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Original Communications.

OBSTETRICS AND GYNECOLOGY.

By A. LAFTHORN SMITH, B. A., M. D., Gynecologist to the Montreal Dispensary, Surgeon to the Women's Hospital, Montreal.

Alexander's Operation.—This operation, as you are aware, consists in cutting down on the external inguinal ring and finding the round ligament of the uterus as it emerges from the inguinal canal. The ligament is then drawn out until the uterus is brought forward close to the symphysis pubis where it is maintained by sewing the shortened ligaments to the inguinal canal. The operation is only suitable in cases of retroversion and retroflexion, in which there are absolutely no adhesions. It has also been employed in cases of prolapsus uteri, although the function of these ligaments or muscles is not to hold the uterus up but to tilt it forward, so that abdominal pressure will fall on its back and not on its anterior surface. The operation has met with varying success, being discarded by some while others have found it very successful. Alexander himself directs that the ligament should be sought for at the external abdominal ring, but at this point it expands into three thin tendinous bands and several operators have failed because they have caught up one of these expansions instead

of the whole ligament. Dr. H. P. Newman, of Chicago, has a very interesting paper in the *American Journal of Obstetrics* for March, in which he advocates a modification of Alexander's directions, cutting down on the middle of the inguinal canal and hooking the round muscle out with a strabismus hook. Dr. Edebohls, of New York, read a paper at the Berlin Congress last year advocating the same method, and Dr. Newman calls his attention to the fact that it originated with Dr. J. Frank, of Chicago, a year and a half previously. I would call the attention of both Dr. Newman and Dr. Edebohls to the fact that I travelled all the way to Battle Creek, Michigan, to witness this same modification of Alexander's operation practised by Dr. Kellogg three years previously, the operation being done moreover under cocaine anæsthesia. This case was Dr. Kellogg's sixtieth.

Laying aside the question of priority, which is a small matter after all, Dr. Newman gives a detailed report of seven cases in every one of which the results were very satisfactory, the patients having remained in good health up to the time of writing, two years having elapsed. The indications for the operation were as follows: Retroversion and prolapsus of both the uterus and ovaries in cases IV, V, and VII; proci-dentia with enlarged and tender ovaries in

case III; while cases I, III and V presented the usual menstrual disorders indicative of the severe types of uterine and ovarian displacements, and were upwards of ten years' standing: Cases IV and VII were of more recent date, being respectively one, three and five years' duration, but pain was a prominent symptom in both, and had resisted careful and persistent treatment. Case VI, of fifteen years' standing, had very naturally tired of routine local treatment, and, having personally observed the benefit accruing in other cases, earnestly requested the operation. Case II was the only one in which adhesions were any material obstacle to the restoration of the uterus to its normal position, though they existed in a minor degree in cases I, V and VII. As before stated, pessaries had been formerly tried in six of the seven cases but in each of those of ovarian complications they were a source of too great irritation to be tolerated, and in the remaining two had resulted in no appreciable benefit.

This operation has now been done many hundred of times and I believe with sufficient benefit to warrant its being placed on the permanent list of gynecological operations. Retroversion, as I have pointed out in several previous reports, is due to relaxation of the round ligaments. Most often this relaxation is due to subinvolution after delivery in women who are kept on their backs for a week or more, during which time the heavy uterus falls by gravity back on to the sacrum. Once the uterus gets there, everything is against its coming forwards again. These cases of retroversion ought never to happen, and they certainly would not if we instructed our patients to discard popular superstition and turn on their side and face and even to sit up on a night chair to pass water and defecate. I believe that faradization of these round muscles by placing one pole on the inguinal canal and the other under the muscle in the vaginal roof may yet do away with the necessity for an operation at all. The patient may besides do a great deal for

herself by assuming the knee chest position several times a day for a few minutes, and by acquiring the habit of sleeping on her face.

The Care of the Lying-in Woman.—Dr. Rutherford of Burlington, Vermont, has a sensible and very practical paper on this subject, in the *American Journal of Obstetrics*. Although I have already called attention to many of the principles he lays down, they cannot be brought to the attention of the profession too often. He sums up his paper as follows: 1. Keep the woman clean, locally and generally. 2. Give her all the nourishing food she can digest. 3. Keep her bowels open. 4. Give her plenty of fresh air. 5. See that she sits up to empty the bladder and rectum, and to nurse the child. 6. See that the uterus is in its normal position. 7. Never allow a woman to get up from child-bed with a retroverted uterus.

The Treatment of Acute Anaemia by Infusion, is the title of a paper by Dr. Bayard Homes of Chicago, in which the author strongly advocates the subcutaneous injection of a boiled and filtered solution of common salt containing six drachms to the gallon of water. From a quart to a gallon of this is injected under the skin of the back near the angle of the scapula by means of the Allan surgical pump or even with a fountain syringe at a sufficient height to give the necessary pressure. Although this does not actually replace the blood, it increases the volume of it so that the pressure of the blood in the aorta is increased, and thereby the coronary arteries receive enough blood, albeit of a poor quality, to keep the muscular organ contracting. Arterial pressure is the secret of the heart's blood supply, for it must be remembered that the heart is not allowed to drink one drop of the immense quantities of blood rushing through it; it can only get it through the coronary arteries. This is clearly proved by the agony of exhaustion evinced by the heart when its blood supply

is cut off by closure of the coronary arteries by disease of their walls.

The Sources of Puerperal Infection.—There are few practitioners who have had over four hundred confinements who have not had the misfortune to lose a case from puerperal fever. There are so many ways in which this accident may happen that the wonder is that in spite of all our precautions it does not happen oftener. Dr. Irwin Hance, of New York, believes that in most, if not in all cases, it is due to septic infection of a laceration of the cervix or perineum. I believe that the absorption of disease germs may take place from raw surfaces at any point from the perineum to the fundus uteri. At the meeting of the Canada Medical Association in Montreal eight years ago I pointed out that the seriousness of the case increases with the height of the raw surface, septic absorption from the placental site being much more serious than the same absorption from a lacerated perineum, and I still hold that view. In every case the temperature should be watched, any rise should be the signal for immediate irrigation of the parts with some disinfectant solution, such as 1-40 Condy's fluid, or 1-40 carbolic acid or creolin, or boracic acid, a drachm to the pint, etc. The perineum should be examined in every case immediately after the expulsion of the placenta, and any laceration, no matter how small, should be invariably sewed, with an ordinary needle and linen thread if you have nothing else. Many are in favor of immediately repairing the cervix if it is lacerated, but the majority rely upon strict asepsis and the chance of its healing itself.

