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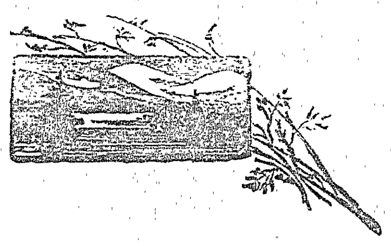

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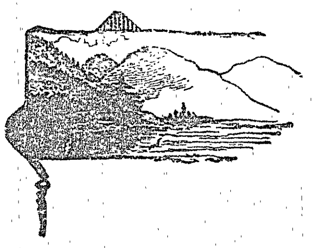

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The Collegiate Courses of this School are a Winter Session, extending from the 1st of October to the end of March, and a Summer Session from the end of the first week in April to the end of the first week in July, to be taken after the third Winter Session.

The sixty-first session will commence on the 3rd of October, and will be continued until the end of the following March; this will be followed by a Summer Session, commencing about the middle of April and ending the first week in July.

Founded in 1824, and organized as a Faculty of McGill University in 1829, this School has enjoyed, in an unusual degree, the confidence of the profession throughout Canada and the neighbouring States.

One of the distinctive features in the teaching of this School, and the one to which its prosperity is largely due, is the prominence given to Clinical Instruction. Based on the Edinburgh model, it is chiefly Bed-side, and the student personally investigates the cases under the supervision of special Professors of Clinical Medicine and Surgery.

The Primary subjects are now all taught practically as well as theoretically. For the department of Anatomy, besides a commodious and well-lighted dissecting room, there is a special anatomical museum and a bone-room. The other branches are also provided with large laboratories for practical courses. There is a Physiological Laboratory, well-stocked with modern apparatus; a Histological Laboratory, supplied with thirty-five microscopes; a Pharmacological Laboratory; a large Chemical Laboratory, capable of accommodating 76 students at work at a time.

Besides these, there is a Pathological Laboratory, well adapted for its special work. It is a separate building of three stories, the upper one being one large laboratory for students 48 by 40 feet. The first flat contains the research laboratory, lecture room, and the Professor's private laboratory, the ground floor being used for the Curator and for keeping animals.

Recently extensive additions were made to the building and the old one remodelled, so that besides the Laboratories, there are two large lecture-rooms capable of seating 300 students each, also a demonstrating room for a smaller number. There is also a Library of over 15,000 volumes, a museum, as well as reading-rooms for the students.

In the recent improvements that were made, the comfort of the students was also kept in view.

MATRICULATION.—Students from Ontario and Quebec are advised to pass the Matriculation Examination of the Medical Councils of their respective Provinces before entering upon their studies. Students from the United States and Maritime Provinces, unless they can produce a certificate of having passed a recognized Matriculation Examination, must present themselves for the Examination of the University on the first Friday of October or the last Friday of March.

HOSPITALS.—The Montreal General Hospital has an average number of 150 patients in the wards, the majority of whom are affected with diseases of an acute character. The shipping and the large manufactories contribute a great many examples of accidents and surgical cases. In the Out-door Department there is a daily attendance of between 75 and 100 patients, which affords excellent instruction in minor surgery, routine medical practice, venereal diseases, and the diseases of children. Clinical clerkships and dresserships can be obtained on application to the members of the Hospital staff. The Royal Victoria Hospital, with 250 beds, will be opened in September, 1893, and students will have free entrance into its wards.

REQUIREMENTS FOR DEGREE.—Every candidate must be 21 years of age, having studied medicine during four six months Winter Sessions, and one three months' Summer Session, one Session being at this School, and must pass the necessary examination.

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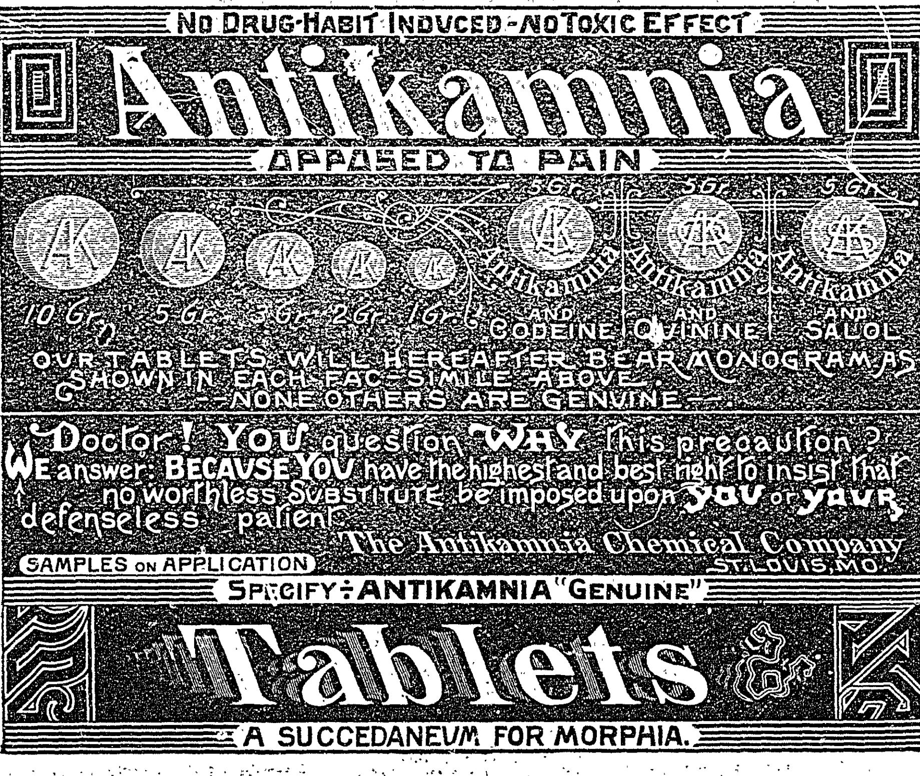

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A MONTHLY JOURNAL OF MEDICINE AND SURGERY.

VOL. VI. HALIFAX, N. S., NOVEMBER, 1894. No. 11.

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Original Communications.

THE USE AND ABUSE OF THE VARIOUS CAUTERY AGENTS IN THE TREATMENT OF NASAL AFFECTIONS.

[Read before the Canadian Medical Association at St. John, Aug. 23rd., 1894, by DR. KIRKPATRICK, Halifax.]

Mr. President and Gentlemen:

It is my intention to deal with this subject in the briefest manner possible. My object, in its introduction, is to sound a note of warning against the too prevalent practice of frequent and long continued applications of cautery agents in the treatment of nasal affections. If we glance for a moment at the functions of the nose we will find that it performs a very important part in the general respiration. A mucous membrane has for its function the secretion of mucus in a certain quantity. A healthy nasal mucous membrane will cover itself with a mucus in which there is 93 per cent of water, and we know that every breath of air passing over that surface must become overcharged with moisture. Physiologists tell us that during twenty-four hours five thousand grains of water are taken up by the inspiratory current of air in its passage to the lungs. And they also tell us that the mucous membrane covering the lower air passages has not the mechanism for the secretion of water, but that such is only found in the tissue covering the turbinated bodies. In this tissue the blood vessels which are very numerous and which are controlled by the vaso-motor nerves dilate or contract with every change in the humidity of the surrounding atmosphere. Many close and careful observers are of the opinion that all this intricate and complex mechanism is not connected with the functions of phonation and olfaction but with the function of respiration.

Furthermore it is not an unimportant matter that cold air is warmed in its passage through the nose and that air filled with floating particles is purified before it comes in contact with the surfaces of the lower air passages.

In view of these important functions of the nose, I believe in its proper care and an active and careful attention to all its ailments, for it has many.

I make this statement here in the out-set for fear that my closing comments might be misunderstood and which might perchance give the impression that I held this organ in little esteem either in the physiological or pathological sense. Taking a number of patients who present themselves (in the average rhinologist's office) because of nasal disorder, we will find a large percentage suffering from chronic hypertrophic rhinitis. Out of 1180 consecutive nasal cases treated during the first half of 1893 at the Central Throat and Ear Hospital of London, 547 are recorded as suffering from hypertrophic rhinitis. The physical examination of such a patient will reveal thickening of one or more of the turbinated bodies. Now when this condition is really one of hypertrophic over-growth of the layers of the mucosa nothing but destructive cauterizing agents will afford any relief. In my practice I confine myself to three of these agents namely:—chromic acid, tri-chlor-acetic acid and the electro-cautery. I do not propose to enter into the discussion concerning the superiority of one of these agents over another. Each when properly managed serves the purpose of a cautery, viz., (*a*) reduction of the superficial layers of the mucosa by the formation of a slough, and (*b*) the shrinking of the underlying vascular tissues by the formation of inflammatory adhesions to the periosteum. (See Lennox Brown.)

