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Original Communications.

A RATIONAL METHOD OF OBTAINING EXTENSION OF THE SPINAL CORD AND COLUMN.*

BY CHARLES F. STILLMAN, M.D., CHICAGO, ILL.

The employment of traction in affections of the spine is not of recent origin, horizontal couches provided with means for stretching the spinal column having been in vogue long anterior to the use of suspension, but the comparatively recent re-introduction of the latter principle has given it a new impetus, and traction in a straight line is

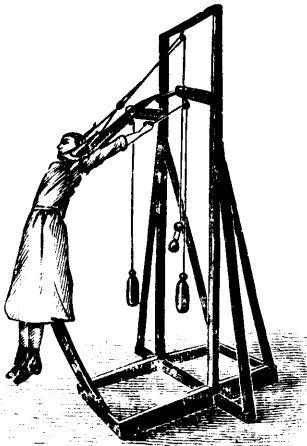


Fig. 1.—Upright Spinal Extension Frame—as originally constructed.

now not only generally advised in the treatment of deformative conditions and diseases of the column, but also for the mechanical treatment of diseased conditions of the spinal cord itself. Traction upon a curved line, however, possesses so many advantages over this, that I am constrained to advocate it strenuously.

* Read before the Chicago Medical Society, Dec. 2, 1889.

Several years ago, while reading a paper upon Lateral Rotary Curvature, before the Orthopædic section of the New York Academy of Medicine,* I called attention to the employment of the curved board in connection with suspension as a curvative measure in that deformity.

At that time I presented to the notice of the section, drawings of two frames (see figs. 1 and 2), devised by me for this purpose, and, as far as known to me, the first ever constructed upon this principle.

These frames I now take pleasure in formally presenting to the profession for their acceptance, but as they differ in some minor details from those originally devised, and as their range of application has since been so greatly enlarged, I have deemed it expedient to bring their claims prominently before you through the medium of this paper.

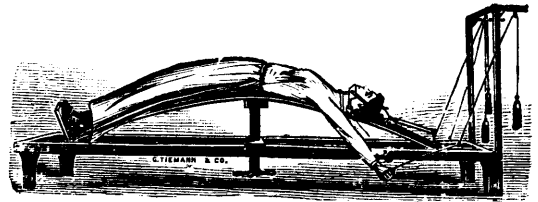


Fig. 2.—Recumbent Spinal Extension Frame—as originally constructed.

The first one to which I wish to direct your attention is standing before you. (See fig. 3.)

You will notice that it consists of a curved board, against which the patient leans, the curve being increased or diminished by means of a strong screw.

Traction is effected by means of pulleys and weights attached to a sling passing under the chin and occiput. The arms may remain free for exercises with dumb-bells, elastic cords or pulleys and weights, and slings may also pass under the axillæ as in the Sayre method.

It will readily be seen that if the posterior surface of the trunk is placed against the curved board, and traction on the spine is exerted by means of the pulleys and weights, the spine will be placed in a state of extension, the chest capacity will be increased and abdominal muscles strengthened, with a minimum of fatigue to the patient.

This frame, for the sake of convenience, I have

* *The Medical Record*, May 21, 1887.

designated as the upright form, to distinguish it from the one to which I now take pleasure in inviting your attention. This, which I shall refer to as the *recumbent* (see fig. 4), is constructed upon

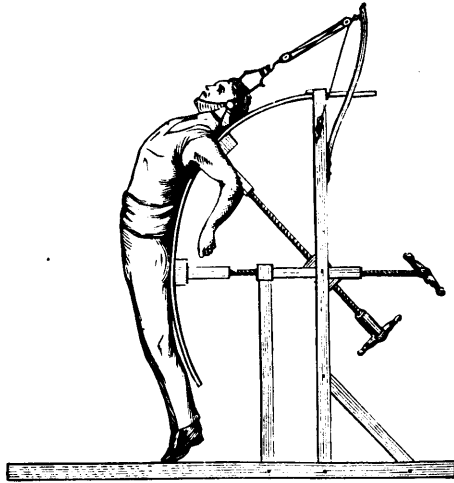


Fig. 3.—Stillman's Upright Spinal Extension Frame. (Posterior Curved Position.)

the same principle, but a longer continuance of the traction is permitted while resting upon it than while using the upright form, and it is therefore better adapted for patients of delicate physique and those in advanced stages of disease.

It should not be lost sight of, that in the use of these frames the patient is combining rest with traction in a greater degree than is possible in suspension by the Sayre method.

I shall proceed to the consideration of my subject mainly with reference to two conditions, viz.: 1st, the Influence of Traction, exerted during *posterior* curving of the spine, as a method of treatment in Pott's Disease and Lateral Rotary Curvature; and 2nd, the Influence of Traction, exerted during *anterior* curving of the spine, as a method of treatment in Locomotor Ataxia.

The use of these frames is not by any means confined to the treatment of these three conditions, but they are the only ones which will engage our attention this evening.

The changes in form of the spinal column under the influence of traction may chiefly be referred to two causes, viz.: the character of the inter-vertebral substance and ligaments connecting the vertebrae—and the shape of the vertebrae.

The inter-vertebral substance at its circumference is composed of fibro-cartilage and fibrous

tissue, disposed in laminæ—these being arranged concentrically one within the other, with their edges turned toward the corresponding surfaces of the vertebrae. The plates of which these laminæ are composed are not quite vertical in their direction, those nearest the surface being curved outward, and closely approximated, protection being thus secured for the vertebrae in case an unsuspected jar or impact is received by them while the spine is curved.

The centre of each inter-vertebral disk is composed of soft, elastic, pulpy matter, and the combined effect of the circumferential and central composition of the inter-vertebral substance is to produce an elastic, tough material, which is both extensible and compressible in its nature, acting as an elastic "buffer" between the bodies of the vertebrae, while superincumbent weight is borne upon the spinal column, and allowing elongation of the vertebral column during traction.

The natural curvatures of the spine in the neck and loins are due in a great measure to the variation of the inter-vertebral disks in shape, size, and thickness.*

In *shape* they accurately correspond with the surfaces of the bodies between which they are placed, being oval in the cervical and lumbar regions, and circular in the dorsal.

In *size* they are greatest in the lumbar region.

In *thickness* they vary not only in the different regions of the spine, but in different parts of the same region; thus they are uniformly thick in the lumbar region; thickest in front in the cervical

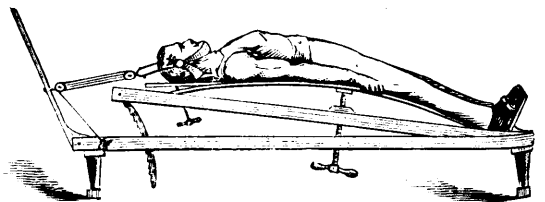


Fig. 4.—Stillman's Recumbent Spinal Extension Frame. (Posterior Curved Position.)

and lumbar regions, which are convex forward, and behind, to a slight extent, in the dorsal region.

The cervical and lumbar regions are thus necessarily given a greater freedom and pliancy of movement than the dorsal region, which has, in proportion to its length, a much smaller quantity

* The writer is indebted to "Gray's Anatomy" for the accuracy of these descriptions.

of inter-vertebral substance than the other regions, and whose concavity is chiefly due to the shape of the bones of the vertebræ and not to the shape of the inter-vertebral disks, as in the other regions.

As the inter-vertebral disks form about one-fourth of the spinal column, exclusive of the first two vertebræ, and as they are both compressible and extensible, it will readily be seen that they exercise a very important influence upon the production of extension of the spine. And here I wish to have it understood exactly what is meant by the word *extension* in this connection.

Extension is a word used to define the condition of a joint, or any portion of the body, produced by traction exerted in such a manner as to stretch it.

Traction is the active cause; *extension* the result—and it should not be confounded with the same word when used to express the motion of a limb as opposed to flexion. In addition to the inter-vertebral substance, the *ligamenta subflava* should also be given prominence as a factor in allowing the vertebral column to be elongated by traction. They are interposed between the laminae of the vertebræ from the axis to the sacrum, and consist of *yellow elastic tissue*, the fibres of which are almost perpendicular in direction. In the cervical region they are thin in texture, but very broad and long; thicker in the dorsal region, and in the lumbar region are noticeably so.

These ligaments are very elastic, serving to preserve the upright posture, and to assist in resuming it after the spine has been flexed. When traction is exerted during posterior curving of the spine, the extension condition is allowed to be produced mainly by the elastic nature of the inter-vertebral disks, and this is limited chiefly by the resistance of the anterior common ligament.

In the same manner, when traction is exerted during anterior curving of the spine, the extension condition is allowed mainly by the elastic nature of the *ligamenta subflava* and is limited chiefly by the resistance of the supra-spinous ligament. The construction of the capsular ligaments is also such as to permit this stretching to be accomplished. They are thin and loose ligamentous sacs attached to the contiguous margins of the articulating processes of each vertebra through the greater part of their circumference, and completed internally by the *ligamenta subflava*. They are longer and more loose in the cervical than in

the dorsal or lumbar regions, and are lined on their inner surface by synovial membrane.

Attention is called to those ligaments particularly, because in anterior curving of the spine it will be noticed that their sac-like construction does not interfere with the gliding upward of each inferior articular process of the vertebræ upon the articular process of the vertebra beneath, and does not oppose an obstacle to the stretching of the *ligamenta subflava*.

I shall first invite your attention to the merits of traction during posterior curving of the spine, as an essential principle of the treatment of Pott's disease. It is a well-known fact that this disease very rarely involves any other portion of a vertebra than its body in the early stages, and this clinical fact must be borne in mind in considering the mechanical treatment of this condition. Traction may also be exerted symmetrically instead of posteriorly in this disease, and it will perhaps lead to a more complete understanding of the nature of the latter if we study symmetrical traction first. By this term is meant the force which tends to convert the spine from a column into a chain, and so exerted that the main portion of the vertebræ and the posterior segments are both stretched to the same degree. This may be produced by any force which pulls the head and pelvis apart in a straight line, and the principle is utilized in several forms in the treatment of Pott's disease.

This form of traction may be produced by: 1st, the *upper extremity* (the ancients used to tie a patient head downward to a ladder in the time of Hippocrates).

2nd, *Horizontal traction*, which is the essential principle of the various flat extension beds and frames employed*; and 3rd, *by the weight of the lower extremity*, which embodies the principle of suspension now so generally employed and known as Sayre's Method.

Heather Bigg, of London, in commenting upon the latter method,† states that by it "the spine is changed from a column into a chain; from a mutual repose upon each other through their facets to a condition of mutual dependence upon their ligaments." He also asserts that "retching

*An interesting account of these can be found in the American Medical Transactions for 1880, by Dr. Benjamin Lee, of Philadelphia.

†Orthopragms of the Spine, 1882, p. 103.

and vomiting not unfrequently supervened—the patient sometimes fainted before its completion, and there are on record one or more instances in which fatal results have followed.”

Prof. Shaffer, of New York, in his work on Pott's Disease, says: “When suspension is employed now-a-days to reduce the deformity of Pott's disease, it cannot, for reasons to be assigned, do more than modify the compensatory curves, unless ether be administered after the plan of the German surgeons.” “If this be done, and it cannot, in my opinion, be other than dangerous or at best useless, it will be found that the pathological condition is more readily reduced, inasmuch as the reflex spasm yields when an anæsthetic is administered.”

He further observes: “When extension by means of suspension is applied, as it frequently is now-a-days, to the whole vertebral column from the cervical vertebræ down, in cases of spinal disease and the curvatures resulting therefrom, how much of the apparent change that takes place in the projection is due to the effect produced upon the projection itself.”

He then says: “It is a well-known fact that our height is increased in the morning after a few hours' rest in the recumbent position. Extension made through the healthy inter-vertebral fibro-cartilage, and the other structures binding the vertebral bones together, for a few moments only, is capable of lengthening the vertebral column to a very considerable extent. But when the extension is applied to the healthy spine the normal curves are also obliterated and the spinal column becomes straight as it is in early infancy.

“When the same force is applied where a portion of the vertebral column is diseased, the compensatory curves which result from the changed center of gravity are also greatly modified, and the deformity is thus placed under far different relations to the healthy parts of the spine; and without, in my experience, affecting to any appreciable extent the true pathological curvatures.”

The effects of a traction force exerted upon the spine while arched backwards against a curved board is not open to these objections, and the application of this principle to the treatment of caries of the spine will commend itself to every surgeon. It must not be confounded with the so-called backward traction of Dr. C. Fayette Taylor, which was

introduced by him at a meeting of the New York State Medical Society, in 1863. In Dr. Taylor's form of backward traction the spine was merely arched backward, to shift the super-incumbent weight from the bodies of the vertebræ to the posterior processes, while no traction force was exerted upon the spine in its entirety; but in the original method which I now present for your consideration, the posterior curving of the spine is produced, and in addition to this, a traction force is exerted through the linear axis of the column while in this backward arched position. (See Fig. 4.) The effect of this combination is to produce a correct extension of the entire spinal column, tending to reduce both the compensatory and actual deformity by the combined effect of the axis traction, and the forward pressure of the curved board at the seat of disease.

It will be found of great advantage to patients in the severer stages of caries of the spine to use the recumbent frame, since in addition to the curative effect upon the disease it provides the most satisfactory form of rest yet devised for their relief, for it provides:

1. Extension of the spinal column on a posterior curve, which of itself is a source of rest to the spine by removing all superincumbent weight.
2. It tends to reduce the deformity already existing, and arrest further progress of the disease by the combination of the extension with the forward pressure of the board at the seat of disease.
3. It allows these effects to be continued indefinitely without fatigue to the patient.

In the early stages of the disease, and during convalescence, both frames may be used to advantage in conjunction with the spring lever brace (see Fig 5.), which I devised in 1883, and have since perfected, and which has since been described in various journals.

The forward pressure of the curved board upon the diseased vertebræ which have a tendency to be absorbed anteriorly and thus form a knuckle, is a powerful factor in the arrest of the disease and obliteration of the deformity when combined with traction. This is easily illustrated by taking a strip of lead or other metal and bending it in the form of a knuckle. If this strip is seized at each end and pulled, it will be found impossible to thus efface the knuckle without the expenditure of great force.

This procedure aptly illustrates the principle governing Sayre's suspension, and demonstrates why so little actual effect is produced upon the diseased portion of the spine by the method he advocates. On the other hand if the strip is arched backward and pulled, the knuckle at the same time being pressed in a forward direction with the thumbs it will be seen to disappear with the exercise of very slight force. This experiment illustrates very well the differences between Sayre's principle of suspension and the one I am advocating before you to-night, and which is exemplified in these frames.

I shall next direct your attention to the consideration of the subject of Traction combined with the curved board in the treatment of Lateral Rotary Curvature.

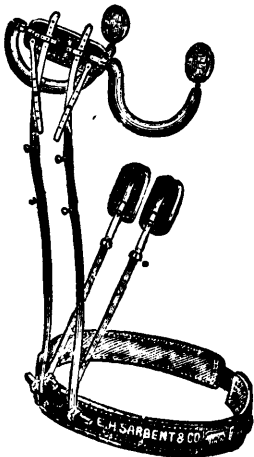


Fig. 5—V-Lever Brace for Middle Dorsal Region.

The idea of stretching the spine, as one of the curative measures in this deformity, is not a new one, Böttcher having advanced a plan in its production early in the present century, in a work on surgery published by him in Berlin.* In this work he illustrates his idea by an engraving showing an apparatus composed of a close-fitting pelvic band inferiorly and a jury mast superiorly—the two being connected by a metallic strip passing along the back of the head and spine—and provided with a ratchet for producing extension. The stretching or traction principle was next utilized in the formation of flat or horizontal extension couches, of which that of the elder Bigg, of Lon-

don, forms a notable example; but traction of the spine did not come into general use until Prof. Sayre, of New York, popularized the plan by his advocacy of suspension.

When a patient is suspended, and the traction force is by this procedure exerted in a vertical direction, it will be seen that the abnormal curves become modified by the suspended weight of the lower extremities. The vertebræ being thus relieved from the pressure of their superincumbent weight, tend to rotate into their normal relations.

(To be Continued.)

INTERALGAMENOUS OVARIAN CYSTOMATA.*

BY S. KEENE, M. D., BROOKLYN, N. Y.

