heat ;
There's corpussels and pigments in the human bein's blood,
And every other kind of thing existin' since the flood.

Them bug; is all about us jest waitin' for a chance
Tew navigate our vitals and tew 'naw us off like plants ;
There's men that spends a lif-time huntin' worms jest like a goose,
And tackin, Latin names on 'em and lettin' on 'em loose.

Prescriptions from Medical Record.

PICRIC ACID IN CHRONIC URETHRITIS. Begin with half of one-per-cent. solution and gradually increase to ten-per-cent strength. Apply by means of a Guyon injector. Contraindicated in the acute stages.—**DESNOS AND GUILLON.** *Medical Record.*

ANAPHRODISIAC.

℞ Lupulin 10 gm.
For ten powders. S. Take one at bedtime.

ELIXIR OF PARALDEHYDE.

℞ Paraldehyde 10 gm.
Syr. menthæ 20 "
Elix. aromat 40 "
Aquæ destil 80 "
M. S. Teaspoonful once or twice daily.

HEMORRHOIDS.

℞ Exalgin 0.30 cgm.
Ext. bellad 0.10 "
Cerae alb 1.0 gm.
Ol. theobr 3.0 "
For one suppository.

STOMACH PAINS.

℞ Morphin. hydrochlorat 0.02
Syr. simp 30.
Aq. chloroformi sat 60.
Aq. aurantii flor 60.
M. S. Dessertspoonful at onset of attack.

—*Jour. des Praticiens.***BASEDOW'S DISEASE IN CHILDHOOD.**

℞ Strontii bromidi 6 gm.
Strontii iodidi 12 "
Aq. destil 40 "
Aq. menth. pip 20 "
Syr. menth. pip 20 "
M. S. Teaspoonful three times daily.

—*Socquart.***SEVERE APHTHÆ.—Paint with**

℞ Ac. salic 2
Spir. vini 10
Glycerini 25

GASTRIC CATARRH.

℞ Acid. hydrochlorici (C. P.) 2.50 gm.
Acid. azotici 0.80 cgm.
Spir. vini rect. (90 per cent.) 18. gm.
Aquæ font 150. "
Syr. limonis 100. "
M. S. A teaspoonful in a half glass of water after meals.

—*Le Progrès Méd.*

HEADACHE IN NEURASTHENIA.

℞ Zinci valerianat.,
 Ferri sulphat.,
 Ext. rhei,
 Asafœtidæ.....āā gr xviiij.
 M. ft. pil. No. xx. S. One t.i.d.

DRINK FOR DIABETICS.

℞ Acid. citrici..... 1 gm.
 Glycerini,
 Sp. vini gallici.....āā 50 "
 Aq. destill..... 500 "

APHTHÆ.

℞ Sodii borat..... 4
 Tinct. benzoin..... 4
 Syr. rubi idæi..... 40

Touch with aid of a brush six times daily.

CHAPPED LIPS.

℞ Paraffin..... 80 gm.
 Vaselini..... 80 "
 Ext. æth. alkannæ..... 0.50 cgm.
 Ol. bergamottæ,
 Ol. Limonis.....āā 1 gm.

Melt in a water-bath and make into sticks

—*La Médecine Moderne.*

The Treatment of Hemorrhage in Pregnancy.

Treatment of December 28, 1899, contains an article by MURPHY which may be summed up as follows:

1. Accidental hemorrhage is not due to external injury, but to disease of the uterus, accompanied in a large majority of cases by kidney mischief.
2. It must be divided clinically into two classes; those in which uterine contractions are absent, and those where they are present.
3. In the latter and milder form, rupture of the membranes and delivery *secundem artem* will suffice.
4. In the former vaginal plugging, uterine binding, and general stimulation should be employed until the cervix dilates sufficiently to allow of delivery.
5. If symptoms of internal hemorrhage continue under this treatment the patient's desperate condition can probably be only best relieved by Porro's operation.
6. In serious cases of accidental hemorrhage, in the absence of positive signs, the child's life need probably never be considered.

