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PAPILLOMA OF THE TONSILS*

BY H. T. MACHELL, M.D., TORONTO.

Maggie S., aged ten years, entered the Hospital for Sick Children here on the 4th of May, 1892, complaining of her throat. Her mother who brought her from Collingwood, gave the following history:

At eight years of age she (*i.e.*, her mother) noticed the enlarged tonsils accidentally one day when the child was crying from toothache. They were then quite large. Since then they have gradually increased in size. There have been no acute attacks of any throat trouble during either of these years. And yet the mother remembers that when the child was two or three years of age she had several attacks of so-called "acute sore throat." This tendency to sore throat disappeared after she was about four years old.

When she was about seven years of age her mother was told by her physician that she had *goître*.

Within the last year her facial expression has changed somewhat; she appears duller and more listless and is slightly deaf. Her voice is changed, and she speaks as though she had a hot potato in her mouth. There is also considerable difficulty in swallowing. Her general health is fairly good.

Her mother reminded me of the fact that she had been under my care in the old hospital six years ago. At that time she came in for a lipomatous tumor of the side of the neck just above the clavicle and shoulder, and which I removed after cautious and deep dissection. The wound was a large one, requiring some sixty or seventy sutures. From this she made a good recovery,

and now only an indistinct scar marks the site of a former large wound.

Present condition.—Well-marked enlargement of either lobe of the thyroid gland, excessive enlargement of both tonsils, which are studded with closely packed papillary bodies, and, as a consequence, difficulty in swallowing, deafness, alteration in the voice, and also in the expression.

The tonsils literally filled the throat. One could scarcely believe that any food could be forced past them, so large were they, and so completely did they obstruct the fauces. They were rough and ragged in appearance at first glance. On closer inspection, however, the rough appearance was seen to be made up of numberless papillæ or pedunculated masses, packed closely together and extending downwards as far as one could see or feel with the finger. They also bulged so far forward as to hide the uvula completely and rest on the base of the tongue. There was very little sensation in them, and, bulging as far forward as they did, there was no difficulty in palpating them. Each papilloma seemed to have a separate and distinct entity. Some had a very small pedicle, others larger, but none sessile. So large and so closely packed were these papillæ that one could not help wondering at her being able to swallow at all. While she could swallow fluids if taken very slowly, there was also difficulty in the deglutition of solids. The solid particles appeared to get tangled up in the papillæ and would only pass on down after repeated efforts at swallowing. With such masses in her throat it is not to be wondered at that there was some difficulty in hearing and speaking. The change in her facial expression was, I suppose, due to her deafness and constantly keeping her mouth open.

The tonsils were so utterly unlike anything I ever saw before that I delayed doing anything whatever for her in order to allow all the members of the staff and several other medical friends to see her at their leisure. The *size*, as well as the *appearance*, was something *unique*. In fact, the case was a "*rara avis*" to each and every one of us who saw her.

That a better idea of the size and appearance of the tonsils might be formed, I asked the photographer to the hospital (a professional) to photograph them. He made a number of attempts to do so, both at the hospital and his studio, but

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without any success whatever. Knowing that our former president, Dr. Powell, was very much interested in amateur photography, and knowing also that amateurs in photography, as in everything else, like to get hold of something which is considered "difficult" by ordinary mortals, I asked him if he would try to secure a view of her tonsils. After a great deal of trouble and several "sittings" he managed, with the aid of the magnesium flash light, to get a photograph of the upper and anterior surfaces of the tonsils. This I now show you. Your imagination will enable you to form an idea of what the whole size and appearance must have been.

Shortly after Dr. Powell's getting the photograph of the tonsils and before any treatment was adopted, the patient was taken ill and died within forty-eight hours. Both scarlatina and diphtheria had been introduced into the hospital a few weeks before this by children or friends coming to visit little patients, and several cases of each disease had been sent up to the isolation wards a few days before this.

Almost the earliest symptom she complained of

was "sore throat." As soon as seen by the house physician her throat was examined, and all the papillary growths and the few intervening spaces were seen to be acutely inflamed and covered with a grayish-white membrane very suggestive of diphtheria. The membrane, though, looked thinner than the typical diphtheritic membrane, even in its initial stage, and yet it could not be peeled off without using undue force. The uvula could not be seen, neither could the pillars of the fauces nor the soft palate, all being hidden by the tonsillar outgrowths. The discomfort and pain in swallowing were increased. The disease was not ushered in by a chill, a convulsion, or by vomiting. There was no rash. The submaxillary and cervical glands were somewhat enlarged and tender to the touch. Her temperature ran up to 102.5° and the pulse was increased to 120 to 130. The countenance was indicative of serious illness. The patient looked more seriously ill than is usual with follicular inflammation of the tonsils; besides, one glance at the tonsils and the uniform and complete character of the membrane showed us that we had to do with something more than follicular tonsillitis.

At this early stage the diagnosis lay between diphtheria and scarlatina, with a leaning toward the former. Both diseases had found their way into the ward occupied by the patient. As the mother lived out of the city we could not consult her as to whether the patient had ever had scarlatina. It was necessarily a case of waiting for more data on which to form a diagnosis.

Within twenty-four hours a typical scarlatina rash appeared. Time thus helped us out of the difficulty in regard to the diagnosis, as it does almost every day in the year.

But with such masses in her throat and such an acute attack the poor girl's chances were almost *nil* from the invasion of the disease.

Toward the end of the second day of the attack several of the staff saw the case with me, and while we were out in the corridor discussing it and our helplessness in such cases, the nurse came out to say the patient had just died.



FIG. 1.

It was thought then, as we had been cheated out of an operation and thereby prevented from getting the tonsils we had better secure one now. Accordingly, with my forefinger I enucleated her left tonsil without any difficulty whatever. And again, through the kindness of Dr. Powell, I am able to give you an idea of its appearance on paper, slightly enlarged.

I also show you the tonsil itself, very much shrunken, of course, from its immersion in alcohol for more than two years.

Dr. John Caven has examined a portion of the tonsil microscopically, and reports as follows :

"Microscopic examination of the tissue shows it to be lymphadenoid in nature. Unfortunately, improper hardening and preservation has so deteriorated the structure as to render sections very unsatisfactory. However, it is really a true hypertrophy of tonsil, tonsillar tissue being reproduced. Whether congenital or not I cannot determine. I have not been able to find a reference to an exactly similar condition in any work ; the nearest to it is a papillomatous condition of the mucosa of the pharynx resulting from chronic pharyngitis. I would compare it with post-nasal adenoids.

"J. C."

My first impression on seeing the tonsil when she entered the hospital was that it would be a good case for the use of the amygdalotome, but I think now, from the ease with which I enucleated the one, that in similar conditions, or in cases of very large tonsils, enucleation would be preferable and probably quicker. There was no difficulty in shelling it out with the forefinger and finger-nail, and I was a very little longer time in doing it than is ordinarily taken in performing amygdalotomy. In enucleation, one could be certain that the stump would give no future trouble—a result which can not always be promised after amygdalotomy.

The Jarvis snare might have been used, and from the large size of the tonsils and the consequent difficulty in getting the tonsils in the ring of the amygdalotome, I think the snare would probably have answered the purpose better than

the ordinary amygdalotome. Even with the largest-sized amygdalotome, and taking ample time over it, I am positive the whole of the tonsil and its outgrowths could not have been drawn through the ring. Therefore it would have been necessary to introduce the amygdalotome two or probably three times before getting away the whole of it. In this way longer time would have been consumed than with enucleation.

That these papillomatous tumors of the tonsils are *very rare* I am convinced from a careful search of all the modern works on pathology at present in our library here. They are not even spoken of in any one of them, nor is there any mention made of them in any of the works devoted especially to diseases of the throat. What is yet more surprising, no reference is made to such a condition in the *Index-Catalogue of the Library of the Surgeon General's Office of the United States Army*, a work which contains a reference to almost everything published for half a century past.

Some of the interesting points in connection with this patient :

1. The presence of a *lipoma of the neck* at four years of age.
2. *Goitre* at seven years.
3. Papilloma of the tonsils first noticed when she was eight years old—that is, at least two years before entering the hospital. Thus showing their *slow growth*.
4. The difficulty experienced in *photographing* the tonsils.



FIG. 2.

5. The *impossibility* of making a diagnosis between *scarlatina* and *diphtheria* in the very early stage of her acute illness.

6. The ease with which *enucleation* was done just after death.

7. The *extreme rarity* of papilloma of the tonsils.

PHLEGMASIA DOLENS.

REPORTS OF TWO CASES, BOTH ENDING FATALLY, ONE FROM SUPPURATIVE PHLEBITIS, THE OTHER FROM EMBOLISM.

BY J. CAMPBELL, M.D., C.M. (M'GILL), AND L.R.C.P.
(LOND.) SEAFORTH, ONT.

Was called upon on the 27th of October, 1884, to attend Mrs. D., æt. 39 years, in her ninth confinement. Found that she had been lying in bed for ten days with what she called her "sore leg." Upon examination found that her left leg exhibited the worst case of varicose veins, without the surface being broken, I had ever seen.

Was informed that she had had trouble at a previous confinement—when the friends were told by the physician in attendance that it would probably go hard with her if she should again become pregnant.

From the description given, would say that the difficulty on that occasion must have been of the nature of phlegmasia dolens. Upon this occasion the whole leg was swollen, and dotted over with blue tumors, larger than a pigeon's egg, which, upon examination, were found to be tense varicose veins, ready to burst. She was five or six hours in labor, but came through it fairly well, without the aid of instruments. There was no flooding. The child was born alive. Remained the usual length of time after delivery, and, as I lived nine miles from my patient, gave particular directions as regards cleanliness. Urged her to lie in bed longer than usual on account of the leg, and advised her to get it bandaged before getting out of bed. I left her, hoping that all would be well; was called upon the fourth day, the messenger saying that she had taken chills, followed by fever, and was quite ill.

Found my patient with a temperature of 105°, pulse 120, and somewhat compressible; the milk had been secreted and the lochia was free and sweet. Examined the leg and found it swollen

and painful, the femoral vein being like a whipcord, and the inguinal glands tender and enlarged. The skin was tense and glazed, and the veins were at places near the bursting point. Told the friends that it was a case of phlegmasia dolens, or, what in common parlance is known as "milk-leg." Caused the leg to be raised, and ordered hot fomentations, and prescribed quinine and ammonia, with whisky and milk. Syringed out the vagina with hot carbolic lotion, 1 to 40, and ordered the clothing to be changed every day, as had been done since delivery; enjoined fresh air and sponging the surface of the body, and left. This was on the 31st of October. Next day the husband called for medicine, and informed me that she was no worse. I visited her on the following day, also on the 4th, 6th and 8th. Expected that the case would be a tedious one, I resolved to visit the patient only on alternate days.

To condense the report, we would say that the case went on from bad to worse, contrary to my expectations, until it reached a fatal termination. The milk was suppressed, the lochia became scanty and of a bad odor, and the limb swelled until it was about double the size of the other one. What was still more serious, abscesses to the number of over a dozen formed along the course of the femoral vein.

These we lanced freely, and ordered to be sponged with carbolic lotion every three or four hours. Linseed poultices covered with pulverized charcoal, were applied, and changed after each sponging. The bowels had been kept open from the first with medicine, but the motions continued unhealthy, and had a bad odor throughout her sickness.

She had a succession of chills, followed by a high temperature, sometimes reaching 106°, then came profuse sweatings, with a dry, brown tongue, and other symptoms of pyæmia. The face now wore an anxious expression; the pulse ran up to 150, then delirium supervened, and finally she sank into a comatose condition, and died in a state of exhaustion.

This was the first and only case of suppurative phlebitis, or what might technically be termed peri-venous cellulitis, which I ever had in a practice extending over a quarter of a century. I had given a favorable prognosis up to the time of the formation of pus in the veins, but after that

event we felt that "chances and war were against us."

At the time I had no literature on the subject. I treated the case on common-sense principles, though I find that even at this distance of time I could not have done much better.

CASE II.—Was called on the 29th of January last to attend Mrs. A., *æt.* 31, in her fifth confinement. Was only half an hour in the house when she was delivered of twin boys, both alive. The second was born about fifteen minutes after the first; there was only one placenta, or the two were so intimately connected that to all appearance there was but one.

It was nearly an hour before the placenta was expelled, and then there was more than the normal amount of blood lost, so much so, that I remained with her another hour, compressing the uterus with my hands, to prevent serious flooding. Ergot had previously been repeatedly given. Was told next day, that after I left, she had lost so much that the friends were on the point of sending for me. Found her somewhat pale, but pulse and temperature were normal, the pulse was moderately compressible.

Put her upon comp. syrup of hypophosphites—told the friends to change her every day—wash the genitals, and keep the breasts empty when milk would be secreted, and said I would not call again unless sent for.

On the fifth day was called in haste by the husband, who said his wife had a severe chill, and was now much fevered. When I reached her bedside I found that the temperature was $106\frac{1}{2}^{\circ}$, pulse over 120, and that she was complaining of a severe headache. The breasts were swollen, hard and lumpy. Found that they had fed the children, and allowed the milk to accumulate in the ducts. The lochia was not suppressed, and, moreover, was perfectly sweet. There was no tenderness over the womb, nor any signs of inflammation or puerperal fever. As a precautionary measure I used the uterine douche, with hot carbolic lotion. Gave gr. x of phenacetine to reduce the temperature, and prescribed gr. x of quinine every four hours. Made them empty the breasts, and ordered the nurse to keep the children at them, so as to prevent future accumulation.

Was not long home when the husband called me back, saying his wife had taken another chill.

Found the temperature 104° . Did not use the syringe, as I thought it possible that the last chill might have been caused by the syringing. Visited her again late in the evening, and found the temperature 102° , which change we attributed to the medicine.

The next day—the sixth after confinement—saw her morning and evening and found the temperature still above normal, though, in other respects, she was apparently doing fairly.

Expected to find the fever gone by this time—on the theory of the milk in the breasts being the sole cause of the trouble. The temperature, on the contrary, ranged from $101\frac{1}{2}^{\circ}$ in the morning to $102\frac{1}{2}^{\circ}$ in the evening, notwithstanding she was getting gr. x of phenacetine and gr. xx of quinine every day. The breasts were also kept empty and the bowels open.

On the evening of the eighth day after delivery the patient complained of pain in the right elbow, but nothing was to be seen and nothing came of it. On the evening of the ninth day she complained of pain in the calf of the left leg—increased upon pressure.

As the temperature had been ranging between 100° and $102\frac{1}{2}^{\circ}$ in spite of the antipyretics she had been taking, I suspected that she might be taking phlegmasia dolens, and told the friends of my suspicions. Said that the next day would clear up the diagnosis. At this time the legs were exactly similar in appearance and of the same size.

Next day, however, the left leg and foot were swollen, the glands of the left groin enlarged and tender, and the femoral vein could be felt hard and round. This was the tenth day and the diagnosis was clear. The leg was slightly raised, hot fomentations of hops and poppy-heads were applied and she was put upon $\text{℥}xx$ doses of iron four times a day. The quinine and phenacetine were still given at night, and her strength was sustained by liquid nourishment given at short intervals, especially milk and whisky, beef-tea and egg-nog. The leg did not long remain clear and shining, but soon began to diminish in size, and pit upon pressure. The temperature, too, went down too 100° and shortly afterwards to the normal.

The patient did not complain of pain. The bowels were kept open by cascara sagrada. The pulse was seldom over 90, and after a time became normal. All the symptoms indicated a mild case

and a favorable termination. Her strength, too, increased, her appetite returned and, in short, she was doing so well that I only visited her every second day. Thus the case progressed from the tenth until the fifteenth day from delivery. She said she felt well enough to get up. Her friends felt somewhat annoyed to think that a woman so well had to lie in bed from three to six weeks as I had told them, hence they asked for a consultation to decide the point.

On the morning of the sixteenth day after delivery, and the sixth from the day the limb began to swell, Dr. Bethune examined the patient and pronounced her, so far as he could see, out of danger. She was particularly well. She had no pain, the tongue was clean, the temperature, pulse and everything else were natural. The swelling was well down and the limb pitting freely upon pressure. Her strength was greatly increased; she was cheerful. Time and rest, the Doctor said, was all that was required.

The consultation took place about 10 a.m. At 2 p.m. same day she complained of pain in the other leg which the friends relieved by rubbing with turpentine and oil. The pain returned near 8 o'clock, when the nurse rubbed it again, and in doing so turned her over on her left side and even had her sitting up in bed. She suddenly turned purple in the face, writhed and twisted around as if in pain, turned her head to one side—and died. The friends thought at the time she had taken a fit and sent for me in haste. Found her dead. The right leg had not swollen, and the swelling in the left had decreased considerably. Gave it as my opinion that the cause of death was embolism, a clot having been carried to the right heart and thence through the pulmonary artery to the lung, cutting off or obstructing the circulation in that organ. Had she lived no doubt she would have had the same disease in the right leg with a very tedious recovery. Her death was indeed more than a surprise. It might be likened to a ship going down as she hove in sight of the harbor with a glassy sea beneath her and a clear blue sky above, and not a cloud on all the horizon.

Remarks on both cases.—(1) The swelling in both cases began at the periphery. The first patient lost power over the limb, the second did not. The first experienced severe pain, the second had comparative immunity from pain.

(2) I feel certain that both veins and lymphatics were involved in both cases, the former being inflamed, the latter obstructed.

(3) In my opinion the phlebitis was produced by the precipitation of the fibrine by the action of a septic agent which had either been developed in the blood or had made its way into that fluid.

(4) As to the predisposing cause in the first case—besides the hyperidrotic state of the blood in all pregnant women—the varicose veins of the first, I believe, were the great cause of the trouble which ended so disastrously.

(5) In reference to the second case—besides the condition of the blood already mentioned and a moderate varicose condition of the veins not previously referred to—I believe that the head and point of offending, so to speak, was the loss sustained at confinement, weakening still further an over-taxed nervous system.

(6) The modes of death were different, the first dying from pyæmia, the second from thrombosis—producing asphyxia from arrest of circulation in the lungs.

(7) In conclusion, we would say that the pathology of this interesting disease is still somewhat obscure and much has yet to be found out in reference to it.

Selected Articles.

THE SEXUAL CRIMINAL.

Though a firm believer in polygenesis and the multiple inception of the human race, I, nevertheless, hold that pithecoïd man, everywhere throughout the world, was, anatomically and structurally identical. All prehistoric skulls, whether unearthed in America or in the Old World, show that man was dolichocephalic or long-headed. They also show that primitive man was prognathous and that his orbital arches were greatly enlarged and developed. The structural characteristics enumerated above are also found in the primitive races yet inhabiting the earth, and most marked in those races that rank lowest in the scale of human intelligence and social economics. This latter fact is to be expected, for it is an acknowledged conclusion that the lower a race is in point of intellect, the nearer that race is to its primeval ancestry. Again, the phenomenon of atavism or reversion teaches us—a mesocephalic race—that our savage ancestors were long-headed and prognathous;

for, in the congenital criminal, emphatically an atavism, we plainly see an individual, anatomically and psychically, closely akin to the savage and barbarous peoples from whom we have been, unquestionably, evolved.