If the rise of temperature is sudden and accompanied by a rigor, the case will be a serious one and the uterus is probably the site of the absorption. It should, therefore, be irrigated with an intrauterine catheter and its cavity filled with a long strip of iodoform gauze so as to ensure drainage.

But where does the infection come from? It may come from the husband who has

had connection with his wife a few hours before. It may come from a nurse who has had her hands in septic matter before coming to this case, or it may come from the doctor who does not believe in antiseptics. I have had at least one case of each kind, but strange to say the only two deaths in nearly five hundred confinements, were my 326th and 453rd, in which I had taken every precaution. I believe that there is another factor which is not sufficiently recognized and that is sewer gas infection. While I was attending women in the very poorest houses in the city where there were no closets, I hardly ever had a case of puerperal fever. It was only when I began to attend women in much be-plumbed and badly sewered houses of the better class that I began to have post partum rises of temperature. On mentioning this fact to Dr. Jos. Price, who is in charge of the Preston retreat, the best arranged lying-in hospital in the world, and where puerperal fever is unknown, he told me that he believed that sewer gas was a very common cause and for that reason all the closets and plumbing in the retreat were outside of the building, and that he had had better results from laparotomies performed in the hovels of the poor than was usual in the best appointed hospitals. I know of an outbreak of diphtheria of the genital tract, occurring in a lying-in hospital where an examination of the plumbing revealed a direct untrapped connection with the public sewer, conveying sewer gas directly into the building.

Dr. E. S. McKee, of Cincinnati, has a short but well written article in the same journal on "Obesity in its Relation to Menstruation and Conception." He points out that very fat women and even very stout men are very often sterile. He thinks that this is one of the explanations of the sterility of the rich and the fertility of the poor. Still more troublesome is the amenorrhoea and dysmenorrhoea which is so common in stout women. The pain, he says, is situated in the sacral region, in the majority of cases,

and begins before the flow and lasts until it ceases. In some cases there is vicarims menstruation. It appears that in these women miscarriages are very apt to occur. The most interesting point is the treatment. Rigid diet he says is *de rigueur*. Hydrocarbons and alcohol must be interdicted. Exercise, either active or passive, cannot be neglected. General and local faradization are of value. Laxatives are useful, but strong purgatives are bad because they cause *anæmia*. I must confess that these cases give me a great deal of trouble.

TENDON REFLEXES.

Dr. Sternberg, of Vienna, read a paper on this subject, based on observations made on 1,500 patients in the clinics of Professor Meynert and Dr. Redtenbacher. The object of the experiment was to determine the "components" constituting the tendon reflexes, that is, the effects produced by shaking of the muscle, the tendons, the bone, etc., and to separate these various phenomena from each other. In this way he succeeded in showing that the so-called tendon reflexes consist of two phenomena, namely, a bone reflex and a pure muscle phenomenon, which, most probably, is also a reflex. The bone reflex consists in the fact that a shock to the bone, particularly in the direction of its longitudinal axis, irritates the nerves of the periosteum and the articular surfaces, and this produces a contraction of all the muscles belonging to the bone. The muscle-reflex consists in the fact that a stretched muscle becomes contracted when a shock is transmitted to it in the longitudinal direction. The tendon only plays a mechanical part. No reflexes originate from the nerves of the tendon. The existence of reflexes of the fascia cannot be proved. In contractures occurring after localized cerebral affections in various diseases of the spinal cord and in articular processes, the tendon reflexes are invariably increased. In contractures which occur in large cerebral hemorrhages, cerebral tumors and abscesses, uræmia and meningitis, and paralysis agitans, the tendon reflexes are never increased, and very frequently are diminished. These two forms of contracture can occasionally be distinguished by the tendon reflexes. In conclusion Dr. Sternberg pointed out that when all the precautions recommended by Schreiber and Jendrassik for the examination of the tendon reflexes were observed, complete absence of the tendon reflexes was much more seldom found than on less careful examination. —*British Med. Journal.*

Society Proceedings.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

Stated Meeting, December 19th, 1890.

F. J. SHEPHERD, M. D., PRESIDENT, IN THE CHAIR.

A Large Aneurysm of the Aorta.—Dr. Johnston exhibited this specimen, which had been sent by Dr. Tunstall of Kamloops, B. C. The specimen showed a diffuse dilatation of the ascending and transverse portions of the arch of the aorta. Springing from the right side of the arch, immediately above the aortic ring, was a sacculated aneurysm rather larger than the fist. The orifice of the sack was about $2\frac{1}{2}$ inches in diameter, and the sinus of valsalva was involved in the dilatation, so that the segment of the aortic valves, which were thick and stretched out laterally, lay across the edge of this space. The sac lay in close connection with the posterior wall of the right ventricle, which was very thin in places, the muscle apparently being atrophied from pressure. Between the muscle fibres the whitish fibrous wall of the sack could be seen in places. Dr. Johnston wished to know if any set of symptoms or physical signs were known to be associated with aneurysm in this unusual situation.

Chronic Calcifying Pericarditis.—Dr. Johnston exhibited this specimen for Dr. MacDonnell. The autopsy showed considerable dilatation and hypertrophy of both chambers with universal adhesive pericarditis. Extending almost entirely round the base of the heart, in the auriculo-ventricular sulcus, was a calcified plate lying within the adhesion, evidently due to unabsorbed exudation. At one spot about a teaspoonful of thick, whitish, purulent fluid lay encapsuled between the adhesion and the heart wall. The calcareous plate was not firmly attached to the heart, but rather to the mediastinal tissue. It was evident, however, that it prevented the mitral and tricuspid muscular rings from properly contracting. The valve segments themselves were almost normal.

Dr. R. L. MacDonnell gave an outline of the history of the case. The patient had had scarlet fever in childhood. There were no heart symptoms until he had arrived to the age of 40, when he had begun to suffer from dyspnoea, præcordial pain, and dropsy of the feet. During his illness there had been severe attacks of epistaxis. In one of these, the posterior nares on the left side had been plugged. This operation had been followed immediately by acute otitis media ending in rupture of the drum membrane. There had subsequently been an attack of acute renal congestion with the passage of bloody urine.

The liver and spleen showed signs of enlargement, and there were evidences of congestion of both pulmonary bases.