As to the general treatment of hemorrhage, nothing need be said except that here, probably even more than in other cases, the beneficial effects of saline infusions, either rectal, subcutaneous, or intravenous, are obtained.

TREATMENT OF BALDNESS. Gessner, of Paris, according to the *Therapeutic Gazette*, claims that the prognosis in chronic seborrhœa is not as unfavorable as generally supposed, providing timely treatment is employed. He advises the use of tincture of soap with a little lavender, and washing with very hot water, then with cold water. Where the skin is irritable or inflamed, or if there is eczema, he applies:—

℞ Ichthyol.....	12 ℥.
Zinc oxide	} of each.....
Powdered starch	
Petroleum.....	1 oz.

On first beginning this treatment many hairs come out, but these would be lost anyway, and simply hang in their follicles. Their removal makes room for others. This treatment is employed once or twice a week, and, to avoid the removal of too much fat, it is followed by an application of oil. After thoroughly cleansing the scalp, the following is applied:—

℞ Precipitated sulphur.....	24 to 48 gr.
Resorcin.....	12 to 24 gr.
Salicylic acid.....	6 to 12 gr.
Tincture of benzoin.....	12 ℥.
Petrolatum.....	1 oz.

This ointment is well rubbed into the scalp and the head covered with a cap at night. As a substitute the following ointment is used;—

℞ Resorcin.....	18 to 36 gr.
Chloral hydrate	} of each....
Tannic acid	
Tincture benzoin.....	12 to 24 ℥.
Castor oil.....	36 to 60 ℥.
Alcohol.....	20 fl. dr.

Where baldness already exists the scalp is vigorously stimulated by applying every night, by the aid of a stiff brush, an ointment containing from 5 to 10 per cent. of chrysarobin, a night cap being worn. Faradisation is practised daily from five to ten minutes with a brush.—*Practitioner*.

A CASE OF ARTIFICIAL IMPREGNATION.—Dr. Elliott Gardner (*Medical World*, April) records the case of a woman upon whom he had operated successfully some five or six months previously for laceration of the perinæum, and of the cervix uteri, with erosions, metritis, and posterior displacement consequent upon her confinement, who worried because she did not again become pregnant, her first child having died shortly after birth. Dilatation of the internal os, coupled with all ordinary treatment and regimen, failing, Dr. Gardner finally injected with a syringe into the os uteri some of the semen ejaculated by the husband, two days after the cessation of menstruation on May 24, 1899. On February 24, 1900, the patient gave birth to a fine boy weighing nine pounds and a half. The labor was easy. Both mother and child did well. This would appear to be the fifth case on record in this country.—*N. Y. Medical Journal*.

The Treatment of Psoriasis.

S. C. Martin (*American Journal of Dermatology and Genito-Urinary Diseases*, November, 1899), advises as the best internal remedy in psoriasis, arsenic, echtol, and potassium iodide. When the disease assumes the diffuse form it is best treated externally by Robinson's soap method, which is applied as follows: The soap is to be thoroughly rubbed into the skin and allowed to remain. The rubbing is to be repeated twice a day for four or six days, then for three or four days once a day, and then nothing is applied for four days, when a bath is to be ordered. The bath is taken only after the epidermis has begun to loosen itself; if taken too soon retention and shrinkage will be so great as to interfere with the movements of the body.

Under this treatment the redness and infiltration rapidly disappear, and involution follows.

In some cases, where the eruption is not very extensive, but the infiltration considerable, the application of echtol is effected in the following manner: Saturate a thin cotton compress and apply to the infiltrated part. It should be applied constantly until the infiltration subsides. The scales should be removed before each application of the echtol with baths and soap. When the eruption is limited and suitably located, chrysarobin may be used, in the strength of twenty or thirty grains to the ounce of vaselin; or pyrogallic acid may be tried as a substitute, in the proportion of one to ten of vaselin. At the same time arsenic in the form of Fowler's solution should be given in five-drop doses three times a day, after meals; or, if this fails, try large doses of iodide of potassium, from a scruple to a drachm, three times a day. Meat should be sparingly used, or, entirely prohibited. Alcoholic stimulants should be strictly interdicted. Mixed forms of this disease or complications require special notice. Plethoric patients will need saline purgatives and alkaline diuretics. Anemic cases require iron tonics and up-builders. Of course, the good sense of the physician will suggest many aids not here mentioned; but what the writer would particularly emphasize is the necessity of constant watchfulness and perseverance on the part of the physician and patient, if permanent success is desired.—*Therapeutic Gazette*.