Concluded from April No.

Treatment.—These cystomata require special treatment, owing to the fact that they are not pedunculated, but incapsulated, the capsule being formed by the broad ligaments. Not only is this the case, but as there are differences in the relations of these tumors to the ligaments, as already pointed out, there are several methods of management necessary to meet these various conditions,

I shall briefly discuss the several methods and the conditions that each is adapted to, and the technique in so far as it differs from ordinary ovariectomy. Enucleation ranks first, because it is adapted to more cases, perhaps, than any other method. This well-known method, devised and introduced by Dr. Minor, of Buffalo, has been practised by many ovariectomists. It was employed in the treatment of pedunculated cystomata when first brought out, but is now seldom practised except in the treatment of par-ovarian cysts; in fact I do not think that Dr. Minor ever employed it in the treatment of the class of cases now under consideration, but if he did he omitted a description of some of the details of the operation. Enucleation is adapted to all classes in which the cystoma descends into the pelvis completely separating one or both ligaments. In all such cases it will answer well unless there has been inflammatory action which has firmly united the cyst wall and folds of the ligaments. In such conditions the enucleation may be impossible, and other means of treatment,

*Berlin, 1795, Johann Böttcher.

to be hereinafter noted, must be adopted. Occasionally, though rarely, the cyst wall is so thin and fragile that the separation is difficult or impossible. Again, in case both ligaments are split up and the cyst lies between the uterus and the bladder, it is difficult to separate the cyst wall and the uterus, and the bleeding is often difficult to control, but in the majority of cases these are not insurmountable difficulties. In regard to the process of enucleation, I hope to be pardoned if I give some of the details with which you are familiar. They will be important in the way of making the description complete if nothing else.

In the first place, it is important to tap the cyst high up, in order to avoid wounding the thickest portion of the broad ligament. To do this it is sometimes necessary to extend the incision in the wall of the abdomen higher than may at first appear necessary. The cyst being emptied and drawn well out of the wound, the separation of the ligament and cyst wall should be begun at the point highest up, where the ligament is so thinned out as to be hardly noticeable. When the dissection is begun all round, the capsule can be lifted up and the separation continued by gently forcing a sponge between the tissues, and finally the deeper portions can be separated by the finger.

When the dissection has to be carried deep into the pelvis it is a great help to "pass one hand into the cyst as a guide, and continue the enucleation with the other" (Keith), the assistant making the necessary traction, which should be made upon the cyst wall, as the capsule is easily lacerated. If an opening is accidentally made in the capsule, it should be carefully closed with fine catgut sutures, applied upon the peritoneal side. The management of the ligamentous capsule after the cystoma is removed should first be directed to the control of hæmorrhage. In some cases a general oozing, which pressure will stop, is all that there is, but usually there are wounded vessels which need ligating. When the cyst extends deep down into the pelvis there is often very troublesome bleeding from veins. These should be ligated if possible, but this cannot be done in all cases. Pressure with a hot sponge should then be tried, and if that fails, styptics may be employed. The parts now present a pouch the inner surface of which is raw, and from which there will be some bleeding and much serous oozing. This calls for

drainage and to do this the cavity should be closed, so as to cut it off from the peritoneum. The redundant tissue, which is frequently great, owing to the growth of the broad ligaments, should be treated as follows: The upper portion of the opposing sides should be folded in so as to bring the peritoneal surfaces together and these should be united by a continuous cat-gut suture. The suturing should begin on both sides and close the parts, except at the points directly beneath the abdominal wound, where space should be left for the drainage tube. If the folds of the ligaments, thus held together by sutures, can be brought up to the lower angle of the wound, they should be fixed to the peritoneal surface of the abdominal wall by silk sutures, passed through the ligaments on each side of the opening for the drainage tube and through the wall of the abdomen. When the ligaments cannot be brought up to the wall of the abdomen, a drainage tube without side openings, should be carried down to the bottom of the cavity and fixed in the abdominal wall. The rule of practice has been to bring the whole mass of capsule into the abdominal wound and fasten it there in order to make sure of completely cutting off the sac in the ligaments from the peritoneal cavity. There are objections to this method, which more than outweigh the safety. It leaves a mass of tissue in the abdominal wound which inclines to break down and cause sepsis, and there is great liability to ventral hernia afterwards. I therefore, prefer the method described, believing it to be as safe and certainly more favorable to prompt healing and future results.

While this mode of treatment is perfectly satisfactory in suitable cases, there are difficulties attending the operation in exceptional circumstances and consequently certain dangers. The cyst wall may be easily torn and hence the danger of leaving a portion of it. When this happens it is necessary to destroy the secreting surface of that which is left. This may possibly be done by applying the cautery or pure carbolic acid, but it increases the liability to suppuration and renders the convalescence more tedious.

The next method of treatment is to remove the cyst and capsule together, by ligating the ligaments below the cyst.

This method is adapted to those cases in which the cyst is situated in one broad ligament, and

does not dip down very far into the pelvis. Such cases are described in books, as having a very broad pedicle but the most that can be correctly said of them, is that they are only partially pedunculated. In that condition the ligament can be ligated with what I may call the repeated continuous ligature, which is applied in the following way: A long ligature is passed through the ligament an inch from the outer edge and that portion tied; then one end of the ligature is passed through the portion already ligated, then carried forward and brought back through the ligament in such a way as to secure another portion and the two ends again tied, and so on, until the whole is secured. The cyst and its capsule are then cut off. This leaves no cavity, arrests all possible hæmorrhage and in this respect is all that can be desired. But there are difficulties and dangers that may arise, even in cases where it is applicable. There is a danger of wounding the ureter, or including it in the ligature, and a knowledge of its anatomical relations is not always sufficient to guard against this accident, as it may be displaced. By drawing the cyst and ligament out of the abdominal wound it may be possible to see that the ureter is not in the way, but when this cannot be done, one must depend entirely upon the touch to localize and avoid it. This is possible, when it can be felt like a cord crossing the ligament, and by holding it in the grasp of the thumb and finger for a moment the upper side will become dilated from the accumulation of urine. This is a sure guide which I obtained from Keith. But in case the tissues are thickened by inflammatory products it is difficult, by any means to find the ureter.

There is still another way of managing these cases and that is a combination of the two methods already described. It is well adapted to the class of cases in which the cyst can be enucleated easily and the capsule is so situated that it can be ligated without injuring the ureter. The cyst is first enucleated and the capsule or so-called pedicle is tied and cut off. The advantages are, that the capsule is easier to handle after the cyst is removed and there is no danger of including any portion of the cyst in the ligature, an accident that may occur in operating by the second method alone. There is one fortunate feature in this method of treatment, viz., in case enucleation cannot be ef-

fectured, ligation alone can be resorted to. It is well then to try enucleation even if it has to be abandoned.

There still remain for consideration cystomata that cannot be removed by any of the methods known at the present time, and there are such cases. A cystoma that descends into the pelvis and has become firmly adherent to the ligaments by inflammatory products cannot be enucleated, neither can the capsule be ligated. At least enucleation cannot be done with any degree of safety. That complete removal of such tumors has been tried is no doubt true, but the result has been to open into the rectum or bladder, or to cause uncontrollable bleeding or peritonitis, either of which may prove fatal.

These complications are always present in suppurating intraligamentous cystomata and hence, when pus is found on tapping, it may be inferred that enucleation is impossible. I have found, also, that cellulitis has so firmly united the cyst wall to the ligamentous capsule that they could not be separated. The treatment of such cases should be by drainage alone. I am well aware that the more skilful the operator the more surely will he overcome difficulties and the more seldom will he have incomplete operations, but when the conditions which have been named are present, I am confident that it is wiser and better to empty the cystoma and unite the cyst to the abdominal wall and then drain by means of the ordinary tube.

In such cases the cyst fluid is usually septic, (this is especially so in suppurating cysts), and it is very difficult to save the peritoneum and abdominal wound from contamination. After emptying the cyst it should be thoroughly cleansed with sponges or absorbent cotton, and papillary tissue if present, may be scraped off. This should be done with the cyst drawn up in the wound. It is also well to remove as much of the cyst as possible. The best means of accomplishing these objects is a matter for discussion. Therefore I may briefly state, that I leave enough to come up and join the abdominal wall without any traction, and then treat the remaining portion in the manner described, in treating the ligaments after enucleation when drainage is employed. To do this and at the same time keep the peritoneum free from septic infection is so difficult, that I may be pardoned for giving some of the details. If the cystoma is

large I prefer to strip off the ligamentous capsule as far down as possible. If that can be done a portion of the cyst wall is then cut off, taking care to take away most on the sides, so that the central portion will come up to the abdominal wall without dragging. Bleeding vessels in the cyst wall are ligated or twisted. The detached portions of the capsule are folded into the cyst and united with a continuous suture, beginning on each side and continuing towards the centre, but leaving space enough between their meeting to admit the drainage tube. In doing this great care has to be taken to keep the hands and the instruments, which have touched the inside of the cyst, from coming in contact with the peritoneum or abdominal wound. Again, in fastening the partially closed capsule or cyst to the abdominal wall, it is necessary to pass the needle from the abdominal wall into the cyst, and not use that needle again, unless it is thoroughly cleansed. If, on the contrary, the sutures are passed from the inside of the cyst outward, septic material will surely be carried into the tissues of the abdominal wall and trouble will follow. One suture on each side of the opening in the cyst for the drainage tube will suffice to unite it to the abdominal wall, and one suture above and one below, carried through the sides of the abdominal wall and into the cyst wall, but not through, will complete the coaptation. If this much is accomplished without contaminating the normal tissues there is very little danger of septic peritonitis occurring, or septic inflammation of the abdominal walls. The drainage is so perfect that though suppuration in the remaining portion of the cyst may go on, there is not much danger of it extending outside of the sac. The drainage must be long continued and the convalescence is very slow, comparatively. In case the secreting surface of the cyst has been thoroughly destroyed by suppuration the recovery is usually not so long delayed. Contraction and closure of the cavity comes in a month or thereabout. If on the other hand a part of the secreting surface is left, the discharge may go on for months, but the patient meantime may regain her health and be able to attend to her duties comparatively. When a small pocket and sinus remain it will facilitate recovery to inject iodine or carbolic acid.

I may be prejudiced in favor of this mode of treating such cases, from the fact that I have had

six, two intraligamentous cystomata and four adherent ordinary ovarian cystomata, which could not be removed, but were treated by drainage, and all of them recovered, while several cases of a similar character, treated by removal of the tumor, were lost.

Correspondence.

OUR PHILADELPHIA LETTER.

(From Our Own Correspondent.)

CLINIC BY WILLIAM OSLER.

A CASE OF AORTIC INSUFFICIENCY, INTERESTING ON ACCOUNT OF INFLUENCE OF TREATMENT.

This case, a liquor dealer, presents the following history:—He has always been healthy, with the exception of rheumatism in 1861; he confesses to a chancre and bubo, although we lose all history of specific trouble beyond the starting point in this disease. These are the only conditions in his past history which we can bring out; he has not been a hard drinker. His present condition is as following. His feet, legs and scrotum are œdematous; he is in the condition of orthopnoea, his respirations are 48 to the minute; his pulse is 96, regular, but feeble and collapsing. The cardiac apex beat is diffused in the fifth and sixth interspace, an inch outside of the nipple line, the impulse is not strong, but impresses one as being fluttering and ineffective. Dullness begins at the upper border of the fourth rib, beyond the nipple, to the left, and the sternum to the right. On auscultation we detect, at the aortic cartilage, a double second murmur. The sounds at the apex are very feeble. Watching the patient's breathing, shows that he has a Cheyne-Stokes breathing—the gradual increasing and decreasing rhythmical respiration.

This is this man's third attack of his heart trouble. The first was in '83, the second in '86, and the third in '89. In '83 he had shortness of breath on exertion; in '86 he had it while at rest in bed. Under careful treatment, over which we will go again, he was relieved each time and enabled to perform his duties with more or less satisfaction to himself. In this attack we will give him eight to ten ounces of whisky daily, with

tincture of digitalis, fifteen drops every two hours, and a third of a grain of calomel for a diuretic every four hours. In addition he will be given a saline purge, one-half ounce of Epsom salt every other morning, with as little liquid with it as possible. This latter arrangement excites very active exosmosis from the tissues; it is tapping the tissues without the necessity of cutting the skin. It was on this treatment he recovered before, sufficiently to avoid the need of a physician, and while by no means a strong man, still able to do his work or rather to oversee his business, as he tells us he did but little work directly.

In these attacks, of course, strict rest in bed was enjoined as one of the most important features. Now we are going to keep him in bed, give him ten saline purges and the whisky, but withhold the calomel and digitalis, to see if they are essential factors in changing his condition.

A week later.—The patient has improved; he rests well; can lie with his head lower; his pulse is regular and moderate, being 72. The dropsy in his legs has disappeared. We dispensed with the digitalis and calomel for the first three days after we studied him. The results were not good or satisfactory; his condition grew worse; it seemed as if rest in bed and the whisky and salts were not sufficient to help the struggling heart to regain that equilibrium which it is essential should be approximated. His symptoms grew worse, his dyspnoea became more urgent, his œdema increased and his heart impulse was more trembling and uncertain; so that four days ago we began the calomel and digitalis.

It is a disputed point as to the actual diuretic value of calomel. We know about the increase of urine when digitalis alone is given, so we can study what it was in this case. On the 6th of the month, two days before beginning calomel and digitalis, the amount of urine passed was eighteen ounces in the twenty-four hours; the same amount was passed on the 7th, and twenty on the 8th. Then these two drugs were started; on the 11th twenty-eight ounces were passed, thirty-two on the 15th, fifty-four on the 18th. There has been no especial action of the calomel in this case; in a similar one now in the house we tried this treatment, without the mercury, and found the results were as good.

Always predict a recurrence of the attack in

these cases. Hoffman's anodyne and aromatic spirits of ammonia are excellent stimulants in these cases; we will try them.

[Three weeks later, the patient was discharged; equilibrium between the heart and its work being fairly well restored.]

To the Editor of the CANADA LANCET.

DEAR SIR,—At a meeting of the Ottawa Medico-Chirurgical Society held on Friday last, 11th inst., the following resolution, a copy of which I am directed to forward you, was unanimously passed.

Moved by Dr. John Sweetland, seconded by Dr. A. J. Horsey, that this society desires to express its sincere hope that Dr. Edward Playter, of this City be appointed a member of the Provincial Board of Health, not only because of his well known and acknowledged ability as a Sanitarian, but also because there is no representation on the said Board from the whole of the Eastern portion of the Province of Ontario. It is further resolved that a copy of this resolution be sent to the Honorable Charles Drury, Minister of Agriculture, Toronto, E. H. Bruesen, Esq., M.P.P., the CANADA LANCET and the *Canadian Practitioner*.

I am, yours truly,

CLARENCE J. H. CHIPMAN, M.D.

Secretary.

Reports of Societies.

HAMILTON MEDICAL AND SURGICAL SOCIETY.

Stated Meeting, 1st April, 1890,

The President, Dr. J. W. Rosebrugh, in chair. Dr. Cockburn reported a case of Malignant Disease of Bladder.

About the latter end of November, 1888, my father came to me complaining of a feeling of discomfort just over the pubes, not severe, which eased at times, but never quite disappeared. During the next 4 or 5 weeks it gradually and almost imperceptibly became more palpable, till one day, about Christmas 1888, a small clot of blood was washed out with the urine, which from its shape must have been lodged in the urethra. I now be-

gan to feel some anxiety, for the sequence of symptoms tallied unpleasantly closely with the earliest symptoms of malignant disease of the bladder. On January 7th, 1889, Dr. Leslie saw my father and took a favorable view as to any vesical trouble, but (if I remember aright) thought he suffered from lithiasis, an opinion afterwards confirmed by Dr. Osler. After this, my father went about as usual; he did not complain much, but when questioned always said the pain was getting slowly worse, and small casts of blood were passed from time to time. Still feeling very dissatisfied with my father's condition, I mentioned my suspicions to Dr. Bertram, of Dundas, the family physician, and suggested he should examine per rectum, which was done. Dr. Bertram discovered nothing abnormal and at this time took a hopeful view. On March 26th my father had a sort of hysterical attack and took to his bed; under Dr. Bertram's care he improved for a time, but he now began to pass small particles of tissue. These were carefully examined microscopically on several occasions by Drs. Malloch, Osborne and myself. Their appearance was suspicious but by no means pathognomonic. Some of these shreds of tissue were sent to Dr. Osler of Philadelphia, who very kindly examined them and (to the best of my recollection) said such particles were often passed by patients suffering from chronic degenerative changes in the kidneys.