The white sexual criminal, and throughout this paper, I mean by sexual criminal, the individual who commits rape, shows, very plainly, to the eyes of those who are versed in such matters, the signs of physical and psychical degeneration. He may have been born degenerate with a bias toward criminality stamped indelibly on his psychic being, or, through excess, he may have engendered certain pathological conditions in his physical organism which make him tend toward anti-social acts. The white congenital sexual criminal commonly presents certain marked physical characteristics. I have personally examined two white men who had been guilty of rape, and both of them were dolichocephalic and prognathous. Their orbital arches were greatly enlarged and their cheek-bones high and prominent. Their genitalia were abnormally developed, and the growth of hair on their bodies rank and thick. Both of them had fair hair and both had malformed ears; in one the lobes were long and pendulous, in the other there was complete absence of the antihelix. Both were below the average in point of intelligence. Says Ottolenghi of the sexual criminal: "On the whole anomalies of the genital organs have, in sexual offenders no small diagnostic importance, especially when united to other characteristics which distinguish them from the honest and criminals in general, as the greater frequency of fair hair, of malformed ears, of bichromatism of the iris, of blue eyes, of twisted noses, of facial asymmetry, of voluminous lower jaws, and of various neuroses, especially epilepsy." These men knew that they would probably suffer death in consequence of their crimes, yet, imprisoned and safe from mob violence, they became jovial and light-hearted, for all the world like children who had escaped, for the time being, well-merited punishment. The child-like nature of savages is well known, therefore I wish to emphasize this fact in these two criminals, for it tends to show the truth of that which I have declared before, *i.e.*, that the white sexual offender is, in the vast majority of cases, an example of psychic atavism.

Love is an unknown emotion both to the violator and to the savage; they are both instigated by lust. In discussing the sensuality of criminals, Havelock Ellis says: "Love, in its highest and strongest forms, seems to be extremely rare." When a man was asked if he really loved the woman for whose sake he had murdered her husband, he replied: "Oh, if you had seen her naked!" I asked one of the sexual criminals examined by me if he loved his victim. "No," he replied; "but her legs were very beautiful."

The criminal is perfectly well aware of the fact that rape is an anti-social act and that it will be severely punished, yet his savage lust, held in check by no moral restraint, will lead him to commit the act if opportunity offers, and he thinks that he can escape punishment. He will commit rape not only once, but many times if he can escape apprehension. I have in my possession a sketch of the skull of P. J.—, a criminal, who, it is believed, raped no less than five different women. An engraving of this skull can be seen in my article on "Criminal Anthropology," in the *Medical Record*, issue of January 13, 1894. This skull points, beyond a shadow of a doubt, to an atavism or reversion to an ancestral type. The Neanderthal skull and the skull of the Man of Spy, both prehistoric skulls, are startlingly like the skull of this modern violator.

False sentiment as well as the law declares that all men are brothers. Science declares that such a conclusion is absurd and fallacious. There is too marked a difference between the dolichocephalism and prognathism of the normal savage, the negro for instance, and the mesocephalism and orthognathism of the normal white man for fraternal relationship. I have pointed out the fact that the dolichocephalism, etc., of the white sexual criminal are abnormalities and the result of degeneration. The long head and the projecting jaws of the negro, however, are normal; they are anatomical characteristics peculiar to the negroid and other savage races. Again, the psychical abnormalities of the white sexual offender are occasioned by degeneration, while the mental habitudes of the negro violator are perfectly natural. It is time that mawkish sentiments were banished, and the negro placed in the category to which he belongs. The negro has had here in America some two hundreds of years in which to acquire civilization. What folly to place his psychical development on the same plane with that of the white man who has had the advantage of him by several thousand years! Civilization, morals, are the result of evolution, of inherited experiences, therefore what arrant nonsense it is to suppose that the negro, who was a savage only yesterday, has become a moral and thoroughly civilized being to-day!*

* "One of the most generally applicable statements we can make with reference to the psychology of uncivilized man is that it shows, in a remarkable degree, what we may term a *vis inertiae* as regards upward movement. Even so highly developed a type of mind as that of the Negro—submitted, too, as it has been in millions of individual cases to close contact with minds of the most progressive type, and enjoying as it has in many thousands of individual cases all the advantages of liberal education—has never, so far as I can ascertain, executed one single stroke of original work in any single department of intellectual activity."—Romanes: *Mental Evolution in Man*, p. 13.

Native-born Americans, whose ancestors came from Great Britain and Europe, are remarkably free from the evil effects of degeneration, consequently the native-born white sexual criminal is of rare occurrence. The negro violator, on the other hand, is quite numerous, springing up everywhere in all of the Southern States, where his race is mostly domiciled. His criminality is not due to degeneration, but is the result of perfectly natural and, for him, normal mental habits. Let us study, for a moment, the psychology of this semi-civilized savage.

The childlike simplicity and happy-go-lucky carelessness of the negro, and I mean, throughout this paper, the true negro, not the half-breed, is notorious. The cares of to-day are sufficiently burdensome for him; he lets to-morrow take care of itself. Two hundred years of civilization have given him a thin, a very thin, veneer of superficial morality. In fact his moral nature about equals that of a white child five or six years old, who has no real knowledge of abstract ethics whatever. The negro cook who steals your flour, butter, sugar, and eggs does not consider her peculations to be thefts; she numbers such acts among her inalienable rights, though she is very careful to conceal as much as possible her petty rogueries. When she drops on her knees and asks God to pardon her, your butter, sugar, flour and eggs do not form any portion of her burden of sin. The negro who robs your watermelon patch and your hen-roosts on Saturday night will be found Sunday morning in the deacons' corner of the sanctuary. His full, rich, sonorous voice will sound all the better in prayer and song, on account of the fat chicken and luscious watermelon that he has eaten before he donned his long-tailed coat and hied himself to church. His religion is pure and unadulterated superstition. God and the devil (Voodoo in some form or other) are equally objects of his superstitious regard.

The records of the police courts, wherever the laws against fornication are enforced, will show that the negro, both male and female, has little or no regard for virtue. Northern sentimentalists have declared that the slave-owning whites were to blame for this moral laxity. This is nonsense, for it is a well-known fact that three half-breeds are born to-day where there was one born during slave time, thus showing conclusively that the negro women voluntarily yield up their virtue. But why argue this question; the history of the world shows that the women of the lower races, wherever found, eagerly enter, as a general thing, into concubinage with men of the white race. The men of the lower races passionately desire the embraces of the women of the white race, and this accounts, in a measure, for the numerous rapes upon white women by negroes. The negro

is rarely accused of committing rape on the females of his own race. The reason for this is found in the natural complaisance of the females of this race; the male being able to easily satisfy his desire without resorting to violence. For the same reason a white man is seldom guilty of raping a negro woman.

No amount of legislation will ever make people accept the negro as their social equal. Common-sense teaches them that he is their inferior, while science shows conclusively that he is of lower origin. Hence it happens that when a white girl has been raped by a negro the disaster is simply appalling. She feels as though she had been dishonored and defiled by some monstrous beast; her moral courage is gone forever; her honor and her virtue can never be regained. These feelings are also entertained, to a certain extent, by her relatives, friends, and, in fact, by every white individual in the whole country.

Not long since, a young lady in a neighboring State was dragged from her horse, carried into the woods, choked into insensibility, and repeatedly ravished by a negro. She was found, half dead, by a searching party late that night. Bloodhounds were put upon the track of her assailant, he was caught, brought before her, identified by her, and at once hung. This young woman came near dying from her injuries, but finally recovered. She, however, never left her home again, but, soon after she was able to leave her bed, she went into an outhouse and hung herself. Her father came home, and on finding the dead body of his daughter, seized his revolver and blew out his brains. The following night her brother drowned himself. Her relatives sold their real estate and personalty and left their native town forever.

The fear of the negro rape-fiend is general throughout the entire South. A remark of an aged negro shows me that this fear is by no means a baseless or groundless one. Said he to me, calling my attention to a young girl who was picking blackberries, "That girl is in danger. At this time of the year men's passions are hot. Some man might see her, seize her, and easily drag her into that clump of bushes." This man, for the moment, forgot his superficial civilization and allowed me a glimpse of his real, savage nature. Had he been a younger man, and if this opportunity had offered, I have not the slightest doubt but that he would have seized the girl, dragged her into the clump of bushes which his lecherous old eyes had discovered, and ravished her.

I know a young woman who is compelled by force of circumstances to take long and solitary country rides. She never leaves home without placing a revolver on the buggy-seat by her side. In the South, women never go out after sundown without an escort. The violator and his savage

lust is ever present to their minds. This is a fearful commentary on our boasted civilization, yet it is true in every particular. The sexual criminal, both black and white, is dangerous to society; so dangerous that the sooner he is destroyed the better it will be for society. The mad dog is not granted the formality of a legal trial before we blow out his brains. He is destroyed at once. The Malay who runs amuck is slain without mercy, society recognizing the fact that the end justifies the means.

It is by fear alone that the savage can be influenced. You cannot influence him by moral suasion, for he has no knowledge of morals; neither can you instil morality into him through the agency of punishments. The fear of death—sudden violent, terrible—is about the only thing that will hold the sexual criminal in check and teach him that he must restrain his savage lust. The sexual criminal, both white and black, is a savage, and should be treated as such. If the law is left to take its slow course, people become accustomed to the idea of that punishment which is eventually inflicted on the criminal, and greet its consummation with indifference. But if the criminal is taken in the act of committing rape, or soon after, and is immediately punished for his crime, the lesson comes in the nature of a shock and is not soon forgotten. Punishment is meant, not only for the criminal, but for society also, and the more forcibly society is impressed by the punishment of crime, the more deterrent will the lesson become.

The question naturally arises: Does lynching act as a preventive and a protection against the crime of rape? My own personal observations, as well as those of many conservative men, both north and south, teach me that it does. For, if a violator is apprehended and lynched in a community, the crime of rape does not occur in that community for many years, or, if it does occur, the individual committing the outrage will be found to be either a stranger who has recently come into the community, or a young man who has reached maturity since the time of the last lynching. Statistics gathered from every section of the country show that a like result does not obtain when the sexual criminal is punished through due process of law. The lesson taught by lynching creates, beyond any shadow of doubt, a profound impression, and this impression remains tangible and vigilant throughout the lives of would-be violators, causing them to curb their lust and to pay a fitting regard to the laws of society. It has been urged as an insurmountable objection to lynching, that many innocent men are put to death by the unreasoning mob, which, carried away by its passions, hangs the first suspicious-looking individual it finds. I have carefully studied the evidence in forty-three lynchings of sexual

criminals and found that the lynchers had, in every case, hung the right man. These forty-three cases have occurred during the last twenty-three years, and have been taken indiscriminately from all over the country. I have gathered my information concerning them from the most conservative and level-headed men of the communities in which the lynchings occurred, consequently, can safely assert that my conclusions are based on indisputable facts. Purists condemn the lynching of the sexual criminal, and declare that his lynching is, fundamentally, an illegal act, hence a criminal act. I hold that no act is criminal that benefits society. There is a higher law than the written law of man, the law of the preservation of species, coincidently of civilization. The crime of rape is distinctly atavistic, hence it is a menace to civilization, and should be suppressed no matter how.*
—James Weir, M.D., in *Med. Rec.*

MYDRIASIS AS A DIAGNOSTIC AND THERAPEUTIC MEASURE IN GENERAL DISEASE.

There still remain here and there a few recalcitrant minds impervious to logic and evidence, who hold that ocular malfunction is never a source of extra-ocular disease. For such impenetrables, of course, no one writes, and they may therefore be warned that the present writing does not concern them. There are, however, other physicians who are in doubt about the matter, or who have never had it brought home to them, and who are willing to test it when occasion presents. There is still a third class, composed of those who believe more or less, but who are undecided exactly as to what extent the fact obtains, or just what extraocular affections are the result of ocular abnormalism. To these two latter classes we have two suggestions to make.

The first is to use mydriasis as a means of differential diagnosis in certain classes of cases of functional nervous disease that are obstinate to treatment or in which the etiology of an affection that may be due to a reflex neurosis is obscure. There is an overwhelming mass of evidence to be found in medical literature leading to the conclusion that ametropia and muscular-imbalance may be the unsuspected cause of headache, sick-headache, functional gastric and digestive derangement,

* If purists object, stating that such a law would be unjust and discriminating, I answer, that as long as society considers the violator to be a normal man, and treats him as such, just so long will society be guilty of injustice and discrimination toward normal, healthy man. There is a higher and unwritten law, which, fundamentally, takes precedence of established law; moreover, I do not consider that which redounds to the good of society either barbarous or savage.

anæmia, anorexia, chorea, convulsive tic, hysteria, and other nervous disorders. The general physician is sometimes puzzled to know how he may in a certain case prove or disprove the theory of a possible ocular reflex. If he is able to induce the patient to visit the ophthalmic specialist, he may be left still deeper in doubt by the fact that, however grand the reputation of the specialist, his patient may fall into the hands of a faddist, or of one who refracts by machinery, or of one who disbelieves in ocular reflexes—in a word, of one who has neither the desire nor the ability to do his work with that degree of refinement, judgment, and precision upon which all success in this department depends. It might as well be confessed that the stock expression, "The patient obtained no relief from ocular treatment," has absolutely no meaning, without the clearest discrimination as to what kind of an oculist the patient consulted.

In all such cases the perplexed general physician has in mydriasis a means of differential diagnosis of often-decisive and of almost-always significant service. Homatropin (ten grains to the ounce) instilled three times a day, or atropin, if more prolonged mydriasis is not objectionable (four grains to the ounce) in ordinary cases of those under fifty years of age, may be recommended for the purpose. It is the most common observation of patients, spontaneously offered the oculist, that during mydriasis their headaches, for example, disappeared and that they felt, generally, "so much better."

If, therefore, the general physician, by following the suggestion, finds that there is relief of distant symptoms resulting from a few days' mydriasis, it is a pretty convincing indication that at least the immediately inciting cause lies in eye-strain. In such cases, if the visit to the oculist brings no lasting relief, one may legitimately suspect that gentleman's treatment is at fault, and in the fact itself one may find a valuable "check" upon or proof of his ability.

But apart from the value of mydriasis as a means of arriving at a differential diagnosis, there are many conditions in which it may be of use to the neurologist and the general physician as a therapeutic and prophylactic agent *per se*.

1. In prolonged illness, patients from their confinement and inactivity are prone to read or sew too much, and the nervous system is unconsciously irritated or wearied, either from an uncorrected ametropia, etc., or from simple over-use of the eyes and the attention, or from the wearisome use of the eyes while lying or in reclining positions. In these ways it cannot be doubted that convalescence has frequently been lengthened and the weakened organism put to harmful effort. Slight mydriasis would effectively prevent all this, and without any possible injury in other directions.

2. Proceeding upon the assumption that eye-

strain may sometimes cause extraocular malfunction, and also assuming that such eye-strain may possibly exist in uncorrected or incorrectly corrected eyes, the general physician may find it of advantage to use mydriasis as an *ad interim* measure of possible relief, the accurate ophthalmologic examination to be secured later. Errors of refraction and muscle-strengths change with almost all decided changes in the general health, and it is often necessary or better to defer local eye-treatment with spectacles, etc., until health has been fairly well established.

3. Mydriasis may also be therapeutically helpful as an adjunct to other treatment. Eye-strain, of course, may be a secondary cause of distant symptoms, or one of several other causes of them. In many cases setting the accommodation at rest may prove one useful aid to other and more important general measures, either as a little means of lessening general cerebral irritation, or specifically in reducing the amount of the derouted reflex to a single organ. A most acute and scientific observer, Dr. Charles G. Stockton, as a result of long experience, has concluded that severe eye-strain (and usually of a definite variety—unsymmetric astigmatism) is a frequent cause of a distinct and distressing gastric malady. (*The Medical News*, Dec. 15, 1894, p. 655.) Now it is the veriest *a b c* of medical wisdom that a long-continued disease, even if only "functional," is not by any means always cured immediately, and as if by magic, with the stopping of the immediately inciting cause. Moreover, it is not an easy matter to secure an absolutely accurate correction of unsymmetric astigmatism in these forlorn days of tenotomomania and machinery. Besides all this, it is often doubtful if re-refraction is not required, whilst still another disturbing thought arises that even with perfect glasses hypersensitive and long weakened eyes may still for a time remain sources of reflexes to similarly weakened organs elsewhere. Under these puzzling circumstances is it not a promising way of escape to keep the eyes under somewhat prolonged mydriasis as an adjuvant to other treatment?

4. In cases of headache, sick-headache, and in all functional and nervous affections, wherein there is a more or less definite periodicity of recurrence, mydriasis may be of service in aborting an on-coming attack. It is readily seen that the instillations of the mydriatic should in such cases begin sufficiently early to lessen long enough the derouted reflex, and thus to give the surcharged centers time to normalize themselves.

To the alert-minded physician the foregoing hints may stimulate other applications of the principle according to the ever-varying circumstances and conditions of his patients; but sufficient has been stated to make it appear possible that in mydriasis we have a hitherto unsuspected

agent, possibly useful both in the diagnosis and in the treatment of many types of functional disease. —*Med. News.*

CALOMEL.

A STUDY OF ITS PHYSIOLOGIC ACTION AND THERAPY IN GASTRO-INTESTINAL DISORDERS IN ONE HUNDRED AND FORTY-FOUR CASES—IS IT A DIURETIC *per se*?

The physical properties of calomel are so well known to the profession that they need little consideration here. One point presents itself at this time and that is, Do you examine into the purity and quality of the calomel you use, or do you accept it as perfectly pure? Have you ever stopped to ask yourself the question why your large doses of calomel always caused griping and pain in the majority of cases?

Calomel is subject to adulteration; to improper purification in manufacture; and to chemic changes both atmospheric and in chemic mixtures. Bichloride of mercury is the most common impurity found in it, and this varies from the smallest to comparatively large amounts. Many instances are on record where the usual large doses of calomel have produced violent griping, cramps and gastro-intestinal catarrh which were undoubtedly caused by the presence of bichloride of mercury rather than a special idiosyncrasy. In fact, instances of fatality are reported from the administration of large doses of calomel contaminated with this poison.