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EDITORIAL.

ASSOCIATIONS FOR THE PREVENTION AND TREATMENT OF TUBERCULOSIS.

When Koch in 1882 announced to the world the discovery of the specific cause of tuberculosis, it was confidently expected by both the medical profession and the public that a brighter day had dawned in the management of the varied forms of this disease. His discovery certainly gave a great impetus to the study of tuberculosis resulting in a most satisfactory increase of our knowledge of all that pertains to it, yet it has to be confessed that so far as abating the scourge is concerned the results have been disappointing. According to statistics, neither the incidence of the disease nor its mortality have been appreciably lessened, though a much more hopeful view is taken of its treatment in individual cases. The appreciation of these facts has led to an inquiry into the methods which have heretofore been adopted for the regulation of tuberculosis, and to the conviction that modern preventive medicine has not put forth its best effort for the control of the disease. Though the infectious nature

of tuberculosis is generally recognized, yet the means adopted so successfully for the control of other infectious diseases have been entirely neglected in dealing with this—the greatest reproach to medical science at the present day. Many difficulties arise in the proper regulation of tuberculosis as compared with other infectious diseases. It occurs so commonly, is so widely diffused geographically and is so chronic in its course, that it is practically impossible to isolate every case and keep it under rigid control until disposed of. The great expense involved in carrying out any plan for its proper management has always stood in the way of those who recognized the inefficiency of the means that have heretofore been resorted to and the necessity for something better.

During the past year or so, however, organizations have been formed in Great Britain, the United States, Germany and other countries for the purpose of enlisting the sympathy and co-operation of Legislative bodies, the medical profession and the public in a supreme effort to lessen the ravages of the disease. In general, the aim of these associations is to disseminate among the public a knowledge of the infectious nature of tuberculosis, the means by which the infection is scattered, the necessity for the proper disposal of sputa and other excreta, and other necessary prophylactic measures against the disease; the erection of sanatoria for the treatment of *curable* cases as well as the providing of suitable accommodation for the isolation of *incurable* cases such are now too commonly received in our general hospitals; the securing of the co-operation of Legislative bodies, philanthropic and charitable organizations and individuals in securing the funds necessary to carry out these objects.

Such an organization known as "The Toronto Association for the prevention and treatment of Consumption and other forms of Tuberculosis" held its inaugural meeting in Association Hall on May 8th. A large audience was present, showing the public interest taken in the scheme. The following officers were chosen:

Hon. President: Hon. Sir John A. Boyd, Chan. H.C.J.

President: E. J. Barrick, M.D.

Vice-Presidents: Rev. Prof. W. Clarke, D.C.L., Thomas Crawford, Esq., M.L.A., Albert A. Macdonald, M.D., W. R. Brock, Esq., E. O'Keefe, Esq., Pres. Jas. Loudon, LL.D., Rev. Father Ryan.

Treasurer: D. W. Alexander, Esq.

Sec'y-Organizer: Rev. C. S. Eby, B.A., D.D.

A vigorous campaign is being instituted to further the aims of the association. That these aims are worthy of not only the sympathy but the active support of all classes of the community, and that good results may be confidently anticipated from their propagation there can be no doubt.

Membership in the league is accorded on payment of an annual fee of one dollar or life membership for twenty dollars. This will give a definite interest in the work to all who become members, at the same time securing a considerable revenue for the requirements of the association.