I almost invariably use the chromic acid, reserving the electro-cautery for posterior hypertrophies, as in these parts acid applications cannot be made without the acid coming in contact with tissues not intended to be touched. In the treatment of this affection we have the greatest use for the cautery agents, and I regret to state that in the hands of careless or ignorant practitioners this condition affords a field for deplorable abuse in the frequent and long continued applications of such destructive agents, applications applied without care and without discrimination. When necessity demands the use of these agents, I endeavor to determine the effect of one application of the cautery before making another and hence often wait three, four, five or six weeks to note the result. The practice of extensive cauterizations being made twice a week for a number of consecutive weeks must inevitably result in the obliteration of the glands and follicles and the production of a general cirrhotic condition of the tissues covering the turbinated bones. A patient consulted me one day last month because of deafness and nasal disorder. When taking the history I learned that the patient had been under treatment during the past two years and had submitted to thirty-five or forty severe applications of the electro-cautery. I judged these applications had been extensive, because the patient stated that she suffered a great deal of pain for twenty-four or thirty-six hours after each sitting. An examination of the nose produced a picture similar to one seen in a very pronounced form of atrophic rhinitis, nothing left but a shiny covering stretched over the turbinated bones. Whether this patient previous to electro-cautery applications had hypertrophic or atrophic rhinitis is immaterial as in either case there had been unpardonable abuse of an agent which when used moderately and intelligently is a measure of great benefit for the amelioration of distressing symptoms and the absolute cure of disease. Another patient consulted me in May last, suffering from phylectenular trouble of the eye, duration three months. I learned that the treatment adopted for the cure was frequent and extensive cauterizations of the turbinated bones the patient being told that his ocular trouble was entirely due to

a catarrhal condition of the nose. The patient being somewhat methodical drew forth a pocket book and noted that he had had seventeen of these electro-cautery sittings, and when I asked him of what nasal symptom he complained previous to this treatment he replied that he did not know that his nasal organ was in the slightest degree deranged. Needless to state his phylectenular disease was worse at the end of this treatment than in the beginning, and in addition he had a rosy dermatitis of his much abused nasal organ. In the atrophic form of rhinitis I cannot conceive any justification for the use of the cautery agents when as we all know the loss of tissue is the great feature of this disease and yet there are some authors who recommend their use in this affection, and it would appear that there are some practitioners within the pale of this Dominion who follow such a line of treatment. If any member of this association has had any experience with the use of the cautery in the treatment of that obstinate form of catarrh known as atrophic rhinitis, I would be glad to hear from him.

The galvano-cautery snare loop is much vaunted by some authors for its superiority over the cold snare in the removal of nasal polypi. I prefer the steel wire of the cold snare because of its being easier in its application about the polypus. and in addition I find by exercising traction when the loop is nearly drawn within the cylinder that I bring away the entire polypus together with a small quantity of tissue at the seat of its attachment. To guard against their recurrence the use of the cautery applied at the seat of origin I believe to be very valuable, and is a procedure I almost invariably adopt. It is not necessary to refer to any other form of disease affecting the nasal mucous membrane. The three already mentioned hypertrophic rhinitis, atrophic rhinitis and nasal polypus, being the common nasal diseases, afford almost the only opportunity for the abuse of the cautery, and while appreciating the rapid strides made in recent years in rhinology, especially operative, I unhesitatingly join hand and heart with those who pursue the more conservative course and are not carried away with such an excessive operative zeal which endangers the credit not only of rhinology but of surgery in general. When a gentleman in the prime of life whose family physician pronounced in excellent health receives a severe electro-cautery burning of his intra-nasal surface on a Wednesday evening, develops a mastoiditis on Friday, becomes unconscious on Saturday and dies on Sunday, notwithstanding a mastoid operation quite naturally the public stand aghast at that kind of treatment, and it becomes us to advise a more cautious and careful use of an agent capable of producing such serious results. An article recently appeared in the British Medical Journal bearing on this subject, in which dangerous and even fatal results were reported from the free intra-nasal use of the cautery producing inflammation in the mastoid region.

When we look over Dr. Carpenter's list of the sequelae of a naso-pharyngeal catarrh namely:—

Reflex cough
Sneezing
Stenosis of nasal cavities
Ocular catarrh
Asthenopia
Aural catarrh
Headache, either frontal, vertical, or occipital
Nasal polypi
Tonsillitis
Enlarged tonsils
Hypertrophy of the submaxillary, anterior, and posterior cervical glands
Patulency of Eustachian tubes
Epistaxis
Laryngitis
Hæmorrhage from the throat, either the naso-pharynx, larynx, or trachea
Tracheitis
Bronchitis
Catarrhal phthisis
Neuralgia, or numbness of the limbs or trunk
Anæsthesia or hyperæsthesia of the skin
Paresis of arm and forearm
Dyspepsia
Hay fever
Irritability
Melancholia

- Partial loss of memory or intellectual faculty
- Insomnia
- Frightful dreams
- Agoraphobia
- Vertigo
- Palpitation of the heart
- Neurasthenia
- Stammering
- Suicidal tendency
- Asthma
- Chorea
- Epilepsy
- Loss of taste
- Anosmia
- Anæmia
- Anorexia
- Deafness
- Reflex irritation of the genito-urinary organs
- An abundant discharge of nasal mucus or sneezing during coitus
- Aphonia
- Erythema and herpes of the nasal integument and lining
- Tinnitus aurium
- Otalgia
- Dysphagia
- Constipation

And when the cautery, the saw or the trephine is used on nearly every ear, nose and throat patient who enters the office of a specialist on the diseases of these organs we cannot wonder at the general practitioner, sitting in the quietude of his office after the day's work is over soliloquizing for a time and finally grasping the pen expressing himself in the following satirical manner:—

"Philosophers and physicians have for centuries discussed the relations of body and mind, and to the brain, the heart, the liver and even the spleen has variously been assigned the honor of being the hub of the little universe of man's. Until lately the claims of the nose have been ignored, but its partisans make up in zeal what they want in historical precedent; and we are now bidden to accept the organ in question not merely as the 'scenter' but as the centre of the human microcosm and to accord it the first place in the human anatomy, for in this the latter part of the 19th century we have discovered it to be the root of all evil. The inventory of its misdeeds is like Hauser's catalogue of the ships or Leperello's list of his master's conquests. If we are to believe Dr. Carpenter we may say in good faith and sober sadness that the nose is the centre of our sinful earth for while the brain is at the head of the Government the nose rules the brain as if it were its better half.

The theory is so seductive in its simplicity that one could insist it were true; bacteriologists might then break their culture tubes, and grievously laden students might burn their books, and the whole art and mystery of medicine might be packed into the formula. "Take care of your nose and the rest of your economy will take care of itself."

THE PRESENT STATUS OF ASTHENOPIA.

[Read before the Canadian Medical Association at St. John, N. B., on Sept 23rd., 1894. By F. Buller, M. D., Professor of Ophthalmology and Otology McGill University. Ophthalmic Surgeon to the Royal Victoria Hospital of Montreal.]

Gentlemen :—

The science of medicine and the art of surgery includes so wide a range of knowledge and experience that no one man can never hope to grasp the whole subject or to become an expert in more than a limited area of the sea of work in which he finds himself floundering so soon as the portals of our profession have opened for his admission. For this reason, specialism has become more and more of a necessity and it is through specialism tempered by a wider knowledge, that future progress must be made. It is therefore well that we can all meet together from time to time and compare notes, so to speak. It is helpful and encouraging to learn what is being down by workers in other parts of the same field. I myself, should feel that I had not done my duty if I did not occassionally have some contribution to offer my colleagues in medical conclave assembled. I know the subject I have chosen for to-day will interest some, perhaps more than a few of you, because asthenopia is of such frequent occurrence that

every physician must time and again meet with it in some of its manifestations. The term asthenopia is of course generic and includes quite a number of visual disturbances all of which present the salient characteristic of inability to use the eyes in near work without discomfort. The asthenope is perpetually reminded that he possesses organs of vision, and many devote a considerable portion of their time to estimating the chances of avoiding what they conceive to be an impending blindness. These gloomy forebodings are often mightily strengthened by the comforting assurances of friends, and I may add, now and again of medical advice that the symptoms probably indicate some serious disease of the optic nerve. The symptoms complained of vary from slight pricking or burning sensation in the eyes themselves to severe distress in or about the eyes or to widely extended and sometimes violent perversions of sensations, such as frequent and intense headache, pains in the back of the neck, or spine, giddiness nausea, and in some instances attacks of vomiting, when the use of the eyes is persisted in. There is in fact, so far as I am aware, no purely functional disease capable of causing a more genuine and persistent distress than is suffered in the severer forms of asthenopia. Taking this affection in its widest sense, I am under the impression that more than half the entire time and attention of ophthalmic surgeons is devoted to discovering the causes and finding means for the relief of this class of patients. If I may be permitted to express another general impression it is to the effect that asthenopia is more prevalent on the North American continent than elsewhere. I am aware, however, that general impressions are often wanting in scientific accuracy and on closer study may prove to be erroneous. This impression is derived from two sources. First from personal observation both in Europe and America and second, from the fact that the American literature of this subject during the last twenty years shows more minute attention has been given to this department of ophthalmic surgery in America than it has received in any other country. Twenty years ago, if one may judge by the text book of ophthalmology of that period, only two forms of asthenopia were recognized by ophthalmologists. First, accommodative asthenopia as met with in hyperopia and astigmatism. Second, muscular asthenopia such as occurs when there is insufficient convergence notably in certain cases of myopia. A very brief discussion of these two forms seems to have satisfied the writers of ophthalmic treatises in those days, that they had done ample justice to the subject. I could name many European authors of much later date who seem to have advanced no further in this direction. I do not think any one can practise ophthalmology very long without discovering that there are many persons who present no appreciable error of refraction and no fault in convergence but are, nevertheless tormented by difficulty in using the eyes in near work, and by other functional disturbances associated with the act of vision, and there are others in whom, when an error of refraction has been ever so carefully corrected there will be little or no relief from the asthenopic symptoms. These circumstances have necessarily led to a closer study of the subject with the result that we are now able to recognize quite a number of conditions other than those already named which give rise to asthenopic manifestations. The errors of refraction are, of course, the most frequent source of asthenopia. Hyperopia chiefly on account of the demand that this condition makes on the mechanism of accommodation, astigmatism the same, with the additional disturbing element

of an impossibility of perfectly correcting the defective retinal images which nature abhors not less than she does a vacuum. Myopia may give rise to asthenopia also but not so often as to the former conditions. The asthenopia of myops is due either to disassociation of the functions of accommodation and convergence, or to the increased difficulty of adequate convergence when the antero-posterior diameter of the eye-ball is considerably increased, as it always is in the higher grades of axial myopia. It is not my purpose to discuss the subject of errors of refraction and their correction; suffice to say that asthenopia associated with any considerable error of refraction, and sometimes even with comparatively trivial errors will generally disappear when the existing error is suitably corrected. If not, some fault in the equilibrium of the extra-ocular muscles will commonly be discovered when carefully sought for. In some instances the refractive error has of itself induced a false state of equilibrium or rather a defective equilibrium, a perverted muscular habit, so to speak, which must be overcome before the optical correction can be worn with comfort, and perseverance in the use of the glasses selected for several days or weeks may be necessary before complete relief is obtained. There is, however, no reason why a pair of eyes presenting considerable error of refraction, or any error of refraction, small or great, should not also have some muscular fault quite independently of the refracted error. This circumstance, has evidently been overlooked by those who claim that faults of equilibrium always disappear with correction of the associated refracted error. I have observed many cases in which the most exact correction wore for months and years has utterly failed in this respect. That there are muscular faults capable of inducing asthenopia in emmetropic eyes is a matter of every-day experience and it goes without saying that such cases are beyond the scope of either spherical or cylindrical glasses. From this fact we are justified in assuming that muscular faults are only susceptible of relief by correction of refraction or defects in accommodation in so far as they happen to be directly dependent on optical defects or some departure from the normal in the mechanism of accommodation.