Gonorrhœal (?) Endocarditis.—Dr. Johnston showed the heart of a man, aged 34, a stone-mason, who had died in Dr. Molson's wards. There had been a history of repeated attacks of gonorrhœa, the last commencing two weeks before admission. At the autopsy the lungs showed extensive chronic bronchitis, with slight bronchiectasis; and multiple small fibrous nodules scattered throughout the lung substance, each being surrounded by a zone of black pigment. The heart was dilated and the muscle wall of both chambers somewhat thick. A large rough, ragged, fibrinous vegetation was found at the base of the middle segment of the aortic valve; this was traced directly through the region of the membranous septum between the ventricles, and extended to the adjacent part of the tricuspid valve, upon which a similar vegetation existed; the intervening tissue was softened and necrotic. The remaining portion of the aortic and tricuspid valves seemed perfectly healthy. The other valves looked normal. The heart muscle showed no change beyond slight fatty degeneration of some of the papillary muscles. No infarcts or abscesses were found anywhere in the body. The urethra showed some thickening near the meatus and about the bulb, but was free from all appearance of acute inflammation. The right ankle and both knee-joints were examined and found normal.

Dr. Johnston was surprised to find, on making cover-glass preparations from the vegetations on the valves, that on staining with watery fuchsin a number of small diplococci were found, having a strong resemblance to gonococci in size and shape. They further resembled gonococci in not staining by Gram's method, others differing from all cocci which Dr. Johnston had found in previous cases of endocarditis. They were not obtained in cultures in pure agar-agar. On the other hand, while they sometimes occurred in small groups, of which each pair of cocci was slightly separated from the neighbors, they did not lie in the substance of the cells when these were present. They also stained less intensely than gonococci in alcoholic methylene blue solution. Scrapings from different parts of the urethral mucosa did not show any gonococci or organism at all resembling them. None of the other tissues were examined for bacteria. Dr. Johnston did not believe these organisms were proved to be gonococci, as possibly the peculiar staining might be due to degenerative changes in some other diplococcus. Still, as a case had been reported where gonococci had been described as occurring in the vegetation, the similarity, if not identity, of these organisms to them was of importance. He had not had any sterilized human serum on hand at the time of making

this autopsy, and had not hoped for positive results from the cultures in any case.

Dr. MacDonnell, who reported the case, remarked that the patient had been admitted to Dr. Molson's wards in the Montreal General Hospital, on December 12th, 1890, complaining of cough, dyspnoea, and sleeplessness. There was a history of intemperance; no history of syphilis, but he had on several occasions contracted gonorrhœa, and had twice been under the care of Dr. Molson for gonorrhœal rheumatism. Six months ago the patient contracted a fresh gonorrhœa, which was followed by a fresh attack of rheumatism, the ankles, knees and wrists being affected. Apart from his affection he had not been in good health for some two months. He had lost weight, had shortness of breath, and pain in the left side of the chest, and a distressing cough with free expectoration. He recovered from the attack of gonorrhœal rheumatism, exposed himself afresh to contagion, two weeks before admission, and the discharge had returned with increased vigor. There is no history of rheumatism or scarlet fever. Parents were both alive. One sister died at nine months of convulsions, one at 14 years of an acute illness lasting but two days, and a brother died at 30 of inflammation of the lungs. The present illness began two weeks ago with cough and dyspnoea. On admission at noon, Dec. 12th, 1890, the temperature was $102\frac{1}{2}^{\circ}$, pulse 120 (weak), and respirations 48 (labored); cough distressing; deficient expansion on right side, with dulness on percussion and weak breathing over a considerable area at the back of both lungs from the angle of the scapulae downwards, and mucous râles were heard over the whole back. Owing to the noisy breathing the heart-sounds could not be distinguished. Nothing was noted beyond accentuation of the second sound. Patient died suddenly at 3 a. m. next day (13th).

Dr. Bell asked if the gonococci had been recognized outside of the genito-urinary tract.

Dr. Jas. Stewart inquired if the joints had been examined in the present case for gonococci.

Dr. Johnston, in answer to Dr. Bell, stated that gonococci had been met with in cases of salpingitis and in gonorrhœal arthritis. To Dr. Stewart's question, he had not examined the joints for gonococci, as they appeared perfectly normal.

Case of Rhinoplasty.—Dr. Jas. Bell brought the patient before the Society and gave the following history: Five years ago, A. S., aged 25 years, lost the cartilaginous and soft parts of the nose, with the exception of a portion of the alae at each side, from a destructive ulcerative disease said to have been lupus. An attempt was made in the London Hospital, England, to restore the nose by the Tagliacotian operation, the left forearm being used for this purpose, but resulted in a complete failure. On admission, portions only

of the alæ were left of the nasal structures anterior to the lower extremities of the nasal bones. These were connected to the cheeks by large keloid cicatrices. The unsupported nasal bones had fallen down, so that the anterior edge of the vomer could be felt projecting between them. The inferior (free) margin of the vomer from which the triangular cartilage had been removed by the ulcerative process was covered by healthy mucous membrane. There was great redundancy of the upper lip, which was made more apparent by the spreading of the alæ nasi. The operation consisted in fitting into the gap described a section from the central portion of the upper lip. The edges of the gap were pared from above downwards, beginning at the centre. The mucous membrane was also pared from the free edge of the vomer. A section was then removed from the center of the lip through its whole thickness, and about an inch in width at its free margin and three-quarters of an inch in width at the base of the flap. The flap was then turned upwards and fitted into the gap by making a cross section through the skin surface near the mucous edge of the lip and splitting it in both directions so that in its centre it was attached to the vomer, while externally the edges of the mucous surface were attached to the skin margin, the parings from which were reflected downwards and attached to the edges of the base of the flap, which formed the calumna nasi. Union by first intention took place throughout, and an excellent result followed, with but slight shrinking of the implanted flap. In two months the mucous surface had become pale and resembled the skin so closely in other respects that it could only be recognized on careful examination.

Plastic Operation for Severe Burn of Face and Neck.—Dr. Shepherd exhibited a patient on whom he had operated for deformity of the neck and mouth, following a severe burn in infancy. The patient was 20 years of age, and when he entered hospital his chin and lower lip were fixed to the sternum, causing the whole head to be bent forward and obliterating the front of the neck. The burn had involved the greater part of the chest and also the sides of the neck and arms. The lower jaw, from continued tension of the scar had been pulled forward and protruded several inches beyond the upper, giving the man a hideous appearance. Several operations were performed. The neck was first freed by a dissection which reached almost from ear to ear; and when granulation had been established, grafting after Thiersch's method was performed. The protruding lower jaw was then excised and the lip restored by Teale's operation. The result was good; the patient's appearance was much improved, and he could use his mouth.

Removal of an Osseous Body from the Knee.—Dr. Hingston exhibited a fragment of bone which he had removed from the knee-joint of a

young man. The symptoms were similar to those commonly met with when loose cartilages are present. An open incision was made and the substance removed. On examination, it was found to be distinctly bony in structure. Its dimensions were about one inch by half an inch.