On the other hand, calomel may contain such large amounts of barium, calcium, lead and other impurities that its action is greatly lessened and rendered almost inert. With these thoughts before us, and a thorough knowledge of making appropriate chemic tests for their confirmation, we can often explain many untoward actions which might otherwise be attributed to a pure preparation.

The methods of administering calomel have undergone a great change during the past ten years, and in general and special applications have been carefully studied and extended. It is an axiomatic fact that calomel should never be administered with acids or chlorides, and not at a time when the stomach is performing its digestive functions, owing to the danger of chemic change from the mild chloride into the bichloride, thus giving the effects of the latter drug. Until recent years, calomel has been administered in its purity, or in combination with other drugs, in doses varying from one to forty grains and in many cases the patient was an innocent victim to an overdose. To-day calomel should be thoroughly triturated with sugar of milk and administered in doses of one-half to five grains. Why this change?

Calomel plain is a heavy drug; is very slowly assimilated and absorbed, owing to its extreme insolubility and the size of its isolated crystals. In this form it is not in its finest state of subdivision, and is confined to a smaller area of distribution over the tissues of the alimentary tract. Calomel, when thoroughly triturated with sugar of milk, is brought into its finest state of subdivision and its presence can be readily demonstrated with the ammonia test in trituration of 1 part in 1000, thus demonstrating the possibility of administering it in such small doses if desired. One grain of triturated calomel is capable of distribution over a wider area than the pure drug alone; is in a finer state of subdivision; is much more readily brought into a condition for absorption.

With a view of demonstrating the value of the pure drug and its trituration, I selected a number of cases in which both preparations were used at different times in the same subject, and under circumstances as nearly similar as possible. The dose selected was one grain of the pure drug and a one grain trituration with sugar of milk. The dose was administered at bedtime. In the majority of the cases where the pure calomel was given there was no evidence of a bilious stool until the next evening, and in many of them there was no apparent action at all. These same individuals some days or weeks later responded so violently to a one grain trituration that next morning one to five bilious stools resulted; and in one, who had not responded readily to the one grain pure, there was such a large number of evacuations produced that measures had to be used to check the bowels. This may be considered a mere matter of coincidence, but my clinical experience teaches me that one grain of thoroughly triturated calomel is worth an equivalent of five to ten grains of the untrituated drug. A simple mixture of calomel and sugar of milk will not produce any better results than the pure drug alone.

When given for its purgative effect, or for its action upon the liver, it is my custom to administer a one-tenth grain trituration every hour or half hour until free evacuation occurs or until one grain is taken; when, if necessary, liquor magnesii citratis is given in one ounce doses until free action is obtained. During the last four years of practice I have not found occasion to use more than one grain of the drug in the same individual for this purpose. A one-tenth grain trituration at bedtime will produce excellent results in small children, except in those who are habitually constipated, when the former method must be used. There is a certain amount of propriety in administering calomel with bicarbonate of soda, as it will prevent the formation of bichloride and, as calomel is most readily absorbed in an alkaline medium it is synergic.

After administering calomel in a large number

of cases and carefully noting the results upon the various organs, I have failed to appreciate the so-called diuretic effects of the drug *per se*. It undoubtedly acts *indirectly* to a slight extent, simply by its general stimulating action upon the emunctories of the entire body thus favoring secretion, excretion, and the elimination of intestinal ptomaines and systemic poisons, all of which act unfavorably upon the secretory and excretory organs when present. In a case of scarlatinal nephritis in a little girl of six years, with decreased amount of urine, calomel in both large and small doses produced no appreciable diuretic effects, while the ordinary diuretics acted nicely. A man of sixty-five, showing mitral disease, chronic Bright's disease and œdema of the lower extremities would not manifest diuretic effects from large doses of calomel frequently repeated, but responded to alkaline diuretics readily. In giving the drug to over one hundred children, in varied doses, I have never noted diuretic effects which could be ascribed to it alone.

Dr. Wm. Pepper has recently reported a case of Bright's, complicating aortic disease, where large doses of calomel were followed by diuretic effects, and where there were manifested no toxic symptoms from its prolonged use in doses of ten grains daily. His experience does not seem to point to its general diuretic action except in large doses, and then it is often uncertain in its effects. While I am still closely observing results in its use, yet I am not convinced that any diuretic action other than a very indirect one is produced by calomel. Typical biliary stools have almost invariably followed the use of the triturated preparation in doses exceeding one-quarter to one-half grain. In some cases there was a regurgitation of bile from the duodenum into the stomach, producing obstinate vomiting. Calomel undoubtedly increases the secretion and excretion of bile by its direct stimulating action upon the cells of the liver. To this cholagogue action is partially if not wholly due its beneficial results in treating diarrhœas.

How does calomel act in diarrhœas? When taken into the stomach in large doses it is slightly irritating; part of it is absorbed and the remainder enters the intestines, where it is further absorbed and possibly may have a slight local antiseptic action. Systematically it acts upon the liver, producing increased flow of bile, which enters the duodenum. Bile is nature's antiseptic and acts in neutralizing ptomaines, preventing germ growth, sometimes destroying germs themselves and aiding digestion. It increases peristaltic action and intestinal secretions, and thus assists nature in cleansing the bowels by the production of free biliary stools. The cause once removed, the cure is apparent. Small doses of calomel act more by a direct cellular impression, by which the cells of the stomach and bowels are stimulated to renewed

physiologic activity. The action upon the liver is the same as in large doses, being proportioned to the size of the dose.

I desire briefly to report the results of treatment in one hundred and forty-four cases of all forms of diarrhœas which I have noted in my work, all of which terminated successfully under the action of calomel alone and in combination. Seventeen cases in adults, all of which were due to the ingestion of improper food. Diarrhœa varied from a mild to a very profuse type. Twelve powders were made from one grain of triturated calomel and one-half grain of podophyllin and one powder given every two hours until free bilious stools were produced. From two to six powders usually gave a curative result—dietetic measures being observed as in all the cases here reported. No astringents or other medication was necessary.

Nine cases of the so-called bilious diarrhœa in adults responded rapidly to one-quarter grain triturate of calomel every four hours for two to four doses. Only one of these cases proved obstinate, and it rapidly reacted to one grain doses of sulpho-carbolate of zinc every hour for six doses.

Sixty-eight cases in children from two months to ten years all received a saline cathartic of liquor magnesi citratis as preliminary treatment. This was followed by a trituration containing one one-hundredth of a grain each of calomel and powdered ipecacuanha every one to four hours. The action of this combination in controlling the nausea and diarrhœa in these cases was marvellous. The saline was often sufficient in other cases, but in those where it was not, the small doses of calomel and ipecac worked excellently. I have seen some cases so obstinate that all other forms of treatment failed, but the institution of this method, combined with strict dietetic and hygienic measures, brought about cures. It also gives me best results in treating adults suffering with diarrhœa, nausea, vomiting, cholera morbus, dysentery, and the diarrhœa of typhoid fever. One case of slight but obstinate dysentery in an old man of seventy-five years failed to respond to ordinary methods, but quickly subsided under this small dose of calomel and ipecac every two hours.

Twenty-five cases of obstinate diarrhœa, which had been running some days before consultation, all responded rapidly to a combination containing one-tenth grain of calomel and one grain each of lactopeptine and sulpho-carbolate of zinc given every two to four hours. Four cases of the diarrhœa of typhoid fever responded rapidly to this same combination given every four hours.

I have met with twenty cases of diarrhœa following excessive use of alcoholic liquors, and in every case have succeeded in getting absolute results in one to three days by administering a combination of one-fiftieth of a grain of calomel and one-hundredth of a grain of podophyllin every

three or four hours as required. Two to four doses answered in several, while others proved rather obstinate but responded in the end.

In summarizing the results in these one hundred and forty-four cases, I am not presenting entirely new facts to you, but merely adding clinical testimony to the true efficiency of calomel and its eliminative power as contrasted with the evil routine methods of astringency and opium in treating diarrhœas. These cases are not selective, but followed each other in succession. It is my general experience that diarrhœas will respond more rapidly to doses varying from one-tenth to one hundredth of a grain of calomel, thoroughly triturated, than to larger amounts. While these small doses may seem homœopathic to many, they are not presented as such, but are given with a full knowledge that they will give certain clinical results which cannot be obtained from larger amounts.—W. Blair Stewart, M.D., in *Jour. Am. Med. Assn.*

WHAT IS CROUP?

It is now a little more than a century ago that Homn, of Edinburgh, introduced the term croup into medical literature. It was no doubt intended by him to denote a new disease of children, or, at least, to make clearer one at that time not fully understood. The term croup since then, however, has been corrupted to designate only the most marked and alarming feature of a group of diseases affecting the larynx in children. It can be readily understood how such a corruption should occur, first with the laity, and later with the medical profession. The danger of the disease, as originally described, was soon associated by anxious mothers with the quality of the cough, and this, without further investigation, was often accepted by medical men, until custom became almost a law in the matter. So much confusion appears to exist in the minds of many young physicians, and old ones also, even at this end of the nineteenth century, in clearly recognizing the different diseases of the larynx characterized by the unnatural, ringing, resonant, metallic tone of the cough, which originally suggested the term croup, that I have thought an effort to elucidate and define, in a concise manner, *what is croup*, would not be inappropriate.

The name is misleading, in so far as the appreciation of danger is concerned, not only to the laity, but to the profession as well; because the feature of the croupy cough does not convey an accurate idea of the condition producing it, so that such a high authority as Trousseau has said that "croup is not croup"; referring, as many will always do, to the quality of the cough as an indicator of the disease. The late Prof. Fordyce Barker has placed upon record the statement that

in twenty-five years' practice of medicine, he did not lose but three cases of croup, and these were seen in consultation only. He attributed his phenomenal success to the treatment he employed, which was emesis, with turpeth mineral, *ab initio*, and later, the use of veratrum viride, to keep the pulse down to eighty per minute. In two of his cases, casts of membrane were vomited. It would seem, from such a statement, that even so clever a practitioner as Barker must have lost sight of the true distinction of the different diseases in which the feature of croupy cough forms so prominent an element. To make matters clear at the outset, the term croup is here used in its properly accepted sense, to mean a pathological stenosis or narrowing of the calibre of the larynx from the deposit and growth of an exudation or false membrane upon its mucous surface. A stenosis of the larynx may be due to other causes, such as an acute swelling of the mucous membrane covering the vocal cords or glottis, either from catarrhal congestion, the inhalation of steam, or mechanical injury. The condition of stenosis from these causes is, for the most part, uninfluenced by pathogenic changes, such as result in a formation of exudate, and, therefore, need not be considered as entitled to be called true croup.

The affections of the larynx that are most likely to be confounded by the young physician with croup are *laryngismus stridulus*, or thymic asthma, as it is sometimes called, and *catarrhal laryngitis*, which, to make matters more confusing (owing to a similarity of names), has been, and is even yet, called by some writers, *stridulous laryngitis*.

Laryngismus stridulus is practically a manifestation of rickets, and should, under no circumstances, be confused with either catarrhal laryngitis, miscalled stridulous laryngitis, and certainly not with true croup, which is always either primary diphtheria or pseudo-diphtheria of the larynx. It is the "holding-breath spell of rickety infants, and is incidental to infancy only. After a more or less prolonged pause of respiration, during which the face becomes livid, and convulsive twitchings of the muscles of the face and extremities may occur, there is a loud, crowing *inspiration* of a rough, grating tone. These spells may be repeated frequently in a short space of time, or may occur at longer intervals throughout the day. They are not to be confused with the snorting breathing of new-born infants. The ready recognition of catarrhal laryngitis or *false croup* is not always so easy, though it is hoped that points here given may be of some aid. Catarrhal laryngitis is manifested in two forms, the *spasmodic* and the *simple*. The spasmodic form is not so difficult to distinguish. It comes on suddenly at night, waking the child out of its sleep, rarely occurs under one year of age, and there is usually a

history of a disposition to former attacks, or enlarged tonsils, post-nasal catarrh and its sequent, adenoid growths of the pharyngeal vault. Its most prominent features are a loud, metallic, ringing quality of cough, with attacks of alarming dyspnoea. These symptoms usually subside to a marked extent through the following day, when only a slight hoarseness of voice will be noticed. The attacks of cough and dyspnoea may occur, to a less degree, for two more nights, when recovery is prompt. The attacks of dyspnoea do not last longer than ten or fifteen minutes; in their interval respiration is not difficult. In the simple form of catarrhal laryngitis the attack comes on more gradually, with hoarseness of cry or voice, and ringing tone of cough. It may begin during the day, but is decidedly more marked in the night. It may occur at all ages up to seven years. There is, at the onset, a marked rise of temperature, but the child shows no special signs of discomfort that could be referred to the larynx. There may be attacks of difficult breathing, but they occur either towards or during the night, never during the day. An exception to this was recently observed in a child one year of age, during an attack of influenza, where the diagnosis for a few hours was in doubt. The hoarseness of voice and ringing cough may persist in the day-time, even accompanied with noisy or hissing breathing; but the difficulty in respiration will always be noticed on *inspiration*, expiration being quiet and easy. The voice is never muffled or completely lost, except, perhaps, during an attack of dyspnoea. After the first few days, all of the symptoms tend to improve. The pharynx, in the act of gagging, becomes filled with muco-purulent secretion; the cough becomes softer, and a bronchitis may follow, from extension of the catarrhal process into the bronchi. The hoarseness and cough may last for a week or more, but, except in very severe cases or those complicated with diphtheria, there is no *progressive development of the disease*.

It cannot be denied that simple catarrhal laryngitis is sometimes fatal, but the rarity of such ending may be judged, when Trousseau, in an immense practice, extending over many years, saw only three deaths.

The cases of simple catarrhal laryngitis that are most perplexing in the matter of diagnosis, or those upon which have been engrafted the germs either of diphtheria or pseudo-diphtheria, during the progress of the attack. A history of exposure to contagion will be of great assistance in such cases, besides the observation that the difficulty of respiration grows steadily worse after the case had commenced as one of simple catarrhal laryngitis.

Two cases of laryngitis, one accompanied by membranous exudation, from entrance of foreign bodies into the larynx, are reported by Dr.

Wharton in "Keating's Encyclopædia of Diseases of Children." These cases presented all the symptoms of true croup, and are mentioned here as rare cases.

Ashby and Wright mention the relief given from inhalation of warm, moist vapor, from either a croup kettle or steam tent, as an important aid in the diagnosis of catarrhal laryngitis from membranous croup in the early stage of the disease. The relief given in the catarrhal laryngitis is marked and permanent, the contrary being the rule in diphtheria and pseudo-diphtheria of the larynx. Steiner regarded sneezing and coryza as signs favorable to the indication of catarrhal laryngitis, true croup, or what is commonly called membranous croup, is either primary diphtheria or pseudo-diphtheria of the larynx. When the exudation is seen in the pharynx or nose, diagnosis is clear, but where no such evidence is presented, bacteriological examination will show that it is one or the other of these affections, notwithstanding the statement of Dr. Dickey in the *Medical Age* for January, 1894, to the contrary. A swab culture taken from a probang, wrapped with a little clean cotton wool (slightly scorched by passing hurriedly over an alcohol flame), which has been dexterously inserted into the larynx of the patient, will show either the diphtheria bacillus, or the streptococcus, with the pseudo-diphtheria bacillus of pseudo-diphtheria, in twenty-four hours. The vast importance of an early diagnosis in these cases will be at once recognized, when the knowledge it gives, not only points out the right course for treatment, but aids in guarding against the further spread of contagion.

According to a recent report of the bacteriological department of the Board of Health of this city, out of 286 cases reported of so-called membranous croup, during a period of ten months, eighty per cent. proved to be true diphtheria, fourteen per cent. pseudo-diphtheria, and six per cent. were doubtful. One hundred and ninety-four of these were of primary laryngeal origin, no exudation being visible in the nose or pharynx. The bacteriological department of the Board of Health of New York now advise *membranous croup* to be included in the list of contagious diseases.

The suggestions offered for making an early diagnosis in true croup, are well enough for city practice, but in the country and small towns no such opportunities exist for scientific investigation, and reliance must, as formerly, be placed upon a correct interpretation of clinical phenomena.

The clinical picture of both forms of catarrhal laryngitis being well impressed upon the mind, the contrast picture of true membranous croup may be brought out in bolder relief. Let it first be borne in mind, that the only difference between

diphtheria and pseudo-diphtheria, concerning its location in the larynx, is, that one shows upon bacteriological examination, the Klebs-Loeffler bacillus, and is more fatal, systemically, than the other; which shows the pseudo-diphtheria bacillus with the streptococcus in mild cases, and both the staphylococcus and streptococcus in severe cases. Both forms of exudation are capable of producing a fatal stenosis of the larynx, and are contagious.

Membranous croup, true croup, is most insidious in its onset. If other cases of diphtheria or pseudo-diphtheria have been known to occur in the same family or neighborhood, the diagnosis will be greatly aided. The patient may not show any marked signs of illness in the beginning. There is little or no rise of temperature, perhaps a slight loss of spirits or appetite, but the patient will have a peculiar expression of apprehension of some impending danger. Later, there is a sense of marked discomfort referred to the larynx. The voice is at first hoarse or husky. This gradually increases in development until it is either suppressed or completely lost, not only during the attacks of dyspnoea, which soon follow, but in the intervals of the attacks as well. The cough, which is at first ringing and metallic in tone, soon becomes smothered and less frequent, until it is unnoticed. The attacks of dyspnoea begin at long intervals, which gradually grow shorter, irrespective of day or night, until *difficult respiration, which is the marked distinguishing feature of true croup*, becomes continuous. This is accompanied with a loud, harsh and hissing sound, heard, even in the early stage, both on inspiration and expiration. There is depression of the substernal and supra sternal and supra-clavicular spaces on inspiration, in the advanced stage. In a word, *all of the signs of difficulty in breathing are progressive in character, until relief is given to the stenosis either by a spontaneous expulsion of the membrane during a fit of vomiting or coughing, or by surgical interference.* After the second day, in true croup, albumen will most likely be found in the urine. The lymphatic glands of the submaxillary region are often enlarged in true croup; but almost never in catarrhal laryngitis.

To repeat: Catarrhal laryngitis or false croup begins suddenly, either with an attack of dyspnoea and croupy cough, or croupy cough alone. Membranous croup, which is either primary laryngeal diphtheria or pseudo-diphtheria is most insidious and slow in its onset. False croup is always worse at night and better in the day-time; membranous croup, while it is worse at night, persists in all its unfavorable features through the day-time as well. The loud, ringing cough in false croup does not change its quality, and is more noticeable than the hoarse or smothered voice; in membranous croup the ringing cough is soon lost,

becoming smothered, and is far less noticeable than the hoarse, husky voice, which finally becomes almost suppressed. In the interval of the attacks of dyspnoea in false croup, respiration is difficult, or harsh only on inspiration; in membranous croup it is so both on inspiration and expiration. In false croup the attacks of dyspnoea occur only at long intervals; that is, either at night, or, if in the day towards night; in membranous croup, the intervals between the attacks grow steadily shorter, until difficult, or harsh, labored breathing is continuous. No reference is made to laryngoscopic examination, as it is at best most difficult for the general practitioner to accomplish, and is annoying to the patient. Moreover, the diagnosis can be made without it.