It is somewhat remarkable that, although for nearly half a century, no one has seemed to doubt the existence of asthenopia from the defective power of convergence or as is commonly and loosely stated insufficiency of the internal recti, yet, it is only within the past few years that attention has been directed to faulty action on the part of the other five pairs of extra-ocular muscles and this, notwithstanding the fact, so well and so long understood, that any impairment in the functions of any one of the twelve extra-ocular muscles necessarily unbalances all the others. Now, it has been found that insufficiency of divergence is a much more common defect than that of convergence and, when present, no less capable of inducing visual disturbance than is the latter. Faults in the vertical movements of the eyes are also by no means infrequent and may occasion extreme distress and a form of asthenopia associated sometimes with widely extended reflex phenomena. Owing to the limited power of rotating the eye-balls possessed by the superior and inferior recti comparatively trivial faults in these muscles are liable to create much disturbance. Just as in the case of refractive errors there is no constant or direct relation between the degree of error, and the inconvenience it may induce. So much depends on the stability of nerve power, occupation, state of health and general surrounding of the individual that each one must be dealt with according to

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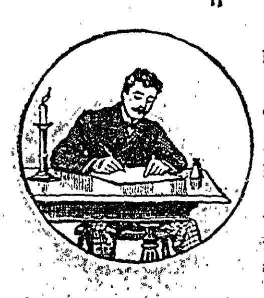

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In each tablespoonful of this preparation there is the essence of one ounce of Beef and two grains of Iron, in solution in Sherry Wine. It is therefore a refreshing stimulant, the effect of which is not merely to quicken the circulation and impart a temporary benefit, but also to supply actual strength.

Physicians and patients have been much disappointed in the benefit anticipated, and often ill effects have been experienced from the use of the many imitations claiming to be the same or as good as Wyeth's. In purchasing or prescribing please ask for "Wyeth's" and do not be persuaded to take any other.

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circumstances and quite independently of hard and fast rules. Sometimes all that may be necessary will be change of occupation, or such treatment as will invigorate or restore the general health. In other cases the use of prismatic glasses suitably adapted will suffice; but in a certain number of muscular faults permanent relief can only be obtained by surgical interference of a kind that will establish more or less completely an equilibrium of the ocular muscles. This may be extremely simple and easy of achievement or it may be a most difficult and tedious undertaking. Under no circumstances should an operation on the extra-ocular tendons be undertaken unless the indications for its performance are clear and definite and even then the result will largely depend on the skill and judgment of the operator. There are a few cases of asthenopia which seem to originate in undue weakness of the ciliary muscle cases in which apart from hyperopia or presbyopia the near point of accommodation is removed beyond its proper limits others in which near vision may be perfect for a short time, but cannot be maintained owing to weakness of the ciliary muscle. In these the local use of eserine or pilocarpine will be of service, so also will general roborant treatment. Now and then among elderly people we meet with asthenopia apparently caused by loss of transparency in the refractive media such as incipient cataract. In these it is probable that imperfect retinal images create a reflex disturbance. Reflex asthenopia of a different kind is by no means uncommon. We meet with it often in connection with nasal catarrh and nasal deformities causing pressure of opposed mucous surfaces, surfaces which under normal conditions are never habitually in contact with each other. Two such conditions are to be especially noted. First, an hypertrophic or polypoid condition of the mucous membrance covering the anterior extremity of the middle turbinated. Second, a spine projecting from the septum and coming in contact with the inferior turbinated. Either of these conditions may require surgical interference for their relief.

Another cause of reflex asthenopia is found in the teeth. Carious teeth with ulcerated roots especially in the upper jaw are to be looked for and set to rights or removed. Sometimes disease of the roots of the teeth will for a time, at least, elude discovery and make the diagnosis perplexing. So too disease of the antrum, and perhaps of the other facial sinuses should not be excluded in making a diagnosis. By far the most frequent, troublesome and persistent reflex asthenopia is met with in young or middle aged women who have suffered for a considerable time from uterine troubles some of these recover from their asthenopia when cured of the uterine disease. I have already alluded to these cases at some length in a paper before this association at a former meeting, and will therefore refer you to that paper for what I might say in this connection. There remains for consideration a considerable class of asthenopes whom we cannot place in any of the groups of causes I have mentioned. These last we can only ascribe to that ill defined condition known as neurasthenia, but why some neurasthenics without discoverable ocular defect should be able to use their eyes with comfort and others with difficulty amounting, perhaps to total disability for near vision, is one of the problems we have yet to solve. There are moreover some persistent cases of asthenopia of unknown origin which present none of the general symptoms supposed to be characteristic of neurasthenia. For these we can only hope to find a more

definite place for their classification after further careful study.

I do not think we are justified in assuming that there is such a condition as asthenopia of centric origin until we can define the centric lesions upon which it is supposed to depend or which are known to give rise to asthenopic symptoms. There may be causes traceable to known forms of dyspepsia, but I have never, to my knowledge, met with such and I am not aware that dyspepsia is associated with asthenopia so often as to justify the assumed relation of cause and effect between them. It is likely that time will unravel the difficulties of diagnosis which surround the remaining obscure cases of asthenopia, but for my own part I prefer an attitude of agnosticism towards all that I cannot understand rather than the easy way of concealing want of knowledge under the guise of unmeaning phraseology.

CASES FROM PRACTICE.

By Dr. Stephen Dodge, Professor of Ophtholmology and Otology, Halifax Medical College. Opthalmic Surgeon to V. G. Hospital, Halifax.

Mr. President:—

I have selected the following cases from my Case-Book, trusting they may be as interesting to this society as they were to myself, on account of their rarity, or circumstances connected with the operation, or the result of treatment.

Case I.

Mrs. I.—Aged 48, consulted me July '84, about 3 years before she first became conscious of trouble with her eyes—noticing coloured circles of lights around the lights in the rink like those of the rainbow. I found slight increase of tension in both globes, subconjunctival vessels enlarged and tortuous. Field of vision not contracted. Vision slightly diminished. She had occasional attacks when the foregoing symptoms were present and she was then having one of them. Pressure on the globe easily caused pulsation of the artery on the disc. Eserine relieved her of those symptoms. Tension of ball and vision became normal. As she was not prepared to have an iridectomy performed. I advised her to take some eserine home with her and to return as soon as she could for the operation. She continued to have recurrences of similar attacks, which were always relieved by eserine as I learned by correspondence.

In July, '86, she returned with the right eye suffering severe pain from an acute attack of glaucoma. Vision almost reduced to preception of light in this eye. Field of vision contracted to a new slit towards the outer canthus where she could see the waving of the hand. Tension markedly increased. Photophobia so marked that she could not bear the light, and she was obliged to sit in a dark room. Marked vascularity of the eye-ball and conjunctiva so swollen as to over-lap the corneal border. Unable to see the fundus.

After the patient had been etherized by Lindsay, I performed an iridectomy on the right eye, removing a large piece of the iris. After the operation the anterior chamber became filled with blood from the iris. I succeeded in getting the greater part of this blood pressed out through the wound and the remainder was absorbed. The left eye at this time was causing very little discomfort. Vision somewhat less than when I saw her two years before. Tension slightly increased. For fear of an acute attack like that of the right, after she had gone home, when it might be inconvenient for her to return, I decided to perform an iridectomy upon it too; while she was under the ether. The operation was performed without any difficulty, but just as I was about to remove the speculum I saw something presenting

at the wound which I took to be vitreous. As soon as possible I closed the eye for a few minutes. The patient was still under ether. I again examined the eye and gently raised the upper lid and found what I at first supposed to be vitreous, was the clear transparent lens which was now advanced further into the wound. With a little pressure below it easily came away. There was no hemorrhage and every thing passed off satisfactorily without any further complication. The operation on the right eye gave her complete relief from pain, photophobia, etc. The intense redness of the eyeball gradually subsided. Slight hemorrhages occurred several times in the anterior chamber, but these were soon absorbed. Tension became normal. Vision $\frac{1}{18}$ with the field still contracted. The left eye healed without any trouble, and after four weeks she went home. She, of course, has to wear ordinary cataract glasses for this eye. I have seen her once since. Neither eye has caused her any discomfort. I may say that her mother became totally blind, and from the description of her case given by my patient, I think there is very little doubt that her blindness arose from a similar cause unrelieved. The chief interest in the case just related lies in the spontaneous expulsion of the lens without any apparent spasmodic contraction of the lids.

CASE II.