The movement is a most commendable one and needs no straining of facts nor misguided enthusiasm to make it appeal to both the profession and the public. Only harm can result from creating any needless "consumption scare" which will result, as it has in other places, in those unfortunates afflicted with the disease being shunned as lepers, often subjected to unnecessary hardship and cruelty and their lives made more miserable owing to the senseless fear or mistaken zeal of persons who have grasped a few distorted facts in reference to the question. While approving of the general work of such an organization when judiciously carried out, there is always a danger in attempting to place technical scientific information before the public, and in this particular instance the greatest discretion should be exercised. We think there are few in the medical profession who will indulge the sanguine views expressed by a lay officer of the association that "tuberculosis is as preventible as small-pox and in twenty years may be as rare." Many a good cause has suffered from the injudicious advocacy of individuals possessed of more zeal than knowledge. The reputation for broad common sense possessed by the members of the executive of the association is, however, a guarantee that its affairs will be administered with tact and discretion.

EDITORIAL NOTES.

Recently we have had some very pleasing results with the use of Suprarenal liquid and chloretone (20 per cent. and 1 per cent.) in eye work. In several cases of inflammation of the tear duct, the last of which was an acute suppurative dacryocystitis; the swelling of the lids and cheek being very great. After the application of the liquid we were enabled, on opening the canaliculus with a small pointed probe, to wash through the duct clearly, and the case improved immediately so that she had no pain. The swelling disappeared in a day or two and she has not complained since. At her next visit, four days later, everything looked normal, and the duct was easily syringed out, not requiring anything to clear it.

We have also been able to pass probes after its use in cases where cocaine was ineffectual in causing sufficient shrinking of the mucous membrane.

C. T.

D. H. Gifford, of Omaha, (January No. of *Annals of Ophthalmology*) in his clinical notes on sympathetic ophthalmia says, that salicylate of sodium is the most important remedy for the disease that he knows of. He gives it in 15 grain doses in 3 ounces of brandy, making the patient stay in bed. He gives from 150 to 200 grains a day for from 3 to 5 days in a week until the inflammation decreases, then the number of days in the week upon which the large doses were given, was decreased; but 150 grs. were taken upon at least one day in each week, for several weeks after the last signs of active inflammation had disappeared. He also uses thick hop poultices and cites several cases with very good results.

In this fearful disease one is glad to hear of anything that promises so well.

C. T.

Sinuses in the Vault of the Naso Pharynx.

Heath (*Journal of Laryng., Rhin. and Otol.*, May, 1900) reports a case of atrophy of the mucous membrane of the middle and inferior turbinals anteriorly and posteriorly; the pharynx also being much atrophied, the cavity large, and posterior-rhinoscopy easy. The Eustachian eminences were enormous and filling the fossae of Rosenmüller, and reaching nearly to the pharyngeal roof. Just behind the upper edges of the choanæ, on each side, then appeared a transverse elliptical opening, $\frac{1}{2}$

long and $\frac{1}{8}$ " across at the widest part on the left side,—a probe entered about $\frac{1}{4}$ ". The openings could be easily felt and the finger inserted into the larger, but the floor could not be felt.

Intra-tympanic injections of Pilocarpine in Middle Ear Sclerosis.

Fischerich (*Laryngoscope*, January, 1900), reports satisfactory results following the use of pilocarpine in the middle ear in 120 selected cases. A 2% aqueous solution of the hydrochlorate was injected into the tympanic cavity, through a flexible tympanic catheter passed through a metallic Eustachian catheter well up into the tube. Six drops were used at first and gradually increased to 16, in a course of 30 to 40 injections. The results had been satisfactory, even where other measures had failed. The average improvement was 2-10 times increase of the previous hearing capacity. In some instances a second course of injections had produced increased improvements.

Epilepsy of Aural Origin.

Lannois (*Journal of Laryngology*) gives the history of a patient of tuberculous inheritance, but without pulmonary symptoms, attacked with double otorrhoea at the age of seven, and epilepsy at age of thirteen. The attacks of epilepsy averaged one a week, when he came under observation. One ear had cicatrized and had been dry for some time, the other was still suppurating, drum and membrane entirely destroyed, cicatrized in part, but with two ulcerations below and in front. HW.=contact cure was obtained in a few weeks with HW.=25c. and at the same time the epileptic attacks disappeared and had not returned two years afterwards, but during one year he had two slight attacks of vertigo.