The pain gradually increased, but no great change occurred till May 26th, when a considerable discharge of blood occurred at the end of micturition. On May 30th, Drs. Malloch and Bertram met me in consultation over my father's case. A perineal section was suggested, pending an examination of the urine. The urine showed a considerable quantity of albumen and the operation was abandoned. From this date my father commenced taking morphia hypodermically. His general condition became worse, the pain over the pubes became more severe, and the whole hypogastric region became intensely tender on pressure. The albuminuria continued to increase, but although the urine was examined for casts by Dr. Malloch and myself on several occasions, none were found.

On August 9th, 1889, Dr. Osler of Philadelphia saw my father in consultation with Dr. Malloch, Dr. Bertram and myself. (Speaking from recollection) Dr. Osler was unable to detect anything definite by firm pressure over the pubes, and digital examination per rectum gave a negative result. Dr. Malloch examined my father per rectum on his first visit and both he and Dr. Osler agreed in pronouncing the prostate normal and no pathological condition to be detected. On

this occasion my father was sounded by Dr. Malloch with a negative result. To the best of my recollection Dr. Osler believed it to be a case of gouty kidneys, remarking that the cause of the hæmaturia was obscure. Dr. Osler opposed any operation and disagreed with me as to the presence of malignant disease in the bladder. This opinion expressed by so eminent an authority gave myself and my family great relief, and I began to hope I might be wrong in my view of the case. From this time my father went steadily down hill, the pain became more severe and constant in the regions indicated, blood and pus were constantly being passed. The morphia was gradually increased. As time went on he began to emaciate; blood was constantly passed at the end of micturition, and the suffering on these occasions became intense, especially towards the close of the act. The pain spread down the penis as in cases of calculus.

Uræmic symptoms appeared from time to time and the urine became loaded with albumen, but in spite of repeated examination, no casts appeared. Morphia was given in increasing doses to mitigate the constant suffering. All the symptoms became worse and worse. From time to time large quantities of blood were passed, sometimes mixed with pus. Albumen was always present in large quantities and the pain in micturition became most intense. On January 28th, 1890, I was telephoned for as there was some obstruction in the bowel. I found a hard mass blocking the rectum which was with difficulty removed. Three days later a second mass presented and was removed under chloroform. The chloroform was pushed to complete anaesthesia and I then proceeded to explore per rectum. I easily mapped out the prostate and satisfied myself that it was normal. In the situation of the bladder I was able to make out a hard irregular mass, movable, and, to a bi-manual examination, apparently about the size of the gravid uterus at the fourth or fifth week.

I now felt absolutely certain I had a case of malignant disease of the bladder to deal with. From the feel of it I judged it to be most probably scirrhus cancer, involving principally the fundus.

From this time my father began rapidly to sink. The suffering became so terrible that he was kept more or less constantly under chloroform, as the morphia seemed to lose all power, an injection of $4\frac{1}{2}$ grains producing no appreciable effect. He died Feb. 15th, 1890; the duration of the case from the earliest onset of symptoms being therefore about one year and three months. From May 30th, 1889, to February 15th, 1890, my father took over 2000 grains of morphia hypodermically, and that with only partial relief to the suffering!

REMARKS.—The specimen showed a growth on the posterior wall, which it infiltrated, measuring about $1\frac{1}{4}$ inches in width, $1\frac{1}{2}$ inches in depth, and one inch in thickness. Over its free surface were numerous papillæ, which formed a fringe-like covering to the growth. The tumor had not a very firm consistence, although it had been in methylated spirits for two weeks.

In the discussion which followed, Drs. Mullin, Malloch and Olmstead dissented from the view of it being scirrhus.

Dr. H. S. Griffin reported the following case of oöphorectomy for chronic ovaritis:

Mrs. H., æt. 41, married, nullipara. Family history poor, several members having died of phthisis. Spare, nervous, menstruation regular.

Dec. 3, 1888.—On making an emergent night visit, I found her suffering from intense pain referred to the lower part of the back and extending into the left inguinal region. She gave a history of previous tenderness and uneasiness in the same locality extending over several weeks, but not sufficiently severe to call for treatment. A vaginal examination discovered a small-sized mass posterior to the uterus, movable but intensely tender; making steady pressure in Campbell's position, I readily succeeded in placing it above the pelvic brim. This relieved the intense pain, but considerable distress and soreness still remained. She was instructed to lie on the face and side as much as possible.

Dec. 4th to 14th.—A few hours after replacing the ovary it again prolapsed, with return of the severe pain. It was quite impossible for her to retain a pessary, but persistent attempts were made to support the ovary with cotton wool tampons, aided by rest and posture. It would, however, invariably descend within twenty-four hours and have to be replaced with the finger. Nausea and anorexia were prominent symptoms.

Dec 14th.—Menstruation occurred, with amelioration of her condition. She was able to be up and attend to her household affairs to some slight extent.

Jan. 2nd to 12th.—The severe pain returned. All local treatment seemed only to aggravate the trouble and irritate the parts. She had to be constantly visited and the ovary replaced. Until the beginning of March this condition persisted. Then occurred an improvement and for two weeks she did not require a single visit.

Mar. 22nd.—In response to a call, I found her suffering intensely. Examination showed the ovary firmly pressed down and so intensely painful that I had to abandon attempts at reduction. Under sedatives and hot water douches I was able to replace it on the 28th. I still hoped that patient treatment would succeed in relieving her, but towards the end of April it was apparent that operative measures were necessary. She had be-

come unable to take sufficient nourishment, and loss of rest with continuance of the pain had greatly reduced her.

April 30th.—Operated at 11 a.m. Dr. Miller gave chloroform and Dr. Leslie assisted in the operation. A two-inch incision in the usual place enabled me to hook up the left ovary from Douglas' pouch. The pedicle was tied and dropped, the right ovary examined and found normal, and the wound closed. Operation occupied about twenty minutes. On returning to the patient a few hours after, I found her suffering from the most severe retching I ever saw. It was promptly relieved, however, by a half grain hypodermic injection of morphia.

May 14th.—The patient convalesced rather slowly, owing to irritability of the stomach. The temperature, which was 100° on the day of the operation, has never reached that point since, and is now normal.

June 1st.—Patient able to leave her room and feeling quite well. Since then (nearly a year ago) she has enjoyed perfect health, and has never had a pain since the day of the operation. The ovary removed was but slightly enlarged and had three small cysts about the size of marrowfat peas.

Selected Articles.

CLINICAL REMARKS ON THE GOUTY DIATHESIS AND ABERRANT GOUT OR LITHÆMIA.

GENTLEMEN:—During the past three months your attention at this clinic has been largely engrossed with diseases of individual organs. We have studied cases of disorder of the stomach, liver and kidneys, affections of the heart and lungs, and of other organs, including some very interesting cases of brain lesion and neuritis, in each of which we were able to locate the morbid action in some individual part of the system.

We have had other patients in whom the disorder was a general one, such as typhoid, intermittent fever, septicæmia, or tuberculosis, where we concluded that we had to deal with an infection of the system from without by a parasitic micro-organism, and believed that we could trace the symptoms, in whole or part, to the chemical or toxic action of certain substances, incident to bacterial development, known as ptomaines or leucomaines.

To-day, I briefly ask your attention to a morbid condition of the whole system, rather than to that of a single organ or group of organs; also due to a chemical substance produced in the body, however, not by the agency of micro-organisms, but by some error of assimilation and the result of a

tendency, either inherited or acquired, which has been called the Gouty Diathesis. One of the common symptoms of this condition of the system is an increased acidity of the urine, which upon standing, frequently yields a deposit of lithates and uric acid; it also often shows a diminution of the water. That is to say, the entire quantity of urine passed in twenty-four hours is considerably below the average quantity, and it is unduly acid. As this indicates a diminished alkalinity of the blood and an increased proportion of its acid constituents, the term "lithæmia" was introduced by Murchison to include both the condition itself and the various systems to which it gives rise. Austin Flint, Sr., proposed "uricæmia" as a substitute, but lithæmia has now become the generally accepted term to describe both the morbid state and the various digestive, nutritive and nervous phenomena associated with it. I must say, however, that the old term of the Gouty Diathesis, or if you please, Aberrant Gout, appears to me to be preferable to lithæmia, because the increase in the acid constituents of the blood is itself the result of disease, and as this has important relations to the malady universally known as gout, it would be proper in the title not to lose sight of this relationship or affinity. From this standpoint, Non-inflammatory Gout or Aberrant Gout is a better name for it than lithæmia.

The symptoms of typical gout are well known, and have not changed since they were described by Hippocrates or caricatured by Lucian; indeed, the causes of the disease seem to have been understood quite as well by the ancients as by modern writers. Luxurious living, excess of food, the over-indulgence in pleasures of the table, which accompanies worldly prosperity, are the causes now as they were when Seneca complained that owing to the prevailing luxurious habits even the women had become gouty, and Pliny, deploring the degeneracy of his times, pointed to the greater tendency to gout among the descendants than among grandparents, and says that it must have been imported on account of its foreign name (*podagra*). At the present day, we have the assistance of biological chemistry to enable us to trace the relation from cause to effect, and we can see the direct connection between the excess of nitrogen in the food, its faulty assimilation by the digestive organs and defective excretion, and the occurrence of every form of gout or lithæmia. This error of assimilation or of excretion may be handed down from one generation to another, the physiological sins of the parents being visited upon the children, just as Brown-Séguard's guinea pigs were born three-toed because their mother had been mutilated. As has been said:—

"The fathers have eaten a sour grape, and the children's teeth are set on edge."

I have not time to dwell upon the hygienic value

of the modern methods of canning fruits and vegetables, by which we have an abundant supply of vegetable food all the year round, but I may call your attention to the fact that the Saxon ancestors of the English people (as described for instance by Scott, in "Invanhoe,") during a large part of the year, lived principally upon meat and pastry, and drank large quantities of malt liquor, a diet very favorable to the development of gout, as many of their descendants can testify.

As Garrod has pointed out, the initial lesion in a gouty attack is the deposit of crystals of urate of sodium in the synovial membrane of a joint, which subsequently cause irritation and excite inflammation. This initial lesion need not be accompanied by inflammation, for we have in the pinna of the ear, or in the eyelids, similar deposits of urates without inflammation, forming the so-called chalky concretions, which are so common a sign of the gouty diathesis that we always look for them in this situation. In many cases the examination of the helix of the ear will throw light upon some obscure symptom of aberrant gout which otherwise might not be correctly interpreted. These spots upon the eyelids or ears, or around the joints of the fingers or toes, are so characteristic of gout that I believe the Latin name "gutta" refers to them. In the dictionaries and text-books generally, gout is said to come from the Latin "gutta, a drop," referring to a drop of morbid humor instilled into the joint, and implying a humoral pathology. But gutta also signifies a "fleck," or a spot upon a stone or other substance, and this is just what we see in the localities just mentioned. The French "Goutte" has the same etymology and definition; the German "Gitch" probably comes from the verb "gitchen," to torture, on account of the suffering connected with it. The classical name of the disease, "*podagra*," has reference to the pain in the foot, which is most frequently the site of the attack; other compound words have been devised by older writers to indicate the gouty invasion of other joints, by prefixing to "agra," the word belonging to the part affected, as *gonagra*, *chier-agra*, etc., which is an unnecessary and absurd refinement of nomenclature—a distinction which is no longer considered worth perpetuating.

With this rather lengthy introduction, I will now take up the notes of the case, and make them as brief as possible. The patient, 32 years of age, a laboring man, complains of symptoms of indigestion, sour stomach and heartburn, bowels rather constipated; but his principal disability arises from muscular pains in different parts of his body, mostly about his shoulders and his legs. He thinks that his feet swell at times. He has no fever. His pulse is about a hundred, and there is a systolic murmur heard all over the cardiac area, but not propagated to the vessels of the neck, therefore due to mitral lesion—mitral regurgitation, in

fact. The heart is not materially enlarged and is performing its function well; there is moderate hypertrophy, which is compensatory. The liver is slightly enlarged. His urine, passed in normal quantity, or rather less, is decidedly acid in reaction, but contains no albumen. Under the microscope are to be seen urates and the common forms of uric acid. I can detect no œdema of the feet, and he has not the physiognomy of chronic Bright's disease. Although he has not the appearance of being very ill, he declares that he has not been able to do any work for nearly a year.

In reviewing the case, we find evidences of gastric disorder, heart lesion and excessive acidity of the urine, with muscular pain and stiffness. I do not pay much regard to his statement that his feet sometimes swell, because the heart is performing its duty well, and the kidneys do not appear to be affected; and moreover, this sense of swelling of the extremities is not an uncommon symptom in some forms of indigestion, as pointed out first by Leared.

He says he has been a moderate user of alcohol, but principally in the form of malt liquor. Let me say here that alcohol, especially in the form of fermented or brewed liquors, is a sort of a physiological test of gout, and where the diathesis exists, indulgence in this form of stimulant is apt to be quickly followed by very disagreeable consequences, either as a typical inflammation in ball, of the great toe, or possibly non-inflammatory pain or disability elsewhere. I can find a slight chalk-like nodule in the pinna of his ear, which places the case in its proper light. He is too ignorant to give us any information of value concerning the health or the habits of his parents or grandparents, and possibly he did not inherit the disease at all, but acquired it himself by eating meat largely and indulgence in malt liquor. The heart-lesion is probably due to gouty changes in the leaflets of the mitral valve, causing deformity and insufficiency.

It would be a mistake in this case to regard it simply as one of dyspepsia and dismiss him with a prescription of soda and gentian. Gastric catarrh in this case, as in many others, is simply a symptom of the gouty diathesis, just as the pains in the muscles are. These muscle-pains may be due to actual deposit of urate of soda in their structure, causing irritation and interfering with motion—just as in the case of the pork butcher at a previous clinic, whose pains were attributed to the presence of trichina, undergoing calcareous changes in the muscles—or the pain may be due to lessened alkalinity of the blood, caused by the acid condition of the stomach, in which case relief will be experienced at once, after correction of the diet and the administration of alkalies. This relief, however, will be only temporary, unless remedies are directed against the underlying gouty diathesis, or

the actual lithæmia, which is largely due, according to Murchison, to defective hepatic activity. J. Milner Fothergill, recently deceased, ably defended the view that there was actually an increased production of uric acid in the economy, owing to degeneration and tissue reversion. Uric acid is merely urea insufficiently elaborated or oxidized. Birds or reptiles pass solid or nearly solid urine, consisting of urates. Mammals have a fluid urine, with soluble urea in place of urates, although traces of the uric acid formation remain even in the highest mammals. When the liver is over-taxed, or is congenitally inadequate, it tends to revert to its primitive uric acid formation, and this is Fothergill's explanation of the gouty diathesis, and a very plausible one. Whether the uric acid is produced in greatly increased amount, however, or is simply retained, owing to deficient excretion, there can be no doubt but that Garrod's statement is correct: that it is present in large excess in the blood, both in the typical gouty attack and at the aberrant or lithæmic form.

With regard to the question of treatment we will not now speak of the acute form, further than to make the observation that the more acute the attack, whether typical or atypical, the more likelihood of there being benefit from the administration of colchicum. In cases of lithæmic pains in the internal organs, I have administered a pill of something like this: Merck's colchicine gr. $\frac{1}{4}$, quinine hydrochlorate gr. iij, and morphine hydrochlorate gr. $\frac{1}{2}$, every four or six hours, with marked benefit. I have also used colchicine (gr. $\frac{1}{100}$) hypodermically in gouty sciatica, with entire relief after a few injections.