Dr. Roddick asked if there was any history of injury.

Dr. Shepherd remarked that the specimen looked like a fragment of bone sometimes found in gouty subjects.

Dr. Hingston replied that there was no history of injury or gout.

Chorea, its Relation to Rheumatism and Treatment.—Dr. G. A. Brown then read a paper on this subject.

Discussion.—Dr. MacDonnell considered the paper of practical interest. He referred to the great frequency of the rheumatic history, when looked for, in many cases of chorea. Rheumatism in children more frequently manifested itself by tonsillitis, chorea, erythema, and various other manifestations of the rheumatic diathesis than by painful and swollen joints.

Dr. Jas. Stewart had no doubt but that rheumatism had a marked influence in the induction of chorea. He considered, however, that there was another element which predisposed to chorea, and that was the condition of instability of the nervous centres.

Dr. Mills spoke of the causes of chorea in dogs. These were mainly reflex and, in his experience, not dependent upon organic disease.

Dr. Gurd had found the iodide of iron with arsenic very beneficial in the treatment of chorea.

Dr. Johnston remarked that he had only met with brain lesions in one case of chorea out of about ten examined in man and animals. This was a case where he had performed an autopsy for Dr. Jas. Stewart, and a number of small cysts had been found in each corpus striatum.

Dr. Hingston had found ordinary chorea to disappear in seven or eight weeks without medicinal treatment.

Dr. Bell thought that the name chorea was rather indefinite, that it was made to include many cases of a definite pathological lesion.

Dr. Brown, in his reply stated that he had wished to show the close relationship between rheumatism and chorea, nevertheless admitting that other causes may enter into its production.

Stated Meeting, 9th January, 1891.

F. J. SHEPHERD, M.D. PRESIDENT IN THE CHAIR.

Ruptured Tubal Pregnancy.—Dr. Armstrong showed this specimen which he had removed from a patient aged 35. Her previous pregnancy, nine years ago, was followed by pelvic symptoms. She was then delivered of a full-grown child. In May last, the patient believed

that she had had a miscarriage, as there had been a bloody discharge from the vagina for seven weeks. On the 5th April, five weeks after her last menstrual period, whilst out walking, she was seized with severe pain and faintness, and had to be driven home. In two or three days she recovered sufficiently to be able to go about the house. On the 14th April she had another attack. On the 16th the patient felt better and went out, when she was seized with a third attack. Dr. Armstrong, who then saw the patient, found, on examination, the uterus pushed up and to the left. In the right side of the pelvis a large mass could be felt about the size of a cocoon. The tumor extended above the brim of the pelvis, and could be detected by external palpation. There was a little bloody discharge from the vagina. The diagnosis was hematocele due to a ruptured tubal pregnancy. This was confirmed subsequently by Dr. Perigo. The symptoms not being urgent, it was deemed advisable to await developments. The patient improved, and in a few days was up. She remained well until August, when chills and hectic fever set in, and the tumor felt considerably softer. On the 1st September Dr. Armstrong opened the abdominal cavity. The right Fallopian tube was ruptured and lay in the sac, which was filled with blood-clot. The sac was easily enucleated, and the tube ligatured and removed. The patient was now perfectly well. Dr. Johnston had examined the specimen and found structures resembling chorionic villi. Dr. A., dwelling upon the etiology of the case, referred to her history of pelvic pain some nine years ago, when possibly, there may have been desquamative salpingitis.

Dr. Wm. Gardner remarked that these cases were far from rare, and that they were not always fatal. In the present specimen the sac was somewhat remarkable. He wished to know if there were any evidence of ovarian structure in the sac. He had frequently found what he believed to be the ovary expanded by blood-clot.

Dr. Johnston replied that the ovary was free from the sac.

Dr. Shepherd wished to know what symptoms led to the operation.

Dr. Armstrong answered that from the softening of the tumor, together with signs of hectic fever, he had considered it advisable to operate.

Tuberculous Arthritis of the Knee-joint.—Dr. Wyatt Johnston exhibited this specimen. Sequestra of necrosed bone existed at the head of the tibia and the condyles of the femur. The opposing surfaces of these sequestra were very dense, and showed eburnation.

Chalicosis.—Dr. Johnston also showed the lungs of a stonemason. A large number of small, firm, fibroid nodules, the size of shot, were found beneath the pleura and throughout the lung substance. These nodules were gray in the centre, and were surrounded by a zone of

black pigment. Analysis of the lung by Dr. Ruttan showed that 8.4 per cent. of the dried lung was composed of mineral ash, of which over 50 per cent. consisted of silica. Traces of iron were also present.

Thrombosis of the Superior Longitudinal Sinus and left Renal Vein following Scarlatina.—Dr. Johnson exhibited this specimen for Dr. Armstrong. The patient, a female child, aged 2½ years, had died six weeks after the onset of an attack of scarlatina with broncho-pneumonia. A large, firm, adherent, darkened thrombus completely filled the superior longitudinal sinus and extended into the adjacent central veins. The brain was perfectly normal. The left renal vein and its principal branches also contained adherent red thrombi. The ovarian veins were not examined.

Dr. Armstrong related the clinical history. The child was two years and a half old. It had been delivered with forceps, and from within a fortnight of its birth it had suffered from convulsive seizures, which had occurred from once to six times a day. Various modes of treatment, including circumcision, had been tried without effect. The parents had persisted in the belief that the forceps was to blame for the unhappy condition of the child. Death was caused by scarlet fever and broncho-pneumonia.

Dr. Mills said that it was difficult to see how forceps could affect the sinus. He thought that more than the blood must be taken into account to explain the convulsive seizures.

Dr. Johnston remarked that thrombosis in the veins of children was not uncommon, especially in the renal vein which probably extended from the spermatic vein.