Otitis in Early Childhood.

Barth (*Archives of Otolaryngology*) found that 80 per cent. out of 600 infants ill with various affections had a lesion of the middle ear. In autopsies the membrana tympani was usually found intact, and the more remote parts of the ear were not involved during acute middle ear inflammation. It is not always wise to open the mastoid cells in a child, if the only symptoms are swelling and redness of the upper and posterior portion of the external meatus. The middle ear may be inflamed and contain pus, yet the membrana tympani show no alteration other than bulging at some point.

In order to keep an opening made in the membrane free, while acute symptoms are present, the author places a crystal of chromic acid directly in the opening. This leaves a smooth round opening which heals readily.

WISHART.

The Ontario Medical Library Association.

The 13th annual meeting of the Association was held in the Library Rooms on June 28th, the President, Dr. J. F. W. Ross, in the chair.

The number present was not large, but included a great many of the members most interested in the welfare of the library.

The reports submitted by the secretary, treasurer and curator were very encouraging, giving evidence of increasing growth and usefulness of the library. Letters received by the secretary from the profession throughout the Province requesting information have been many. A circular letter sent to all the medical practitioners whose addresses could be obtained, in reference to the advisability of approaching the Legislature for an annual grant, was responsible for their increased interest. In this connection we are glad to learn that a deputation waited upon the Premier and presented a petition asking for Government aid, and that it was favorably received. Though nothing has been granted as yet, the President, Dr. Ross, assures us that next year a grant will probably be made which will materially help to make the library even a greater success than it has been in the past. The Board take this opportunity of thanking those who, by their signatures, gave their assistance in this matter. In a short time the association will be able to send copies of the By-laws and Catalogue, now in course of publication, to the members of the profession. At present, however, the attention of city members is drawn to the fact that their annual dues (\$2.00) should at once be forwarded to the treasurer, Dr. H. A. Bruce.

Books are sent to medical men throughout the Province on their paying express charges both ways, and returning them within two weeks. This is a privilege secured to the profession at large through the kindness of the Ontario Medical Council in granting the association rooms in which to store their books.

The Curator, Dr. Powell, reported that 161 new volumes and three cases still unopened had been added to the library during the past year. Dr. Powell is a member of the American Association of Librarians and is enabled to secure duplicates from other libraries in exchange. The Secretary, H. J. Hamilton, will be glad to give further information to those writing for the same.

At a meeting of the Board of Directors held on July 4th, Dr. Ross was again elected President; Dr. R. A. Reeve, 1st Vice-President; Dr. A. A. Macdonald, 2nd Vice-President; Dr. G. H. Carveth, 3rd Vice-President; Dr. H. J. Hamilton, Secretary; Dr. H. A. Bruce, Treasurer; D. N. A. Powell, Curator, and Dr. W. J. Wilson, Assistant Curator.

PERSONAL.

Dr. G. N. Fish (Trinity '98), who is retiring from the staff of the Home for Incurables, was yesterday afternoon presented with a gold-headed cane, a silver-mounted umbrella and an ebony-backed hat brush. Mrs. Colonel Hamilton and Miss McTavish made the presentation, on behalf of the inmates and staff.

Dr. Alex. McPhedran has removed to his handsome new residence, 151 Bloor St. West.

Dr. R. S. Thornton, Deloraine, has been elected Grand Master of the Grand Lodge of Manitoba.

Dr. E. B. Oliver (Trin. '98) has been appointed Demonstrator of Pathology and Bacteriology in the Sioux City Medical College.

The sincerest sympathy is felt for Dr. W. H. and Mrs. Harris, of Parkdale, in the death of their only little girl, aged 8 years.

Dr. H. C. Wrinch (Trin. '99), of last year's House Staff, St. Michael's Hospital, was married recently to Miss A. J. Breckon, of Merton. Dr. and Mrs. Wrinch leave this week for British Columbia, where the doctor will labor as a medical missionary to the Indians in the Skeena River District. A man of sterling worth and ability, we wish him the same success in his new field that has attended him in the discharge of his duties in Toronto.