Other diseases, such as measles and scarlatina, are likely to be complicated with croup. Whenever such a complication occurs, it may safely be regarded as diphtheria or pseudo-diphtheria of the larynx.

Nothing is intended to be offered as to details of treatment, but it must be at once apparent to all, how important a matter the differential diagnosis of the various laryngeal disorders, attended with croupy cough or voice, in children, is, as bearing upon an honest and correct treatment. While a simple emetic or steam inhalation, with the internal administration of a diaphoretic, will suffice in false croup; or cold sponging several times daily, together with the internal use of cod liver oil and phosphorus, will do in laryngismus stridulus; any such waste of valuable time would be criminal in the management of true croup. Here we have to treat the effect of the disease upon the general system, as well as the local condition; but, while much improvement in our past methods may be possibly obtained by the newly introduced serum-therapy, the resort to calomel sublimations and intubations will continue to be necessary, in order to tide the patient over the dangers of suffocation. Thorough disinfection in every direction should always be carefully borne in mind in the management of true croup.—S. H. Dessau, M.D., in *Archives of Ped.*

SULPHONAL AND TRIONAL COMPARED.

During the last few years several hypnotics, differing in value, have been introduced to the profession. Among the drugs of this class two, sulphonal and trional, deserve especial favor; and it may be interesting briefly to compare them, as they both give good results, yet differ so much in their effect that it is well to know to what class of patients each is the more suitable.

Sulphonal is sparingly soluble in cold water, and is slow in its action. Sometimes as long as two

or three hours are required for it to induce sleep. So slow is it at times that patients became impatient waiting for its effect, hence it is better to give it in the evening a while before bedtime. I have sometimes thought that the slowness of its action interfered with the induction of sleep, the patient becoming so nervous waiting for sleep that he was thoroughly aroused. The effect of a full dose, however, continues long; and it will often produce sleep the second night, and in a few cases even the third.

Trional is much more soluble. It produces sleep much more quickly, within a few minutes. In one case the drug was taken before preparing for bed, and its effect was felt so soon that it was an effort for him to get into bed. Its action is less prolonged than that of sulphonal. I have never known it to produce sleep on the second night as markedly as sulphonal, though patients may sleep well the night after taking it, but not from its direct effect.

The day after taking sulphonal there may be great drowsiness during the day. This is less likely to occur after a dose of trional, and if it does is much less intense.

In consequence of the more rapid action of trional, some patients much prefer it to the slowly acting sulphonal. This is especially true of those who have difficulty in getting to sleep when they first go to bed. Those who suffer from this form of insomnia became impatient at their inability to sleep, and each minute finds them more restless; indeed, it is in part owing to this restless nervousness that they are unable to get to sleep, and for this reason they are desirous of seeing an early result from any medicine they take. To such patient it may be well to give trional.

Another class of patients have no difficulty in going to sleep when they first go to bed; but they wake in a short time and lie awake two, three or four hours, or may have no more sleep that night. To this class sulphonal is the better drug, as it does not interfere with the first early sleep of the night, and acts later so that the patient does not wake at midnight as usual.

The effects of trional do not continue so long towards morning as sulphonal. It gives good refreshing sleep for four or five hours, or perhaps six; then the patient wakes and does not sleep again. In such cases it is possible that the next time a larger dose will produce a longer sleep. The effects of sulphonal are more likely to continue through the whole night until morning.

The dose of either of these drugs is 10 or 20 grains. In many cases 10 grains are sufficient, but where there has been obstinate wakefulness it is better to give more, 15 or 20 grains. I have only very rarely given 30 grains of sulphonal. I have never had occasion to give more than 20 grains of trional; possibly not having tried it in

such obstinate cases as the other drug. In the case of either drug it is better to give one sufficient dose than to give two or more insufficient doses.

After taking sulphonal there is not infrequently more or less cerebral heaviness and distress the next day. In a few cases the discomfort has been so great that patients have objected to taking the medicine, and preferred to get along with less sleep. I have found much less of this unpleasant effect after trional. One patient, who refused to take sulphonal on account of this after-effect, had little or no discomfort after a dose of trional.

After 15 or even 10-grain doses of trional, I have known slight vertigo or dizziness to be felt before sleep was induced, if the patient rose from bed, lying down caused this to cease; but for a short time it was somewhat distressing. I do not remember this after the ingestion of sulphonal. It may be well, therefore, to warn some patients not to rise after taking trional, to wait until fully ready for the night before taking it, and then to stay in bed without getting up so as to avoid this unpleasant experience.

Sulphonal may be given in small doses, not more than five grains, to quiet restlessness in neurasthenia, hysteria and mania; given three times a day and, if necessary, during the night, it will often have a most soothing effect. I have not tried trional in this way, but should not expect such an effect, as it acts so much more quickly and its action is so much less lasting.

It will be readily seen from this comparison which of these two drugs to choose in combating insomnia; but it must be remembered that neither is a certain cure for this distressing symptom, and that the treatment must be directed to the patient's condition and not simply to the symptom insomnia. —*Boston Med. and Surg. Jour.*

DOES ETHERIZATION CAUSE CROUP- OUS PNEUMONIA?

We have called attention in recent numbers of the *Therapeutic Gazette* to the fact that ether may produce secondary effects which are frequently credited to intercurrent diseases following the operation rather than to the administration of this anæsthetic. In an interesting paper upon this subject in the *Boston Medical and Surgical Journal* for March 28, 1895, Prescott details two cases in which acute croupous pneumonia followed etherization. In discussing the question as to the ether being the exciting cause, he is careful to point out that in recording instances of this kind we must take care to carefully separate the instances of broncho- or catarrhal pneumonia from the true croupous variety. Every one with experience has probably seen some cases in which

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broncho- or catarrhal pneumonia followed etherization, but Prescott states that in looking over a large series of records he found that croupous pneumonia was a very extraordinary sequela.

We can readily understand why it is that broncho-pneumonia and catarrhal pneumonia so frequently follow etherization, since the chilling of the lungs as well as the entire body in association with great irritation of the mucous membrane of the bronchial tubes and smaller air-passages readily results in congestion, stasis, and a certain amount of consolidation. The frequency with which croupous pneumonia is produced by etherization must depend almost entirely upon the presence or absence of the infectious micro-organism which is now recognized as the cause of this disease. While at the present time clinicians are practically in accord that exposure to cold itself cannot alone produce pneumonia, they also believe that the exposure to cold may so decrease the vital resistance of the patient that the micro-organism of pneumonia, which was formerly unable to produce a pathological process, finds a suitable field for its growth and multiplication. In an earlier number of the *Gazette* we called attention in a leading article to the very great loss of bodily temperature which is apt to ensue during and after the administration of ether, and it seems to us self-evident that both the broncho, catarrhal, and croupous forms of this disease might in a certain proportion of cases be prevented by the maintenance of bodily heat during, as well as after, the operation. Even if this be done, the irritation of the respiratory passages by the vapor of the ether may be quite sufficient to cause the irritation which opens the way for the infectious process.

The answer which Prescott believes is the correct one to the question which heads this editorial is that ether very rarely acts as the exciting cause of acute lobar pneumonia, and therefore even when this disease occurs it must be regarded rather as a coincidence than as the outcome of cause and effect.—*Ed. Therap. Gaz.*

MEDICAL NOTES

Salicylate of soda is recommended by Chibret in Basedow's disease as being quick and lasting in beneficial effects.

It is stated that the best remedy for bed-wetting in children is Normal Liquid Ergot.

A mild gargle will usually be more beneficial in simple pharyngitis than a markedly astringent one.

The oil of eucalyptus will be found very useful in some forms of rheumatic headache, or in cases of headache due to malarial fever.

There is perhaps no one remedy which is so efficient in all cases of asthma, regardless of their source, as sodium iodide.

Dr. Weill claims that every form of vomiting during gestation, can be relieved by a twenty per cent. solution of menthol in olive oil; dose, ten drops on sugar whenever nausea appears.

Dr. Elmer Lee, of Chicago, claims that hydrozone is better than peroxide of hydrogen for internal administration, he having given both in a large number of cases of typhoid fever.

Dr. Roberts Bartholow gives papain in ten grain doses t.i.d. for tapeworm.

Fifteen-grain doses of salipyrine is advised in the treatment of menorrhagia of the climacteric.

Salicylate of strontium is considered one of the best intestinal antiseptics in doses of five grains. In doses of ten to fifteen grains it acts decidedly in gouty and chronic rheumatic conditions.

Methylene blue applied to abrasions of the os uteri by means of a cotton probang, is an effectual remedy.

For erysipelas, paint the parts with ichthyol with a little carbolic acid. It will relieve the pain, protect the parts, and check the progress of the disease.—*Med. Summary.*

THE ECONOMICS OF PROSTITUTION.—(*The Medical News*).—At the recent meeting of the American Academy of Medicine in Baltimore, Dr. Woods Hutchison, of Des Moines, Iowa, said that reproduction is heaven's first law. "Be fruitful and multiply" is the first commandment in Genesis, and yet every religious or moral code has inveighed against the sexual instinct. It is hard to control, but instead of being degrading it is of the highest rank and holiest nature. Upon this foundation are built the whole of morality and the social instincts; the family is the nucleus of civilization.

And yet everything connected with the sexual instinct is tabooed in polite society. Modesty affects to ignore its existence. Boys and girls are kept in disgraceful ignorance of one of their most important functions. From this arise many forms of vice. The second evil influence of this denunciation and taboo is to destroy the feeling of obligation to bear children. Married men and women are either refusing or limiting their output to two or three. This is the fruitful source of prostitution, abortionism, onanism, and mental and moral degeneracy. Parents need training as well as children, and no man's or woman's education is more than half completed without such education.

What, then, is the excuse for this ban which has been laid on the sexual instinct? Its excesses

solely. To hear most sermons one would think that adultery, fornication and prostitution were its principal results. Its beneficial results overbalance these a hundred to one.

Even its excesses have their uses; they are a means of sterilizing or exterminating the unfit. This is especially true of prostitution. It has the earmark of a process of nature having existed from the earliest ages in every clime, under every religion (a part of the cult of many, in fact). It has been attacked with merciless severity, absolutely forbidden, crushed out, "regulated," and with only one effect, to cause it to flourish with greater vigor and wider effect. "Regulation" simply does not "regulate," but increases clandestine intercourse, lessens marriage-rates, lessens fear of arrest and of infection, and increases illegitimacy.

Prostitution is a huge garbage dump, a sewer, a crematory. It draws into it women mainly of the lower class or most degenerate impulses. It cuts short their life expectation. It practically sterilizes them. Very few of them marry, and these are mostly infertile. Only a very small per cent. reform. The chief motives leading to this trade are idleness and love of dress and bad family surroundings. This class of women we can best spare. As to the men, if they get gonorrhœa, they sterilize their wives by salpingitis; if syphilis, they either refrain from intercourse, or abortions result until the virus has run its course.—*South. Cal. Prac.*

THYROID GLAND IN TREATMENT OF GOITRE.—

Some time ago Dr. P. Bruns, Professor of Clinical Surgery at the Medical Faculty of Tübingen, announced that he had obtained very encouraging results in the treatment of goitre from ingestion of the thyroid glands of sheep or calves (*The Medical Week*, 1894, p. 526). At that time his experience was limited to 12 cases of goitre, but he has since had occasion to employ this treatment in 48 additional cases, the total number of patients, consequently, being 60, which is amply sufficient to warrant one's drawing definite conclusions as to the therapeutical results.

Of Professor Bruns' 60 patients, 14 were completely cured, the thyroid gland having resumed its normal dimensions; in 20 the result obtained was practically equivalent to a cure, seeing that the reduction in size of the hypertrophied thyroid, though incomplete, was nevertheless very considerable, and the disturbances due to the presence of the cervical tumor had entirely disappeared; 9 patients had improved—that is to say, there was marked decrease in the size of the goitre and the intensity of the disturbances which it determined; in 17 cases the effect of the treatment was *nil*.

One important fact, which Professor Brun had already noticed in the first series, is rendered more prominent than ever, now that he has at his dis-

posal a much larger number of observations for comparison; it is, that the age of the subject has a great deal to do with the therapeutical results. In this respect the patients in question may be grouped in four categories: The first group comprises 7 children from one to ten years of age, all of whom recovered completely. The second group comprises 28 patients from ten to twenty years of age, of whom 21 were cured (the tumor disappearing completely in 7 cases, while in the other 14 a certain enlargement of the thyroid gland persisted, although the morbid disturbances subsided entirely), 4 improved, and three only were refractory to the treatment. In the third group of 14 patients between twenty and thirty years of age, there were 4 clinical recoveries, 3 improvements, and 7 failures. Lastly, in the fourth group of 11 individuals between forty and sixty years of age, there were 2 cases of clinical recovery, 2 of improvement and 7 of failure.

The thyroid treatment, therefore, speaking generally, is the more efficacious the younger the patient. More particularly as regards complete cure, anatomically or clinically considered, of the hypertrophy of the thyroid gland, it is hardly likely to take place unless the patient is under twenty years of age.

The preceding considerations evidently apply only to purely hyperplastic goitres, for thyroid medication can have no effect when the goitre has already undergone cystic, colloid, or fibrous degeneration.—*Medical Week*.

A PATIENT WITH A SILVER TESTICLE.—In weak-minded men the generative organs are not infrequently a fertile source of hypochondriacal delusions. In such cases the slightest deviation from what is believed to be the normal condition of the parts, or their functions, is magnified at once into a physical defect. But where the mental calibre is wanting in the patient, nothing is more difficult than to make an impression for good, with sound advice and reiterated exposure of fallacies, such as, for example, is the case with those unfortunate persons who have perfectly convinced themselves that "something is wrong" with their generative organs. A notable instance of this has been recorded in the current number of the *American Journal of Insanity*, by Dr. Hermance. A young man, aged twenty-one, consulted the author in consequence of having only one testis, a defect which had preyed upon his mind even from his childhood, and so much so lately, that he had been unable to sleep. On examination it was found that the left testis had not descended into the scrotum, but in all other respects the parts were in a perfectly normal state. The position of the retained testis precluded any attempt being made to bring it down, and, despite the patient's urgent entreaty to have something done, he was advised

that nothing was necessary. In a few days' time the man returned and confided to the author that he was about to be married, that he had made up his mind that he could not have any children unless he possessed two testicles, and that he would not marry until the defect was made good. Under the circumstances, therefore, the author, after consultation with a colleague, agreed to attempt to bring the retained testis down. But this attempt had to be abandoned. Accordingly, the patient was informed of the result, and he immediately said, "Why can you not introduce an artificial testicle." This suggestion was acted upon. A model of an ordinary-sized testicle was made in silver, and on an appointed day the patient was chloroformed, the tunica vaginalis opened, the silver testis introduced, and the wound afterwards closed. The patient in five days' time was out of bed; he returned to business, and has ever since worn the silver substitute for the absent organ. His marriage took place shortly after the operation, and he has become the joyful father of two children. All's well that ends well.—*Med. Press.*

TREATMENT OF AFFECTIONS OF THE HEART FOLLOWING INFLUENZA.—Dr. Ernest Sansom gives an account in *The Practitioner* of the nervous disturbances of the heart following influenza, and adds some practical points in treatment. For influenza itself, Dr. Sansom seems to rely chiefly on sulpho-carbolate of soda in half-dram doses, for what reason he does not tell. He adds to this, however, when needed, quinine and phenacetine for fever, and, in adynamia, five grains of musk.

The signs and symptoms referred to the heart resulting from influenza, in cases under the writer's observation were thus distributed: In one hundred cases: pain referred to the heart, twenty-three cases; the rapid heart (tachycardia), thirty-seven cases; the irregular heart (arrhythmia cordis), twenty-five cases; the slow heart (bradycardia), five cases; organic disease of the heart, ten cases.

In heart pain he give a hypodermic of morphia with a diffusible stimulant, such as: Spiritus etheris, ʒ ss.; spiritus ammonia co., ʒ ss.; tinct. aumbul, ʒ ss.; aquæ camphoræ, ʒ iss.; to be taken as a draught before the administration of morphia, and repeated an hour afterward. Once the severity of the pain is thus mitigated, other agents than morphia should be employed. Quinine in five-grain doses dissolved in hydrobromic acid is often very effectual. Local sedative and counter irritant applications may also be required.

Tachycardia after influenza is sometimes not noticed, and the pulse may not be much above 100. Some of the vaso-motor and eye symptoms of Graves' disease may be present. Dr. Sansom regards digitalis and strophanthus as not only

useless but dangerous, and he also avoids opium. He prescribes bromides with arsenic and symptomatic drugs for dyspeptic symptoms which are apt to be present. In many cases drugs are of no avail, and he advises that a mild galvanic current be given three times a day for six months! He states truly that patience is required. The irregular heart is usually associated with symptoms like those with tachycardia, and much the same treatment is indicated.

Bradycardia sometimes occurs, and may be severe and persistent. In one case the pulse fell to 19 per minute. Phenacetine and camphor with local warmth and counter-irritation are effective in mild cases. In the more obstinate tincture of belladonna may be given in ten-drop doses.—*Medical Record.*

PARALYSIS CONSECUTIVE TO A PSEUDO-MEMBRANOUS ANGINA RECOGNIZED AS NON-DIPHTHERITIC BY THE BACTERIOLOGICAL EXAMINATION.—Under the above title Bourges (*Archives Experimentelle de Pathologie*) describes a case with the clinical picture of diphtheritic paralysis, but in the throat of which no Klebs-Löffler bacilli were found. The case occurred in a boy of seven years, in whom appeared suddenly high fever, headache and pain in the throat. The next day the tonsils were gray and swollen, but no false membrane was present. Two days later the local signs had gone. Nine days from the first attack a second attack of malaise and fever occurred, with marked erythema on the neck, forearms and limbs, but not on the trunk; the throat was normal, and the eruption disappeared two days later without desquamation.

A week from the beginning of this second attack the patient was taken with headache, fever and sore-throat, and the next day a white, easily detachable false membrane was present over the tonsils; this remained until seventeen days later, when it had entirely gone, and the child was in fair health, though remaining pale and thin.

Sixteen days after the disappearance of the membrane the child became restless at night, and the next day complained of abdominal pain and headache; a little fever was present.

Two days later convergent strabismus developed, followed in forty-eight hours by usual intonation of the voice and regurgitation of liquid food.