Mrs. M.—Aged 66, V. G. Hospital, Halifax. Four years ago cataract began to form in left eye. It is now mature. General health good. Marked arcus senilis around the corneal border. On the 27th May I proceeded to remove the cataract. After cocaine had been applied so as to make the eye-ball insensible, a downward incision was made. I was just proceeding to the next step of the operation and remove a small portion of the iris, when I observed her upper lid to move freely and cautioned her to keep quiet; but before I could seize the speculum she caused a sudden spasmodic contraction of the lids, which produced so much pressure upon the speculum that it forced the lens enclosed in its capsule to come out upon the cheek with a very slight loss of vitreous. I immediately cleansed the wound, and saw that the iris was not embraced in the lips of the wound and then carefully bandaged the eye. She was a very nervous person, in fact, her intellect had been weak for some time, and she had very little self control. I gave her a mixture containing morphine and bromide potassium to be taken at bed time. During the night she became delirious, tore off the bandage, and was repeated by getting out of bed : so that a nurse required to be at her bedside constantly. She had several recurrences of this delirium during the week following; and required the presence of the nurse at her bedside nearly all the time. I apprehended a very unfavourable result to the eye, but nothing pronounced occurred. There was no iritis, but some injection of the vessels of the ball, not circum-corneal, but general. The wound, however, healed very slowly. Indeed, it is not well healed yet. A year before I operated upon the other eye (the right), making an upward section. The healing of the wound occupied about the same time as in the present case. I attributed this in both instances to the arcus senilis. The sight is improving satisfactorily and promises a very good result.

These two cases are interesting from the fact that the lens was expelled spontaneously—in the first case it was transparent, and without any apparent spasm of the lids; in the second it was cataractous, and spasm of the lids was very manifest. The rough usage to which the latter was subjected led me to regard the loss of the eye as almost inevitable, yet little harm followed.

CASE III.

This was a tumor of the cornea extending partly over both the cornea and the adjoining conjunctiva, towards the inner part of the eye-ball. The patient was a laboring man, aged 55 years, seen at the Halifax Dispensary in Oct., 1892. The size of the growth was ⅝ of an inch in diameter, partly covering the pupil, circular in outline, smooth on surface, thickness in centre ⅜ of an inch, gradually becoming thinner towards the edge. It was almost as white as snow. Its size interfered with the closure of the lids, and it had been growing about two years. I removed it carefully, very little bleeding followed from the conjunctival connection. It did not extend beneath Bowman's membrane. It healed up very readily. He left in a short time for his home in Newfoundland, and I am not prepared to say anything of its subsequent history.

CASE IV.

This is a similar case, seen on the first of May, 1893, married woman about 60 years. Healthy in every respect except for this corneal tumor. which was about the same size as the previous one, but rather thicker in the centre and situated also towards the inner part of the cornea, partially covering the pupil. I removed this and found Bowman's membrane had not been invaded. It also healed very soon, and in a month's time it was not easy to discover any trace of the growth in the shape of a scar. Vision as good as ever. The former specimen was examined by Dr. Morrow. In removing it, it was found to be very much harder than the second, and on microscopic examination there was found numbers of small round cells with a good deal of connective tissue. Dr. Campbell examined the second and it appeared to be composed of small round cells with scarcely a trace of connective tissue fibres. They were doubtless round celled sarcomata in both instances. They are the only two cases of this kind of disease in the cornea that I have seen in a period extending over 22 years. It is difficult to say what may be the ultimate result in these cases, but from the fact that they were free from pigment and had not involved Bowman's membrane there is much less likelihood of a recurrence.

CASE V.

This case is an aural one. Rev. Mr. F. consulted me in the winter of 1874, aged then 55 years. His right ear had been discharging for 36 years. He had consulted Mr. Harvey of London, fourteen years before, and he was considered one of the leading aurists there. He gave an unfavourable opinion. The hearing in the left ear had always been good and he was able to discharge his clerical duties satisfactorily. But now the hearing in the latter had failed to such an extent that he feared he would be obliged to relinquish his charge unless he got relief.

W. R. neg. Wh. R. neg. to words.
W. L contact, Wh. neg. to words.
V. R. 3', L. 4½'.

He had naso-pharyngeal catarrh, obstruction of eustachian tube in both ears, and catarrhal inflammation of the middle ear in the left. The right ear when cleansed showed a large perforation of drum membrane and mucous membrane of middle ear hypertrophied. The tympanic cavity of the right ear was kept carefully cleansed, the borders of the opening in membrane lightly touched with a solution of argent. nitrat. 15 grs. to the oz. and the mucous membrane of the cavity carefully touched with solution of the same varying in strength from 30 grs. to two drachms to the oz inflated with Politzer's bag. The pharynx was occupied with a thin frothy secretion—mucous membrane was of a dark mahogany hue—vessels enlarged and tortuous. For this condition and that of postnasal region I used at first a 30

grs. solution of argenti nitrat and tannic acid and glycerine alternately. As it improved I used a weaker solution of argent nitr. to the throat, etc. The discharge from the right ear soon diminished rapidly, and at the end of three weeks had nearly ceased. The size of the opening in the drum membrane was perceptibly less. The hearing for the voice had increased to 30′ in both ears. W. L. 2″, Wh. 2½′, R. W. contact, Wh. 9″. He was now anxious to return home. I gave him a weak solution of nitrate of silver 5 grs. to the oz. for the right ear, and tannic acid and glycerine to the pharynx. I saw him again the next summer when he came to Halifax. His hearing was very much improved in both ears, and on examining the right ear I thought the appearance indicated a healed perforation. On using Politzer's Bag I satisfied myself of the fact, and it has remained so ever since, as he always calls upon me every summer to have it examined. I have often succeeded in healing perforations when the disease was acute, but this is the only one where the disease had lasted so long, nor do I remember to have met with any such in the literature of the subject.

Correspondence.

TESTIMONIAL TO SIR JOSEPH LISTER.

To the Editor of the
MARITIME MEDICAL NEWS:—

Dear Sir,

Sir Joseph Lister having recently retired from active Hospital and Teaching work, the occasion has been thought appropriate for presenting him with a Testimonial of the esteem in which he is held by his former colleagues and pupils, and Committees have, therefore, been formed in Glasgow, Edinburg and London for the purpose of raising the necessary funds.

It is proposed that the Testimonial shall take the form of a Portrait. Subscriptions have been limited to two guineas and it is hoped that sufficient funds will be collected to permit of some memento of the occasion being presented to each subscriber of that amount.

As there are probably many Surgeons in Canada who may wish to join in the movement, but whose names and exact addresses it has been difficult to ascertain, I should be glad if you would permit me to state that subscriptions may be sent to me at 29 Weymouth Street, Portland Place, London W., England, or to one or other of the following gentlemen who have kindly consented to act as Treasurers, viz:— Dr. James Finlayson, 4 Woodside Place, Glasgow, Professor Chiene, 26 Charlotte Square, Edinburgh, Professor William Rose, 17 Harley Street, London W. England, Dr. Malloch, 124 James St. South, Hamilton Ont. or J. Stewart M. B. Pictou, Nova Scotia.

I have the honor to remain Sir,

Yours faithfully,

J. FREDK. W. SILK,
Honorary Secretary.

P. S. Two guineas are about $10.23.

VERNON RIVER BRIDGE, P. E. I.
27—9—'94.

Editor MARITIME MEDICAL NEWS.—

Dear Sir,

Kindly insert the following and oblige:—

E.—L.—was spraying his throat and and a portion of the instrument became detached and slipped down his throat, curvature downwards, actual curvature 1½ inches, actual length 2½ inches.

The problem to determine was whether it was in stomach or trachea.

There was no shortness of breath, no dyspnoea, no distress on taking a deep inspiration. On aucultation nothing could be detected. In short all symptoms pointing to its being in

respiratory tract were negative. This, together with the probabilities of its being in stomach, led us to believe it was in alimentary tract, altho' we felt that there was a possibility of its being in former situation notwithstanding the absence of symptoms. The treatment for foreign bodies in alimentary tract was adopted. We waited 10 days, and it did not pass. A ride on horseback brought on a hacking cough which persisted for 36 hrs. I again sounded him carefully and could not find any trace of tube in his trachea etc. The cough and the circumstance which brought it on were suspicious. I reasoned that it could not be beyond first bifurcation, as curvature being fully half an inch could not pass through the bronchi. The question was if it were there how to get it out. A happy thought struck me that if he were inverted, and directed to cough while he was being thumped on the back and chest, and as it was somewhat heavy it might slip down, if it could not be coughed up. He did so and on the first attempt up or rather down it came.

It may be asked why it did not cause more trouble? Well the curved end may have been across the bronchus leading to one of the lungs without excluding enough air to cause distress in breathing, while it would not cause enough irritation to cause cough on account of its smoothness, (i. e.) while the patient was at rest. On the other hand the jolting of the horse shook it around on tracha, and caused the irritation necessary to produce the hacking cough.

Yours, &c.,

A. Ross.

Digital Examination.—In making a digital examination in a case of face presentation, great care must be exercised by the obstetrician; it must be made very gently, so that no injury be inflicted to the face, especially to the eyes.—*Col. and Clin. Record.*

Books and Pamphlets Received.

A Manual of Human Physiology. By Joseph H. Raymond, A. M., M. D. Published by W. B. Saunders, Phila.

Essentials of Diseases of the Ear. By E. B. Gleason M. D. Published by W. B. Saunders, Phila.

Syllabus of Lectures on Embryology. By W. P. Manton, M. D. Published by F. A. Davis Co., Phila.

The Modern and Humane Treatment of the Morphine Disease by J. B. Mattison, M. D. (Reprint from Medical Record).

Morphinism in Medical Men. By J. B. Mattison, M. D. (Reprint from Journal American Medical Association).

Clinical Address. By David Webster, M. D. (Reprint from New York Polyclinic).