Alkalies, as you might infer from what has been stated above, are also highly serviceable. But as soda forms the urate of soda, which is insoluble, we generally give potash, preferable in combination with a vegetable acid, as the citrate or the benzoate, or simply as the carbonate. Where there has been swelling around the joints, the iodide of potassium has been used with much benefit. As lithia forms the most soluble salt of all with uric acid, it is frequently given; the principal objection to its use being that of greater cost. In the present case we will give the iodide of potassium (gr. iij), ammonium hydrochlorate (gr. xij), ext. rhei fld. ℥v, aq. menthæ pip. q. s. ad f $\frac{3}{4}$ ss, in a cupful of hot water before meals. In some cases I have resorted to the very soluble iodide of lithium (gr. ij-ij, with decided benefit. The natural mineral waters containing lithia are largely used for this class of cases, but in most of them the proportion is infinitesimal. Vichy and Carlsbad waters have long been employed in the gouty diathesis, but, as the former contains mainly carbonate of sodium, the latter is preferable. Although this water contains sulphate of sodium and chloride of sodium in decided proportion, the

taste is neither disagreeable nor brimy. Carlsbad has had a reputation extending over a century for its great success with gouty subjects, who resort there for treatment from all parts of the world, this country not excepted. Fortunately for those who cannot undertake a journey to the Springs, the mountain comes to Mahomet, for the water is now bottled under government supervision, exported to this country, and can be taken at the patient's home with equal benefit. Indeed Sir Henry Thompson considers the home treatment preferable, as it involves less disturbance and can be continued for much longer time. It is of interest in this connection to note that Prosser James, a short time since, made the important discovery that the water, of the Carlsbad Springs contains lithia in combination with the salts already named, thus giving an additional explanation of its acknowledged usefulness in lithæmia and aberrant gout,

As uric acid is a lower form of oxidation than urea, it is eminently desirable to introduce more oxygen into the system in treating gouty subjects, and this can best be done by the classical method of systematic exercise in the open air. Where there is an evident deficiency of red-blood cells to act as oxygen carries to the tissues, it is proper to give iron and Fowler's solution of arsenic, and this is sometimes of great advantage where the patient is neuralgic as well as gouty. It has been proposed to administer oxygen by the digestive tract as in the Bergeon method of treating phthisis but the rectal form of administration will hardly meet with favor either with physician or patient in this country. It is possible, however, that an oxygenated water, which has been used in Paris hospitals by Dujardin-Beaumez and others, might yield good results and it is worthy of further trial, as by this means an increased amount of oxygen has been found to enter the blood. If to these we add due regulation of the diet, limiting the amount of nitrogenized food, and especially the amount of alcohol, keeping the emunctories in good working order, we will do much toward overcoming the gouty diathesis and preventing lithæmia and its various concomitants.—Frank Woodbury, A. M., M. D. in *Coll. and Clin. Rec.*

FACIAL PARALYSIS. PERIPHERAL EPILEPSY.

FACIAL PARALYSIS.

Gentlemen,—Observe the difference between the eyes of this patient, one of which is shut closely, the other partly open. This indicates weakness of the orbicular muscle of the eye, which is innervated by the seventh nerve, so that there is disease in the seventh, or facial nerve, which is distributed to the side of the face.

As he smiles one side of his face is drawn up, while the other is motionless, and it is impossible for him to pucker up his lips—a movement which is effected by the action of the orbicularis oris muscle. As he cannot close the eyelids on account of lack of contractile power in the orbicularis palpebrarum, so in the mouth he cannot adjust the lips because the right half of the orbicularis oris is paralyzed. He is able, you notice, to blow out his cheeks. He says that in eating the food gets between the teeth and gums.

The patient informs us that in June last he fell from a second-story window some twenty feet upon a stone slab, breaking his wrist. Blood came from his ears, which indicates that rupture of the tympanic membrane had occurred. Whatever hæmorrhage took place must have been due to rupture of the blood vessels in the middle ear.

This history leads us to infer that the injury was to the nerve where it lies in the bony canal, and that, perhaps, there was fracture of the bone with consequent compression of the nerve trunk. If this were the case we should expect the chorda tympani to be involved.

His sense of taste is unimpaired on the left side, but on the right it is diminished. If in a case of this kind the sense of taste is preserved, we infer that the injury is outside of the point where the chorda tympani springs from the main trunk, and that the lesion is a peripheral one, involving one portion of the nerve, and leaving the other intact. Where the sense of taste is involved, the lesion is nearer the brain than the origin of the chorda tympani nerve.

This patient perceives the taste of an acid applied to the right side of the tongue, so that the paralysis is not complete. There are some who believe that the glosso-pharyngeal nerve is the only nerve of taste, but this varies in different persons.

The structures of the inner ear are not destroyed. The probability is that the tympanum was ruptured, which was followed by thickening, so that the drum-head is no longer capable of taking up sound vibrations and communicating them from the ossicles of the ear to the internal structures.

What is the proper treatment for such a case? It is not an uncommon thing to find patients suffering with paralysis of the facial nerve consequent upon simple exposure to damp or cold, but such patients are predisposed to rheumatism and demand specific treatment. But it would be useless to treat this patient with salicylate of sodium, or with other remedies given for the purpose of curing rheumatism. You must recognize the fact that there is injury to the nerve within the bony canal through which the nerve passes from the base of the brain, and endeavor to remove the exudation that probably causes compression. It is possible that we may not succeed in doing this, for there may have been

sufficient displacement of the walls of the bony canal to produce permanent compression analogous to what occurs in the spinal cord where there is caries of the vertebræ. You know how patients suffer from caries of the vertebræ. After a time the vertebræ collapse, an angular curvature of the spine is produced, and the cord is compressed at the point of curvature. The pressure is sufficient to cut off all functional power in the cord, and the lower part of the body is consequently permanently paralyzed. We have a similar condition of things in the case before us, and it is possible that we may never succeed in relieving the nerve from the pressure.

Mercury and the iodide of potassium are efficient for this purpose, and in this case I would advise doses of five grains of the iodide of potassium, and one thirtieth of a grain of the bichloride of mercury. Let the patient make use of these remedies as long as symptoms of deafness or paralysis exist. Electricity should also be applied to the face. The faradic current should be used, not because it will cure the disease, but because it will keep the muscles of the face exercised. What we desire is to preserve the muscles from atrophy while we are endeavoring to relieve the nerve from pressure. This is the only line of treatment that can be used with any prospect of success in such a case.

EPILEPSY OF PERIPHERAL ORIGIN.

The next patient I present to you is a girl ten years of age. About a year ago, while apparently perfectly well, she was seized with convulsions. The first attack came on about nine o'clock in the morning, the mother finding her lying on the floor. She bit her tongue, frothed at the mouth, and, her mother says, remained unconscious for half an hour or more. After recovering from the fit the patient continued in a more or less feverish condition the remainder of the day. This was doubtless a typical epileptic convulsion. The next day she had two convulsions, one immediately following the other.

It is important to ascertain, if possible, whether she had fever, or whether the pulse grew more rapid during the attacks and remained so, because we must make a distinction between convulsions that are epileptic in their character, recurring one after another, and constituting what is technically known as the *status epilepticus*, in which there is a rise of temperature, and those cases where we have simply a succession of eclamptic fits unattended by any febrile movement. The former is much more dangerous to the patient.

The mother did not bring the child here wholly on account of the epileptic convulsions, and we learn that there are other interesting points in connection with the case furnished us by her physician.

The child, you remember, is ten years of age,

and you observe that she presents a maturity beyond her years. The mother informs us that in her family the occurrence of puberty is earlier than in the majority of families. Usually menstruation does not develop before the twelfth or fifteenth year, but from the appearance and development of this girl, I should say the commencement of menstruation was not far distant. Again, her physician has made a vaginal examination, and has discovered an ulcerated condition of the cervix uteri. This seems almost incredible in a child of her age, but is, of course, possible, and does sometimes occur.

We do not know positively the cause of these convulsions, but the probability is that they are due to the ulcerated cervix. It must not be forgotten that in some of these cases we have hysterical epileptiform paroxysms, or there may be a combination of the two disorders in a delicate and exceedingly nervous organization, producing all the convulsive manifestations common to *hystero-epilepsy*. But in epilepsy we have certain marked symptoms which enable us to discriminate between it and true hysteria. *True* hysteria is very rarely accompanied by unconsciousness. In a complete hysterical convulsion the patient preserves a certain amount of consciousness; in fact, she knows under what circumstances the convulsion is to take place, and, therefore, guards herself against a fall when the fit comes on. Again, the tongue and lips are not bitten. There are some physicians, however, who claim that this latter may occur, but I should want strong confirmatory evidence to make me believe that a patient bites her tongue and becomes entirely unconscious in a true hysterical convulsion. Hysteria manifests itself in the day-time, during the hours when the nervous system is exposed to excitation; in other words, it belongs to the waking period. The convulsions do not occur during sleep. This patient has convulsions in the night and while asleep, which is characteristic of true epilepsy.

Whatever may be said as to the general condition of her nervous system, its excitability, perhaps its hysterical predisposition, I think we have in this case an element of true epilepsy governing and controlling the manifestations. If that be the case, where is the source of irritation that excites the convulsions? This is not a case of congenital epilepsy, for, according to the statements of the mother, it is only a year ago since the convulsions first manifested themselves. Having, as we are told, an ulcerated condition of the cervix uteri, the probability is that *there* was the starting-point of the irritations which were communicated to the brain centres and brought about the convulsive movements. We may call this a case of *peripheral epilepsy*.

The treatment should, of course, be directed principally to the peripheral organ, and the ulcer-

ated condition of the cervix must be remedied before we can hope to relieve the convulsions. It is highly probable that the occurrence of menstruation and the periodical relief that is obtained through that function will help to relieve the patient of the seizures. She must be cured of all swelling, inflammation, and ulceration about the cervix. In addition, the ordinary treatment of central nervous diseases must be resorted to, which I have detailed in previous lectures.—Henry M. Lyman, M.D., in *Med. News*.

A NEW METHOD FOR EXTRACTION OF THE BREECH.

Mars (Krakau), describes a new method, by which he has succeeded in three cases in extracting the presenting breech, when he had failed by the ordinary manual methods. In his first case the breech presented, S. L. A., os fully dilated, breech arrested at superior strait; beginning acute œdema of the lungs in the mother. Failing to extract by means of the fingers hooked into the groins and by other manual methods, he adopted the following procedure: Supporting the fundus with the left hand, he introduced his right hand flatwise within the uterus between the uterine wall and the child's sacrum, until the hand was high enough to enable him to grasp the fœtus with the thumb and little finger just above the iliac crests, while the other fingers were extended along the foetal spine. He then drew upon the foetal trunk during the pains, which pressed his hand firmly against the child's body, until the breech was brought to the pelvic floor, when the fœtus was easily extracted.

THE DELIVERY OF THE AFTER-COMING HEAD.

At the annual meeting of the German Society for Gynæcology in Halle, in May, 1888, Winckel (Munich) described the various methods which have been given for extracting the after-coming head, numbering in all twenty-one, from Hippocrates to the present time. The method which Winckel especially recommended was the one originated by Wigand and introduced by A. Martin; briefly described, the method is as follows:—After the birth of the body it is supported on the left arm and thus raised up; one finger of the left hand is introduced into the mouth and the lower jaw thereby drawn down to the neck, but no farther, that is, no further traction is exerted on the jaw. The right hand then grasps the uterus and exerts pressure on the head in the direction of the forehead.

The advantages of this method are—

- (1) That injuries to the child through traction on the chin and shoulders are avoided.
- (2) That pressure from without excites contractions of the uterus.

(3) That an assistant is not necessary.

It is believed that an assistant cannot exert pressure in the right direction as well as the operator himself, who can best judge of the results of pressure when made by his own hand. Winckel insists that traction must be made with the finger in the mouth, but that the chin should be simply guided, while the chief force is exerted by external pressure on the head; he has treated a series of difficult cases by this method, and has often been surprised at the ease with which delivery was accomplished.

In the discussion of Winckel's communication, Breisky (Vienna) and J. Veit (Ber'in) both expressed a fear that in thus exerting forcible suprapubic pressure while the head was in the lower uterine segment there would be great risk of rupturing or otherwise injuring the uterus.

Eisenhart, assistant in Winckel's clinic, wrote an instructive paper later on the comparative merits of the Mauriceau (otherwise known as the Smellie-Veit) and the Wigand-Martin or Winckel methods of delivering the after-coming head. He based his studies on a series of fifty cases, from which were excluded macerated fœtuses and those which were not at least 18.6 inches long; and he examined these cases with reference to maternal injuries incurred through delivery and to the ultimate results in regard to the foetal life and injuries. Eisenhart's conclusions are as follows:—The prospect of delivering a living child, and one which will remain alive, is at least seven times greater by *expression* of the after-coming head by Winckel's method than by *extraction* of the same the Smellie-Veit method. Occasional fatal injuries and a great number of less severe injuries of the child are wholly excluded by the skilful practice of Winckel's method. The mother is exposed to no danger by the proper application of this method; the puerperium runs a normal course for the most part, and is less often accompanied by unpleasant complications than when delivery has been performed by the Smellie-Veit method.—Dr. Charles M. Green in *Brit. Med. and Surg. Jour.*

SULPHONAL, CHLORALAMID, EXALGINE.

SULPHONAL.

Field (*Therap. Gaz.*), after experimenting with the remedy in 200 cases, believes it stands first in the list of the hypnotics. The failures to obtain success will be few, if certain rules are observed. It is considered essential to bear in mind the following:

1. Time of administration.
2. Method of administration.
3. The dose. Sulphonal requires from one to two hours before its action becomes manifested. It should not be given when the

digestive process is in full activity. *The dose should be taken one or two hours before retiring.* The patient should not prepare for sleeping until a feeling of drowsiness is experienced. The drug should always be given in *finely divided powder*. Mechanical irritation from the coarse grains may produce enuresis. These grains are less soluble in the stomach. Tablets of the compressed drug should not be used. Five grains in powder produced the same effect as fifteen grains in the tablet form. It should not be given in milk or water, as its imperfect solubility will cause some of the crystals to adhere to the sides of the glass, preventing the patient from receiving the full dose. It may be used in wafer or merely placed upon the tongue. Rectal administration produced same results.

After continued use of the drug the author finds that the dose may be decreased. The patient who has used it night after night will require his large doses at first; later on a small dose will answer. If a dose of fifteen grains be first given, after a time five grains will be found to produce sleep. The drug, from these observations, was rarely at fault in producing sleep, but it was noticed that if the dose were too large, or if the sleep were interrupted, a feeling of languor, drowsiness and physical weakness was experienced next day. A small dose will produce sleep, and its effect will be spent upon waking. The sleep is refreshing and never depresses. The nerves and circulatory systems are not objectionably affected.

Age and idiosyncrasy may sometimes cause the non-action of the drug. In children gastric disturbance always prevents its action. Semile organic change causes non-action; also profound mental disturbance. If, after the repeated administration of doses, varying from ten to twenty grains, observing the rules above given, the drug does not produce sleep, some idiosyncrasy must be suspected. The author believes that the drug is curative, and mentions a case where it was used for months, producing sleep during the course of the treatment. Upon omitting the drug, normal sleep followed without interruption. Sulphonal should never be given in more than ten grain doses, as a rule. Fifteen grains are sometimes used. Twenty grains is the maximum dose, and should not be exceeded. It is a perfect hypnotic, because, although the means is artificial, the result is physiological.

CHLORALAMID.

(*Therap. Gaz.*) Chloralamid is a combination of chloral and formamide. It comes in colorless crystals, having a bitter taste, being soluble in ten parts cold water and in one part alcohol. It is more freely soluble in warm water under 140° F. Excess of temperature causes separation of the ingredients.

It may be given in wine, water, or capsule.

The dose is from twenty to forty grains.

It produces sleep in twenty-five to thirty minutes. The sleep lasts from six to eight hours.

The indications for its use are:

Nervous excitement.

Neurasthenia.

Insomnia in heart or lung disease.

It does not act where the insomnia is accompanied by severe pain or mental disturbance.

EXALGINE.

(*Therap. Gaz.*) From various papers on exalgine the following conclusions as to its action may be given:

1. The dose is from two to five grains every three or four hours.

2. It reduces neuralgic and muscular pains.

3. It is not poisonous and produces no depression.

4. It is non-irritant.

5. It tends to reduce and prevent convulsive movements.

PHENACETINE IN PERTUSSIS.