A case of Abortive Typhoid Fever, with a Severe Relapse.—Dr. J. A. Springle related the history of the case. The patient, a young man aged 19, had consulted him on the 25th September last, with unmistakable symptoms of typhoid of about the seventh or eighth day of the fever. On the following day rose spots were observed, and on the tenth day of the illness there was retention of urine. On the morning of the eleventh day the patient was extremely jaundiced, but was feeling quite well. His temperature, which had ranged between 100° and 102°, had fallen to 98½°, and all the abdominal symptoms had disappeared. Retention of urine, however, persisted. This condition lasted until the end of the thirteenth day, when he recovered power over his bladder, and the jaundice gradually disappeared. His pulse and temperature had been normal since the eleventh day. His general condition was so much improved that he was allowed to partake of solid, though light food. He steadily improved, and on the seventeenth day was out for a short walk. On the eighteenth day he complained of not feeling well, and on the following morning presented all the symptoms of a severe relapse. For the first

week of the relapse the fever ranged from 100° to 105° ; pulse 100 to 140, markedly dicrotic. The spleen was enlarged, and there was great illiac tenderness; vomiting was incessant for forty-eight hours. Towards the end of this week hemorrhage set in, small in quantity at first, but subsequently becoming very profuse. There was considerable abdominal distention. During the following week there was vomiting, retention of urine, and a slight diarrhoea, which lasted forty-eight hours. A profuse rose rash was observed over the chest. The tympanitis, hemorrhage and other graver symptoms subsided towards the end of the week. From the end of the third week the patient progressed favorably. The total period of the pyrexia for the relapse was thirty days. Dr. S. could not explain the coincidence of jaundice, furthermore than the patient had had fever and ague five years ago, and since then, his skin had at times been discolored, but not of the decided tint observed in this illness.

Dr. MacDonnell considered this case an interesting one. That many cases of abortive typhoid were put down as febricula, he had no doubt. Jaundice in typhoid fever was not rare, though not often seen here. He mentioned a case of a patient in the hospital, who developed jaundice after a relapse of typhoid fever.

A Method for the Quantitative Estimation of Acetone in Urine.—Dr. Ruttan, in referring to the various methods of detecting acetone in urine, said he had no hesitation in recommending Leben's iodoform test as superior to all others both in the delicacy of the reaction and in the ease with which the test could be applied.

If much acetone be present it can, with little experience, be detected by applying the test directly to the filtered urine. This method is rendered more delicate by first precipitating the earthy phosphates by caustic soda or potash, and then applying the test. The test consists in adding to the urine a few drops of a strong solution of iodine in potassium iodide, and then adding an alkali (caustic soda, etc.) until the solution is just decolorized. A yellow opacity with precipitation of iodoform occurs if acetone be present. Nothing else that occurs in urine, except acetone, is able to give this precipitate of iodoform without warming.

When but minute traces (less than 0.05 per cent.) are present, the urine should first be made acid with sulphuric acid and distilled. When half the urine has been distilled, all the acetone has been found to be in the distillate.

He then demonstrated the application of a piece of apparatus he had constructed to use in connection with his method of determining the quantity of acetone in urine. This method depends on the fact that with the same quantity of iodine and alkali, variations in the quantity of iodoform produced in Leben's test are caused by a proportionate increase or diminution of the

acetone. He used 5 c.c. of a standard strength of iodine, 10 c.c. of similar strength of caustic potash, and 1 c.c. of the distillate of the urine to be tested. The iodoform produced is dissolved up by shaking the mixture in a sort of separating flask with pure ether, then the aqueous mixture below is run out, and the ethereal solution measured in the flask as it is graduated from the tap up. Half the etherized solution is run out on a weighed watch glass and allowed to evaporate at ordinary temperature. The iodoform left is weighed, and the quantity so obtained multiplied by 0.55 will equal the acetone in 1 c.c. of the urine.

In a chemical laboratory from forty to fifty estimations could be made in a day, and the percentage of acetone determined to the third place of decimals with perfect accuracy.

Acetonuria.—Dr. Ruttan and Dr. Wyatt Johnston read a paper upon a fatal case of cerebral apoplexy, in which sugar and acetone had been detected in the urine.

The patient, a man aged sixty-seven, had been under the care of Dr. R. L. MacDonnell, who had been his medical attendant for the last seven years, and had repeatedly examined the urine during that time, always with negative results. The fatal illness had set in suddenly with an apoplectic seizure. Coma had set in immediately, and had lasted for twenty-four hours. The urine was found at the time of the seizure to contain 1.7 per cent. of sugar, which had increased next day to 2.4, and then had disappeared entirely. Acetone to the amount of 0.31 to 0.37 per cent. was found associated with the sugar, and the quantity had persisted for five days after the sugar had disappeared.

The patient had partially recovered consciousness, and had complained of severe occipital pain. Death had occurred suddenly and unexpectedly on the twelfth day of the illness. The condition had been regarded as one of diabetic coma, but at the autopsy an extensive cerebral hemorrhage was present, involving the whole of the base of the brain, but most extensive over the medulla. Dr. MacDonnell concluded from this instance that in every case where there is sugar in the urine it was not necessarily a case of diabetes.

Dr. Mills said that the present case appeared to him like one that was being gradually poisoned from some retained substance in the body, which was unknown to us, and deranged metabolism generally.

Dr. Johnston stated that in view of the post mortem, poisoning by acetonuria could not be regarded as being the cause of any of the symptoms. The hemorrhage had produced both the coma and the acetonuria. The blood obtained at the autopsy was free from acetone. The death was probably due to a recurrence of the hemorrhage.

Dr. Ruttan thought that the urine of the patients suffering from coma should be examined for acetone, as well as for sugar and albumen.

Stated Meeting, January 23rd, 1891.

F. J. SHEPHERD, M. D., PRESIDENT, IN THE CHAIR.

Epithelioma of the Mouth.—Dr. Johnston exhibited this specimen for Dr. Bell. The tumor, the size of a walnut, was situated behind the symphysis of the lower jaw. The surface was ulcerating. The growth infiltrated the submucous and muscular tissue in its neighborhood and had extended into the periosteum. Microscopic examination showed the growth to be an epithelioma. At the autopsy, performed four days after the operation, the wound was granulating. No thrombi were found in the vessels of the neck or the pulmonary arteries. The lungs showed a patch of acute pneumonia, as large as an orange, in the upper lobe of the left lung. At the right apex was an extensive fibroid area, evidently of tuberculous origin, in the centre of which was a small cavity the size of a cherry, with smooth walls, communicating directly with a bronchiole. There were no signs of food in the air passages.

Dr. Bell briefly related the history of the case. The patient was 59 years of age, an old soldier and a smoker. His trouble dated back to May last, but it was only in August that his mouth became sore. The patient's condition was rather poor. There were signs of old tubercular disease at the upper lobe of the left lung. The patient died on the morning of the third day after the operation, somewhat suddenly, from an apparent syncopal attack.

Dr. Johnston believed the cause of death to have been septic pneumonia, without any mechanical cause.

Hæmatocele of the Testis.—Dr. Bell, who showed this specimen, remarked that it had come on suddenly, in one night, whilst the patient was ill in bed. The tumor had been tapped at the hospital, and a cellulitis of the scrotum had followed. Dr. Bell made an incision into the scrotum and found the visceral layer of the tunic dilated with blood-clot. On section, the testicle was found considerably injured by pressure. Dr. B. remarked that it was unusual to find hæmatocele without any history of traumatism.