Drs. E. S. Ryerson, H. S. Hutchinson, Paul L. Scott, and A. J. G. McDougall, recent graduates, have been appointed House Surgeons to the Hospital for Sick Children for the ensuing year.

Drs. F. W. Marlow and Lees have been appointed House Surgeons to St. Michael's Hospital. Dr. McKenna, of last year's staff, will act as superintendent during the absence of Dr. R. J. Dwyer, in Europe.

A volume of over 1000 pages, beautifully illustrated, of original contributions to the science of medicine has been dedicated to Dr. W. H. Welch, Professor of Pathology in Johns Hopkins, by his pupils, on the 25th anniversary of his doctorate. We notice the names of several Canadians among the contributors—Dr. W. G. McCallum, Dr. T. S. Cullen, and Dr. L. F. Barker.

Despatches from the seat of war in South Africa continue to give great praise to Lt.-Col. Ryerson for his services as Red Cross Commissioner in South Africa. Dr. Ryerson sailed for home on July 4th.

Dr. Wm. Goldie has removed to 84 College St., the house recently vacated by Dr McPhedran.

Dr. Allen Baines, of Simcoe St., has sailed for Europe, where he will spend the summer.

BOOK REVIEWS.

POST MORTEM EXAMINATIONS.—METHODS AND TECHNIQUE.

By John Caven, B. A., M. D., (Toronto L. R. C. P., (London), Professor of Pathology, University of Toronto Medical Faculty. Illustrated. Price \$1.00. J. A. Caweth & Co., Toronto.

This little work contains nine chapters.

The first chapter deals with the equipment and preparation for a post mortem examination, mentioning the outfit ordinarily required for both the section and for the bacteriological examination. This chapter also has an excellent paragraph on the care of the hands of the operator and the treatment of post mortem wounds.

The second chapter, dealing with the care of the cadaver, the opening and closing of the body etc, is particularly good. We know of no work on the subject which treats of this important matter in so practical a manner.

Chapter three deals with the proper method of keeping records.

Chapters four and five treat of the examination proper under two headings—inspection and section. The proper method of making a complete examination of all the organs is taken up in the thorough and systematic way one would expect from an operator of the skill and experience of the author.

Excellent chapters are also devoted to examinations in cases of poisoning and of suspected infanticide.

The book concludes with a chapter on the preservation of tissues, and Cullen's rapid method of making sections for microscopic examinations, and a table of weights and measurements of organs.

Throughout the book shows evidence of originality and there is a complete absence of padding. It would be difficult to imagine more substance compressed into less space. In fact in at least one instance we think the author errs in being too brief, viz., in dealing with the bacteriological examination of the dead body. We are also surprised at the omission to mention the use of formaldehyde in aqueous solution in the chapter on the preservation of specimens, though this is mentioned incidentally in another part of the book. The capacity of the stomach as given in the table—from $\frac{3}{4}$ to $1\frac{1}{2}$ pints we believe is quite below the normal. These, however, are very minor matters and do not detract from the general usefulness of the work.

Altogether the book forms an admirable guide to the subject with which it deals and can be confidently recommended. An able and energetic worker and a brilliant teacher; those of his medical friends who know him best will agree with us that the author has published all too little from the storehouse of his wide experience.—H. B. A.

A TEXT-BOOK OF PRACTICAL THERAPEUTICS.

With especial Reference to the Application of Remedial Measures to Disease and their Employment upon a Rational Basis. By Hobart Amory Hare, M.D., Professor of Therapeutics and Materia Medica in the Jefferson Medical College of Philadelphia. With special chapters by Drs. G. E. de Schweinitz, Edward Martin, and Barton C. Hirst. New (8th) edition. In one octavo volume of 796 pages, with 37 engravings and 3 colored plates. Cloth \$4.00; leather \$5.00, net. Lea Brothers & Co, Philadelphia and New York.