Can Physicians honorably accept commissions from orthopedic instrument makers. By H. Augustus Wilson, A. M., M. D. (Reprint Philadelphia Polyclinic).

VIS MEDICATRIX NATURÆ.

" The murmur of a waterfall
  A mile away,
The rustle when a robin lights
  Upon a spray,
The lapping of a lowland stream
  On dipping boughs,
The sound of grazing from a herd
  Of gentle cows,
The echo from a wooded hill
  Of cuckoo's call,
The quiver through the meadow grass
  At evening fall,—
Too subtle are these harmonies,
  For pen or rule,
Such music is not understood
  By any school;
But when the brain is overwrought,
  It hath a spell,
Beyond all human skill and power,
  To make it well."

—*Jour. Am. Med. Ass'n.*

Maritime Medical News.

NOVEMBER, 1894.

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Communications on matters of general and local professional interest will be gladly received from our friends everywhere.

Manuscript for publication should be legibly written in ink on one side only of white paper.

All manuscript, and literary and business correspondence to be addressed to

DR. G. M. CAMPBELL,
9 Prince Street, Halifax.

We have to thank many of our subscribers for a prompt remittance. There are still some to hear from.

THE October number of the *Nineteenth Century* contains an article on cholera, by Ernest Hart. Mr. Hart reiterates his characterization of cholera as "*a filth disease carried by dirty people to dirty places and chiefly spread by dirty water*," and claims that when this doctrine is universally acted upon, cholera will become a thing of the past, that it will become extinct in the epidemic form and become "a pathological rarity and a clinical curiosity." In the meantime while "waiting for a sanitary millenium of cleanliness" he strongly condemns the folly of sanitary cordons and quarantines, showing that quarantine fails not because it is theoretically useless but because it is practically unworkable, that however strong the proof of its being ineffectual in practice, while it seemed the only protection "it was clung to with the tenacity of despair." A better way and with immeasurably better results is to systematically attack the disease both in its home in India and along the pilgrim's track, and to isolate individual cases as they may arise, with proper disinfection and prevention of cholera discharges from gaining access to the water supply or damp soil.

A new phase and a new method in the history of the war with cholera was begun by "a mutual international co-operation." A method of sanitation for the healthy and isolation for the sick, alone is the key to all future measures. Cholera is not directly contagious from man to man. "Men can eat cholera or drink cholera, but they cannot 'catch it.'" One of the safest places to go to in a time of epidemic would be a well managed cholera hospital. The contagium is a living particle capable of rapid and enormous multiplication in suitable surroundings, "either within its human host or under certain conditions in water or damp soil." "The individuals by whom cholera is imported to any place are few in number, and the occurrence of anything approaching an epidemic is always proof that the disease has already taken root, has infected the soil, fouled the water, is already being swallowed by the people and is producing a *second crop*." "Short of surrounding ourselves with a condition of sanitary perfection which no nation has yet attained, the only real protection lies in the capture and isolation of the early cases and it is fortunately capable of definite proof that well directed measures with this object are perfectly effectual. A definite proof that the capture and isolation of the early cases confers protection is afforded in the case of Hull, into which for the last two years cholera has been repeatedly introduced but was not allowed to take root. Hull's sanitary condition is exceptionally bad, no better than some towns we could mention on this side of the Atlantic, with its drains water-logged and its soil in many parts sewage soak-

ed. "Means were provided for the immediate notification and removal to hospital of every case; an active sanitary column of ambulances, scavengers, disinfectors and whitewashers was organised which whenever a case was notified rushed to the spot carried the patient off to hospital and removed every trace of contamination; and thus, if one may say so, in spite of its dirt Hull escaped the danger unhurt except in pocket." Thus two outbreaks of cholera in England last year were isolated and stamped out. In Hamburg two years ago where a severe epidemic prevailed with a loss of life of 7611, the old condition of things prevailed, the drinking water was sewage soaked and the germ of cholera had been permitted to gain access thereto. The enormous death rates from former epidemics in Europe—with quarantine alone as the only protection—are given, while it is unnecessary to give these figures here, we are proud to point to the lesson they teach of the marvellous saving of human life as a result of preventive medicine and sanitation. Our Western civilization is as yet very low from the millenium of sanitary perfection, but compared with the Eastern where the villagers use for culinary purposes water from tanks in which they bathe and wash their clothes, and around which is an accumulation of all sorts of unmentionable filth, we may be said to have made an appreciable progress to that desirable goal. Antiseptic surgery, that is preventive surgery, has saved its tens of thousands but this other preventive science its millions formerly sacrificed to cholera, smallpox, typhoid and other preventible diseases. If Prof. Behrings autitoxin should prove successful it is estimated that in Austria and Germany alone one million and a half lives would be saved every ten years, from which a fair idea can be formed of the possibilities of preventive medicine in all other directions.

As the so-called gold cure for inebriety has received a great deal of publicity in these lower Provinces during the last year or two, and as it is administered frequently by persons who have had no medical training or education, we think it is well to publish the ingredients of these prescriptions and hypodermic solutions, so that those of our readers who are unacquainted with these formulae and who may be asked to advise patients as to whether it would be judicious for them to undergo this treatment, may be in a position to give their advice intelligently. We do not say that all of the various commercial companies—for that is really what they are—who are making a business of this so-called cure, use these formulae exactly without the slightest variation, but we have reliable information that those here given are the original prescriptions used, and we think they will be found to be pretty correct as regards the very large majority in use generally. Whatever opinion one may hold as to the ultimate value of this treatment in the cases for which it is used, we think no one will deny that some of the ingredients are of such a powerful and poisonous character that they should only be administered under the strictest supervision of a competent physician, perfectly aware of the composition of the mixture he is using. We believe this is not now the case, and that physicians (?) are employed by some of these companies to administer these or similar remedies without being made aware of the composition of the formula given them to prescribe. It has been stated that the use of the medicine produces such a disgust for liquor, that no attempt is made to keep it away from the patient, that they are in fact encouraged to drink it. The use of apomorphia will show very clearly how this is brought about. We see nothing in this treatment that will prevent a person from breaking out drinking again, unless he has strength of will to resist the temptation, nor can the

FELLOWS' HYPOPHOSPHITES!

(SYR: HYPOPHOS: COMP: FELLOWS.)

To the Medical Profession of Canada:

In submitting to you my Canadian combination, Fellows' Compound Syrup of Hypophosphites, permit me to state four facts:

1st. The statements contributed are founded upon experience, and I believe them true.

2nd. This compound differs from all hitherto produced, in composition, mode of preparation, and in general effects, and is offered in its original form.

3rd. The demand for Hypophosphite and other Phosphorus preparations at the present day is largely owing to the good effects and success following the introduction of this article.

4th. My determination to sustain, by every possible means, its high reputation as a standard pharmaceutical preparation of sterling worth.

PECULIAR MERITS.

FIRST.—*Unique harmony of ingredients suitable to the requirements of diseased blood.*
SECOND—*Slightly Alkaline re-action, rendering it acceptable to almost every stomach.*
THIRD—*Its agreeable flavour and convenient form as a syrup.*
FOURTH—*Its harmlessness under prolonged use.*
FIFTH—*Its prompt remedial efficacy in organic and functional disturbances caused by loss of nervous power and muscular relaxation.*

GENERAL EFFECTS.

When taken into the stomach, diluted as directed, it stimulates the appetite and digestion, promotes assimilation and enters the circulation with the food—it then acts upon the nerves and muscles, the blood and the secretions. The heart, liver, lungs, stomach and genitals receive tone by increased nervous strength and renewed muscular fibre, while activity in the flow of the secretions is evinced by easy expectoration following the stimulant dose. The relief sometimes experienced by patients who have suffered from dyspnœa is so salutory that they sleep for hours after the first few doses.

NOTICE—CAUTION.

The success of Fellows Syrup of Hypophosphites has tempted certain persons to offer imitations of it for sale. Mr. Fellows, who has examined samples of several of these, FINDS THAT NO TWO OF THEM ARE IDENTICAL, and that all of them differ from the original in composition, in freedom from acid reaction, in susceptibility to the effects of oxygen, when exposed to light or heat, IN THE PROPERTY OF RETAINING THE STRYCHNINE IN SOLUTION, and in the medicinal effects.

As these cheap and inefficient substitutes are frequently dispensed instead of the genuine preparation, physicians are earnestly requested, when prescribing to write "Syr. Hypophos. FELLOWS."

As a further precaution, it is advisable that the Syrup should be ordered in the original bottles; the distinguishing marks which the bottles (and the wrappers surrounding them) bear can then be examined and the genuineness—or otherwise—of the contents thereby proved.

For Sale by all Druggists.

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THE MEDICINAL USES OF STRONTIUM SALTS.

Disorders of Digestion, with or without dilatation of the stomach, associated with cardiac and renal affections are promptly ameliorated by the exhibition of strontium bromide. According to M. Germain See (*l' Medicine Modern*, October 29, 1891,) this salt seems to enact the role of a carminative, preventing acid fermentations—acetic and lactic.

Albuminuria—MM. Constantin Paul and Germain See, have both reported that strontium bromide and lactate have been employed in Rheumatism and Bright's disease with good results. Dujardin-Beaumetz reports the employment of strontium lactate in a number of cases of Albuminuria due to various causes, in all of which the proportion of albumin was reduced fifty per cent. in from one to four days. His remarks upon this matter conclude thus: "In lactate of strontium we possess an invaluable agent whose action is at the same time certain and inoffensive."

The dose of strontium bromide will vary from ten to twenty grains, for the relief of Atonic Dyspepsia, Nervous Disorders, Rheumatism and Bright's Disease. In Epilepsy, double the quantity mentioned above.