Dr. Roddick agreed with Dr. Bell as to the rarity of cases of hæmatocele without traumatism. When this case had been tapped, a grumous and bloody serum escaped which led Dr. R. to believe that a cyst had been punctured, particularly as the testicle could not be felt.

Multilocular Cyst of the Ovary.—Dr. Laphorn Smith showed this specimen, which weighed 45 lbs., which he removed from a wo-

man aged 31. There were a great many adhesions. Hemorrhage had been very profuse during the operation, and the abdomen had to be reopened the following day owing to a recurrence of the hemorrhage, due to a small fissure between two segments of the pedicle. The patient was very weak from the loss of blood, and died three and a half days after the operation.

Dilated Tubes.—Dr. Smith also exhibited this specimen, on which he would report at a later date.

Bone-marrow and Liver; Pernicious Anæmia.—Dr. Johnston showed the femur of a man, aged 50, who had died in Dr. Molson's wards from pernicious anæmia. The medullary canal was filled with red lymphoid marrow, except in the lower third, where traces of the fatty marrow still existed. The liver, from the same case, showed a large amount of yellow brown pigment in the peripheral zone of the lobules. This pigment gave a marked iron reaction on treating the sections with ferro-cyanide of potassium and hydrochloric acid. The skin and subcutaneous tissues were stained a lemon-yellow tint. Numerous nucleated red blood corpuscles were found in the blood.

Plastic Operation for Extrophy of the Bladder.—Dr. Shepherd exhibited a case of extrophy of the bladder in a boy aged 12, on whom he had operated, and restored the anterior wall by Maury's operation. A large oval flap was first taken from the perineum and fixed beneath a short flap dissected from above. After union had taken place, the sides of the flap, which were unattached, were further dissected down and fixed beneath short lateral flaps. In the first operation, a hole had been made in the centre of the perineal flap for the rudimentary penis. The parts all united well except at the upper part, where a small portion sloughed and allowed urine to exude, and so prevented skin-grafting being to any large extent successful. This fistulous opening had, however, been closed by a recent operation, and now the bladder was completely covered and the parts had all skinned over. The boy was able to retain a couple of ounces of urine, and the double hernia which had previously existed as the parts contracted, was completely cured.

Dr. Roddick considered the operation admirable. He had operated on a young woman some years ago for extrophy of the bladder, and had selected Ayer's method. A large square flap had been dissected from the abdomen above the bladder and turned down with the cuticular surface innermost. The raw surface was subsequently covered over by lateral flaps. The operation thus far had proved very successful. The patient left the hospital with the intention of returning in a few weeks to have the operation completed. She failed to do so. It was learned that she had got married.

Study of Koch's Treatment in Berlin.—Dr. G. T. Ross read a paper on the above subject.

Brief reports of cases submitted to Koch's treatment in the Montreal General Hospital were made by Drs. Roddick, MacDonnell, Jas. Bell, and Johnston.

Dr. Roddick was not yet convinced that the results would be as good as predicted. He agreed with Dr. G. T. Ross that the remedy was a dangerous one, and that all experiments should be made in hospital.

Dr. R. L. MacDonnell stated that recognising the responsibility resting upon those who, occupying positions in public institutions, were entrusted with the experiments with the Koch fluid, he had endeavored to fulfil his duty towards the profession and the public. The profession regard with eager interest the result of the work. It was therefore necessary that the members of it should be put into full possession of all the facts of the cases on trial and the records of the observations made. The profession could then judge fairly of the result. Towards the public, it was the duty of those using the fluid to use the utmost caution. To pronounce a decided judgment upon the merits of the treatment was not possible, and therefore the members of the profession should be slow in the expression of opinion on the matter. Unless care were taken, the Koch treatment would develop into a form of cruel quackery. He had endeavored to secure cases in which (1) the diagnosis was beyond a doubt; (2) cases which had been under observation previously, so that a just comparison of their condition before and after treatment could be made. Three cases were selected, and the treatment was commenced on the 12th January:—

Case 1.—A boy of 18, who had been six weeks in hospital in early autumn. The temperature had always been normal, or nearly normal, never having reached 100°. The symptoms were debility, loss of weight, cough. The physical signs were indicative of consolidation at the right apex, involving the upper third of the lung, and commencing consolidation of the left. Tubercle bacilli and elastic tissue in the sputum. For a week before the injections were made the temperature was taken hourly. It never went as high as 100°. The result of the treatment had been little more than negative. A reaction has occurred, inasmuch as it is plain that the temperature rises to a point higher than was observed before, after each injection. Up to date, Jan. 23rd, the patient observes no change. The physical signs are unchanged. The sputum has been examined every day, but no change in the number of bacilli has been noticed. The patient has lost weight since he had been under treatment.

(To be continued.)

Progress of Science.

WASHES AND SPRAYS IN THE TREATMENT OF NASO-PHARYNGEAL CATARRH.

By E. Baldwin Gleason, M. D., Surgeon-in-Charge of the Department for Diseases of the Nose, Throat and Ear of the Northern Dispensary.

The secretions of the nasal mucous membrane are derived from its mucous glands, and also almost directly from the numerous blood-vessels of the mucous membrane, especially those of the so-called erectile tissues covering the turbinated bones. Whenever a nasal discharge consists of a clear, watery fluid—which in hay fever or nasal hydroorrhœa is often very abundant—the fluid comes from dilated blood-vessels and indicates vasomotor paresis, and may be the reflex of irritation of some of the sensory nerve-filaments in the nasal mucous membrane. In such cases, irritating astringents, especially if applied in the form of a powder, invariably do harm and increase the watery discharge. If, however, a 4 per cent. solution of cocaine be applied to the interior of the nose, contraction of the vessels is brought about and the discharge ceases. The effects of the cocaine in thus controlling the discharge may be usually maintained for several hours by following the cocaine application, by spraying the interior of the nose with an atomizer containing a 4 per cent. solution of antipyrin. The nasal stenosis and excessive secretion of acute coryza are at once relieved by this treatment, which may be repeated as often as twice or thrice a day, with the result of obtaining a speedy cure of "cold in the head."

A patient, during an attack of fever, should be directed to saturate small pieces of absorbent cotton with a 4 per cent. solution of cocaine and place one loosely within each nostril, and to renew the application as necessary to obtain complete relief from his more distressing symptoms. An efficient wash for the nose and pharynx to be used by the patient at home should have the following characteristics:

1. It should be alkaline.
2. Its specific gravity should be a little less than 1027, or about that of blood serum.
3. The temperature of the wash when used should not be below 100° Fahrenheit.
4. It should be an agreeable odor, taste, and appearance.
5. It should be antiseptic.
6. It should be so medicated as to be appropriate to the condition of the mucous membrane of the nose and pharynx of the patient for whom it is prescribed.