The regurgitation disappeared in a short time, but three days after its appearance the child was unable to stand, though still able to move its limbs in bed.

The paralysis remained incomplete, sensation normal, knee-jerks absent. Cure was complete at the end of two months.

The bacteriological examination of the false membrane showed the only virulent organism

present to be the streptococcus pyogenes. The child's mother, who had been constantly nursing him, was attacked during his illness by a similar pseudo-membranous angina in which the sole pathogenic organism was the streptococcus pyogenes.—*Amer. Jour. Med. Sci.*

THE PARASITES OF MALARIA.—Professor Wm. Osler, of Johns Hopkins University, communicates some general conclusions on parasites observed in types of malarial fevers in and about Baltimore. The observations cover more than 600 cases, in all of which the blood has been carefully studied. Three varieties of the malarial parasite are distinguished, viz.: (1) the tertian parasite; (2) the quartan parasite; (3) the estivo-autumnal parasite.

(1) The *Tertian Parasite* requires about forty-eight hours to accomplish its complete development, and is associated with relatively regular tertian paroxysms, lasting on an average between ten and twelve hours, associated almost always with the three classical stages—chill, fever and sweating. Infection with two groups of tertian organisms frequently gives rise to quotidian paroxysms; infection by multiple groups of organisms rarely give rise to more irregular subcontinuous fevers.

(2) The *Quartan Parasite* is an organism requiring about seventy-two hours for its complete development. It is rare in this climate, and is associated with a fever showing regular quartan paroxysms similar in nature to those associated with the tertian organisms. Infection by two groups of the parasite causes a double quartan fever (paroxysms on two days, intermission on the third). Infection with three groups of the parasite is associated with daily paroxysms.

(3) The *Estivo-autumnal Parasite* passes through a cycle of development, the exact length of which has not yet been determined. It probably varies greatly from twenty-four hours or under to forty-eight hours or more. But few stages of development of the parasite are found ordinarily in the peripheral circulation, the main seat of infection being apparently in the spleen, bone marrow and other internal organs. Infection with this organism is associated with fevers varying greatly in nature. There may be a quotidian or tertian intermittent fever, or more commonly a more or less continuous fever with irregular remissions. The individual paroxysms last on an average about twenty hours. The irregularities in temperature depend probably upon variations in the length of the cycle of development of the parasite, or upon infection with multiple groups of organisms.—*Br. Med. Jour.*

LEUCORRHOEA IN THE UNMARRIED.—In the treatment of leucorrhœa in young unmarried

women, instances frequently occur in which the usual practice of making an examination to ascertain the condition of the pelvic viscera is so obnoxious to the patient, or so firmly opposed, that the physician is forced to abandon it and have recourse to medicine.

In such cases, Dr. Slocum (*Cincinnati Lancet-Clinic*) depends upon the specific action which cantharides appears to exercise upon the cells constituting the genital as well as the urinary system. It is probable that by direct stimulation of the cells just to the point of successful resistance, the benefit is secured, as the dose is very small. Strangury or other unpleasant symptoms have not been produced. The action of the drug has been so uniformly satisfactory that when it fails such result forms a strong basis for suspecting the presence of something more than simply hyperæmia or mild inflammation. Lessening of the discharge is sometimes noted within five days, but in several cases of profuse discharge of four years' and longer duration the treatment was not successful until after a month's persistent use.

The formula which has seemed the best is:

| | |
|--|------------------------------|
| Tincture of cantharides, | 96 minims. |
| Tincture of ferric chloride, | 160 " |
| Dilute phosphoric acid, | 160 " |
| Syrup of lemon, | 2 fluid ounces. |
| Water, | sufficient to make 4 ounces. |

One teaspoonful, in water, after meals.—*Maryland Medical Journal.*

HEADACHE.—Dr. Lauder Brunton says that one great difficulty which is to be met with in treating nervous headaches, or so-called bilious headaches, is that once the headache has become severe both secretion and absorption from the stomach are generally arrested, and that any medicine which is taken by the mouth when the headache is fairly begun lies in the stomach unabsorbed and useless. Consequently it is sometimes almost imperative to treat such cases, when the headache is intense, by the subcutaneous injection of morphine. It may not infrequently be noticed that if the headache comes on shortly after food has been taken, for example an hour or half an hour after breakfast, the secretion will have occurred before the pain has commenced, and the gastric juices will dissolve the food. But the food will not be absorbed and will be brought up in full quantity, but well digested, many hours afterwards, say in the evening. Should the headache, however, have become well established before breakfast, and food be taken, notwithstanding the pain, the gastric secretion is often arrested, so that the food will be returned, unchanged, at night.

In consequence of this want of absorption, drugs administered by the mouth, after the pain has

become severe, are of little or no use ; but if taken before absorption has ceased, they frequently act like a charm upon the headache.

This is especially true of antipyrine. Some very severe cases call for subcutaneous injection of morphine. Dr. Brunton highly praises a combination of salicylate of soda and bromide of potassium in these headaches, about half a drachm of bromide and 10 or 15 grains of salicylate in half a tumbler of water, at bedtime, and again in the morning, if necessary.—*Ex.*

THE FALLACY OF EARLY RISING.—Proverbs are responsible for a great deal of folly, and none perhaps for more mischief under the present conditions of town life than those which inculcate early rising as a virtue. When the great majority lived in villages and were engaged in the cultivation of the soil, early rising may have been conducive to health and wealth, if not to wisdom, but even our early forefathers probably did no more than make a virtue of necessity. It is said to be natural—that is, physiological—to rise early and enjoy the beauties of the sunrise ; if we ask why, we are treated to various transcendental theories about the vivifying influence of the sun, and are told to take example by the birds of the air and the beasts of the field, or so many of them as are not nocturnal in their habits. But as a matter of fact physiology, so far as it has anything to say on the subject at all, is all against the early rising theory. Physiological experiment appears to show that a man does not work best and fastest in the early morning hours, but on the contrary about midday. The desire to rise early, except those trained in youth to outdoor pursuits, is commonly a sign, not of strength of character and vigor of body, but of advancing age. The very old, often sleep much, but they do not sleep long. A long deep sleep, the sleep of youth, requires for its production a thoroughly elastic vascular system. The stiffening vessels of age are not so completely nor so easily controlled by the vasomotor nerves. Hence shorter sleep. Thus paterfamilias, who goes to bed at 11 P.M., wants to get up at 5 or 6 A.M., and looks upon his healthy son, who prefers to lie till 8, as a sluggard. When this foolish interpretation of a proverb about the health and wealth to be got from early rising is combined with the still more foolish adage which says of sleep : Six hours for a man, seven for a woman and eight for a fool," then we have a vicious system capable of working great mischief to young people of both sexes. There is a tendency, greatly encouraged in towns by the spread of cycling, to curtail unduly the hours of sleep. Parties of young men and lads are to be met careering about the streets at midnight. They would be far better in bed. They have probably to be in their offices or shops by 9 A.M., or

even earlier and when time is deducted for supper, toilet, breakfast and the journey to the place of business, it is evident that the hours for sleep cannot exceed six, or at most seven. These young men are no doubt encouraged by the silly adage quoted above. There is a disposition in town youths to overdue outdoor exercise ; the cycling club "night spins" are instances in point. As Nordau has said, with a great deal of truth, the town-dweller of these last decades of the nineteenth century suffers from nervous fatigue, and is so ill-advised as to make his very recreations sources, not of recuperation, but of increased exhaustion. If our forefathers were early risers they went also early to bed. It would be well for the rising generation if it paid more heed to this part of the proverb.—*British Med. Jour.*

DISINFECTATION OF ROOMS.—Dr. Sheridan Delépine (*Med. Chronicle—Am. Jour. of Med. Sci.*) recommends bleaching powder in solution for the disinfection of poor lodgings in which tuberculous patients have lived, because : "(1) The parts to be disinfected would necessarily be saturated with moisture ; (2) chlorine, in the nascent state, would be generated where it was not wanted, and much smaller quantities of disinfectant would be therefore sufficient ; (3) there would be no necessity to use any complicated contrivance to secure the diffusion of chlorine, or to prevent its escape, though it might be well to keep the air saturated with moisture to prevent the too rapid drying of the walls ; (4) the assistants could apply the material without discomfort, and much less intelligence would be required on their part in the carrying out of their duties ; (5) after the application of the solution, chlorine would continue to be evolved as long as all the chlorinated lime had not been decomposed, and that without anything further to be done after the first two or three hours ; (6) the rooms would be fit for use as soon as dry again, and no poisonous substances would remain attached to their walls, as when perchloride of mercury is used ; (7) if necessary, it is easy to increase its activity by adding acids to the solutions, or by saturating the air of the rooms with acid fumes, and raising the temperature for a few hours."

Three series of experiments to demonstrate the efficacy of this method yielded entirely satisfactory results. The method of procedure is as follows : (1) A solution of chlorinated lime (1-10) should be prepared. (2) The walls, ceilings and floor should be washed with this solution, applied in the same way as lime or whitewash is usually applied. (3) This process should, for safety, be repeated two or three times in succession. By starting each time at the same corner of the room each layer would have time to penetrate into the paper and partly dry before the next is applied.

(4) The room should then be closed as well as possible, a small, safe petroleum-stove being first placed in the middle of the room, precautions being taken to prevent any chance of fire. Over this stove a large tin basin, full of water or chlorinated-lime solution, should be placed. (By a devised water-bath arrangement a small capsule full of strong acetic acid or hydrochloric acid might be placed over the boiling water, and in this acidity of the air would be secured. This would cause a more rapid setting free of chlorine.)

"Chlorinated lime itself does not spoil things as much as one would expect, and can be used as indicated without any fear of damage in rooms from which all hanging and carpets have been removed, provided the walls and ceilings are not decorated with valuable paintings or papers. In the poor dwellings it is evident that this is not an obstacle to its use. Small petroleum-stoves, perfectly safe and giving much heat, can be obtained for a few shillings, and large tin dishes for a few pence."—*Gaillard's*.

DIPHTHERITIC PARALYSES.—Dr. Felsenthal, of Hannheim, very interestingly reviews this subject, the essential facts of which are as follows:—

Even during convalescence from diphtheria, death may take place suddenly from paralysis of the heart. Paralysis of the heart may occur at any stage of the disease, and as late as six weeks after every local symptom has disappeared, hence the advice of Hensch is apposite: "Never give a favorable prognosis in diphtheria until six weeks have elapsed, since all local symptoms have disappeared. Paralysis of the heart is preceded by the following symptoms: apathy, pallor, insomnia, anorexia, emesis and precordial pain. The heart tones are distant; the second tone shows the gallop rhythm, a certain sign of cardiac weakness. The pulse is weak and arrhythmic; the liver, in consequence, of stasis, is enlarged, the respirations are increased, and, at the termination of the sickness, merges into the phenomenon of Cheyne Stokes. If the case terminates in recovery, which is rare, the heart tones become stronger and less irregular, and after weeks or months recovery can be perfect. The cause of the cardiac relapse is now supposed to be myocarditis. The treatment of cardiac collapse is almost negative, the essential object being to maintain the strength of the heart until the diphtheritic intoxication is overcome. Diphtheritic paralyses usually follow the milk, rarely or never the gangrenous or septic cases. Paralysis of the velum is manifested by nasal voice, regurgitation of food into the nose, and anaesthesia of the palate and pharyngeal wall. In connection with this form of paralysis, there may be paralysis of the larynx and oesophagus, and motor weakness of the extremities; anaesthesia may also occur. Muscular paresis of the trunk

and upper extremities may develop later; paresis of accommodation, and paresis and paralysis of the facial, oculomotor, and abducens may occur. Relative to the cause of diphtheritic paralysis, it is conceded to be dependent on a neuritis of the peripheral nerves; changes in the spinal cord, however, may co-exist. The infectious neuritis begins in the nerve endings contiguous to the primary point of infection, and travels further along the nerve sheaths. The light forms of paralysis recover spontaneously, whereas the gaver forms demand active treatment. The writer details the conventional methods of treatment, but emphasizes the use of the soft rubber tube for the purpose of conveying nourishment to the stomach. This method of treatment has the double advantage of conveying food to the stomach when swallowing is difficult, and prevents, if anaesthesia of the larynx and paralysis of the epiglottis exist, the entrance of food into the larynx and bronchi. —*Den Kinder Artz; Occid. Med. Times*.

ABORTIVE TREATMENT OF ERYSIPELAS—I don't know that I am strictly warranted in using this term, for I doubt whether there is, or can be, such a thing as aborting erysipelas, and yet I do believe the treatment I have adopted for the past twelve months comes as near to it as possible. I have treated in all eight cases, the average duration being a little less than four days. Five of the eight cases were facial, the remaining three of the lower extremities. The following formula was used in each individual case:—

R—Ichthyol, ̄ iiss.
Collodion flex., ̄ iss. — M.

This was directed to be applied every three hours, always commencing the application about one inch beyond the line of demarcation between the healthy and inflamed skin. I believe this to be of the greatest importance. By adopting this method you will in nearly every case prevent the spread of the disease. The strength of the solution can be varied if thought best, but after several trials I have found the one suggested the more reliable. A great deal will also depend on the quality of the collodion. If good it will not crack and peel off in a few hours, but, on the contrary, will adhere firmly for some time, affording a perfect protection to the surface. In case it becomes loose and partially detached from the surface, it should at once be removed and followed by a fresh application. At no time should the surface be left exposed longer than possible.—*Lancet-Clinic*.

HEADACHES OF PREGNANCY.—These, if persistent, should always be regarded with suspicion, *Glasgow Med. Jour.* They too frequently give evidence of uremia and threatening eclampsia.

THE CANADA LANCET

A Monthly Journal of Medical and Surgical
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TORONTO, JULY, 1895.

Editorial.

THE ONTARIO MEDICAL COUNCIL.

This body, of which so much has been written and said in Ontario, has just finished its deliberations. Usually one week suffices for the completion of the work, but owing, we suppose, to an increase in oratorical material, this year it has required nearly *two weeks* to make all the speeches which some of the members thought essential to be made.

This was to have been the meeting of meetings. This was to have shown the admiring province, not only professional, but lay, what a little leaven could do. What about the expenses of this meeting? We have heard much about the down-trodden Doctor and his paltry fee of *two dollars* a year, which some of them, however, have been very careful not to pay; and of the expensive and wasteful methods of the old Council. If we are not entirely misinformed, the expense to the profession of the meeting will be, not in the neighborhood of \$2,500 as heretofore, but nearly twice that sum.

We hold, however, and have always held, since the inception of the movement against a two dollar fee, that objection to the payment of such a sum, is idle and paltry, and not worthy the consideration of any doctor in this province; and that objection to its enforced payment has been made largely from ulterior motives. So that if

any improvement in the manner of legislation has obtained, or any benefit to the profession has accrued, then let us pay this much increased bill gladly and freely. But if it be shown when the whole result of this session is totted up, that the time of the Council has been spent in useless and childish altercation and obstruction, then the profession will have a right to call the Council to account, or at least those members of the Council who have been instrumental in adding to the already too heavy money liabilities of that body.

The most important matters which have taken form, are first, the curriculum for matriculation. It will be seen when the proceedings come before our readers, that there has been a slight increase in the difficulty of this examination. The Chairman of the Educational Committee is to be congratulated upon having successfully carried on the raising of the standard, the old policy of the Council, without making so great a leap as to injure those who are already on their way to the study of medicine. We think the change judicious and wise.

The advance is quite in line with what has gone on for years past, and, strange as it may seem, the committee this year consisted of eleven men, *seven* of whom were *school men*. This quite takes any point out of the oft-repeated cry that the school men were adverse to the raising of the standard.

Another matter which met with universal endorsement is the five years' course. There can be no doubt that a five years' course of study, should, if the authorities see well to how these five years are spent, give the Province a better class of men than the old four years' course. We are still, however, of the opinion that we are too young and too poor a country for such course.

Then the question of an eight months' session in lieu of the present six months' course for medical students was taken up. Very properly the Council decided to wait till all the universities shall be heard from. We shall probably have something to say at a later date as to the proposed change. There may be something to say in favor of it, certainly there is a great deal to say against it.

Then as to the printing contract. The outcome of the lengthy discussion on this question teaches a valuable lesson as to what may be done by persistent effort in even so pure and

intelligent a body as our Council. If a number of members go into session pledged to a certain course, and no amount of argument can move them, then discussion is idle, principle is nothing, and money can be saved to the profession by letting a manifest wrong go by default.

We still maintain that the subsidizing of one journal to the exclusion of all others, and that one journal the mouthpiece of the Council, though not its official organ (something of a paradox this), is a gross wrong which should be righted at the earliest moment possible if the Council wish to retain the respect of the profession of this Province.

It is a matter for congratulation that the question of fees is settled, though the compromise is, we think, regrettable. Time will soon remove the weak spot in the by-law, and then, when every practitioner shall pay his annual two dollar fee, again let us insist a paltry sum for the protection given him, we shall have our College out of financial difficulties, and able to maintain an institution worthy of the medical profession of this, the banner Province of our Dominion.

NOURISHMENT IN TYPHOID.

We can all remember when milk was the only food allowed in enteric fever, from the time a diagnosis was made till from seven to ten days after the temperature struck the normal line. Those of us who have had much experience with the disease have little fault to find with the result of such feeding, except the complaints of the patients, especially in the last ten days of the milk term. Clinically milk, and milk alone was all right. But science and reason got to work, and young, progressive, thinking and writing physicians began to add various other matters to the dietary, even during the height of the fever. Animal broths, beef tea, calves' foot jelly, raw meat juice, vegetable broths, clear soups, fruit soup, beaten-up egg, with or without stimulants, peptonized foods, Mellin's, Nestle's, flour ball with milk, milk toast, oatmeal gruel, oysters, barley water rice water, etc., were allowed when the patient showed a disinclination for milk, and during convalescence many other articles were added, some of them solid, at once when the temperature reached the normal.

Many older and experienced physicians, in spite of apparent scientific reasoning, have clung to the pure milk diet. Long and varied experience has been more to them than an accurate knowledge of the different processes of digestion of various articles of food, no matter how completely worked out, and though called old fogeys, by the young progressive physician, they have stuck to their position.

We believe that a typhoid case will do better on a pure milk diet, judiciously carried out, than on any other. Experience with the two methods carried on side by side, was the reason for this belief primarily. The pure milk patients had less complications and more recoveries than those who had a mixed diet. Brieger, has quite recently, by a series of investigations, shown why this is so.

Eberth's bacillus does not readily reproduce itself and its poisons in peptones and well-digested milk, but it does very actively in meat broths, and jelly which has not been acted upon by the digestive juices.

He has shown that these bacilli generate two poisons, "one of which causes, when given to animals, salivation, paralysis and diarrhoea; the other, violent and exhausting diarrhoea alone."