Strontium being liable to contain other substances, such as barium, which seriously interfere with its therapeutic effects, we have made a special point to obtain the chemically pure salts from the well known laboratory of Merck, of Darmstadt, and physicians specifying our products may depend upon securing for their patients a perfectly reliable preparation.

WYETH'S ELIXIR STRONTIUM BROMIDE. Each fluid ounce contains forty grains of the pure crystalline salt.

WYETH'S ELIXIR STRONTIUM LACTATE. Each Fluid ounce contains forty grains of pure strontium lactate. DOSE.—One to three tablespoonfuls three times a day. Saccharine is used to disguise the taste instead of sugar.

PRICES.	Strontium Bromide.	Strontium Lactate.
Per dozen bottles of 16 fluid ounces	$19.00	$23.00
Per Winchester " 80 "	7.00	8.00
Per Demijohn " 128 "	10.00	11.50

JOHN WYETH & BROTHER.

WYETH'S COMP. SYRUP WHITE PINE.

A most valuable remedy in chronic or pulmonary affections of the throat or lungs—relieving obstinate coughs, by promoting expectoration—and serving as a calmative in all bronchial or larnygeal troubles.

Each fluid ounce represents White Pine Bark 30 grs., Wild Cherry Bark 30 grs., Spikenard 4 grs., Balm Gilead Buds 4 grs., Blood Root 3 grs., Sassafras Bark 2 grs., Morp. Sulph. 3-16 gr., Chloroform 4 mins. Per doz. 16 oz. bot., $9.00. Per. Winch. 80 oz., $3.50.

Wyeth's Glycerole Chloride of Iron.

(NON ALCOHOLIC.)

THIS preparation while retaining all the virtues of the Tincture of Iron Chloride, so essential in many cases, in which no other Salt of Iron (the Hydrochloric Acid itself being most valuable) can be substitute to insured the results desired, is absolutely free from the objections hitherto urged against that medicament, being non-irritant, and it will prove invaluable in cases where Iron is indicated. It has no hurtful action upon the enamel of the teeth, even after long exposure. Each fluid ounce represents 24 minims Tinct. Chlor. of Iron. Per doz. 16 oz. bot. $9.00. Per. Winch. 80 oz., 3.50.

NOTE—We will be pleased to mail literature relating to any of Wyeth's preparations, particularly of the new remedies.

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AGENTS FOR CANADA FOR

JOHN WYETH & BRO.

treatment be at all expected to increase his strength of will or resistance to temptation.

The following are the prescriptions:

No. 1.—Tonic.

℞. Aurii et Sodii Chlor....grs. xij.
Strychnine Nitr........gr. i.
Atropive Sulphatis.....gr. ¼.
Ammon. Mur..........grs. vi.
Aloin ....gr. i.
Hydrastin..............grs. ij.
Glycerini .... ℔ ℥ i.
Ext. fl. Cinch. Co....... ℔ ℥ iij.
" " Coca erythrox.. ℔ ℥ i.
Aquæ destill........... ℔ ℥ i.

M. Sig.—One drachm, to be taken at 7, 9, 11, a. m., and 1, 3, 5, 7, 9, p. m.

No. 2.—Strychnia Nitr....grs. ix. 1/10.
Aquæ distill...... ℔ ℥ iv.
Pot. permang, q. s. to color faintly.

M. Sig.—Begin with gtt. v. and increase gtt. i. each injection till physiological effects are produced. Give 4 hypodermic injections daily—at 8 a. m., 12 m, 4 and 8 p. m.

No. 3.—Aurii et Sodii Chlor. grs. ij ss.
Aquæ distill......... ℔ ℥ i.

M. Sig.—3 gtt. every 4 hours in combination with the Strychnia solution, for the first four days. This is used for *moral* effects, as it turns a yellow color and looks like liquid gold. A solution of apomorphia is also added to hypodermic injection, in order to produce emesis, after giving patient a glass of whiskey.

We would direct the attention of our readers to Dr. Silk's letter on another page with reference to the "Lister Testimonial Fund." This testimonial is from "former colleagues and pupils," and we have no doubt there are some doctors in Nova Scotia and the adjoining Provinces who have attended Lister's lectures and who would like to subscribe. Subscribers to this fund will please note that any subscriptions sent to Dr. Stewart may be sent to him at the office of the Maritime Medical News.

HEMORRHOIDS.

In complaints of rectal troubles, make diagnosis before you prescribe. If piles, discover what kind, whether external or internal, bleeding or not bleeding, protruding or not protruding. External, inflamed piles require, in a degree, the same treatment as internal, yet the external require an astringent which internal can not bear. Bleeding piles need different treatment from those that do not bleed, and protruding piles special treatment, especially if they resist reduction. External piles are of two varieties: 1, external tags of skin; 2, venous tumors. External tags of skin, when inflamed, constitute one of the most painful varieties of piles. An ordinary prescription can do but little good. Ointments can not be absorbed. The application of heat or cold is productive of more positive results; use flaxseed poultices or cloths wrung out of hot water and changed often. If heat is unpleasant to the part, apply very cold water in the same way. If an astringent is necessary, make solution of sugar of lead, bowels should be moved daily, salines as good as any. An injection of a quart of cold water will afford some relief. A radical cure consists in the removal of the tumor. Never try to push tumor inside of the rectum. The treatment of internal piles is different from the class just cited. The danger from this class is hemorrhage or strangulation; either may endanger life. An indiscriminate prescription of an ointment accomplishes nothing. Far better is an application of cold water, when not protruded; an injection of cold water, when not protruded but painful, gives more comfort than all the combination of ointments usually prescribed. If, when the person who is troubled with the protrusion of internal piles, is directed to take a cold water injection every morning to move the bowels, to bathe the pile tumor in cold

water after an evacuation, anoint the mass with plain vaseline, then push it back, and under no circumstances to use paper as a detergent, much comfort will be gotten out of these directions

If internal piles both bleed and protrude, a little different treatment is used. The hemorrhage must be looked to. When protruding, an examination can be made, and if no bleeding points are found, the following will be found good:

R. Vaseline.................. 1 ounce.
Acetate Lead............20 grains.
Pulv. Opii..............15 grains.
Balsam Peru............. 1 drachm.
M. Sig.: Apply to pile after washing with cold water.

If protruding external piles are accompanied with much pain, some complication exists: usually ulceration. Washing with hot water will be found more agreeable, to be followed by the following prescription, which contributes much to relief:

R. Cocaine.................. 7 grains.
Ext. Opii....... .. .... 20 grains.
Ext. Belladonnae..........16 grains.
Lanoline...... .. .. 1 ounce.
M. Sig.: Apply after washing. Then return mass.

At bed time use the following suppository:

R. Iodoform .... 4 grains.
Morph. Sulph.............. ⅓ grain.
M. ft. sup. No. 1. Sig.: Insert at bedtime.

Itching is often mistaken for piles; if itching is a most prominent symptom, it will most likely be found to be pruritis. If with piles we have an itching of the surrounding parts, the following is suggested:

R. Vaseline.................1 ounce.
Ichthyol..................1 drachm.
M. Sig.: Apply often.

—*Matthew's Med. Quarterly.*

THE BUSY PHYSICIAN.—Who looks so deep into the very depths of the human soul as the physician—I mean the physician who can see, observe and is familiar with the mental as well as physical make-up of man.

No man has to carry so much knowledge as the doctor. He must decide questions involving life and death in a minute. The lawyer has "briefs between his briefs," when he can look up his case and his authorities and prepare himself for the hearing. The minister can choose his time for preparation and take this week to get ready for Sunday. The druggist can look up his questionable points in the dispensary or pharmacopoeia behind the prescription counter and let the patient wait for the medicine until he gets time to prepare it properly. So with the chemist. He has ample time to consult authorities. In fact, every scientist—save the physician—has to look up what he needs as he goes. Not so the doctor. He must be ready to tie an artery; to perform tracheotomy, etc., on short notice, and if he does not decide right, he is scorned by a thoughtless multitude and abused, and talked of, to say the least, disrespectfully.—*Ex.*

TREATMENT OF EARLY ABORTION.—A conservative treatment of early abortion is recommended by Schauta, of Vienna, in a recent article. The old rule that pain and hemorrhage combined mean inevitable abortion he does not indorse, and thinks the accident preventable as long as the hemorrhage is not excessive or the cervix dilated. He does not try to check the bleeding and trusts, to rest, which is continued for eight days after the last bleeding. In those cases where the os dilates and abortion becomes inevitable he tampons with a strip of iodoform gauze about two yards long and the width of three or four fingers breadth. He prefers to retract the perineum with the fingers of the other hand instead of using the speculum and renews the tampon at the end of twenty-four hours at the least, removing it sooner if the appearance of sacral pains indicates that the ovum has been expos-

ed from the womb. This method of treatment is in sharp contrast to the radical advice so often given of late to go in at once and curette out the womb as soon as an abortion becomes inevitable, a practice which Schauta objects to because of the danger of leaving fragments of membrane behind.—*Western Lancet.*

VOMITING OF PREGNANCY.—A writer in *The Lancet* (London) says: "I have not failed once for many years, by a single vesication over the fourth and fifth dorsal vertebræ, to put an end at once to the sickness of pregnancy for the whole remaining period of gestation, no matter at what stage I was consulted. The neuralgic toothache and pruritus pudendi of the puerperal condition yielded as readily, and to one application.—*Medical Age.*

THE TREATMENT OF WARTS.—The *Union medicale* for September 20th, says that when one has to deal with isolated warts, they may be taken off with a scoop; a rather abundant hæmorrhage follows, which may be arrested by compression or by cauterization. When warts exist in large numbers, this procedure is no longer applicable, particularly on account of the numerous cicatrices that follow its employment. In these cases the better way is to shrivel the excrescences with nitric acid. The tincture of thuja is also a very efficacious topical application.