The specific gravity of the wash should be about 1027, or that of blood serum, because the Schneiderian mucous membrane is exceedingly

thin and vascular, and presents the most favorable condition for the occurrence of osmosis and exosmosis. If the specific gravity of a "nose-wash" is much less than that of blood-serum its use is followed by osmosis of the more fluid parts of the wash into the capillaries of the mucous membrane; while, if the specific gravity of the wash is much above that of blood-serum, its use is followed by exosmosis from the capillaries of the mucous membrane. In either case there is produced an irritation of the sensory nerves of the mucous membrane, indicated by smarting sensations or actual pain lasting some moments, and soon followed by swelling of the erectile tissues and a "stuffed up" sensation in the nose.

When masses of partially inspissated mucus are retained within the nasal chambers they soon begin to undergo putrefactive changes and the products of these changes are very readily absorbed through the thin, vascular, mucous membrane.

A 20 per cent. solution of cocaine, when applied on absorbent cotton to the nasal mucous membrane, produces a more rapid, but, at the same time, more superficial and less profound local anæsthesia than when a 4 per cent. solution is used for this purpose.

Applying the foregoing considerations in the construction of a formula for a nose-wash to be used by patients at home, we may make a wash that is bland and unirritating, alkaline, antiseptic, and of the right specific gravity for use within the nose in simple chronic or hypertrophic catarrh:

| | | |
|---|--------------------|----------|
| R | Sodii bicarb., | |
| | Sodii bicorbat., | aa ʒj. |
| | Sodii salicylatis, | gr. iij. |
| | Glycerinæ, | fʒj. |
| | Thymol., | gr. j. |
| | Menthol., | gr. ss. |
| | Aquæ, | ad fʒiv. |

M. Sig.: Add to a quart of water and use as a wash.

If to the above formula table salt or extract of liquorice (1 drachm of either) be added, we still have a cheap and effective wash, whose solid ingredients may be prescribed as a powder, a heaping teaspoonful of which added to a pint of water will form a wash of the required strength; or the powder may be compressed into tablets of such a size that one of them added to 2 ounces of water will form an efficient wash.

Powders used as a "snuff" irritate the nose mechanically, and sometimes bring about a condition of affairs resembling that of hay fever. Simple chronic rhinitis is then, perhaps, best treated by the patient's use, two or three times a day, of a bland and unirritating alkaline wash, and the application by his physician of an alterative and somewhat stimulating solution to the inflamed Schneiderian membrane two or three times a week to bring about absorption of the

products of inflammation within and beneath the structure. The following solution, applied to the nasal mucous membrane by means of a piece of absorbent cotton wrapped around the end of a probe, answers very well for this purpose:—

| | | |
|---|------------------|-----------|
| R | Iodi, | gr. viij |
| | Potassii iodid., | gr. xxiv. |
| | Glycerinæ, | fʒss. |

The solution, when applied to the Schneiderian membrane, should produce a slight amount of irritation, or the proportion of iodine and iodide of potassium to the glycerin should be increased. Treated in this manner, an apparent cure of simple chronic rhinitis can frequently be brought about within six weeks.

In atrophic rhinitis, however, where mucous glands and blood vessels are shrunken or destroyed, and the mucous membrane itself is thin, pale, lacks sensibility, and is covered by crusts of inspissated mucus, an irritant wash for the patient's use at home would seem desirable. If the proportion of water in the wash mentioned above be decreased, it becomes somewhat irritating, and its specific gravity is, at the same time, so much increased as to favor exosmosis from the vessels and thus decrease the tendency to the formation of crusts. In the treatment of atrophic rhinitis, the wash should be used two or three times a day, and be of such a degree of concentration that it will produce a slight smarting sensation each time it is used. The stimulation of the atrophied mucous membrane may be maintained during the day by the use of an irritating powder, which the patient can carry in a box in his pocket and use as a snuff four or five times a day. The following formula has answered very well for this purpose:—

| | | |
|---|--------------------|---------|
| R | Argentii nitratis, | gr. ij. |
| | Amyli, | ʒiiss. |

The use of washes by means of the nasal douche has been very justly abandoned as dangerous, from the fact that, if obstruction of the nasal chambers exists that interferes with the free escape of the wash from the post-nasal chamber, some of the fluid may be forced through the Eustachian tube into the ear and produce acute otitis media. In most cases of naso-pharyngeal catarrh, simply sniffing the wash from a cup or hollow of the hand through one nostril into the fauces is sufficient to cleanse the nose and naso-pharynx of their accumulated mucus. An atomizer throwing a coarse spray may also be used for the same purpose, the spray being allowed to play through the nostril into the naso-pharynx.

When diphtheritic or croupous inflammation has covered part of the mucous membrane of the nose or pharynx with a false membrane, it can often be loosened from its attachments by the use of an alkaline wash, and here simple liquor calcis answers a useful purpose in rendering the membrane more friable and easy to detach. It

may be used with an atomizer, or injected into the nose of a child with a medicine-dropper or small syringe, and in the same manner a 1 to 2 or 3000 solution of corrosive sublimate may be used as a germicide and antiseptic. In relaxed conditions of the mucous membrane, for example the relaxed fauces of smokers and others, astringents are indicated. Here a solution of sulphate of copper, 2 grains to the ounce of water, used with an atomizer upon the fauces once or twice a day, gives immediate relief, and often enables the physician to bring about a cure of this annoying affection without resorting to amputation of the uvula. Where syphilitic ulcerations of the nose, pharynx, or larynx are present, zinc chloride seems to act well as an astringent. If 2 grains of the salt and 10 grains of extract of liquorice be dissolved in 2 ounces of warm water, the solution may be used with the post-nasal syringe, with the result of abating any fetid odor that may be present, diminishing the discharge, improving the condition of the ulcer, and decreasing the inflammation and swelling of the surrounding mucous membrane.—*Med. Bulletin. Med. Review.*

OBSERVATIONS ON THE MOVEMENTS OF THE INTESTINE OF MAN.

Rosbach (*Deutsch. Arch. f. Klin. Med.*, 1890, xlv, 323) says that there is, as far as he knows, only one case described—that of Busch—in which there had been an injury to the intestine from which the patient recovered, and which yet permitted satisfactory observation of the intestinal movements. This was a case of abdominal hernia with an artificial anus in the upper part of the small intestine. Through this abdominal opening the movements of the intestine under various conditions could be well seen.