This explains why better results are obtained from a pure milk diet; and as Hare says, we are able once more to explain a clinical fact by a scientific discovery.

Many physicians, who, five years ago, allowed a wide range of food in typhoid, now keep pretty strictly to milk, and we think with much benefit to their patients.

ACUTE PERIMENINGITIS.

Among the latest diseases that have become recognized by diagnosticians, is acute perimeningitis. According to the *New York Medical Journal*, April 6th, 1895., M. Theulier, of Paris, has given an elaborate and scientific dissertation upon this very rare disease. He states that acute perimeningitis is an inflammation of the cellular fatty tissue around the cerebral dura. Its evolution is sometimes acute, spontaneous, with no appreciable pathogenic cause, and sometimes secondary, with cellulomuscular inflammation near the spinal col-

umn. The symptoms resemble somewhat those of ordinary meningitis. It begins with sharp pains, with alternate remissions and exacerbations in the legs and along the spine, which are accompanied by stiffness of the limbs or of the neck. At the same time there is fever and constipation. Afterwards there are pains in the abdomen and along the lumbar region, also in the legs. During the suppurating period, when the spinal canal is invaded with pus, the disease becomes infectious; sometimes paralysis of various muscles occur, and death occurs in a short time. In this evolution the meningitic symptoms may fail to show themselves, and the diagnosis is consequently rendered more difficult.

The differential diagnosis of acute perimeningitis is at times somewhat difficult, but with sufficient care it should not fail to be recognized. From cerebral meningitis it is differentiated by the absence of the meningitic tripod, of ocular complications, and the typical course of the temperature. Cerebro-spinal meningitis is epidemic and associated with infectious localizations in the lungs and in the heart, and its characteristics are distinct from those of acute perimeningitis. In the diagnosis, on the other hand, of acute spinal meningitis great difficulty often arises, although in the beginning the early development of the paralysis is a symptom of the disease. If it appears later on, there is reason to believe that it is a question of acute perimeningitis.

Perimeningitis, says M. Theslier, may be confounded with typhoid fever, osteomyelitis, and rheumatism. For this reason, in the analysis of the symptoms, we should remember that perimeningitis shows three different types in the beginning: A subacute type, with violent invasion, chills, headache and renal pains; an acute type, the first symptoms of which resemble lumbago, and which is accompanied by insomnia, pains, cramps, and febrile movement; and the third type, which is slow, developing slowly for several months before the symptoms appear. The treatment of acute perimeningitis in the beginning is the simple expectant method, and, where it is possible, operative opening of the spinal canal.

We shall be pleased to send sample copies of this Journal to any address upon application.

THE ONTARIO MEDICAL ASSOCIATION.

As we are sending out with this issue a full report of the proceedings of the Ontario Medical Association, very few words need be said here. We wish to refer, however, to the fact that the meeting was quite as successful, if not more so, than any former meeting of the Society. Too much praise cannot be given to the Committee of Arrangements; everything went smoothly. The programme was got through, and discussion was pretty full and varied. The place of meeting was, on the whole, better than the Normal School, being nearer the business portion of the city and the hotels.

A good deal of influence was brought to bear to have Windsor as the place of meeting for next year. This may be all right, but we fear it will be more difficult for those who have the management of affairs to secure as large and representative an attendance at so extreme a point to the west. Let us hope, however, that this may not prove true, and that Windsor may have the glory of the bumper meeting of the Association.

By our report it will be seen who are the officers for next year. The President, Dr. Grasett, of Toronto, is well chosen as a popular and able man to fill the position.

We must refer to the admirable way in which the late President, Dr. Bruca Smith, performed his onerous duties. No better President has ever occupied the chair at the meetings of the Society.

HOW TO TAKE CREOSOTE.—Dr. C. W. Ingraham gives, in the *Medical News*, the following directions: "I give the patient a one-ounce bottle of creosote and an empty eight-ounce bottle. Upon the eight-ounce bottle I place the following label: '*Directions*.—After putting in the correct number of drops, according to directions on the small bottle, fill with cold water and take the entire contents of the bottle during the day, in equally divided doses, at regular intervals. Make at least six or eight doses. Shake thoroughly each time before taking.'

"Upon the bottle of creosote this label is pasted: 'Put four drops in the eight-ounce bottle, and take according to the directions on that bottle. The second day put in five drops, and the third

day put in six drops, etc. Continue to increase one drop per day, until twenty-four drops are taken daily. Do not increase beyond twenty-four drops without instructions.'

"One ounce of creosote will last the patient a full month at the beginning, but after the first month two ounces will be taken each month. Creosote in this form may be entrusted to the care of any intelligent adult, and I have never had an accident to occur from the method. As the daily amount reaches from twelve to fifteen drops, it will require further dilution. The dose can be emptied into a glass tumbler and a sufficient additional quantity of water quickly added. By this method the patient has a fresh preparation daily, and when taken in this highly diluted aqueous suspension it is wholly non-irritant to the mucous membrane of the mouth, throat, or stomach. When desirable, a small amount of some one of the vegetable bitters may be added each morning to the eight-ounce bottle, which will assist in stimulating the appetite."

THE EVILS OF NIGHT WORK FOR CHILDREN.—Sir James Crichton Brown, speaking on the subject of pursuing young children with lessons into their home life, says, *Charlotte Med. Jour.*: "It seems to me high time for a declaration of rights on behalf of helpless children, and on behalf of future generations also, whom, if we are not careful, we shall load with a burden more grievous than the national debt—a burden of degeneration and disease. I trust that some one of my medical brethren will bring this subject to the front and obtain an emphatic condemnation of 'home work' in the case of children under twelve years of age. I have encountered many lamentable instances of derangement of health, disease of the brain, and even death, resulting from enforced evening study in the case of young children, with the nervous excitement and loss of sleep which it so often induces, and I am fully persuaded that even when it does no perceptible injury to health, it is inimical to true progress. To pursue young children with lessons into their home life, and those hours when they should be roaming fancy free, is to embitter their existence and that of their parents, and to endanger their symmetry of growth. It is indisputable that evening work by artificial light is peculiarly detrimental to vision and conducive

to that short-sightedness which is increasing amongst us so rapidly, and that it tends more than day work to cause deformity of the spine."

THE TREATMENT OF FRACTURES.—Bunts (*Med. News.*), after an instructive paper on the treatment of fractures, terminates his paper as follows:

The indications for the treatment of fractures are positive and fixed.

All fractures should be adjusted at the earliest possible moment consistent with the obtaining of proper appliances or assistance.

We should not wait for inflammation to subside before placing the fracture in some kind of a retention apparatus or splint.

Chloroform should be administered more frequently to facilitate diagnosis and adjustment.

When properly reduced there is comparatively slight tendency to redisplacement.

Simple splints are to be preferred to moulded ones.

Use the splint that best fulfils the indication, regardless of preconceived ideas.

Non-permanent are ordinarily to be preferred to permanent dressings.

Dressings should be opened up and fractures examined not later than the second day.

Rest and elevation are the best means of combating inflammation.

Cold is not contra-indicated in robust patients, particularly if the fracture extends into a joint.

Pain is best relieved by revision of the dressings. Early passive motion and frequent massage are the best means of restoring function.

TRANSIENT CLUBBING OF FINGERS DURING EMPYEMA.—Schon (*Ugeskrift for Læger, Times and Reg.*), reports the following case: A girl, aged 10, presented symptoms of a localized pneumonia in the upper part of the lower lobe of the left lung, which later spread over the whole lung. As the disease did not progress in the orthodox manner and the temperature kept high an empyema was suspected. On the seventeenth day of illness there were physical signs of fluid, and pus was withdrawn by the aspirator. The following day the usual operation was performed, and the same evening the temperature was normal, and remained so throughout the illness. Some time after the operation the deformity of the fingers

was noticed. This became very marked; the terminal phalanges were enlarged, both from side to side and in the dorso-volar direction; the nails were abnormally convex, but their color natural. The deformity quickly disappeared, and by the time the sinus had closed the patient's fingers were quite normal again. The author regrets his neglect to make a bacteriological examination of the pus evacuated from the pleura, as he thinks affection must in some way be connected with pyogenic bacteria or their products. It has been noticed in connection with other suppurating processes, as, for instance, by Marfan in a case of pyelonephritis. The author has found only four similar cases previously published, two by Maigard.

FIBROIDS AND CONCEPTION; PREGNANCY AND LABOR.—Dr. Hofmeier (*Zeitscher. f. Geburtsc. u. Gynak*) in a very complete and well-tabulated essay denies that fibroid diseases of the uterus has any direct influence in causing sterility. *Med. and Surg. Rep.* Statistics do not show that, as has been alleged, subserous myoma predisposes considerably to sterility, whilst polypi and myoma of the cervix have little influence in that direction; nor can it be shown that fibroids promote sterility. These tumors seldom begin to appear till late in sexual life, so that if the patient is barren or a multipara the causes of her sterility or fecundity must have influenced her long before the development of her fibroid.

The alleged frequency of this disease in elderly virgins is based on a fallacy. It is the local affection which the most readily drives a spinster to the gynecologist, whilst middle-aged married women trouble less about small and slow-growing abdominal swellings. Women with fibroids who marry late in sexual life are fairly fertile, though Hofmeier can hardly make out cause and effect in this fact. Fibroids by no means strongly predispose to abortion. It seems that this accident happens only when the uterine cavity is rendered unfit to bear through the size and relations of the tumor; nor does fibroid greatly interfere with the uterine contractions during labor. The best time for hysterectomy is not immediately after delivery, but a few weeks or months later.

PERIOD OF INFECTION.—The Pennsylvania State

Board of Health has adopted the following regulations in the diseases mentioned below:

Small-pox—Six weeks from the commencement of the disease, if every scab is fallen off.

Chicken-pox—Three weeks from the commencement of the disease, if every scab has fallen off.

Scarlet Fever—Six weeks from the commencement of the disease, if the peeling has ceased, and there is no sore nose.

Diphtheria—Six weeks from the commencement of the disease, if sore throat and other signs of the disease have disappeared.

Measles—Three weeks from the commencement of the disease, if all swelling has subsided.

Typhus—Four weeks from the commencement of the disease, if strength is re-established.

Typhoid—Six weeks from the commencement of the disease, if strength is re-established.

Whooping Cough—Six weeks from the commencement of the disease, if all cough has ceased.

Under judicious treatment the periods of infectiousness may be considerably shortened.

Length of Quarantine—Teachers, or children, who have been exposed to infection from any of the following diseases may safely be re-admitted to the school, if they remain in good health (and have taken proper means for disinfection), after the following periods of quarantine:

Diphtheria, twelve days; scarlet fever, fourteen days; small-pox, eighteen days; measles, eighteen days; chicken-pox, eighteen days; mumps, twenty-four days; whooping cough, twenty-one days. Adults may be re-admitted immediately, if they disinfect their clothes and persons.

THE TREATMENT OF MORNING DIARRHŒA.—Francis Delafield, M.D., says, *Med. Rec.*:—Under the term of morning diarrhœa, the writer designates a group of cases in which there is a tendency to one or two loose movements of the bowels during the early morning hours. The pathology and etiology appear obscure. In some cases there may be no disturbance of the general health. In others, the exhaustion is so great that attention to business or work is impossible. Those cases in which we meet with considerable mucus in the discharges are the most unyielding to treatment. His recommendations for treatment are change of climate, especially a prolonged residence in a dry inland climate, a careful dietary, and occasionally

lavage of the stomach. In the matter of drugs, opium, he says, effects no permanent improvement. His results from the use of the subnitrate and the subgallate of bismuth and of beta-naphthol bismuth have not been satisfactory. Salol and naphthalin answer well in a few cases, but have absolutely no effect in others. Arsenic, quinine, ipecac, belladonna, and cannabis are occasionally useful, but the drug which has given him the best results is castor oil in doses of five to ten drops.

TREATMENT OF EPITHELIOMATA.—Professor John A. Wyeth, M.D., in a clinical lecture delivered at the New York Polyclinic, *International Journal of Surgery*, speaks of the benefit he had derived from the use of arsenious acid in the treatment of superficial epithelioma. He says: If I had a superficial epithelioma develop anywhere on my body where I could use Marsden's paste, I would prefer that method of treatment to the knife. In cases where the disease has existed for so long a period that the paste alone can not be relied upon, I would prefer to have the malignant process first cut or scraped away, and then have the paste applied. In this way we get more satisfactory results than by any other treatment I know of.

The formula for Marsden's paste, which I have given a number of times, is as follows:

R—Acid arsenious, ʒ ij.
Gum Arabic, ʒ j.
Cocaine muriate, gr. xviii.

This powder should be made into a paste by adding water when it is to be used; and "the paste should be of the consistency of rich cream, and applied to the wound on a small piece of cloth, and left on from eighteen to thirty-six hours. This can be repeated as often as necessary. The above is the formula for the stronger paste. In the weaker, only one drachm of arsenious acid is used, and twelve grains of cocaine.

THE TREATMENT OF INOPERABLE CANCERS BY THE INTERSTITIAL INJECTION OF SALICYLIC ACID.—Among the methods proposed for the treatment of inoperable cancers, this one proposed by Bernardt (*Cent. f. Gynæc.*) has produced extraordinary results. Not only were the local symptoms (hemorrhages, sloughs, odors, pains, etc.) alleviated and sometimes dispersed, but the general condition of the patient showed marked improvement after a

few days. These results led Tofius, of Moscow (*Rev. Méd de Moscow*), to apply these interstitial injections in seven of his cases, with results which he considers far superior to any other method of inoperative treatment. The injections of salicylic acid produce a rapid diminution in the amount of hemorrhage, and sometimes its complete cessation, and also of the sloughing, lessening the pain, and producing a gain in the general condition of the patient, and finally a retarding in the progress of the disease. These results were obtained by the injection every four or five days, after careful antiseptic, of 1 to 4 cubic centimetres (15 minims to 1 drachm) of a six per cent. alcoholic solution of salicylic acid, repeated seven to thirteen times.

AGAINST "CHRISTIAN SCIENTISTS."—The following is the full text of the measure now before the New Hampshire Legislature to govern and regulate fraudulent medical practice and the so-called Christian science or faith cures (*Jour. Am. Med. Assn.*):

SEC. 1.—No person within the limits of this State shall treat, attempt to heal or cure any other person or persons by the so-called Christian science or faith cures.

SEC. 2.—If any person shall treat, attempt to heal or cure, or claim or pretend to heal or cure any other person or persons by either of said methods, and shall directly or indirectly accept or receive any money or other thing in payment for or on account of such services, or directly or indirectly accept or receive any gift or reward therefor in any form, such person so offending against the provision of this act by so accepting or receiving such money, gift, reward, or other things shall be fined a sum not exceeding three hundred (\$200) dollars for each and every offence, and half of such amount to be given to the complainant, the other half to the State.

SEC. 3.—This act shall take effect upon its passage.

A WORD IN REFERENCE TO THE OPIUM HABIT.—The medical profession has always been responsible for the opium habit of patients or the laity, by its reckless and indiscriminate prescription of anodynes and narcotics—generally used for the treatment of symptoms: rarely does the

routine practitioner make a precise diagnosis before giving opium, if pain is present. *Charlotte Med. Jour.* Opiates are commonly used without a clear recognition of an indication except that of pain. The opium habit is rarely acquired, except it be antedated by pain or an illness for which some doctor has given morphine or some preparation of opium. There is scarcely a remedy in the *Pharmacopœia* used so recklessly and ignorantly, and none doing more general mischief—it has always done thrice as much harm as good. In the general practice of medicine, some of the preparations of opium are to be found in about every prescription. This practice has made thousands of opium eaters.

THE USE OF TRIONAL FOR THE SLEEPINESS OF CHILDREN.—Dr. Klaus, *Lancet*, has used trional in some diseases of children, such as chorea, epilepsy with persistent sleeplessness, and sleeplessness due to indigestion. He has obtained gratifying results, but in one case symptoms of irritation were observed. According to the age he recommends the following doses: one month to one year, 0.2 to 0.4 gramme (3 to 6 grains); one to two years, 0.4 to 0.8 gramme (6 to 13 grains); two to six years, 0.8 to 1.2 gramme (13 to 18½ grains); six to ten years, 1.2 to 1.5 gramme (18½ to 23 grains). The remedy is to be taken in hot milk or honey half an hour after the evening meal.

HIS PARTING BENEDICTION.—*Ram's Horn.*—A country minister in a certain locality took permanent leave of his congregation in the following pathetic manner: "Brothers and sisters, I come to say good-bye. I don't think God loves this church, because none of you ever die. I don't think you love each other, because I never marry any of you. I don't think you love me, because you have not paid my salary; your donations are mouldy fruit and wormy apples; and 'by their fruit ye shall know them.' Brothers, I am going away to a better place. I have been called to be chaplain of a penitentiary. Where I go ye cannot come, but I go to prepare a place for you, and may the Lord have mercy on your souls. Good-bye."

ANTIPYRINE IN PRURITUS.—F. Arnstein, *Gazette Lekaeska*; *Br. Med. Jour.*, has tried antipyrine

internally in powder, 1 gramme at bedtime in two severe cases, one of which was that of a woman, aged twenty-eight, with pruritus nervosus of three months, referred to a woman, aged sixty-six, with inveterate pruritus senilis. In both cases the itching quickly subsided, to disappear altogether in a couple of weeks. Both of the patients had been previously treated by various ordinary methods without obtaining any relief.

INEBRIATES.—The report of the Departmental Division on Prisons (Great Britain), marks a very important advance toward the solution of the problem of chronic drunkenness, *Med. Press*. It is declared that the present system of "sending up" an inebriate time after time for short periods is all wrong; that he ought to be treated as an ill man, and committed to an asylum for a considerable period in order to give him a chance to recover.

VACCINE VIRUS CONTROVERSY.—We would call the attention of the profession to the advertisement of Dr. E. M. Bowker, of Boston, Mass., to be found in another column. It will be seen that the law suit between the Doctor and Mrs. Martin, widow of the late Henry A. Martin, has been decided in favor of the defendant, giving him the right to advertise himself as the successor of the firm of Dr. Henry A. Martin & Son, of Brookline, Boston, Mass.

MESSRS. WM. R. WARNER & Co. have removed their New York Branch to the more commodious and convenient quarters No. 52 Maiden Lane. This change became imperative, the space at their former salesrooms having at last become inadequate to admit of the proper conduction of their largely increased business. There will constantly be on file a complete list of the leading Medical and Pharmaceutical Journals of the United States, and a cordial invitation is extended to the profession to consult them at any time.

THE KOLA NUT.—We have received from Fred. Stearns & Co., samples of the Kola nut, from which they are making their celebrated preparation of "Kolavin." These will be sent to any physician upon application. They may be planted, producing a handsome tree.