In cases of condyloma the small tumors may be dusted with powdered resorcin or salicylic acid; they may also be covered with a plaster containing these substances in the proportion of from ten to twenty per cent. When the face is studded with a large number of these little warts, which often appear suddenly, Dr. Kaposi covers them with a piece of flannel spread with a layer of black soap. This is left on the warts for twenty-four hours and adheres to the skin, gradually becoming detached with the warts.

Another very good application is the following mixture: Flowers of sulphur, 20 parts; glycerin, 50 parts; pure concentrated acetic acid, 10 parts. The warts are painted with this mixture for several days without taking off the first layer, and gradually the excrescences dry up and become detached.

For keratosis of the palms of the hands and the soles of the feet plasters of resorcin and salicylic acid are also efficacious If the case is one of molluscum-like naevus it is better to employ electrolysis. The needle connected with the positive pole is plunged into the tumor, and a current is passed of from one to two milliamperes for about thirty seconds. This operation is repeated at the end of eight and fifteen days. When the naevus is very large, the galvano-cautery is preferable.—*N. Y. Med. Jour.*

PREGNANCY AT THE AGE OF FIFTY-NINE.—In the Gazette de Gynecologie, Dr. Depasse reports an aged-looking lady with white hair, supposed to be suffering from a large uterine fibroid, whom a careful examination proved to be pregnant. She was confined of a boy at the full term, and was able to nurse him; she weaned her son on her 60th birth-day. She was a widow and had a married daughter aged 40. The age was verified by a certificate of birth. Such late pregnancies are extremely rare.—*Times and Register.*

COOLING LOTION FOR PRURITUS—

℞. Liq. ammon. acetat. ℥ii.
Acid. hydrocyan. dil. ℥i.
Spts. rectif. - - ℥iii.
Aq. rosae, ad - - ℥viii.

To be locally applied.

—*London Practitioner.*

PREMEDITATED SUICIDE.

I ask a glass of water, or of claret, or of beer,
I go to kiss a pretty maid, she turns away with fear,
I eat some lemon jelly that's been standing on the sill,
And they tell me all are loaded—warranted to kill.

I put a pencil to my ips, I gulp down pounds of air,
I visit all the cattle at the Wayback county fair.
I buy a paper of a boy and handle dollar bills
And they tell me every one of these has that on it which kills.

I'm not much up in science, but I know a thing or two;
I know that if I do not eat or drink or kiss a few
Of these fashionable, dreadful germs, I certainly will die,
For I'd have to give up breathing to escape the bacilli.

Bacteria! Bacteria! I'm not afraid of you,
The world will roll around the sun for all that you can do;
So on dollars and on papers and on kisses and on food,
Just hand me common bacilli—I'm not a science dude.

And what's the use of living if you cannot eat or drink,
If pretty girls and dollar bills, and even printer's ink.
And county fairs and pencils are only other terms
For the rapid transit system of the scientific germs.

—Judge.

NEPHRITIS IN ITS SURGICAL ASPECTS.—Dr. E. L. Keyes (*American Journal of the Medical Sciences*) says:

Healthy urine is sterile.

Purulent urine is always microbic.

Microbic infection takes place from within the body by a number of methods in the course of disease; it is often brought about by instrumental manœuvers on the part of the surgeon.

A healthy organism and vigorous bladder may cope successfully with microbic invasion, and rid itself spontaneously, or with a little aid, of all damage arising therefrom—showing little or even no inflammatory response.

A suitable condition of the patient's soil is essential to the propagation and perpetuation of inflammatory phenomena upon the urinary tract—after microbic invasion.

This condition, intensified by traumatism and physical weakness, notably of the degenerative variety, is most intense where there is vesical distention with atony, and when the ureters are dilated and the kidneys involved in the changes incident to tension below—namely, atrophy and sclerosis above, with or without surface catarrh.

Under these circumstances surgical pyelo-nephritis is most likely to declare itself as a result of microbic infection from below (occasionally from above)—in the course of suppurative disease or after operative interference.

Asepsis, antisepsis, and sterilization of urine are ends to be aimed at in genito-urinary surgery—but, like all other greatest goods, not yet attained in perfection. Much, however, can be done by local means in a prophylactic and curative way, little by internal medication, and possibly as much or more than by any other means by flushing the urinary passages with natural mineral waters.—*Amer. Lancet*

BENZOATE OF SODIUM.—The combination of borate of soda and benzoic acid is extremely beneficial in various forms of kidney and bladder difficulty. Perhaps the most advantageous results are obtained when there is an excess of insoluble urates or of uric acid; the urates are at once converted into soluble, harmless, easily eliminated hippurates.

In high specific gravity of the urine, excesive urea in lithemia, in lithemic albuminuria, and renal hyperemia resulting from those conditions, the mixture is exceedingly serviceable.—*Med. Times and Register.*

Sodium Nitrite as a Therapeutic Agent.—Gordon Sharp (*Practitioner*, May, 1894), draws the following conclusions from his experience with sodium nitrite:

1. Sodium nitrite, being stable, may replace the less stable amyl and ethyl nitrites.
2. It dilates all the arterioles rapidly, and so relieves the heart quickly.
3. Disagreeable symptoms may be overcome by combining it with ammonia water or spirit of chloroform, and small dose of morphine.
4. It is most useful in anginal affections and in irregular heart action.
5. To obtain the most benefit from its use it should be continued some time after all symptoms have passed away. By this means the heart is able to regain its tone, and so to repair itself.
6. The maximum dose is four, or the most five, grains, and generally one or two are enough.
7. Grave's disease would appear to be aggravated by it.
8. Bronchitis and asthma, in the author's experience, are not benefited by its use.—*University Medical Magazine.*

Technique of Curettage.—Dr. M. Sanger states that aside from the infectious, gonorrheal forms of chronic endometritis, the most frequent and important varieties are endometritis menorrhagica and hypersecretoria (*Int. Jour. Surg*). For the former (endometritis interstitialis, fungosa, climacteria) the best treatment consists in curetting, followed after a few days by the application of caustics. In endometritis hypersecretoria, which is usually limited to the cervix uteri, irrigation, gauze "drainage," and cauterization are especially indicated. Irrigation must be preceded by dilatation of the cervix with laminaria tents, and rarely effects a cure unless associated with other measures. As a preparatory procedure to cauterization, washing out the uterus with a soda solution is of service. The use of gauze tampons, especially of medicated gauze, has a favorable action, although they should not be regarded as promoting drainage. They have the disadvantage of requiring to be frequently renewed. This objection does not apply to cauterization; the stronger the caustic the less frequently it has to be repeated. Sanger believes that in general the cauterization resorted to is too mild and too frequently repeated. Among caustics he prefers a 50 per cent. solution of chloride of zinc, which is suitable both for catarrhal as well as chronic, infectious and menorrhagic forms. In cases where the cervical canal is narrow, in virgins and nulliparæ, weaker solutions are in place. If a 50 per cent. solution be employed, the application should not be repeated until the end of sixteen to twenty days. For cauterization Sanger employs a long, thin silver sound.—*St. Louis Med. and Surg. Journal.*

Mammary Affections.—Where the nipple was cracked, Dr. Tucker applied a solution of nitrate of silver after each nursing, wiped it and put on a dry powder. This caused a scab to form under which healing would take place, and in order to protect it during nursing a nipple shield was used. The latter consisted of a glass cup, over which was placed a plain rubber nipple which could be removed, inverted and cleansed. One or two days' use of the silver nitrate would probably suffice. If the parts were inflamed and painful under its use apply a little cocaine.

Regarding cake-breast, when the breast was over-distended one section of it might be hard, other sections soft, the hard section being more or less painful. Relief was usually afforded

by stroking the breast from the pheriphery towards the nipple for ten or fifteen minutes. Extraction of milk by the pump, hand or child's mouth would give some relief, but not so much as massage.

Mastitis, in the author's experience was always due to inflammation of the nipples, and treatment of the nipples was prophylactic against mastitis. After mastitis had developed, the best treatment was drainage and cold. If the case were neglected it would end in abscess, when abscess became inevitable, a hot poultice would bring much relief until time for incision. To dry up the milk, belladonna, etc., were entirely superfluous; simply cease nursing and apply a tight breast-binder let the latter make uniform pressure.—*Arch. of Pediatrics.*

MECHANISM AND TREATMENT OF COMPLETE PROCIDENTIA UTERI.—Dr. Grace Peckham-Murray (*American Journal of Obstetrics*) says:

Restore uterus to place. If sensitive and eroded, use antiseptic tampons of cotton. If tissues are soft and relaxed, astringents, as tannin and iodine, should be used. Heal the erosions with 5 per-cent. solution of nitrate of silver. If the tissues are hardened by long exposure outside the vagina, astringents should not be used, but vaselin or some oily preparation should be employed.

Massage has not been found of much benefit in these cases. If it is to be of use, the improvement will be immediate. It would not avail in cases where there is a congenital tendency to displacements, but in those in which involution has not gone on to completion, or there is trouble with the circulation, massage and gymnastics may be of use.

Pessaries which are well fitting may relieve the patient greatly, and should be used as soon as possible, as they hold the uterus better in place than any tampon. Many patients are made very comfortable with pessaries, which they learn to take care of themselves, and some cases have been cured after a time by the support of the organ, the congestion has been relieved, the tissues have become normal, and the ligaments have regained their tonicity.