Heinman (*Jour. d'Med.* July, 1889) writes of the value of the above remedy in producing a calming effect upon the nervous system, and its action in restraining spasmodic action, nervous or muscular. In pertussis it had no action whatever on the duration of the disease, but seemed perceptibly to lessen the frequency of the paroxysms of coughing. This was conclusively proved in several cases in which, upon omitting giving the medicine, the child immediately had a return of violent fits of coughing, which were again held in check by exhibiting phenacetine.

Six grains may be given to a child three years of age in divided doses.—Bartley in *Med. Jour.*

HOW SOME TRY TO PASS THE NAVAL MEDICAL BOARD.

Medical Director Delevan Bloodgood, United States Navy, in responding to the toast of the Medical Corps of the Navy at the banquet of the Medical Society of the State of New York, among many other good things said: "A wrong impression has gotten abroad that great and increasing gaps exist in our ranks. There are a moderate number of vacancies in the grade of assistant surgeon, but more than enough available candidates for the places are booked and awaiting examination. Now I desire to explain a bit concerning our required examination, and the bruit that it is too 'exacting.' The origin of the complaint cannot better be demonstrated than by some quotations from the records of the Examining Board. Bear in mind, gentlemen, please, that all these candidates, whose essays I will cite, hold

the degree of Doctor of Medicine, and many of them the baccalaureate also, and several were practitioners of from one to three years' standing. Thus one writes in making his application: 'I am a graduate of the Medical College of—, and I think I can fill the bill. Is there any vacancies now? Is the examination as rigid as reported? I am a lover of surgery and hope I will fill the bill.' One aspirant was asked in the oral examination, 'Who was Hannibal?' 'Hannibal was a Hun and a Vandal,' he replied; next, 'How did Hannibal get into Spain?' and answered: 'He must have crossed around through Asia.' Question to another: 'Who succeeded Julius Caesar?' 'Pontius Pilate,' was his prompt reply. Another answered that 'the Suez Canal connects the Atlantic and Pacific Oceans at Panama.' One stated that 'Galen, who was born in the eighteenth century, discovered the circulation of the blood;' another mentioned that 'Harvey was a celebrated electrician.' One doctor had never heard of Jenner, but another knew all about him, and said that Jenner lived before Christ and practised vaccination in India, where he was born. One, when directed to write a prescription in Latin, said, 'We don't write Latin prescriptions out in—County.' Another sent his note from his writing-table to the president of the Board: 'Sir, you ask me in your question, "What is the mediastinum?" As I never heard of it I would like to have your advice about withdrawing from the examination.' Another wrote in answer that 'phimosis is a disease coming on in old age.' One, who had been in practice for two years in a large city, closed his remarkably original treatise on diarrhoea thus: 'But the best treatment of all to be given is them old opium pills found in shops and other places about town.' And here is another doctor's exhaustive thesis on opium: 'Opium is grown extensively, that is the tree from which the gum opium is obtained, in the West Indies. The tree grows a small papula, which is of a gummy consistence; this is then gathered and the inside of the papula is then formed upon cakes or lumps, in which way it is transported to market. It is also grown in some of those foreign countries like China, which produces a very superior article. I find that opium is not borne as well by the stomic as codei. This active salt, which is very soluble in aqua, gives us a form of giving the effects of narcotism in very minute doses.' These candidates, and very many others like them, and but only they, denounce our examinations as too exacting; and this is the way that one of them, not unlike the worm, turned and addressed the president of the Board: 'Sir, in your conversation with me you made a simile, the fore part of which I have forgotten because I was so forcibly struck with the latter part, which was that something was like a man

having won a girl's love he then cared nothing for it. Owing to your at the time superior position I said nothing. As I said nothing you may have thought that I agreed with you. The difference in our position was removed by your rejecting me as a candidate. I now say that I do not agree with the sentiment. On the contrary, I believe that if there is one thing more than another which relieves life of its barrenness and renders it worth living it is the love of a true woman, and the longer a man has won that love, and the more he has fathomed its depth, the more he will value it, if he be a man. And further allow me to say that in my opinion the most despicable individual on the face of God's earth is he who under the guise of a pleasing exterior seeks to win a pure girl's love, simply that he may have the diabolical pleasure of trampling upon it. I could not leave you under the impression that I had such an opinion of my fellow-men in general, as agreement with you would signify. Should even twenty years' service in the Navy force upon me such an opinion, I thank you for rejecting me; contact with my fellow-men in private life will, I am sure, show me a better side of human nature than that. I have had my say. Yours, M. D."—*Med. Rec.*

WHAT IS CONGESTION OF THE LUNGS?

There is no expression among the many used by the members of our profession that has for so many years occupied a position of usefulness as the word congestion. To the laity it represents a comfortable kind of disease which can be handled with safety by the attendant, and from which recovery is more than probable. When we read in the newspapers that a certain public person is confined to his house by a mild attack of congestion of the lungs, we often wonder what the real condition of the lungs is. Is it pneumonia, or a passing bronchitis, or the result of cardiac or renal changes? We often hear the question, "Is it congestion or inflammation of the lungs?" And with a sigh of relief sometimes the patient's wife receives the intimation that the man who is lying in the next room with a stitch in his side, rapid breathing, and a temperature of 103°F., is only suffering from congestion so far, not inflammation. And there are cases where a medical man speaks of having so treated a case to prevent congestion going on to inflammation.

In a recent number of the *Lancet*, Dr. Wilks, of Guy's Hospital, publicly asks the question, What is congestion of the lungs? And he goes on to say: If by congestion of the lungs is meant pneumonia, then let a spade be called a spade, and in the name of pathology, of honesty, and of common sense let the term congestion be discarded. He thinks that the upper classes have their lungs

congested, while those who occupy a lower place in the social world have the same disease diagnosed as inflammation, or pneumonia. But this is not strictly true. It all arises from the fact that with our hospital patients we are not subject to much questioning, and consequently are not obliged to give a diagnosis to suit the popular standard of comprehension or to disguise a dangerous disease under an innocently sounding stage name.

The use of all these pet names for disease is dishonest. By relieving the fears of a timid family, by calling pneumonia congestion of the lungs, and scarlet fever scarlatina, we are guilty of falsehood, and we expose our patient to risk by not representing fully and honestly the danger to which his life is exposed. The public should be made to understand that scarlatina is scarlet fever and that a "diphtheric sore throat" is diphtheria. Some timid mothers will be frightened, it is true, but perhaps some children's lives will be saved.

We are sorry to say that perhaps there is another *raison d'être* for these vague and unmeaning expressions. As charity covers the multitude of sins, so the use of vague terms covers up a multitude of vague diagnoses. The practitioner who does not know whether his throat case is one of follicular inflammation of the tonsils or diphtheria, places himself in a secure position on the fence of doubt by calling it one of diphtheric sore throat, and can bring himself with ease and comfort to a safe diagnosis according to the subsequent course of the disease.—*Ed. N.Y. Med. Jour.*

THE SURGICAL TREATMENT OF HEPATIC ABSCESS.

Mr. Rickman J. Godlee summarizes as follows the essential part of his views on the treatment of hepatic abscess, recently published in some extremely valuable lectures which embrace the whole subject, and embody the latest and most authoritative opinions as to its surgical aspect :

1. Pyæmic abscesses do not call for surgical interference, or, if in rare cases one should point, it is only opened to relieve symptoms, but without hope of doing permanent good.

2. The same observations apply to abscesses resulting from suppurative phlebitis of the portal vein.

3. Multiple abscesses associated with dysentery or ulceration of the bowels are very unfavorable for surgical treatment. They must, however, be opened and treated on the same lines as the single or tropical abscesses, because they cannot be certainly diagnosed.

4. Single abscess of the liver, whether tropical or not, must, if it approach the surface, be opened, the following precautions being adopted :

(a) If it present at the epigastrium, the presence of adhesions must be ascertained before incising the liver.

(b) If through the chest-wall, a spot must be chosen below the normal limit of the pleura ; but if by chance either pleura or peritoneum be opened, the opening must be closed with a double row of stitches before incising the liver.

(c) Strict antiseptic precautions must be throughout adopted, either carbolic acid or some slightly soluble salt of mercury being employed for the dressing.

(d) The tube must be of large size at first, and a tube of some sort must be kept in until the discharge is reduced to a very minute quantity.

If the abscess have burst in the lung, pleura, pericardium, peritoneum, or kidney, and the position of the abscess can be clearly determined, it must be opened without delay. If the position of an abscess be only suspected and the patient be losing ground, it is right to puncture the liver in the most likely situation, bearing in mind that, although usually quite harmless, a slight amount of risk accompanies this very trivial operation.

This rule applies to cases in which the abscess has ruptured into any of the cavities enumerated above. If, on the other hand, whether the abscess has ruptured or not, there are no means of diagnosing the whereabouts of the matter, and the patient is not losing or is even gaining ground, the surgeon should hold his hand for a time.

5. Hydatids of the upper and back part of the liver are to be treated upon the same lines ; but in cases of this sort, and in those of subdiaphragmatic abscess, it must be remembered that the diaphragm may be pushed up to a very great height, thus closely simulating intrapleural suppuration.

6. Empyema, pericarditis, and peritonitis caused by rupture of an hepatic abscess or hydatid must be promptly dealt with on general principles.

A CURIOUS HYPNOTIC TEST.—Dr. J. M. Charcot, writes in the *January Forum* :—"The end I have ever held before my eyes, then, and which I hope I have never lost from view, is this: to study the hypnotic phenomena according to a strictly scientific method, and for this purpose to employ processes, purely physical, and which can always be compared with one another, so that the results obtained by me may be rigorously tested by all observers who shall use the same processes under the same conditions.

"Take one example from among a thousand. I present to a woman patient in the hypnotic state a blank leaf of paper and say to her: 'Here is my portrait; what do you think of it? Is it a good likeness?' After a few moments hesitation, she answers: 'yes, indeed, your photograph; will you give it to me?' To impress deeply in

the mind of the subject this imaginary portrait, I point with my finger toward one of the four sides of the square leaf of paper, and tell her that my profile looks in that direction; I describe my clothing. The image being now fixed in her mind I take that leaf of paper and mix it with a score of other leaves precisely like it. I then hand the whole pack to the patient, bidding her go over them and let me know whether she finds among these anything she has seen before. She begins to look at the leaves one after another, and as soon as her eyes fall upon the one first shown to her (I had made upon it a mark that she could not discern), forthwith she exclaims: 'Look, your portrait!' What is more curious still, if I turn the leaf upside down, as soon as her eyes rest upon it she turns it over, saying that my photograph is on the obverse. I then convey to her the order that she shall continue to see the portrait on the blank paper even after the hypnosis has passed. Then I awaken her and again hand to her the pack of papers, requesting her to look over them. She handles them just as before when she was hypnotized, and utters the same exclamation: 'Look, your portrait!' If now I tell her she may retire she returns to her dormitory, and her first care will be to show to her companions the photograph I have given her. Of course her companions, not having received the suggestion, will see only a blank leaf of paper without any trace whatever of a portrait, and will laugh at our subject and treat her as a visionary. Furthermore, this suggestion, this hallucination, will, if I wish, continue several days; all I have to do is to express the wish to the patient before awakening her.

"The foregoing experiments have been made hundreds of times, by me and by others, and the fact can easily be substantiated; their objectivity is as complete as could be wished in researches of this kind. Hypnotism is directly amenable to our means of investigation, and must needs be an integral part of the known domain of science. To that goal our efforts ought to be directed."—*Bost. Med. and Surg Jour.*

CHEYNE STOKES BREATHING.—The remarkable respiratory phenomenon, for the recognition and description of which medical science is indebted to the two great Dublin physicians, Dr. Cheyne and Dr. Stokes, has always excited much interest and no little speculation. It may be remembered that Stokes ascribed it to fatty degeneration of the heart, considered it of fatal prognostic significance, and pointed out that although Dr. Cheyne's patient died of apoplexy, yet he had also the above cardiac condition. Traube did much to dispel the idea of its entire dependence on cardiac changes, showing clearly, as has frequently been shown since, that it was quite as much a symptom of

cerebral disease alone. Of all the theories as to its mechanism the most rational appears to be that of Filehne, who advanced the question a stage beyond where Traube had left it. For the last-named distinguished authority was content to refer it to variations in the arterial blood-supply of the medulla, whilst Filehne contended that the phenomenon could be best explained by assuming a difference in the relative excitability of the vaso-motor centre on the one hand, and the respiratory centre on the other. If from any cause a condition of arterial spasm were induced by asphyxia, so as to produce anæmia of the medulla, this anæmia, and not the primary asphyxia, would succeed in exciting the dormant respiratory centre to violent and excessive action. The respirations thus initiated would proceed with increasing depth and frequency, until the blood surcharged with oxygen would temporarily relieve the vascular spasm, and, at the same time, annul the excitability of the respiratory centre, so that a period of apnœa would result, lasting until the asphyxial state once more excited its action on the centres concerned. If this doctrine be accepted, it will serve to harmonize the many conditions—circulatory, nervous, and toxic—under which Cheyne-Stokes breathing is known to occur. Of equal interest is the practical importance of the phenomenon—viz., its prognostic significance—which Dr. Stokes thought so serious. The question was raised by Dr. Stephen Mackenzie at a recent meeting of the Clinical Society, and has elicited some interesting experiences contributed to our columns, from which it would appear that cases have been known to recover, although they must form but a small minority. It should also be borne in mind that in meningitis and other cerebral affections the breathing may be irregular, even with apnœal periods; but, as Biot showed, such do not conform to the classical type of Cheyne-Stokes breathing, of which the regular rhythm is so marked a feature.—*Lancet.*

CHRONIC INDOLENT ULCERS.—The subject that I wish to bring to notice for your consideration is the treatment of chronic indolent ulcers. Realizing that with many physicians these ulcers are hard to cure, I venture to present to you a treatment that has in my hands proved very successful.

I will not take up your time with a technical description of these ulcers, for you have all seen them. They are characterized by slowness of progress and are generally found in persons with a debilitated constitution. The limb is usually swollen, and the circulation in the œdematous tissues is feeble; the surface of the sore is smooth and glassy, more or less irregular, and generally presents a few weak ill-conditioned granulations, the edges are raised, often undermined, and the limb emits a very disagreeable odor, especially in

hot weather. Oftentimes the healing process remains stationary, or without any apparent reason sloughing occurs and ulceration spreads rapidly.

These ulcers are generally the result of injury and debilitating influences, such as exposure, drink, disease, lack of cleanliness, etc. In my opinion a great many physicians fail in the cure of these ulcers by using applications that are too irritating, and by not enjoining cleanliness and attention to the details of the treatment.

The treatment that I have employed with much success in these cases is as follows: I commence by the administration of an alterative tonic mixture, which I consider of much importance in the cure of these cases, such as the following:

R—Potass. iodidi, ℥ iij.
 Liq. potass. arsenit., ℥ j.
 Syr. sarsaparillæ co., ℥ iv.
 Aquæ, q. s ad. ℥ viij.—M.

Sig.—One teaspoonful before meals.

For external treatment I use:

R—Iodoformi, ℥ j.
 Ung. petrolii, ℥ j.—M.

Sig.—Use in a thin layer every night.

For a bandage I apply light weight woollen flannel, and much prefer it in one strip and of good length. I employ two bandages and render them *antiseptic* before using, and while one is in use, I have the other washed, dried, ironed and disinfected before the second application. The best means of doing this is to order a mixture, such as the following:

R—Hydrarg. chlor. corros., ℥ ij.
 Alcohol, ℥ ij.—M.