Books and Pamphlets.

THE PHYSIOLOGY OF THE CARBOHYDRATES ; Their Application as Food and Relation to Diabetes, by F. W. Pavy, M.D., LL.D., F.R.S., etc., formerly Lecturer on Physiology and the Practice of Medicine at Guy's Hospital. London : J. & A. Churchill. Toronto : Vannevar & Co. 1895. Pp. 280. \$2.50.

To any one interested in the carbohydrates, this work will come as a blessing. Dr. Pavy has given the labor of a life time, with increasing laboratory work to the working out of the matter contained in his book. The author holds that by the glycogenic doctrine the mind has been conducted in the wrong direction, and in consequence we have been fruitlessly groping in the dark.

The teachings of experience in connection with diabetes, have been quite irreconcilable with prevailing physiological views, but they agree with the doctrine set forth in Dr. Pavy's volume.

Unfortunately too few men in active practice can find time to keep up their physiology. Here and there one is found, who from pure love of the science, goes on investigating and studying it after leaving college. So great a subject as the carbohydrates, constituting as they do by far the largest part of organic matter, will necessarily take much of the time and attention of such students. To them we recommend the book as clear, concise, the result of long experience of a practical teacher, and having a theory which is workable.

A PRACTICAL THEORY AND TREATMENT OF PULMONARY TUBERCULOSIS. By Frank S. Parsons, M.D., editor of the *Philadelphia Medical Times and Register*. Philadelphia : Philadelphia Medical Publishing Co. Price, 25 cents. Paper cover.

This monograph covers seventy-seven pages of a neat little volume. It treats of a subject of universal interest to all scientifically inclined persons. The author views tuberculosis in a new light, and holds that this work marks a new era in the study of this disease.

The first pages are devoted to an interesting introductory, illustrative of the present condition of medical thought upon the subject. The causation of tuberculosis is then taken up, and it is shown that the dominant theory regarding the tubercle bacillus as a causative agent is not based on the true pathological condition in the early stage of phthisis. Bacilli are to be regarded only

as developments, existing because a favorable medium presents. This medium exists before the bacillus is demonstrable, and consists of the waste elements of the blood congregating in a locality through lymphatic obstructions or stasis.

In the pages devoted to a consideration of symptomatology it is suggested that, in view of the universal dislike of fats by phthisical persons, there doubtless exists a disordered condition of the pancreas, which condition may be congenital or acquired.

Dr. Parsons has based the treatment of consumption on the lines of this new theory, calling attention to the advantages to be gained by elimination, nutrition and oxygenation. The low price of the book places it in reach of everyone, and no physician should be without it.

THE TREATMENT OF WOUNDS, ULCERS AND ABSCESSSES. By W. Watson Cheyne, M.B.Ed., F.R.S., etc., Professor of Surgery in King's College, etc. Philadelphia : Lea Brothers & Co. Toronto : Carveth & Co. 1895. Pp. 197.

This little work gives shortly and definitely the methods of treatment employed by Professor Cheyne for wounds, abscesses, and ulcers. He holds that a thorough practical knowledge of bacteriology is of the first importance to the surgeon. The work is thorough and will be very useful to the student and young practitioner. Professor Cheyne has impressed his personality upon it, and these who know him know that he never gives an uncertain note.

INDEX OF MEDICINE. A Manual for the use of Senior Students and others. By Seymour Taylor, M.D., Member of the Royal College of Physicians, Senior Assistant Physician to West London Hospital. Philadelphia : Lea Brothers & Co. Toronto : Carveth & Co.

This book should be a valuable aid to students in their final course, as it treats of all the subjects in medicine, as in Fagge, Bristowe and others, with exception of skin diseases. Entering into the description of the various ailments known to man, it is very concise and at the same time sufficiently thorough, as a prelude to the more lengthy discourses in the general text books.

THE DYNAMICS OF LIFE : An Address delivered before the Medical Society of Manchester. By W. R. Gowers, M.D., F.R.S. London : J. & A. Churchill.

The author does not claim any novelty in the conceptions presented, but he has given them a fresh form, which he hopes may aid in a clearer perception of the truth.

Supplement to the "Canada Lancet."

ONTARIO MEDICAL ASSOCIATION.

The fifteenth annual meeting of this Association convened in the building of the College of Physicians and Surgeons, Toronto, June 5th and 6th, under the presidency of Dr. R. W. Bruce Smith, of Hamilton.

The first paper was presented by Dr. Geo. A. Peters, of Toronto, who gave a succinct account of "Delayed Union in Fractures." He said that although the progress in many lines in surgery had been very marked, yet that in the treatment of fractures had not. Fractures might repair themselves spontaneously through osteo-plastic activity; union might occur and be followed by deformity; and fibrous union might occur, making a false joint. Certain constitutional diatheses might account for non-union, or improper setting or imperfect retention. But in some cases there was apparently no cause, even when the setting was well performed, the surroundings good and the patient's health unimpaired. In unpromising cases the medical man should always fortify himself by securing a consultation. The reader dealt with the various points in the preventive treatment, and referred at length to the treatment by rubbing the ends, and to the method of cutting down upon the ends of the fragments.

Dr. MacKinnon, of Guelph, spoke of the great advantage gained in the setting of fractures by the use of anæsthetics. Particularly was this the case in children. The essayist spoke of the use of plaster splints in the treatment of these cases. If they were used at the time of setting, the case required watching, as there was shrinkage both in the limb and the plaster, which would allow mobility and probably lead to delayed union.

The essayist then gave the history of a case of non-union occurring in his early practice, in which he had used plaster Paris, the patient after the setting not being under supervision. But upon the application of a stiff cardboard splint and a starch bandage, after five months perfect recovery followed.

Dr. F. J. Shepherd, of Montreal, said he thoroughly endorsed what Dr. Peters had said in

regard to the establishment of perfect immobility, and the use of anæsthetics. Where union was delayed, the treatment recommended by Dr. Peters was the only one to adopt.

Dr. Holmes, of Chatham, said that many cases of non-union were due to improper adjustment of the fragments at the time of the accident. He thought the removal of the dressings frequently was a good thing, but he did this more for the purpose of ascertaining the amount of pressure, etc., than for the benefit of the air and light. He had never had the misfortune to have a case of non-union, but had seen delayed union in several cases. He believed free circulation would assist in bringing about union.

Dr. Grasett said that he had had a good deal to do with fractures in hospital and private practice, but in only a few had he seen delayed union, and in these there was a very distinct and definite cause. He was, therefore, inclined to think that the surgeon was more or less at fault in cases where non-union occurred, by not securing proper apposition, or not maintaining it. The speaker then recited a case in which non-union existed through the supervention of an attack of pneumonia. If more was known about fractures there would be fewer cases of delayed and non-union. Many cases, particularly in women, fell into the hands of young surgeons who did not like to subject the patient to the pain which would accompany the perfect setting. Too often it was a slight pull, and the application of splints, with an unsatisfactory result; whereas if pains were taken to unlock the fragments (as in a Colles' fracture) a perfect result would ensue.

Dr. Cameron said that he did not agree altogether with Dr. Grasett. All cases of delayed union were not due to the fault of the surgeon. If that were done mal-practice cases would become very frequent in our courts.

The speaker rehearsed the history of a case which proved very intractable, having been in the hands of several surgeons. A leather splint was applied, and the patient went about his work for some months, a perfect recovery following. He disputed the idea of the necessity for perfect immobilization. A reasonable degree would suffice. The clavicle and the ribs when broken united—bones impossible to immobilize perfectly.

Dr. Gibson, of Belleville, reported a very bad case, where the patient had lain ten months. Suppuration had taken place at the seat of fracture. There were three inches of shortening. On operating, a large loose fragment of bone was removed from the cavity. The ends were sawn

through and brought into apposition and in five weeks recovery followed.

Dr. Marr reported a case under his care where the patient kept testing his arm frequently to see if union had occurred, before a sufficient time for healing had elapsed. He (the patient) had consulted several surgeons about it, and had submitted, without chloroform, to the rubbing of the ends of the fragments; but without success. Dr. Marr's father and himself immobilized the arm, and recovery followed.

Dr. Meikle reported a case of fracture, where he had immediately used a plaster of Paris splint. Recovery took place in three weeks, when the splint was removed.

Dr. Harrison reported the history of a case of delayed union in a girl who had sustained a compound fracture. He rubbed the ends of the fragments together and wondered why they did not unite. In about six months, he said, he was called to see her and found that she was pregnant. Union had taken place, but not the union he had thought of.

Dr. N. A. Powell reported a case he had seen, lasting eleven weeks, occurring in an old woman. At the same time she sustained an injury to the hip which became erysipelatous, suppuration taking place beneath the skin.

Dr. Powell said further: "One point has struck me; where there is delayed union and the people begin to talk and look ugly, and begin to think of consulting some other physician, a son of Ishmael very likely, very likely also a lineal descendant of Ananias; when they begin to act crusty in this way, it is good practice to make a photograph of the actual apparatus upon the limb. It is wise for the surgeon to own the apparatus."

Dr. Powell commended the use of the lactophosphate of lime internally in the cases under discussion. He also agreed in the use of plaster Paris if applied in the right way.

Dr. Dickson expressed his disbelief in the statement that cases of non-union were attributable to the fault of the surgeon. He had no experiences of non-union in his practice.

Dr. Peters, in replying, said that he quite agreed with what had been said in regard to plaster Paris as a permanent dressing, completely enfolding the limb. One of the speakers had said that the dressing shrinks, but the greater trouble was the shrinking of the limb. Some of the speakers disagreed about the removal of the splints. It appeared to him a wise thing to remove the splints every few days and expose the seat of fracture for a few moments to the sunlight and air and to subject the skin and muscles to friction in order to prevent local scurvy, but all without permitting the slightest movement of the fragments. The weight of authority was entirely against the value of the lactophosphate of lime.

Dr. Francis J. Shepherd, of Montreal, read a paper on "The Surgical Treatment of Certain Forms of Bronchocele." The essayist reviewed the history of the treatment of these growths. He then described the method he had employed in some fifteen cases, namely, enucleation. He makes the incision through the skin, directly over the tumor, rips up the cyst wall, evacuates a portion of its contents, and then enucleates the cyst wall. One of the great dangers is hæmorrhage. He had commenced the series of operations by using chloroform as an anæsthetic, with the idea that with it there was less congestion of the veins. But as one of his colleagues had lost a patient by chloroform poisoning, he began the use of ether. The matter of venous congestion he found to be a bugbear. The patients recovered in about a week. The Doctor then related some of the most interesting of the histories of the fifteen cases he had had. He had as yet no fatalities from the operation.

Dr. Atherton said that he had seen three or four operations of this sort, and was favorably impressed with the ease with which these thyroid growths were removed. There was no doubt that the radical treatment was the best. He was under the impression that the incision should be in the median line. He thought the thyroid tissue should not be incised, as it was very vascular.

Dr. Grasett said that he had an early and vivid impression from seeing an attempted thyroidotomy in which the trachea was opened, followed by the death of the patient. This had kept him from operating on these cases. But from the encouragement he had received from the recital of Dr. Shepherd's very successful cases, he would be led to attempt the operation with more confidence.

Dr. Cameron said that he had seen a few cases of bronchocele, but he believed they were not so common in Toronto as in Montreal. Here such cases were handed over for treatment by electrolysis. He remembered of only one unsatisfactory result, where suppuration took place, and he was obliged to resort to removal, the case ending happily.

Dr. Mitchell, of Enniskillen, reported having treated a case by the injection method. Suppuration followed for some months, after which he operated with success.

PRESIDENT'S ADDRESS.

Dr. R. W. Bruce Smith opened his address by expressing his gratitude to the Association for the honor conferred upon him. He thanked those who had assisted him in the work of preparing for the meeting, and he stated that he was more impressed than ever with the strength and importance of the Association.

He said that the Committee deserved great

credit for their untiring efforts, the proof of their work being in the splendid programme they had provided for the meeting.

The President paid a touching tribute to his predecessor of two years back—the late Dr. R. W. Hillary, of Aurora—saying in conclusion, “No words of mine are needed to add lustre to his memory.” The Doctor then said, “In the early years of this Association, when much of its future success depended upon the foundation upon which the organization rested, we were favored with the services of a most energetic Secretary, whose zeal might be described as almost boundless—Dr. J. E. White, whose very sudden death a few months ago, was deeply regretted by the large circle of friends his geniality had won for him.” Continuing, the Doctor said, “The influence which is exerted by such a meeting as this is manifold.”

He said that only a few years ago the lives of doctors were all much the same, but that now the lives of medical men are developed under the most diverse and different conditions.

The specialist in his well appointed office, with his definite time for labor and his hours of undisturbed rest to be employed as his tastes and inclinations may direct, can hardly enter into the feelings of those who hold themselves in readiness to answer a summons at any hour of the twenty-four.

The laryngologist, his life spent in a darkened room, his vision limited to the length of his reflecting mirror and his view confined to the illuminated spot, resembling in size the gold piece, which will be the reward of his skill and dexterity, is not likely, as time goes on, to fully understand the trials and triumphs of the man in general practice, who passes from stone front to shanty, from alley to suburbs, through mud and snow, and who is likely to turn at a moment's notice from measles and whooping cough to gout and broken bones. It must not be forgotten that both are doctors. The speaker said that it was for such a gathering to bind together all the diversified elements and combine in our programme all the phases of professional work.

The President continued with a cursory survey of the past twelve months; he spoke shortly on “Thyroid Feeding” and “Auto-intoxication,” and in speaking of the present state of Bacteriology, he said, “Surgical pathology was never more zealously or successfully cultivated. Therapeutic surgery is, along the line of antiseptics, making rapid advancement, and rendering more sure the work of the knife”; and again, “In whatever direction the surgeon may look to-day, the prospect is gratifying, and with due regard to the caution gleaned from experience, he may justly be animated to strive for still wider achievements.” The Presi-

dent then spoke at some length concerning the relation which medical men bear to the community. He said, “It is our duty to stand by man in all his waywardness, and although our warnings are unheeded, we must ever be ready to extend a helping hand and endeavor to restore the decaying parts.” The speaker, in conclusion, spoke at some length on the Ontario Medical Act and its provisions, and also on a Tariff of Fees. With regard to the latter, he said, “There are now three courses open for adoption:—(1) Let the Medical Council arrange a tariff for the whole Province. (2) Let the practitioners of each county meet together and form a tariff. (3) Let us do without any medical tariff, as some of the United States are at present.”

Dr. K. N. Fenwick, of Kingston, read a paper on the “Primary Repair of the Genital Organs of Childbirth.” This will appear in our columns in a later issue.

Dr. H. T. Machell, Toronto, said, in discussing the subject, that he did not think there could be any two opinions upon the necessity of immediate operation on tears in the genital canal. He claimed that in the case of the perineum, it had been the rule for the last ten or fifteen years; and why not also in tears of the vagina, which are of more consequence than those of the perineum? The Doctor said that the presence of a tear could be easily determined by systematic examination, and if present, could and should be repaired at once. If in the perineum, an ordinary darning needle would suffice; but if in the vagina, of course special needles would have to be used. The speaker also urged immediate action in cases of torn cervix, and that medical men should look upon the repairing of ruptures as part of the confinement.

Dr. Macdonald, Toronto, thought medical men were one in the opinion that lacerations of the perineum should be repaired at once, but not so in lacerations of the cervix unless they are very extensive, causing hæmorrhage which cannot be controlled otherwise. The Doctor did not agree with Dr. Fenwick in that the repairs could be done without an anæsthetic, or an assistant, as he preferred to have both. In conclusion, the Doctor said that one reason for not operating hastily, was the invariable *post-partum* exhaustion.

Dr. Adam Wright, of Toronto, on being called upon, said that he only knew of one case where delayed operation for torn perineum was successful. He also said that he had tried needles of many descriptions for sutures, but that he had fallen back on the old-fashioned darning needle as the most useful. In conclusion, he said that

he thought that a great deal of the so-called septicæmia occurring after tearing of the cervix, was caused by too much manipulation.

Dr. Temple, of Toronto, disagreed somewhat with the former speakers. He said that, to begin with, he had always found it more convenient to operate on a lacerated perineum while the patient was on her back. Again, he said that he had tried a straight needle in such cases, but vastly preferred a curved one. In ending, the Doctor said that nine-tenths of the small tears of the cervix will heal in a night if left alone.

Dr. Fenwick said, in reply, that it was a matter of interest and election. If there is a tear in the artery and bleeding, it is a case of interest. It is a matter of importance when the tear is sufficiently deep to say in nine cases out of ten it will heal. The Doctor then reiterated his statement that he preferred to operate with the patient on her side. In concluding, the Doctor said that in olden times the physician had to work by touch entirely, but that with modern appliances he could now use his sight, which was of great advantage.

Dr. Stephen Lett read a paper on "Narcotic Addiction." He said that science should be brought to bear with full force on this growing evil. The speaker outlined the Levantine method of treating morphine takers, and spoke tersely of other methods, and in conclusion expressed it as his opinion, based on experience, that the patient should be given the drug until it had been reduced to an infinitesimal dose. That this treatment, combined with a general knowledge of the idiosyncrasies of the patient's nervous system, and a nourishing diet, would do away with the chance of an agonizing crisis. The paper was discussed by Drs. Trimble, Dickson, Harris, Noble, Clark, Spohn and Lett.

A paper on "Puerperal Insanity" was read by Dr. Beemer, Mimico. He said that was the form of insanity which the general practitioner was most interested in. This neurosis occurred in 1 of every 400 puerperal women. The essayist gave a graphic description of the symptoms. In one word he summarized the treatment—nourishment.

Dr. Clark recommended institutional treatment for these cases; for they were difficult to deal with at home.

Dr. Hodge read a paper on the "Stomach-Tube," in which he pointed out its uses. He also spoke of the great importance of lavage in the treatment of dyspepsia. He cited a number of interesting cases in which he had had very satisfactory results. This paper will appear in August No. of the LANCET.

Dr. McPhedran said the tube was of more especial value in the diagnosis of gastric affections. He also cited cases in which he had used it.

Dr. Noble said he found it difficult to get his patients to swallow it. Indeed, he had failed himself, until one day, by mistake, he took a dose of poison, when he managed to swallow the tube with despatch.

Dr. Hunter had found it helpful in a patient who was unable to swallow her food—a hysterical case.

Dr. Doolittle recommended lubrication of the tube with glycerine.

Dr. Burrows' paper on "Rectal Enemata" was read by title.

Dr. McPhedran presented a patient suffering from morphæa. He related the history of the case, and gave the pathology of the disease.

Dr. Fotheringham, of Toronto, described a case of Pseudo-Hypertrophic Muscular Paralysis—exhibiting the patient. The latter, a man of 27, was a clinical patient of the Doctor's at the hospital.