This is the eighth edition, of this most timely and up-to-date treatise, giving many of the newer non-proprietary drugs, with a very valuable section devoted to therapeutics and treatment, in which the author does not vaunt specifics, but suggests the most rational remedies giving his reasons for their use. Another feature—the comparative dosage table—is useful. The old apothecaries' weights are given with their equivalents in the metric system. There is a growing "cult" which effects to despise medicine as a curative agent; true, we cannot arrest death, but we can certainly ameliorate suffering and lend to nature (the vital processes) a helping hand. As Dr. Hare says, "A good physician is one who having pure drugs knows when to use them, how to use them and, equally important, when *not* to use them."

This book is one of the very few which the student will buy in his under-graduate days and keep at his elbow all through his life of practice, as it is eminently common-sense and free from *theoretical* padding.

T. C.

NEW BOOKS.

A Manual of Obstetrics, by A. F. A. King, M.D., Professor of Obstetrics and Diseases of Women in the Medical Department of the Columbian University, Washington, D. C., and in the University of Vermont, etc. In one 12mo. Volume of 612 pages, with 264 illustrations. Cloth, \$2.50, net. Lea Brothers & Co., Publishers, Philadelphia and New York.

The eighth edition of this work, somewhat enlarged and improved has just appeared. As a text-book for students it is most valuable. It is written in a style clear and intelligible. The reader is impressed with the idea that the writer is not a theorist only. Before the book is half read, the author has our confidence and we are willing to trust his opinions, for we feel that they have been formed not in the study but at the bedside, most of them probably in the early morning, in the company of at least one parent in distress.

The chapters on the "Mechanism of Labor" are particularly pleasing. They should make clear to a student of ordinary care the relations of the different parts of the child's head to the points of the canal through

which it passes during labor. The author has not done that which many have succeeded in doing—hopelessly beclouding the above subject in an attempt to make it very clear. On such subjects as the etiology of puerperal septicæmia, treatment of hæmorrhages, antiseptics in obstetrics, his doctrines are sound and his teachings safe.

His treatment in some of the departments of the work has been anything but exhaustive—for example, the chapter on “Instrumental delivery.” The subject, however, is put plainly, and enough has been said. This book should be well to the front as a text-book for students. It will certainly be interesting and useful to the practitioner.

D. G. G.

PROGRESSIVE MEDICINE—VOL. II, 1900.

A Quarterly Digest of Advances, Discoveries and Improvements in the Medical and Surgical Sciences. Edited by Hobart Amory Hare, M.D., Professor of Therapeutics and Materia Medica in Jefferson Medical College of Philadelphia. Octavo, handsomely bound in cloth, 401 pages, with 81 engravings. Lea Brothers & Co., Philadelphia and New York. Issued quarterly. Price, \$10.00 per year.

This volume is quite up to standard and worth its price to any one for the sake of the single article in which he may be specially interested. W. B. Coley's chapter on Surgery of the Abdomen, including hernia, will appeal to any surgeon. J. G. Clark, of the University of Pennsylvania, under the wide head of Gynaecology, contributes what is really a series of most useful monographs on such interesting subjects as hermaphroditism, Endometritis Dolorosa, Hemorrhage in Uterine Myoma, Streptococcus Pyogenes in gynaecological diseases, and other subjects most tempting to the reading practitioner. Ophthalmology is treated by Edward Jackson, while Medicine is in the hands of Stengel of the University of Pennsylvania, who brings up to date such modern subjects as Diseases of the Blood, Diathetic and Metabolic Diseases, Diseases of the Glandular and Lymphatic System.

J. T. F.

Sajou's Annual and Analytical Cyclopædia of Practical Medicine, Vol. V. Philadelphia, The F. A. Davis Company. Toronto, Carveth & Co., 1900.

This fifth volume—from Methyl-Blue to Rabies—is to hand. What we have within as to previous volumes may be truly repeated as to the present one. The reader gets the kernel and gist of up-to-date serial medical literature, arranged and digested, in the smallest possible space. The work is invaluable as a handy reference.

We note with gratification, the reference by the editor to the demise of our Dr. Graham. It is pleasant to be reminded of the way in which our kind and beloved friend was regarded, and is remembered by scientific men across the line.

We endorse the work most heartily.

J.L.D.

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