A teaspoonful of this mixture to a quart of water makes a 1.2000 solution, in which the bandages are to be disinfected. I use tar soap to cleanse the parts, dress the sore every night, and occasionally stimulate the surfaces with a pencil of nitrate of silver. I apply the bandage in the manner recommended by the text books commencing just back of the toes and bandaging quite tightly up to and above the ulcer. This is the treatment I have employed in these cases with remarkable success. I claim nothing particularly original or new for it, but if any of you have an old ulcer that is giving you some trouble, you will be both pleased and surprised by following this method of treatment.—Dr. Emerson, in *International Jour. of Surg.*

DRAINAGE OF THE PERITONEUM.—Dr. Delbert discusses this subject at great length in the *Annales de Gynecologie* for February. He compares drainage by means of large tubes with capillary drainage, effected by iodoform gauze or some similar agent. As the result of clinical and anatomical experience, he concludes that capillary

drainage alone can ensure the escape of liquids secreted during the first hours after operation. All forms of drain, tubes or gauze alike, become rapidly surrounded by adhesions, and thus, as in the case of *tamponnement*, they may cause a dangerous focus of infection to become practically extraperitoneal. To that result he believes the efficacy of drainage to be principally due. The capillary drainage of Mikulicz is affected by packing Douglas' pouch with iodoform gauze. That authority specially recommends his method in cases where a large cavity is left, at the lower part of the abdominal wound, not to be closed by sutures. The gauze, he believes, acts as a hæmostatic plug, prevents the entry of septic germs, drains most efficaciously by capillary attraction, and, by promoting adhesions in the surrounding structures, cuts of the cavity from the rest of the peritoneum. M. Pozzi combines the two methods of drainage. He packs the cavity with the gauze, in the centre of which a drainage tube is inserted, and prevents the retention of liquid too thick to filter through the gauze. Dr. Delbet finds that by drainage with a glass tube very little fluid can be evacuated even by aspiration by means of a syringe. If a litre of water be poured into Douglas' pouch into which a glass drainage tube of the usual form is inserted, hardly a drop of the water can be removed by means of a rubber tube attached to a glass syringe and introduced into the glass drain. In fact, according to this experiment, drainage after the manner practised and advocated by so many well-known British operators is useless. Yet the system of Mikulicz is little practised in the United Kingdom, whilst results prove that glass tube drainage is admirably efficacious. However aspiration by tube and syringe may fail in experiments, it succeeds in removing ounces of fluid after operations. —*Br. Med. J. ur.*

TREATMENT OF STRICTURE OF THE URETHRA BY THE RETENTION BOUGIE.—The author has treated several cases of urethral stricture successfully with the bougie à demeure, which should not be confounded with the catheter à demeure. This method has also been employed by Langenbeck and Hartmann. It consists in introducing a fine bougie—a filiform if necessary—which is not so large as to completely fill the lumen of the stricture, and permits the urine to escape at its sides. The instrument is allowed to remain for two days, in which time it is usually possible to pass a full-sized bougie. This plan of treatment is somewhat different from the ordinary method of urethral dilatation. In the latter, the result is due to pressure or slight superficial laceration of the stricture; in the former, to a continued localized irritation which causes a softening of the cicatricial tissue. Hence for strictures requiring imme-

diate and forcible dilatation this method is not applicable, while it is also contra-indicated in cases in which there is extensive formation of callous tissue, a purulent condition of the urine, with the presence of tight strictures. The method is indicated:—1. In cases in which the urethra is very sensitive, so that the frequent introduction of instruments is to be avoided. 2. In injuries of the anterior urethra, resulting from the use of instruments, especially if false passages are present. 3. If the introduction of instruments is difficult on account of the nature of the stricture (valve-like condition). 4. In cases where it is desired to rapidly dilate the stricture without resorting to divulsion or urethrotomy.

The instrument should be employed under strict antiseptic precautions, the urethra being previously cleansed of blood, mucus and pus. The injection of cocaine is sometimes of value.—*Deut. Zeitschr. f. Chirurgie.—Intern'l Jour. of Surg.*

THE INFLUENCE OF BROMIDE PREPARATIONS ON MENSTRUATION.—In the *Wiener Med. Blatter*, Dr. M. Ernst calls attention to a fact which has, perhaps, been already frequently observed by others, that bromide preparations, especially bromide of potassium and bromide of sodium, exert a marked retarding influence on the periods of menstruation. He reports, as illustrative of this statement, the case of a young girl, eighteen years of age, who was under treatment for epileptic convulsions. For the four previous years she had menstruated regularly, and, according to the mother, the first epileptic attacks occurred when she was six years of age, and since puberty the intervals between the convulsive seizures had been rapidly decreasing. For the last few months the patient had been taking thirty, and then later forty-five, grains of bromide of sodium daily, with the result that the attacks appeared at much longer intervals, and were much milder in character. At the same time it was noticed that the menstrual periods, instead of occurring perfectly regularly as before, now occurred only every five or six weeks, and sometimes eight weeks elapsed before the reappearance of a period. A second similar case is also referred to, likewise that of an epileptic woman, in whom again the menstrual periods were retarded in their appearance under the influence of the bromides. These cases seem to prove that the interference with menstruation was not attributable to the epilepsy itself, but seem to show that it was directly due to the action of the bromides. Further observations are desirable to determine whether this result is accidental, or whether it may be expected to follow prolonged use of the bromides.—*Therap. Gaz.*

THE TREATMENT OF ACUTE CATARRH OF THE RECTUM.—Quite frequently the practitioner of

medicine sees cases in which the entire list of remedies generally found of value in the treatment of diarrhoea have proved useless, or merely palliative in effect. While they may control the frequent movements of the bowels for a time, the trouble reasserts itself, as soon as the medicine is withdrawn, at the best in a somewhat modified form. Careful inquiry will show, in such cases, several points of value as to diagnosis and treatment. The attack has probably been preceded by a few days during which there has been a sensation of weight or fulness in the rectum and about the anus; following this, a sensation of bearing down asserts itself, accompanied by violent pain referred to the region of the stomach, or small gut. So severe is the pain in its paroxysms that the patient may cry out with it, and the perspiration break out over the body. At first small passages may occur, but after a few stools they consist of wind and a few drops of mucus, which is expelled after a period of agonizing pain and tenesmus. Opium makes the state ultimately far worse than before, and nearly all astringents are valueless. Under these circumstances, small doses of chlorate of potash injected into the rectum are most serviceable, only one or two injections being necessary in some acute cases to produce a cure. A saturated solution of the potash in water should be employed, and about half a tumblerful injected each time, very slowly and without force, and retained for ten or fifteen minutes. Large injections will cause pain and expulsion of the liquid, and no result will be attained.—*Med. News.*

EFFERVESCENT SALTS.—Effervescent Bromo Soda. (W. R. Warner & Co.) This is a combination of Caffeine gr. i. and Bromide Sodium grs. xxx. After its use personally for several years, and prescribing it in a large number of cases, I must be pardoned if I speak enthusiastic of it in nervous headache. This difficulty being so often met with a prompt, pleasant and effectual remedy is a boon indeed. This the physician has in Bromo Soda. A nervous headache, resulting from over-work, study, worry, debility, etc., from one to three doses of Bromo Soda will in a very short time put new life and vigor in the sufferer.

From personal experience I can speak of this agent in the most positive terms. And that is, its almost magic effects after it has been necessary to use an opiate for some time, until that peculiar disagreeable sensation, so often felt in the brain, is produced. A dose of Bromo Soda drives this sensation from the brain almost as rapidly as the sun will a "fog" from dark places. The sensation to the patient reminds him of a mist disappearing at the approach of sun light. The head is left as "clear as a bell" in a few minutes.

A teaspoonful in half a glass of sweetened water, drank at once, is a very grateful, sparkling drink.

Granular Effervescent Citrate of Magnesia is another preparation of superior worth. Far superior to the usual liquid form.

"Crab Orchard Salt," an exact analysis of the Crab Orchard Spring, producing the effect of that valuable agent.

Messrs. W. R. Warner & Co. have presented to the profession a long list of "Effervescent Salts," many of them of superior value as therapeutic preparations.—Dr. C. W. Peckerill in *Medical Free Press*.

THE STUDY OF PRACTICAL ANATOMY.—During the first few months devoted to practical dissection the student practically only learns to handle his scalpel, and wastes a large quantity of very useful material. An American anatomist suggests that the difficulty of providing a proper supply of "subjects" common to this country and the States, would be minimised by the simple and satisfactory device of using the bodies of dogs and cats for such purposes. The beginner has to learn the appearance of muscle, fascia, artery and nerve, and the position of the larger viscera. This could be done as well on the body of the dog or cat as on the human cadaver, and at vastly less expense. The same observation would apply to classes in operative surgery where students are taught to make incisions and apply ligatures and sutures. Indeed, trephining, resection of bone, tenotomy, &c., could be practised just as well on the bodies of animals as on man. If the system led to the acquisition by the student of ideas of comparative anatomy, this would not constitute an insuperable objection. Even if the human body is in certain respects to be preferred, the impossibility of obtaining a supply commensurate with the demand, and the fact that instruction in practical surgery as at present conducted in reality amounts to nothing at all, should suffice to commend the proposal to our teachers.—*Hospital Gazette*.

IODINE IN VOMITING.—M. Dার্থier records in *L'Union Medicale* his testimony as to the value of the internal administration of tincture of iodine for the relief of vomiting—a method which has been employed for years both in America and England. He has observed its use in nineteen cases, eleven of which were tuberculous subjects, and has formed the opinion that it is of more value in the vomiting of early phthisis than in the later stages of that disease. He relates instances of advanced cases with obstinate vomiting, where the symptom was largely controlled by the drug. One case was that of a female with bronchial dilatation (subsequently fatal from acute tuberculosis), who for three weeks had regularly vomited after each meal. Following the commencement of the drug she ceased to vomit; and the symptom was completely cured after a week's treatment. The

drug also proved useful in cases of alcoholic gastritis in gastric ulcer, and in the vomiting of pregnancy and of chlorosis. M. Dার্থier recommends the French tincture of iodine to be administered in ten-drop doses, diluted with two wine-glassfuls of water, to be taken in three portions immediately after meals.—*The Lancet*.

THE EFFECT OF ALCOHOL ON THE FUNCTION OF THE STOMACH IN HEALTHY PEOPLE.—Dr. Blumenuau, in a preliminary communication to the Russian medical journal *Vrach*, publishes certain conclusions he draws from his experiments on the effect of alcohol on the function of the stomach in healthy people. The author says that in the beginning of the digestive process the functional activity of the gastric juice, the general acidity, as well as the amount of hydrochloric acid and the corresponding digestive power of the juice, are diminished; and in people who are not used to alcohol this decrease is even more distinct. The stronger the solution of alcohol, the greater is its effect. During the first three hours or a little less after its consumption the digestion is slower, but after that it becomes much quicker, to compensate, as it were, for the previous loss of time. The quantity of acid in general, and of that of hydrochloric acid in particular, rises from 1½ to 2 per cent. above the normal, and the gastric juice has consequently a greater digestive power in the later hours. The secretion of the gastric juice also lasts longer and is more ample when alcohol is consumed. The activity of the pepsine remains about the same, although the coagulation of milk seems to be somewhat slower at the beginning. The motor power of the stomach and its capacity for absorption are diminished in direct proportion to the strength of the alcoholic solution.—*Lancet*.

CLEANING THE TEETH.—Dentists are daily committing the error of not instructing their patients in regard to the proper methods of cleansing their mouths—brushing, picking, rinsing with warm water after meals and at night before going to bed. Our observations must show that people who do those things faithfully, have little or no dentistry to do. It is astonishing what ignorance exists among people of all classes and conditions, as to what cleanliness of the mouth means. They will tell you frankly that they do not brush their mouths as well as they ought to, for they did not know they were going to be examined, and when you looked, *you really thought so*, and the second thought was, *probably not for a month*. Cleanly habits are part of an individual's education and can be formed only in childhood. Too much care cannot be bestowed on the subject for the little ones. Not much dentifrice of any kind is needed—small quill tooth-picks are best, narrow strips of rubber dam for spaces the quill will not clean.

Water used frequently for rinsing, with a motion of the tongue on all the surfaces of the teeth and gums, lingual, palatal, labial and buccal. So much for preventive dentistry, which should be our highest aim.—*Exchange*.

J. E. PRICHARD, M.D., Baltimore, Md., says: The Aletris Cordial I think a most excellent remedy, and have used it in ten cases of suppressed menstruation, in all of which with the best results. Among my patients were four unmarried women, one aged 20 years, had her menstruation arrested six months, when she came under my care. She was swollen and suffered considerable pain at each monthly period, but she had no show of any catamenial discharge. I placed her on Aletris Cordial, teaspoonful doses, three times a day. She continued it for seven days, when she menstruated. I ordered her to commence again five days before her expected time to menstruate, which she has done. She is now regular and suffers no pain. Have also used it in cases of vaginal leucorrhœa with a happy result. In cases of hysteria which we sometimes find complicated with leucorrhœa, I have combined it with Celerina:

R—Aletris Cordial, $\frac{5}{3}$ iv.
Celerina, $\frac{3}{3}$ iv.—M.

Sig.—Teaspoonful every three hours for one day, then the next would give it four to five hours.

I am happy to say that it has not failed to give relief in all cases in which I have prescribed it.

MARITAL SELECTION.—The Japanese seem to use their reasoning powers in the selection of a partner in a way that we outer barbarians might envy. The physical antecedents of a girl are thoroughly scrutinised, and candidates with any diathetic or hereditary taint are infallibly black-balled. Would that a little of this caution could be introduced into our own "courting" customs instead of leaving this important matter to be decided by passion, proverbially blind, or interest, not less proverbially indiscriminating, from a health point of view. The physiologist, who discourses so eloquently on the inexorable laws of heredity, is often no better advised in his choice than the burly costermonger who, at an early period of his career, takes the first opportunity of gratifying his sexual appetite without let or hindrance. Protests on such a matter may, however, be likened to a voice howling in a wilderness—of unphysiological sentiment.—*Hospital Gazette*.

THE TREATMENT OF CROUPOUS PNEUMONIA WITH CALOMEL.—Dr. Enrico Pieragnoli, in *Le Sperimentale*, pleads for the more general use of calomel in croupous pneumonia. His method consists in the use of calomel combined with opium, and in the discarding of expectorants during the first few days of the disease. The results were very satis-

factory; five adult patients not treated with calomel all died (the treatment which they received is not stated); of fifteen cases in which calomel was employed but one died. The results in children were equally good. The course of the pneumonia treated by calomel was milder, and the solidification was not so firm and had less tendency to spread. Even the diarrhœa which resulted seemed to exercise a favorable influence upon the course of the disease.—*Cent. f. d. ges. Ther.—Weekly Med. Rev.*

BLOODLESS TREATMENT OF FISTULÆ.—In the Moscow therapeutic weekly *Novosti Terapii*, Dr. Gëorgy I. Tarabrin, of Ekaterinovka, warmly recommends the treatment of incomplete fistulæ (sinuses) by the intrafistulous injection of a two per cent. solution of carbolic acid or a solution of corrosive sublimate (from three to ten grains to six ounces of distilled water), repeated two or three times a day. The injection should be preceded by probing (in order to determine the direction which the jet should take). It is advisable to commence the treatment with a weak solution and then to gradually pass to stronger ones. The treatment is said to prove successful in a couple of weeks even in old cases of deep fistulæ penetrating into the bone.—*Med. and Surg. Rep.*

ONE of those singular malformations described as "parasitic fœtus" has been attracting some attention at Demerara. A coolie was admitted into the Colonial Hospital suffering from a tumor in the right loin. The man died, and at the post-mortem examination the "tumor" proved to be possessed of a cranium, with hair attached, an imperfect nose and mouth, no hand or feet, but the rudiments of male genitals. The subject of this "autosite" was thirty-two years of age.—*Lancet*.

THE MICROBE OF ERYSIPELAS.—Professor Leroy has published in *Comptes Rendus de la Soc. de Biologie*, 6th December, 1889, some interesting observations on the cultivation of the *streptococcus erysipelatis*, from which it appears that this fungus, after growing and developing in gelatine, may disappear and remain inert for a time (over a year in these experiments), may resuscitate itself, again grow actively, and become capable of inoculating fresh gelatine cultivations, and exciting true erysipelatos inflammation in the ear of the rabbit. Professor Leroy thinks that this property accounts for recurrent and periodic erysipelas.

ITCHING OF ANUS AND GENITALS IN WOMEN.—

R—Linseed oil (raw), $\frac{3}{3}$ iv.
Kennedy's Ext. Pinus Can., $\frac{3}{3}$ ij.—M.

Sig.—Apply two or three times a day.

THE CANADA LANCET.