Family History.—One of 13 children. Father very intemperate, drowned. Mother living, fair health. Two brothers suffering from same affliction as patient—one worse than the other.
Personal History.—Worked hard until unable to get into wagon or climb stairs. Case showed plainly the intermission in the progress of disease mentioned by authorities, viz, worse till puberty and then was able-bodied and fairly active for 8 or 9 years. *Present condition.*—Body apparently healthy, except with reference to nervous system. Power of motion disturbed, but not sensation. Calves of legs an inch more around than thighs; the latter somewhat atrophied. Gluteal muscles small and soft; prominence of lumbar muscles exaggerated. Hypertrophy of deltoids and pectorals absent; mentality unimpaired, etc. Cannot rise from chair without using his arms, and on sitting down so far drops suddenly. The attempt to rise from the kneeling position is the characteristic one of "climbing up upon his legs." *Prognosis* favorable as far as course of disease is concerned; recovery, of course, not sought for. *Treatment.*—Many systems of treatment have been proposed, among which electricity and arsenic seem to be favorites.

The Doctor then described the pathology of the disease.

SURGICAL SECTION.

Dr. Welford, of Woodstock, 2nd Vice-President, occupied the chair, Dr. J. C. Mitchell, of Enniskillen, acting as Secretary.

Dr. Howitt, of Guelph, read a paper on "An Operative Procedure for Spina Bifida." The Doctor gave seven salient points why his method of procedure should be adopted, and concluded by reading notes of seven cases treated by his method. Four of them are alive and well to-day, one made

complete recovery, but died of meningitis, one died of hydrocephalus, present at time of operation, and only one died of the operation.

The paper was discussed by Dr. Ross, of Huntsville, and the author of the paper.

Dr. F. Le M. Grasett then read a paper on "Tumors of the Bladder," which was discussed by Dr. Groves. It will appear our columns.

Dr. Groves, of Fergus, read a paper on "Hare Lip." He believed the principle laid down in the texts was wrong—remedying a malformation by defect by sacrificing tissue. The two defects to be overcome were, a notch on the lower border, and a thinness of the lip at the line of union. He then detailed his method of operation to overcome these. The same principle of operation he employs in the treatment of vesico-vaginal fistulæ.

Drs. Bingham, Peters and Powell discussed the paper.

Dr. Geo. McDonagh read a paper on the operation for cleft palate. It was very important that the edges should be pared freely, that the lateral incisions should be long, and that there should be a thorough loosening of the flaps, so that the edges might be brought together without any tension. He preferred chloroform to ether in these cases.

Dr. Holmes, of Chatham, read a paper on "Appendicitis." After citing the present concensus of opinion as to the advisability of operating on these cases, he gave statistics of his cases. Of 49, eight had died from rupture of the abscess into the peritoneal cavity; four from general septic peritonitis; sixteen had been operated on with one death four months after the operation, but not as a result of it. Twenty-one had recovered without operation, but five of these had still some tenderness at McBurney's point. The essayist then detailed the history of a most interesting case occurring in a pregnant woman, in which the abscess ruptured into the peritoneal cavity, with recovery.

Dr. Atherton said that if all cases were operated on there would be more recoveries. But inexperienced surgeons would be slow to operate, when so many recoveries followed without operation.

Dr. Howitt pointed out that typhlitic cases seldom required operation. He described the symptoms of appendicitis when operation was called for.

Dr. Jeffrey, of Lindsay, said that he had had many cases of this kind, and the majority recovered without surgical interference.

Dr. McKinnon thought operating boldly soon after rupture of the abscess, with free cleansing of the peritoneal cavity, would often save the patient. He gave the history of a case of this sort in which operation saved the patient's life.

Dr. J. J. Cassidy's paper on "Metallic Sutures in Fracture of the Patella" was read by title.

Dr. Mitchell, of Enniskillen, read a paper on "Traumatic Septicæmia," which will appear in these columns.

Dr. Bray, of Chatham, presented a paper on "Pneumonia." This will be published in the LANCET.

Dr. T. F. McMahon read a paper on "Calomel Fumigation in Laryngeal Diphtheria." He referred to the great mortality under old methods of treatment, even intubation and tracheotomy saving but 20 to 30 per cent. of cases. Antitoxin had not been yet given a sufficient trial. He proved that 70 per cent. of cases in an average epidemic had been cured by calomel fumigation, and he was sure that he had seen cases cured by the treatment, which would have proved fatal under other treatment.

The subject of "Diphtheria" and its treatment was discussed by Dr. Wilson, of Richmond Hill, Dr. Sheard, of Toronto, Dr. Holmes, of Chatham, and Dr. McPhedran, of Toronto.

Dr. H. A. Macallum, of London, Ont., read a paper on the "Physiological and Therapeutic Action of Iron," with a discussion of its newer pharmaceutical compounds.

"Laryngeal and Tracheal Tuberculosis, the Importance of their Early Recognition and Treatment," was the subject of a very interesting paper read by Dr. W. F. Chappel, of New York. The Doctor spoke at length on the necessity of, and the benefits gained by, an early treatment. He showed a water-colored sketch illustrating the condition, and also an instrument, devised by him, for the sub-mucous injection of the larynx and the trachea.

The paper was discussed by Drs. Ryerson, Palmer, Price-Brown and Wilson.

Dr. A. Primrose, of Toronto, gave a series of lime-light views of anatomical sections.

A paper on "Home and Foreign Climates in Consumption," by Dr. Plater, of Ottawa, was read by title.

Dr. Geo. Acheson, Galt, reported some peculiar cases in practice, the first double cephalhæmatoma, in a child with enlarged thyroid; recovery. The second, leucoma on the inner side of the jaw, caused by a badly fitting plate. The third, a retropharyngeal abscess, complicating capillary bronchitis; évacuation by incision and recovery. Fourth, the removal by dissection of an atheromatous cyst of the neck. The next, dacryocystitis with loss of sight in the eye affected. The last, membranous colitis, with recovery from use of copious injections of weak solutions of copper sulphate, and syr. hypophos. co. internally.

Drs. Machell and Peters discussed the paper.

Mayor Kennedy was then introduced to the Association by the President. The Mayor delivered a short address.

Dr. MacFarlane then related the history of a

case in which he had performed nephrectomy for pyelonephrosis.

Dr. E. E. King read a paper on "Seminal Vesiculitis." The acute stage of this trouble, he said, was likely to be overlooked, the gonorrhoeal urethritis which it accompanied claiming attention. He believed many cases treated as cystitis and prostatitis were in reality vesiculitis. The essayist referred to the anatomy and physiology of the vesicles. The symptoms of the disease were frequency of micturition accompanied by pain in the neck of the bladder or head of the penis, pain on evacuating the bowels, a discharge from the penis after defecation. Erections may be frequent and painful, or ephemeral, a discharge without any apparent exciting cause. The diagnosis is usually confirmed by palpation per rectum when the bladder is full. The dilated vesicles can usually be made out, and their contents stripped out. If the patient now urinates in two bottles the first will contain the expressed fluid. The essayist then reviewed the bibliography of the subject. As to treatment, after emptying the bowels the operation of stripping is performed by the finger introduced through the rectum. Deep urethral injections were recommended, and the fluid said to enter the vesicles, but of this he was doubtful, as he was also of the efficacy of this method of treatment. These seances he would not recommend oftener than every fourth day. The Doctor then recited the history of several interesting cases.

Drs. Peters and Spencer discussed the paper.

"Antitoxine in the Treatment of Diphtheria; with Clinical Notes of Cases," was a paper presented by Dr. J. D. Edgar, of Hamilton.

Dr. Stowe Gullen related some observations on "Cases of Diphtheria," made abroad.

Dr. G. A. Bingham, of Toronto, described two very interesting cases of movable body in the knee joint. This will appear in a subsequent issue of THE CANADA LANCET.

The latter paper was discussed at some length by Dr. Shepherd, of Montreal. He said he had met with many cases in practice, none of them having serious results.

Dr. H. T. Machell read the history of a case of "Infantile Scurvy." It was discussed by Drs. Shepherd and Mitchell.

Dr. Gibson, of Belleville, read two papers, the first being the history of a case of "Extra-uterine Gestation." The patient was in great distress; aspiration was done twice with improvement in patient's condition. Sac was opened later. On removal of foetus, hæmorrhage was great, but patient recovered.

The second paper read by the Doctor was on a case of "Mental Aberration following Removal of

Ovarian Cyst," beginning on the sixth day, the patient being unmanageable on the tenth. Recovery followed in a few days.

The paper was discussed by Drs. Oldright and Ross.

Dr. J. F. W. Ross read a paper on "Experimental Surgery on Man and Woman; a Criticism of Operations done and the Results Obtained." He held that the modern use of antiseptics was an excuse for the performance of many operations which could be left undone with advantage. The Doctor deplored the fact that there were so many operations for removal of pyloric cancer of the stomach and intestinal anastomosis, and he thought that practitioners would soon be afraid to recommend a consultation with a specialist in gynecological surgery.

Dr. Oldright said where operation for cancer of the breast would extend life for a couple of years with comparative comfort, he would operate.

Dr. Cronyn, of Buffalo, said that experimental surgery would give place to conservative surgery. He had lost no cases from septic trouble, simply because he always operated with clean hands and cleaned his own instruments.

Dr. Shepherd also discussed the paper

THURSDAY P.M.

After a sumptuous luncheon at the Royal Canadian Yacht Club and a delightful ride on the yacht "Cleopatra," the members again met in general session.

Dr. Campbell, of Seaforth, then read a paper on "Two Cases of Plegmasia Dolens." This appears in full in our present number.

Dr. A. H. Wright agreed with the speaker as to the cause of death, and stated that he treated such cases with large doses of quinine, phenacetine, or antipyrine.

Drs. Harrison, Walker and Acheson also discussed the subject.

Dr. W. B. Thistle read a paper on the "Antiseptic and Eliminative Treatment in Typhoid Fever," which was discussed by Drs. Wright, Graham, Harrison, Saunders, McKinnon and Bethune.

Dr. F. Oakley read a paper on "Science and Medicine."

Papers by Drs. Reeve, Sweetnam, Davison and Teskey were read by title.

Dr. D. Marr rendered a paper on "The Treatment of Pulmonary Tuberculosis." He dealt at length on the etiology of the disease, and gave some excellent prescriptions in its treatment.

Dr. D. Campbell Meyers read a paper on a case of "Traumatic Neurasthenia," and exhibited the patient. The case was an interesting one and had been treated successfully with central gal-

vanization and static electricity, combined with the exhibition of sod. brom., arsenic, ergot and strychnine.

Dr. E. H. Stafford read a paper by title, the subject being "Notes on Paresis."

An interesting display of bacteria was made by Drs. J. Caven and F. M. G. Starr.

THURSDAY EVENING.

The first item of business was the election of officers for the ensuing year. These officers were elected: President, Dr. Grasset, Toronto; 1st Vice-President, Dr. McKinnon, Guelph; 2nd Vice-President, Dr. Gibson, Belleville; 3rd Vice-President, Dr. Wilson, Richmond Hill; 4th Vice-President, Dr. McCallum, London; Secretary, Dr. J. E. Brown, Toronto; Assistant Secretary, Dr. Chas. A. Temple, Toronto; Treasurer, Dr. G. A. Carveth, Toronto.

Windsor was named as the next place of meeting by a three to one vote.

The report of the Committee on Public Health was, after some discussion, referred back, on account of a few debateable clauses.

Much was reported to have been done in regard to the prevention of tuberculosis. Mr. W. J. Gage's gift of \$25,000 toward founding a consumptive hospital had been supplemented by the offer of the G. T. R. and C. P. R. to transport 100 poor patients free. The Ontario Government had agreed to a *per diem* allowance for each patient.

The report favored more general tubercular test of meat and milk, but the stumbling block in the clause was the recommendation that all cases of consumption be reported to the Medical Health Department and placed under sanitary restrictions.

Another clause that was objected to was that recommending the periodical examination of all school children's teeth, in view of the prevalence of dental caries and its evil effects.

The report further commended Toronto as a summer resort, and condemned the practice of incarcerating the insane in common jails.

The report on legislation, read by Dr. Britton, congratulated the Association on the signal defeat of the Haycock Bill, which aimed to do away with the safeguards at present existing and degrade the noble profession of medicine. It was pointed out that the representatives of the people of both political parties had stood together to defeat the Patron attempt.

The report also stated that the Legislature's action in repealing the tariff clause of the Medical Act was a subject for congratulation. It did not change the position of the physician, as the legal tariff allowed such a wide latitude between the maximum and the minimum charge that it really did not determine the fee at all.

The report recommended that each territorial representative on the Medical Council be requested to ask his constituents to frame a tariff for submission to the Council, and that a general tariff be adopted therefrom. While not legally binding, such a scale of figures if produced in court would be evidence of a public consensus of opinion as to a just charge. It would also prevent unfair competition among physicians. The report suggested further legislation for the suppression of quacks. According to the Act all unlicensed practitioners could be summoned and fined, but by the present wording of the law many can evade it. For instance, alleged Christian scientists, charging for their services, had escaped because they had prescribed no medicine and had performed no surgical operations, whereas the Act specifically limited the offence to the unlicensed practice of surgery and medicine.

After the reports of the other committees were received, and the usual votes of thanks the Association adjourned.

RAILWAY OR TRAIN SICKNESS.—Inquiry elicits the fact that there are many who suffer from railway sickness. I am not aware that direct attention has been given to this special cause of megrim; I am satisfied, however, that the inconvenience is real and that there are many who are more or less knocked up by a long journey, and in whom a railway journey of two hours produces as much dread and misery as a sea passage. I venture to draw attention to the value of sulphonal in these cases, and to suggest its further and more extended trial in both railway and sea journeys. In children train sickness is common, while in adults railway megrim varies from undue fatigue and inability to sleep the same night to intense headache, sickness, and prostration coming on after some two hours in the train. The dose of sulphonal would vary, of course, according to the severity of the symptoms and the length of the journey. In my own case I find that ten to fifteen grains are sufficient for the day journey to Edinburgh, while twenty to thirty grains in divided doses are necessary for the night and day journey to the North of Scotland. The following cases are further illustrative. 1. A married woman who generally suffers from headache, nausea, and sleeplessness after a long journey took on starting fifteen grains of the drug. She travelled from London to Newcastle-on-Tyne on a day journey without headache and sickness, while refreshing sleep followed at night. 2. Another married woman who journeyed from Paris to Pau, on taking ten grains, felt well and fresh, while her governess and little boy, who are usually sick, travelled better and were not sick on taking ten

and five grains respectively. She thinks a second dose might have been taken by them with advantage. 3. A single woman who journeyed from London to Cannes, after taking fifteen grains, did not feel the journey more than is going from London to York, though usually knocked up. I might say I have tried antipyrine, phenacetine, the bromides, the chloral, but have not experienced the same benefit as with sulphonal. An aperient dose the day before travelling is, I think, advantageous, while facing the engine or lying down is helpful. As to the value of sulphonal in sea-sickness I can only produce three cases in its favor. Many patients who suffer from railway sickness do not suffer from sea-sickness, or only slightly. 1. A married woman travelling from London to Guernsey, who was usually sea-sick, after taking ten grains had a good journey and was not sick. 2. A single woman travelling from London to Flushing, who was always sea-sick in the calmest weather, after taking fifteen grains slept well and was not sick, arriving fresh. 3. A married woman travelling from London to Dublin, who had always been sick and dreaded the journey, after taking ten grains slept well, was not sick, and arrived altogether fresh and well.—*Lancet*.

THE TREATMENT OF GALL-STONES WITH LARGE DOSES OF OLIVE-OIL.—(*Brit. Med. Jour.*) has reported the case of a woman, forty-eight years old, who presented herself in an attack of biliary colic. She was suffering from acute pain, situated over the hepatic region and extending to the right shoulder-blade, accompanied by severe retching and vomiting and collapse. The pain was relieved by hypodermic injections of morphine. The attack was followed by well-marked jaundice, which, however, passed off in a few days' time. There was a history of similar attacks at various intervals for upward of four years, and these were invariably followed by slight jaundice. The stools were examined for gall-stones, but none was found. Two months later the woman was again seized with a severe attack of colic, but careful search failed to detect any trace of gall-stones in the stools. These attacks continued, at intervals of from three to six weeks, for nearly five months, although the patient was constantly under treatment, and all the usual remedies were tried without avail. In no instance was a gall-stone ever found in the stools. The last attack was particularly severe and protracted, and cholecystotomy was advised. Before operating, however, resort was had to large doses of olive-oil. Accordingly, three grains of mercurial pill were given at bedtime, and followed on the next morning by three ounces of olive-oil, the patient being instructed to

lie upon the right side. The oil was given in tablespoonful-doses every three hours during the day: and in the stools six large gall-stones were found. Two measured nearly half an inch and were faceted. No pain was experienced during the passage of the stones, nor did the oil cause much nausea. The jaundice passed off in a few days, and the patient made a complete recovery, for twelve months afterward having no attacks of colic.—*Med. News*.

DRY SURGERY IN GERMANY.—The American practitioners and students of medicine who have been trained to look upon irrigation as essential to the aseptic handling of wounds in their after-treatment, are always quite astonished at the apparent disregard the German surgeon seems to have for this method of securing good results. While in Gottingen, I was present every day at the surgical polyclinic held daily by Professor Rosenbach, and I do not believe I saw a drop of water or other irrigation fluid used during the whole time. The patient is brought in, the dressing removed, the wound examined, squeezed lightly, oozing pus is wiped off, and dressings, dry or wet as may be necessary, are reapplied. Even in the treatment of deep abscesses, or where neurotic processes are going on, irrigation is never resorted to, the surgeon seeming to have all faith in his drainage tubes, without resorting to the stream of bichloride water as used by our American surgeons. They probably get just as good results here in Germany as we do in the United States, but their methods of wound-handling are certainly not so cleanly as those used in the latter country.—*M. and S. Rep.*

TREATMENT OF TUBERCULOUS DISEASES OF THE GENITALS.—Dr. Desnos (*La France Médicale*) recommends injections of five to ten per cent. solutions of zinc chloride in cases of tuberculosis epididymitis and prostatitis, especially where the tuberculous foci are circumscribed and isolated. He usually injected two drops of the solution at several places into the mass, preferably at the periphery. The injections are followed by redness, pain and swelling, which subside in the course of a week, when another injection is made. The ultimate result is induration and atrophy of the affected structures. In tuberculous disease of the prostate the author cuts down upon the prostate from the perineum, and after making the injection, keeps the wound open until the induration has subsided.—*Inter. Jour. of Surg.*

In Sweden, ten years of study is incumbent on every medical student.