The surgical procedures from the earliest times have been without number. Many have become obsolete. Not much reliance has been placed upon those which simply narrow the vaginal outlet. The most serviceable of all these is the Le Fort operation. Many surgeons perform high amputation of the cervix, and combine with it, if the case would seem to demand, some of the operations for narrowing the vagina. The shortening of the round ligaments is generally conceded at the present day as not applicable to the cure of complete procidentia, and many believe that the time is not far distant when it will cease to be considered. Conservative surgeons regard ventrofixation and hysterectomy as measures too radical to be employed generally; and the success of vaginal fixation, as recommended by Schucking and many others who have followed his method, has not been established. Gynæcologists will look for the results of the new and simple procedure recommended by Freund with the greatest interest.—*Amer. Lancet.*

IT IS OFTEN A DISAPPOINTMENT.—

1. Because the patient does not follow directions.

2. Because drugs cannot benefit the case.

3. Because the dosage is incorrect.

4. Because a wrong remedy is selected.

5. The remedy is deficient in strength or is over active.

6. The vices or habits of the patient neutralize or abort treatment.—*Phar. Era.*

MEDICAL JOURNALS NOT APPRECIATED.—The following reply was returned to a circular letter soliciting subscriptions to a certain medical journal :

FARIBAULT, MINN.

Your Copy of the——Jurnal come, and the letter to—askin me to send fifty cens and git it fur a yeer. I don't nead no jurnals. When I git a tuff case I go off inter sum secrit plase and tell the lord all about it and wate for him to put inter my minde what ter do. That's bettern jurnals and syklopedes and such. If we hed more lord trustin docters and less colleges weed fare better. The lord noes morn all the doctors and if we go to him fur noledge it ill be bettenr jurnals.

Fraternally in the lord,
A CHRISTIAN DOCTOR.

P. S.—I've practist medisen morn fifty yeers. Yore ken publish this letter if you want ter.—*Northwestern Lancet.*

AULDE (J.) ON THE TREATMENT OF TONSILLITIS.—Tonsillitis, in the early stages, is readily amenable to mild treatment. For example, I have a patient, a young lady, who suffers from spasmodic asthma, the attacks being frequently brought on by indiscretions in diet, followed or not by exposure to inclement weather. She is given to wearing thin-soled shoes and light-weight clothing, and has occasional attacks of sore throat, which have generally developed into tonsillitis. Now, however, these attacks can be promptly arrested by the exhibition of a solution containing mercury biniodide, gr. $\frac{1}{25}$, and atropine sulphate, gr. $\frac{1}{500}$, to four ounces of water, taken in teaspoonful doses at intervals of ten minutes during the first hour and at hourly intervals thereafter. Fever, increased pulse-rate, or chest-pains, would of course call for other medication, such as aconite, gelsemium, or bryonia; a rheumatic diathesis would indicate the employment of the salicylates, and a malarial cachexia, quinine; while in the later stage of the disease, under either condition assumed, calcium sulphide would prove most beneficial.—*Am. Therapist.*

BOWDITCH (V. Y.) ON THE EFFECT OF CHANGE OF POSTURE UPON HEART MURMURS.—From forty-two cases which I have examined with special reference to the point in question, I find the following results :

Twenty-one showed an increased intensity of murmur when the patient was lying down.

Of these, 9 were murmurs at the base ; 8 at the apex ; 2 both in base and apex ; 2 could not be located absolutely.

Five showed increased intensity of murmur when the patient was sitting up.

Of these, 2 were murmurs at the apex ; 3 could not be located, but were more or less diffused.

Sixteen showed no special difference in the murmurs upon change of position.

Of these, 6 were murmurs at the base ; 9 at the apex ; 1 could not be located.

Out of one hundred cases examined by Dr. Campbell the murmur became more distinct in the recumbent position in seventy-eight, more distinct in the upright position in six, unaffected by change of position in twelve, not heard standing but developed by lying down in four.

It would seem, therefore, that there is no definite law by which we can determine which position affects these changes most. The fact remains, however, that the murmurs are frequently affected in character by change of position, and this once noticed may lead to something more definite in the future.—*Internat. Med. Mag.*

SOCIETY MEETINGS.

The Annual Meeting of the Nova Scotia Branch of the British Medical Association was held at the Queen Hotel, Thursday evening, Oct. 11th. After routine business the officers for incoming year were elected as follows:

President—Dr. Thomas Milsom.
Vice-President—Surg. Capt. Barefoot.
Treas.—Dr. M. A. B. Smith, re-elected.
Secty.—Dr. Carleton Jones, re-elected.
Executive Council—
Dr. E. Farrell.
Dr. D. A. Campbell.
Dr. G. M. Campbell.
Dr. T. Trenaman.
Dr. Barefoot.
Dr. J. Black.
Dr. E. Kirkpatrick.

Dr. D. A. Campbell was appointed Representative of the Branch on the General Council of the Association. The Annual Report of the Council was then considered.

ANNUAL REPORT OF COUNCIL, 1894.

Your Council has the very pleasant duty to report that the seventh year of the Branch has been very satisfactory in many details. Its existence as a permanent organization is now assured, it has proved that it is exactly suitable for what was so long required in Halifax We have had twelve meetings, three times no quorum was obtained, but this in all cases may be put down to the very inclement weather. The Council, however, feels bound to regret that the average attendance should not be higher than twelve, which is extremely small in a membership nearly fifty. The experiment of having light suppers after every third meeting was tried, but owing to the small attendance had to be abandoned.

At the suggestion of your president, members of the profession outside of the city were asked to read papers—with a very satisfactory result, papers being read by Dr. N. S. Muir of Truro, and Dr. Murray McLarren of St. John, both papers being of great interest and importance. Your Council suggests, therefore, that this plan be continued. We regret to have to chronicle the first death in the history of the Branch, Dr. R. H. Crawford, who twice held a seat in the Council, passed away in April last. Dr. Crawford was a regular attendant at our meetings, and always took a keen interest in the affairs of the association.

There is every possibility that the annual meeting of the parent association for 1896, will be held in Montreal, this would be a very important era in medical affairs in the Dominion, and it is hoped that this Branch which is the senior Branch in Canada will then be in a more flourishing condition even than it now is. The Council recommend that the question of a place for holding our meetings be carefully considered, for the number attending the meetings depends considerably on this fact. And also that a representative on the General Council of the association be appointed.

The Council in retiring wish success to the Branch during the coming year Success which can only be obtained by each individual member taking a keen interest in the affairs of the Branch and the association, and doing everything in his power to aid the scientific work and the social aim which are the objects for which we formed.

G. CARLETON JONES,
Hon. Sec.

A NATURAL SUPPOSITION.—Mr. Tulkinghorn—"There is a very fine picture of our minister in to-day's paper."

Mrs. Tulkinghorn—"Indeed! What has he been cured of?"

Treatment of Cholera.

Dr. Chas. Gatchell, of Chicago, in his "*Treatment of Cholera,*" says: "As it is known that the cholera microbe does not flourish in acid solutions, it would be well to slightly acidulate the drinking water. This may be done by adding to each glass of water half a teaspoonful of **Horsford's Acid Phosphate.** This will not only render the water of an acid reaction, but also render boiled water more agreeable to the taste. It may be sweetened if desired. The **Acid Phosphate,** taken as recommended, will also tend to invigorate the system and correct debility, thus giving increased power of resistance to disease. It is the acid of the system, a product of the gastric functions, and hence, will not create that disturbance liable to follow the use of mineral acids.

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THIRTEENTH YEAR—SESSIONS OF 1894-95.

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In calling the attention of the profession to the institution, the Faculty beg to say that there are more major operations performed in the Hospital connected with the school than in any other institution of the kind in this country. Not a day passes but that an important operation in surgery and gynecology and ophthalmology is witnessed by the members of the class. In addition to the clinics at the school published on the schedule, matriculates in surgery and gynecology, can witness two or three operations every day in these branches in our own Hospital. An out-door midwifery department has been established, which will afford ample opportunity to those desiring special instruction in bedside obstetrics.

Every important Hospital and Dispensary in the city is open to the matriculates, through the Instructors and Professors of our schools who are attached to these Institutions.

FACULTY.

Diseases of the Eye and Ear.—D. B. St. John Roosa, M. D., LL.D.: President of the Faculty: W. Oliver Moore, M. D., Peter A. Callan, M. D., J. B. Emerson, M. D., Francis Valk, M. D.

Diseases of the Nose and Throat.—Clarence C. Rice, M. D., O. B. Douglas, M. D., Charles H. Knight, M. D.

Venereal and Genito-Urinary Disease.—L. Bolton Bangs, M. D.

Diseases of the Skin and Syphilis.—George T. Elliot, M. D.

Diseases of the Mind and Nervous System.—Professor Charles L. Dana, M. D., Graeme M. Hammond, M. D.

Pathology, Physical Diagnosis, Clinical Medicine, Therapeutics, and Medical Chemistry.—Andrew H. Smith, M. D., Wm. H. Porter, M. D., Stephen S. Burt, M. D., George B. Fowler, M. D., Farquhar Ferguson, M. D., Reynolds W. Wilcox, M.D., LL.D.

Surgery.—Lewis S. Pilcher, M. D., Seneca D. Powell, M. D., A. M. Phelps, M. D., Robert Abbe, M. D., Charles B. Kelsey, M. D., J. E. Kelly, F. R. C. S., Daniel Lewis, M. D., Willy Meyer, M. D., B. Farquhar Curtis, M. D.

Diseases of Women.—Professors Bache McEvers Emmet, M. D., Horace T. Hanks, M. D., J. R. Nilsen, M. D., H. J. Boldt, M. D., A. Palmer Dudley, M. D., George M. Edebohls, M. D., Francis Foerster, M. D.

Obstetrics.—C. A. von Ramdohr, M. D., Henry J. Garrigues, M. D.

Diseases of Children.—Henry D. Chapin, M. D., Augustus Caillé, M. D.

Hygiene.—Edward Kershner, M. D., U. S. N.

Pharmacology.—Frederick Bagoe, Ph. B.

Electro-Therapeutics and Diseases of the Mind and Nervous System.—Wm. J. Morton, M. D.

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