**A Monthly Journal of Medical and Surgical Science
Criticism and News.**

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AGENTS.—DAWSON BROS., Montreal; J. & A. McMILLAN, St. John, N.B.; GEO. STREET & Co., 30 Cornhill, London, Eng.; M. H. MAHER, 23 Rue Richer, Paris.

TORONTO, MAY, 1890.

*The LANCET has the largest circulation of any
Medical Journal in Canada.*

TRINITY MUSICAL DEGREES IN ENGLAND.

The dense ignorance in regard to Colonial matters and Institutions which prevails in England, even in circles composed of otherwise well educated people, is astounding. The recent excitement in certain quarters there in regard to the holding of Examinations in Music in England, by Trinity University, and granting degrees to those who come up to the high standard required, presents a striking illustration of this.

Newspaper articles and correspondents have been vapouring away as though these degrees were conferred at random and for money, irrespective altogether of musical attainments and without having any curriculum laid down, or even thought of.

Nothing can be further from the truth, and long before this is in print, the very papers that have been misled in this matter will no doubt have ascertained their mistake, and they will not be slow in duly acknowledging it.

The curriculum in the Faculty of Music in Trinity University is very high, and includes three annual examinations for the Degrees of Mus. Bac., is practically identical with the musical requirements of the English universities, and was drawn up independently for Canadian undergraduates in 1883.

Indeed, the extension of the examinations to England was the result of the action of the Eng-

lish Musical Press, unknown to, and unsought by Trinity University.

The Examining Board is composed of some of the best musical authorities in the world, and with regard to the standard, it is sufficient to say that in the last three years fifty-two per cent. of the candidates for the final Mus. Bac. examinations alone, have been rejected by the Examiners.

Some of the English Medical Journals have gone so far as to hint that "Medical Degrees" would probably be obtainable in England from "Trinity University" on "favorable terms." This is sheer impertinence, the outcome of gross ignorance of the very high ground taken, not by Trinity University only, but, we are proud to say, by all our Canadian Universities, in regard to Degrees in every department.

No British medical man can obtain the medical degree of Trinity University who does not comply with every requirement laid down in the calendar. He must be duly qualified and registered in Great Britain for five years, and must, in order to get a "Trinity" degree, come to Canada, and undergo at the same time and place as our own students a complete examination in all the final subjects. Just as our Canadian graduates are required to undergo in Britain, examinations in the final branches before they can get a British qualification, so the same examinations are exacted here from all British practitioners who desire to obtain a medical degree in Canada, either from Trinity, or from any other Canadian University.

The *Hospital Gazette*, in speaking of this matter is apparently actuated by mere friendly feelings towards our Colonial institutions, though not, we believe, thoroughly informed as to the requirements of Trinity University in the granting of medical degrees. In a recent issue it says:—The fact that the authorities of the University of Trinity College, Toronto, have decided to grant their "M.D." degree under certain conditions as to examination to duly qualified English practitioners of medicine, has caused no little consternation among the heads of English Universities, and strong pressure is being put on the Government to use their powers in order to stop this infringement of their privileges. For many years the Brussels "M.D." degree has been conferred—for a consideration—upon English doctors with-

out exciting any opposition, and it appears strange that such an outcry should be made now that one of our colonial universities announces its intention to do the same thing.

ONTARIO MEDICAL ASSOCIATION.

The arrangements for the annual meeting on the 11th and 12th of June are nearly completed, and the invitations and railway passes will be sent out early in May. The meetings are to be held this year in the College of Physicians and Surgeons, Bay street, instead of the Education Department, a change which it is hoped will be to the advantage of the visiting members of the Association.

Dr. J. A. Temple, of Toronto, will preside, and will deliver the annual address. Among the "Members by Invitation" who are expected to be present are Dr. Andrew Smith, of New York, who will read a paper on "Empyæma, with the mechanical results of opening the thorax," which he will illustrate by apparatus, Dr. Wm. Goodell, of Philadelphia, who will read a paper entitled "What I have learned to unlearn in the Diseases of Women," and Drs. Emmet and Bull, of New York.

The discussions have been arranged for as follows:—

Medicine.—Dr. Aylesworth, of Collingwood, reads a paper entitled, "A plea for a more liberal or scientific spirit of investigation on the part of the Regular or Rational School of Medicine." Discussed by Dr. A. A. Macdonald, Toronto, and Dr. W. A. Ross, Barrie.

Surgery.—Dr. Sullivan, Kingston, followed by Dr. Grasett, Toronto, and Dr. Waugh, London, will discuss "Hernia."

Obstetrics.—Dr. A. T. Carson, Toronto, will read a paper on "The Prevention of Post Partum Hæmorrhage," which will be discussed by Dr. Powell, of Ottawa and Dr. Baines, Toronto.

Therapeutics.—Dr. J. L. Davison, Toronto, will open a discussion on Expectorants, and will be followed by Dr. Taylor, of Goderich, and Dr. Gillies, of Teeswater.

Ophthalmology.—Dr. Ryerson, of Toronto, will read a paper on "The ophthalmoscope in relation to Diseases of the Nervous System," which will be discussed by Drs. Palmer and Wishart, of Toronto.

The following gentlemen will read papers:—
Dr. Duncan, Chatham, "Duodenal Ulcers"; Dr. B. E. McKenzie, Toronto, "The Management of Club-foot"; Dr. Irving, Kirkton, "The Vomiting of Pregnancy and its Treatment"; Dr. Barrick, Toronto, "Hydrothorax"; Dr. T. R. Dupuis, Kingston, "Traumatic Tetanus and its Treatment." Dr. A. B. Atherton, Toronto, will report on a "Case of Hysterectomy for Fibroid," and will exhibit the specimen. Dr. Osborne, Hamilton, "A case of Squint"; Dr. H. J. Saunders, Kingston, "Paroxysmal Hæmaturia"; Dr. Smith, Orangeville, "Ruptured Perinæum"; "Dr. McPhedran, Toronto, "Hæmoptysis"; Dr. Chas. Trow, Toronto, "The Diagnosis and local treatment of Tubercle, or so-called Phthisis of the Larynx"; Dr. Addison, St. George, "On the treatment of Pneumonia"; Dr. Groves, Fergus, "Perityphilitic and Pelvic Abscess"; Dr. Henderson, Kingston, "A case of Ichthyosis"; Dr. Fenwick, Kingston, "Etiology of Puerperal Eclampsia"; Dr. Johnson, Toronto, and Dr. Olmstead, Hamilton.

OPENING OF THE NEW WOMEN'S MEDICAL COLLEGE, TORONTO.

The opening of the new building on Sumach St. on the 25th ult., was an auspicious event in the history of this institution, as well as an important one in the matter of Medical Education in this Province. The ladies and gentlemen, who, through good report and evil report have struggled bravely onward against countless and apparently insurmountable difficulties, to the present happy consummation, are to be congratulated on the marked success which has attended their efforts. Perhaps as much credit is due to the Faculty as to any one connected with the movement. For a man or woman with means, it is not nearly so trying a matter to write a check in aid of such an undertaking as it would be to give a certain portion of their time each day at a certain hour, when perhaps other duties were pressing upon them, or weariness made the task a hard one. And yet this is what the members of the Faculty of the Women's Medical College have been doing, not for one, but for many winter sessions, with practically no reward except the approbation of conscience in good work done.

We congratulate the promoters of the institution, its friends, graduates, and students upon the very creditable position it has attained to, as one of the factors in our Educational System, and wish them every success for the future.

MEDICAL EXAMINATIONS.

TRINITY UNIVERSITY.

Primary Examination.

Class I.—*Honor Certificates*—D. Beattie, H. L. Barber, H. B. Anderson, H. C. Parsons, R. G. Wallace, J. J. Thompson, W. E. Mathew, D. McEachern, A. S. Tilley, A. Quackenbush, W. Cousens, T. M. Williamson, W. E. Brown.

Class I.—J. W. Brien, A. P. Chalmers.

Class II.—W. H. Millen, R. M. Mitchell and W. E. Sitzer (æq.), W. E. Ogden, H. J. Orchard, R. M. Curtis, W. Northrup and D. C. Jones (æq.), W. Potter, J. A. Mitchell, R. E. Cooper, W. M. Robertson, Miss J. Gray, H. Morell, E. B. Blain, G. K. McDowell, D. A. McPherson, Miss E. R. Gray, Miss A. Chambers, H. Robins, F. L. Switzer, E. F. McCullough, A. W. Allingham, W. O'Connor.

Class III.—D. B. Alexander, T. M. Allan, W. J. Awty, E. O. Bingham, R. A. Buck, A. M. Cleghorn, G. W. Davidson, Miss B. Dymond, R. G. Feek, A. Flath, J. G. Jardine, A. P. McLaren, F. C. Merritt, A. L. Murphy, F. C. Spilsbury, W. A. McPherson, J. A. Ogilvie.

1st Silver Medalist—D. Beattie.

2nd Silver Medalist—H. L. Barber.

Final Examination.

Gold Medalist and Certificate of Honor—F. R. Clarke.

Silver Medalist and Certificate of Honor—R. M. Hillary.

Certificates of Honor—A. Gaudier, R. Hill.

Class I.—R. J. Niddrie, E. J. Boyes and A. J. Murchison (æq.), J. W. S. McCullough, A. Ross, J. R. Macdonald, C. McCue, C. B. Oliver.

Class II.—C. A. D. Fairfield, A. H. Speers, J. Lockridge and J. F. Dolan (æq.), H. H. Gray, Miss S. P. Boyle, L. E. Rice and J. M. Sifton (æq.), J. F. Wren, T. B. Richardson, Mrs. J. Lynd and C. B. Coughlin (æq.), H. T. Arnall, J. H. Bell, E. T. Boyes, F. J. Ewing and Miss M. J. Hutton (æq.), A. P. Ardagh, Miss M. Agar, O. E. McCarty, M. McClelland, E. R. Morton, R. F. Hay, D. McLeod, W. S. Ferguson, G. Harrison, R. L. Langstaff, F. Preiss and H. W. Welch (æq.), G. J. Tweedie, J. C. Bell, W. Wright.

Class III.—F. A. Drake and E. H. Webster

(æq.), L. E. Morgan, W. A. Gray and J. Housberger (æq.), J. B. Rogers, W. J. Fletcher, W. C. B. Murray, G. Wright, T. E. Watts, W. A. Jones, J. A. Dinwoody and D. K. McQueen (æq.), J. A. McGregor, J. C. Auld, A. C. Beatty and J. D. Berry (æq.), H. S. Smith, J. W. Dixon, D. A. Coon, W. A. Cameron, W. J. Alexander and J. Reid (æq.), S. J. Todd, J. A. Mills, W. A. Sargent, J. J. Gee, W. O'Connor, T. P. Camelon, M. Caves, C. W. Morey, H. E. Strathy.

TRINITY MEDICAL COLLEGE.

First Year—Scholarships.—The 1st First Year's Scholarship, \$50, J. T. Robinson; the 2nd First Year's Scholarship, \$30, C. B. Shuttleworth; the 3rd First Year's Scholarship, \$20, J. A. G. Wilson.

Certificates of Honor—75 per cent. and over:—J. T. Robinson, C. B. Shuttleworth, J. A. G. Wilson, J. K. M. Gordon; H. G. McGill and R. E. Macdonald (æq.), A. B. McGill and H. Bird (æq.), F. J. Burrows, D. E. S. Sager, C. McPhail, T. Douglas.

First Class—70 per cent. and over:—J. Semple, W. Doan, M. S. Lane and W. W. H. Cartmell (æq.), R. T. Corbett, J. H. Duncan; J. R. Bingham and R. Brodie (æq.)

Second Class—60 per cent. and over:—H. Alger, G. D. McB. Ruthven, N. Campbell, E. Tomlinson and W. H. Tufford (æq.), W. J. Ross, J. T. Bowie, B. O. Coates, E. C. Coates, J. C. Stinson and J. A. Wesley (æq.), R. V. Fowler; R. E. Darling and F. W. Mulligan (æq.), D. J. Dunn, E. Orton, H. P. Temple, D. D. Wickson, P. J. Moloney, T. W. Carlaw.

Passed.—W. J. Arnott, R. S. Dowd, H. R. Frank, J. B. Ferguson, J. E. King, W. C. Belt, J. R. Roseborough, C. Carter, W. A. Thomson, D. A. McPherson, J. J. P. Armstrong, H. T. Thorne.

H. A. Maclean passes in Physiology, Botany, and Practical Anatomy. W. Brent passes in Materia Medica, Anatomy, Botany, and Practical Anatomy. D. Sylvester passes in Physiology, Materia Medica, Anatomy, Chemistry, and Practical Anatomy. H. St. J. Montizambert passes in Physiology, Anatomy, Chemistry, Practical Anatomy, and Botany.

Primary Examination—Scholarships.—The 1st Second Year's Scholarship, \$50, D. Beattie; the 2nd Second Year's Scholarship, \$30, H. L. Barber.

Certificates of Honor—75 per cent. and over:—D. Beattie, H. L. Barber, H. B. Anderson, H. C. Parsons, J. J. Thompson, W. E. Mathew, D. McEachern, A. S. Tilley, A. Quackenbush, W. E. Brown.

First Class—70 per cent. and over:—R. M. Mitchell, H. J. Orchard, R. M. Curtis, W. Northrup.

Second Class—60 per cent. and over :—R. E. Cooper, H. Morell, E. B. Blaine, H. Robins, W. E. Switzer.

Passed.—T. M. Allan, G. W. Davidson, A. L. Murphy, D. B. Alexander.

Final Examination—Certificates of Honor.—75 per cent. and over :—J. S. W. McCullough, J. M. Sifton, J. R. Macdonald, F. R. Clarke, A. Ross, F. J. Ewing.

First Class—70 per cent. and over :—A. J. Murchison, E. J. Boyes, R. Hill ; H. H. Gray and R. J. Niddrie (æq.), J. F. Dolan, A. H. Speers ; H. T. Arnall and C. B. Oliver (æq.), F. A. Drake ; R. M. Hillary and R. F. Hay (æq.), L. E. Rice, T. B. Richardson.

Second Class—60 per cent. and over :—C. McCue, W. J. Fletcher, O. E. McCarty ; J. F. Uren and L. E. Morgan (æq.), J. A. Dinwoody ; J. A. McGregor and H. W. Welch (æq.), A. P. Ardagh, J. L. Auld, R. L. Langstaff A. C. Beatty.

Passed.—W. G. Alexander, J. J. Gee, W. A. Jones, C. N. Laurie, J. Lockridge, E. R. Morton, R. McGee, J. A. Mills, F. Preiss, W. A. Sargent.

The Special Prize for the highest in Physiology of the First Year, value \$25, A. B. McGill ; 96 per cent. in Physiology.

Medals.—The Second Trinity Medal, J. R. Macdonald ; the First Trinity Silver Medal, J. M. Sifton ; the Trinity Gold Medal, J. W. S. McCullough.

THE THERAPEUTICS OF CHLORALAMIDE.—So many new drugs are being put on the market, that no practical physician can hope to take cognizance of all of them. The Germans manufacture new compounds ad infinitum, and have been doing so for years, but only a few have taken and held any recognized place in the therapeutics of to-day. Chloralamide is a comparatively recent one, but it would appear that it has come to stay. In an interesting article on this drug by Dr. Steele, *Pacific Med. Jour*, he gives the following as its therapeutical indications :—Chloralamide is successfully employed in conquering insomnia, and particularly that form denominated simple or idiopathic insomnia, not due to excitement or severe pain. It is, furthermore, possible for the wakeful patient to enjoy several nights of natural sleep after a single dose. The best results occur when the drug is used in insomnia due to nervousness, neurasthenia, hysteria, "spinal disease" or old age ; next best when the causes are chronic alcoholism, alcohol excess, cardiac and

bronchial asthma, pleuritis, phthisis, pericarditis, arterial sclerosis, organic heart disease, typhoid fever, gastritis, subacute nephritis, ascites, diabetes mellitus and in the morphine habit. It is less effective when wakefulness is due to tabes dorsalis, neuralgia, progressive paralysis, the excitement of insanity, cerebral softening with delirium, melancholia, chronic mania and acute mania. In these conditions, doses of from thirty to sixty grains are required, providing such doses are tolerated. The drug is useless when the insomnia results from paralytic dementia, maniacal excitement or hallucinations, severe neuralgia or other pain, violent cough, distressing headache, delirium of cerebral apoplexy and from delirium tremens. Even pain, when not acute, is often relieved, and the large doses necessitated are, by many patients, preferred to morphine. Chloralamide, in doses of from twenty to sixty grains, has checked the pains of thoracic aneurism, carcinoma of the stomach and liver, sarcoma of a rib, erysipelas, rheumatic fever, floating kidneys, neuralgia, gallstone, varicose ulcer and alcoholic neuritis. In chorea, a boy of eleven years of age was cured in five days by fifteen grains of the drug three times daily, and in like manner, a girl, after receiving no benefit from other forms of treatment, was afforded relief in eight days. When administered in phthisis it was found that the troublesome night sweats disappeared.

THE RELATION OF THE PANCREAS TO DIABETES.—There are two chief theories for the explanation of the facts of diabetes, writes M. Lépine (*Lyon Med*): The first that the glucose in the blood is not oxidised as much as in the normal state—a view supported by the low temperature of the diabetics ; the second that too much glucose is produced from the food, perhaps by the liver. This may be due to nervous influence, and may explain the usefulness of opium and antypirin. Both theories may be in part true, but they are incomplete : they do not explain cases of pancreatic diabetes. Such cases M. Lancereaux has proved to be genuine ; and when there is complete atrophy of the pancreas there is always sugar to be found in the urine. MM. Mering and Minkowski have recently shown that in the case of dogs complete removal of the pancreas is followed by the passage of sugar, but that this is avoided

if a small part of the pancreas is left, even though the duct is removed. The result consequently is not due to the absence of the pancreatic juice in the intestine. It is most easily explained by the hypothesis that the pancreas manufactures a sugar ferment, which is absorbed by its veins and carried to the liver by the portal vein, where in a normal condition it helps the usual change of glucose. An experiment was carried out on two dogs of equal size. They were both kept fasting for thirty-six hours. The first was left untouched and unfed for sixty hours, and then bled to death. The second had the pancreas completely removed some time before; and after fasting sixty hours was also bled to death. When the blood was taken from the two bodies there was nearly three times as large a percentage of sugar in the one without its pancreas as in the other; and the other important point was that after the two specimens of blood had been left for fifteen hours under the same conditions, the blood from the healthy dog had lost 33 per cent. of its sugar, whilst that from the other dog had only lost 6 per cent. This M. Lépine considers to be proof of the loss of ferment in the animal that had previously been deprived of its pancreas.

THE WILLIAM F. JENKS MEMORIAL PRIZE.—The second triennial prize, of four hundred and fifty dollars, under the deed of trust of Mrs. William F. Jenks, will be awarded to the author of the best essay on "The Symptomatology and Treatment of the Nervous Disorders following the Acute Infectious Diseases of Infancy and Childhood." The conditions annexed by the founder of this prize are, that the "prize or award must always be for some subject connected with Obstetrics, or the Diseases of Women, or the Diseases of Children"; and that "the Trustees, under this deed for the time being, can, in their discretion, publish the successful essay, or any paper written upon any subject for which they may offer a reward, provided the income in their hands may, in their judgment, be sufficient for that purpose, and the essay or paper be considered by them worthy of publication. If published, the distribution of said essay shall be entirely under the control of said Trustees. In case they do not publish the said essay or paper, it shall be the property of the College of Physicians of Phila-

delphia." The prize is open for competition to the whole world, but the essay must be the production of a single person. The essay, which must be written in the English language, or if in a foreign language, accompanied by an English translation, should be sent to the College of Physicians of Philadelphia, Pennsylvania, U. S. A., before January 1, 1892, addressed to Louis Starr, M.D., Chairman of the William F. Jenks Prize Committee. Each essay must be distinguished by a motto, and accompanied by a sealed envelope bearing the same motto and containing the name and address of the writer. No envelope will be opened except that which accompanies the successful essay. The Committee will return the unsuccessful essays if reclaimed by their respective writers, or their agents, within one year. The Committee reserves the right not to make an award if no essay submitted is considered worthy of the prize.

MEDICAL EXAMINATIONS IN VIRGINIA.—The constituted authorities in Virginia have been endeavoring for some time past to rid the State of the vast army of quacks by which it is overrun. This effort has been made none too soon, as the following answers to the questions set will show. The answers were given by *graduates of Medical Colleges*, who, under the law now in force in Virginia, applied for license to practise medicine in that State. The condition of affairs evidenced can hardly be conceived of by us in Canada.

Describe the larynx. A.—The larynx is composed of cartilage. The œsophagus passes through the larynx.

What is the function of the liver? A.—Do not know.

Give tests of arsenic. A.—Sulphuretted hydrogen is one. Don't know rest.

Give test for mercury. A.—Do not remember.

Give dose of tartar emetic. A.—Ten grains.

Give dose of sulphate of atropia. A.—Hypodermically, ten grains; by mouth, sixty grains.

Give dose of corrosive sublimate. A.—One grain.

How would you treat placenta prævia? A.—I don't know what it is.

Give dose of powdered cantharides. A.—Forty grains.

What is the source of iodine? A.—It is dug out of the earth in blocks, like iron.

Describe dengue or breakbone fever. A.—By four applicants: A fever that comes on soon after the bones are broken. By one applicant: The patient should be cautioned against moving, for fear the bones should break.

Describe the peritoneum. It is a serious membrane lining the belly, and extending into the chest, covering the heart and lungs.

THE TREATMENT OF POST-PARTUM HÆMORRHAGE.—Küstner (*Deutsche Med. Woch., Am. Jour. of the Med. Sciences*) regards post-partum hæmorrhage as generally caused by improper management of labor. Death from this cause rarely occurs in good hands. Hæmorrhage from the vagina and cervix may be immediately checked by closing the lacerated tissue by a stitch or by an antiseptic tampon. Uterine hæmorrhage may be avoided by emptying the uterus slowly; the child's body should never be removed forcibly, but should be expelled by uterine contractions; traction should be made by forceps with the pains only. Rapid delivery of the placenta should be avoided; at least fifteen minutes should elapse before any effort is made, and then uterine contractions should be aided, not superseded, by pressure. Cornutin is thought the best preparation of ergot for use in these cases.

There remains a class of cases in which hæmorrhage is not caused by failure of uterine contraction, as usually, but by rupture of an artery or atheromatous degeneration and rupture of the vessels at the placental site accompanying nephritis, in which the intra-uterine tampon is indicated. In cases occurring where the practitioner has no assistance the tampon may be easily, quickly, and safely applied in all cases of post-partum bleeding; iodoform gauze is the best material. Kustner reports eight cases successfully treated by this means.

A NEW TREATMENT FOR CHANCROIDS.—Dr. G. Letzel, of Munich, says *The Weekly Med. Rev.*, describes a treatment for chancroids which he has employed for some time with excellent results. The results attained by Winckel in the treatment of tears and abrasions occurring in labor by painting with solutions of chloride of iron induced Letzel to employ the same remedy in soft chancres. He was careful to use it only in cases in which no

other treatment had been undergone, the cases coming into his hands on an average about eight days after infection. The sores were painted with the undiluted solution once daily for about four days, at which time they were usually found to be covered by smooth, healthy granulations, after which five or six days' use of sublimed calomel as a dusting powder would suffice to cover the sore with a growth of epithelium. The glandular swellings in the groin rapidly disappeared with the use of strong lotions of the subacetate of lead.

The pain caused by painting the sores as described was easily borne, and there was but little inflammatory reaction around its margins. The paintings seemed to have no influence upon the swellings in the groin. In but two cases was the pain so severe as to require the previous application of cocaine, and in these the patients were very nervous individuals.

A point of some importance is that the applications must not be entrusted to the patient, but should be carried out by the physician himself, by means of a small wad of absorbent cotton which is held applied to the sores for some little time, and with which all parts of the sore are brought in contact.

CHLORAL IN RIGID OS.—A. W. Garry gives a case (*Br. Med. Jour.*) in which, with a rigid os, the pains had been strong but ineffectual, and the patient was becoming exhausted, with dry tongue, quick pulse, etc. He gave 15 gr. of chloral, intending to repeat the dose every half hour till a drachm had been taken. After the second dose, however, the os was sufficiently dilated to permit delivery by the forceps. He adds:—"From my experience, both in hospital and private practice, of the use of this drug in the treatment of the above condition, I am of opinion that it is vastly superior to any other pharmacopœial preparation, when properly administered and with due precautions (should not be given, or at least very cautiously, in a case where fatty heart or atheromatous arteries is suspected), and would strongly recommend my young medical friends to give it a trial before adopting extreme measures, which, in my opinion, are rarely if ever required."

DILUTE sweet spirits of nitre is said to be an efficient application for the acute stage of ivy poisoning,

CHLOROFORM WATER IN CROUP.—Dr. Bashere has lately obtained excellent results (*Med. Rec.*) from chloroform water in the treatment of false croup, and regards it as superior to chloral in this affection, in that it is not so dangerous and is eliminated in part by the lungs. Of course its action is local, and its value, probably, due to the sedative effect upon the sensory filaments of the superior laryngeal nerve. He uses a solution consisting of 5 to 10 minims of chloroform to an ounce of water, to which is added a little glycerine to aid the solubility of the chloroform. A teaspoonful of this is given every half hour during an attack, and if there is any dyspnoea the following day, a teaspoonful is given every two hours, increased in frequency to every hour during the evening. This method of treatment is especially applicable to those cases in which the dyspnoea and cough continue during the day.

GLYCERINE OF BORAX IN DIARRHŒA OF INFANTS.—E. Mansel Sympson has found glycerine of borax to answer capitally (says *The Lancet*) in diarrhœa of infants. The children like it, it lessens griping, renders sweet the offensive motions, and stops the diarrhœa. Its use may be supported by the following theoretical arguments: In diarrhœa infantum, the character of the motions suggests excessive fermentation of the contents of the alimentary canal. Glycerine and borax both possess well known antiseptic and soothing properties. The ordinary dose for a child is about twenty minims given every one, two, or three hours, according to the severity of the symptoms. The medicine should be diluted with a teaspoonful of distilled water, and flavored to suit. Glycerine of borax is composed of one ounce of borax in five fluid ounces of glycerine.

DR. G. S. RENNIE, L.R.C.P. & S., Edinburgh and Glasgow (Trinity Medical College), has recently passed the L. R. C. P. London Examination. Dr. Rennie intends to remain in England in attendance upon some of the metropolitan hospitals until October, when he will return to Canada.

CARBOLISED OIL IN SCABIES.—Dr. Tresilian, (*British Medical Journal*) has had excellent results from the use of Carbolised oil, 1 in 15 of olive oil, as a local application in scabies.

CARBONATE OF AMMONIA IN MASTITIS.—Dr. J. R. Frith, writing to the *Weekly Medical Review*, says: "I wish to state the mode I have used for the last six or seven years, invariably with marked success. I do not remember where I obtained it, and never since I commenced its use have I had need for the lance. Even in cases where I have thought it impossible to prevent the formation of pus, I have been able to succeed with it. Simply use carbonate of ammonia (ʒij), boiling water (ʒvii). I saturate in this solution a flannel bandage three inches wide and two feet long, and apply to breast, covering this with oil silk. Solution is used as hot as can be borne, and is renewed every two or three hours. Relief will be derived from the first application.

BORIC ACID IN ACNE.—Dr. Sarah Post (*Med. News*) says she has had very satisfactory results from the following treatment of acne:—Bathe the face at night in hot water containing a few drops of ammonia; do not use soap. Rinse the face in cold water; dry the face. Then apply the solution, half an ounce of boric acid in eight ounces of alcohol, perfumed if necessary, sopping it on with the corner of a handkerchief or a piece of clean soft rag. In the morning do not wash the face, but apply the solution. Carry the solution with you, and apply it several times a day if the skin becomes moist.

SOME USES OF CREOLIN IN GYNÆCOLOGY.—Chiron has given considerable attention to the therapeutics of this remedy. For specific vesical inflammation he holds it very useful. He used two and five per cent. solutions without causing pain or any toxic symptoms, while the trouble was speedily relieved. In gonorrhœal vaginitis and endometritis he used douches and applications of a five per cent. solution with marked benefit. Creolin gauze was found to be a good substitute for iodoform in tamponnade of the uterine cavity.

ANTI-PRURITIC OINTMENT.—Dr. Bulkley (*Coll. and Clin. Rec.*) recommends:

R—Camphor,

Chlor. hydrat., āā ʒj

Rub together till a liquid results and add one ounce of rose water.

COLLEGE OF PHYSICIANS AND SURGEONS, N. W. T.—The first meeting of the Council of the College of Physicians and Surgeons of the North-West Territories was held on the 10th of March, 1890, at Regina, N. W. T., and the following officers were appointed:—Dr. O. C. Edwards, *President*; Dr. J. D. Lafferty, *Vice-President*; Dr. R. B. Cotton, *Reg. Treas.*; Drs. O. C. Edwards, R. G. Brett and R. B. Cotton, *Executive Committee*.

CANADIAN MEDICAL ASSOCIATION.—The meeting of this Association for 1890 will take place at Toronto, September 9th, 10th and 11th. A Committee of Arrangements has been appointed, with Dr. Canniff as chairman. This Committee has met, and taken into consideration the various means by which the meeting in the Queen City may be made most pleasant and profitable to the visiting brethren.

ONTARIO MEDICAL ASSOCIATION.—As the Provincial Elections take place, on the 5th June, it has been decided to postpone the Meeting of the Ontario Medical Association to the following week. The Association will therefore meet in Toronto, on Wednesday and Thursday, the 11th and 12th of June.

DR. V. H. MOORE, of Brockville, has been elected for another term of five years, as representative of Queen's University, to the Ontario Medical Council.

DR. WILLIAM T. HARRIS, of Brantford, has been re-elected the representative of Trinity University on the Medical Council of Ontario for another term of five years.

Books and Pamphlets.

THE INTERNATIONAL MEDICAL ANNUAL AND PRACTITIONER'S INDEX, FOR 1890. Edited by P. W. Williams, M.D., Secretary of Staff, assisted by a corps of thirty-six collaborators—European and American—specialists in their several departments. Six hundred octavo pages. Illustrated. \$2.75. Toronto: J. A. Carveth & Co.

The eighth yearly issue of this handy reference one-volume manual is at hand. In its Alphabetical Index of New Remedies and its Dictionary of

New Treatment it richly deserves and perpetuates the well-earned reputation of its predecessors. In this volume its corps of department editors has been largely increased, and important papers upon "Thermo-therapeutics," "Electro-therapeutics," "Sanitary Science in City and Country," and "The Medical Examiner in Life Insurance," are features of special interest. It is truly a helpful volume, a *résumé* of the year's progress in medicine, keeping the busy practitioner abreast the times with reference to the medical literature of the world. While there is a generous increase in size and material, the price remains the same. There are few practitioners of medicine, be they ever so well read in the advances made in therapeutics or in the introduction of new remedies, who will not derive valuable information and instruction from the perusal and study of this interesting and comprehensive book.

MAY'S DISEASES OF WOMEN, being a concise and systematic exposition of the theory and practice of Gynæcology, for the use of students and practitioners. Second edition, revised by Leonard S. Rau, M.D., attending Gynæcologist to Harlem Hospital, etc.; with thirty-one illustrations in wood. Philadelphia: Lea, Bros. & Co. 1890. Toronto: Vannevar & Co.

The first edition of this work appeared in 1885, and has always been popular as a concise exposition of the subject treated of. It is useful to the student desiring to review his work, and refresh the mind on matter obtained from more extensive works. In the present edition the editor has brought the work up to the latest date as regards new theories and methods of treatment. It may be regarded as one of the best of its class of compends.

EXAMINATION OF URINE, CHEMICAL AND MICROSCOPICAL, FOR CLINICAL PURPOSES. Arranged in the form of questions and answers, by Laurence Wolff, M.D., Demonstrator of Chemistry, Jefferson Medical College, etc. Colored plate and numerous illustrations. Philadelphia: W. B. Saunders. Toronto: Vannevar & Co. 75c.

This little work presents the subject more from the clinical than the chemical standpoint. It will not take the place of more elaborate works on the subject, but as an *aid*, for which it is intended, it is excellent.