The author has been fortunate enough to find an individual, a woman, suffering from constipation and movable liver, whose abdominal parietes were so remarkably relaxed and thin that the movements of the bowel could be observed with accuracy. Careful study of these, with the graphic plotting of curves representing them, seemed to render certain observations beyond doubt.

1. In the early morning hours the intestinal peristalsis as well as the gastric movements appeared to be at rest.

2. As soon as food is taken into the empty stomach and passes thence into the intestine an evident peristalsis begins, alternating with intervals of quiet. Sometimes the movements begin within a quarter of an hour.

3. No difference could be perceived in the intensity of action of different articles of diet upon the intestinal movements; except that coffee, whether taken fasting or after the mid-day

meal, almost always produces the strongest peristalsis.

4. The general irritability of the intestine appeared to have grown very slight by evening, since often no peristalsis was to be observed either immediately or a long time after the ingestion of the evening meal.

5. Except as mentioned, there appears to be no regularity in the intestinal peristalsis. The movements may be present before, during, or after a meal, may be marked or slight, may develop at once after eating or only after one to two hours.

6. The peristaltic motion never lasts long with the same intensity. Large waves alternate with small ones, or with intervals of rest.

These observations apply to the intestine under the influence of ordinary nourishment only. The author has examined also the effect of various agents upon the movements with the following results:

1. Slight degrees of cold, as the mere exposure of the abdomen, produce peristalsis after a few minutes, or strengthen it if already present.

2. Greater degrees of cold water, as sprinkling the abdomen with cold, likewise increase the peristalsis only in slight degree.

3. The drinking of cold water produces at once a lively peristalsis.

4. Rubbing of the abdominal walls has no effect.

5. Moderate pressure in the space between the two *recti abdominis* is followed by an unusually active movement.

6. Pressure and squeezing of the intestine itself produce no movement.

7. After coughing the peristalsis becomes evidently stronger during a considerable time.

8. Through pressing [evacuation of the bowels] an increased peristalsis is produced.

9. Respiration does not cause an active peristalsis to cease, but a prolonged holding of the breath does have this effect, though the movements return later.

10. Purgation, accomplished by means of enemata, develop very violent peristaltic movements, accompanied by rumbling and distention of the abdomen.

11. One to two drachms of castor oil taken internally have no effect upon the bowel during the first half hour, but then develop active peristalsis combined with rumbling in the abdomen.

12. Intense sensations of hunger always occasion active peristalsis.

13. The excitement of the emotions (as moderate fright, the sudden refusal to allow the patient to eat when hungry, etc.) causes the immediate disappearance of peristalsis, even when strong. After five to ten minutes the movements return.

14. The employment of electrical irritation produces very varying results. (a) The faradic current supplied to different parts brought out

or strengthened peristalsis in a few cases, but its action is very inconstant. (b) The galvanic current in like manner usually produced no or but slight peristalsis, and only in a few instances when applied through the rectum succeeded in developing active movements.—*Amer. Jour. Med. Science.*

THE TREATMENT OF SUPPURATING CAVITIES WITH RIGID WALLS.

Kuester, Berlin (*Centralblatt f. Chirurgie*, 1890, No. 29), calls attention to the error committed by surgeons in the treatment of abscess cavities with rigid walls, in delaying opening the same, and in frequent irrigations of the same after opening. He insists upon the following :

1. The earliest possible incision.
2. The incision must be made at the most dependent point.
3. In case of large cavities, a counter-opening is to be avoided as far as possible. He dwells particularly upon the subject of empyema, and describes his method of dealing surgically with this condition as follows :

After exploratory puncture, an incision is made at the lowest point of the dull percussion note, usually in the fourth or fifth intercostal space, giving exit to the accumulated pus. A probe is then passed through the wound to the posterior boundaries of the cavity and pressed firmly between the ribs posteriorly until its point is felt in an intercostal space, at which point a portion of the superadjacent rib is resected. The opening thus made must be sufficiently large to enable the surgeon to obtain a view of the interior of the cavity. Should the lowermost portion of the cavity not have been reached by the first resection, a portion is removed from the subadjacent rib, until the junction of the diaphragm and inferior reflection of the pleura is reached. The cavity is then, under slight pressure, irrigated with a warm solution of salicylic acid, and the walls of the cavity carefully sponged of all traces of fibrinous matter, by means of a sponge in a handle, and through and through drainage established by drawing a tube from one opening to the other and securing it. The wounds upon the anterior and posterior chest wall are covered by iodoform gauze, upon which is laid a cushion of moss, which may remain undisturbed for upward of eight days. If, in case of a recent empyema, the lung begins to expand in the course of ten days, the through and through drain is substituted by a short tube through the posterior wound. The author anticipates that complete cure will follow this treatment, in recent cases, in from three to six weeks.

The author further treats of the treatment of cavities, which, unlike the pleural, are surrounded upon all sides by rigid and unyielding

walls; as, for instances, empyema of the antrum of Highmore. Of the three methods usually employed for gaining access to diseased conditions of the antrum, Kuester chooses that which perforates its wall from the face, for the reason that the indications considered by him most important of fulfillment can but be followed out by this route (through cleansing of the walls, and the identification by the figures of the different portions of the cavity). This is done subperiosteally, and the cavity is irrigated but once with an antiseptic fluid, and then tamponed with iodoform gauze. As soon as the suppuration becomes but slight (which sometimes occurs in a very short time), the iodoform gauze is removed and a small drainage-tube substituted therefor. In the empyema of the frontal sinuses, Kuester drains through the nose. Diseased conditions of the mastoid cells and of the cavity of the tympanum belong to this division of the subject; their treatment, however, is somewhat complicated as compared to the others, the preservation of his hearing, as well as the prevention of brain complications entering into the question. The same principles, namely, early and free opening, however should be followed.—*Fowler, Brooklyn Medical Journal. Amer. Pract. and News.*

BLACK WASH IN RHUS POISONING.

I have had a very large experience with the dermatitis of rhus poisoning, and have never seen the application of "lotio nigra" fail in any stage of the disease. The part or parts may be freely bathed with black wash or wrapped in absorbent wool or cotton previously soaked in the solution. Immediate relief of subjective symptoms follows and the objective signs rapidly disappear. I have never seen untoward symptoms.—*Dr. J. A. Kite, in Med. News.*

TEA A CAUSE OF COLD FEET.

Mr. Hutchinson says in the *Arch. of Surg.*, July, 1890, that he once advised a lady to drink more tea. "I cannot touch it," was her reply. "It makes my feet icy-cold, and wet with cold perspiration." On further inquiry, she assured Mr. Hutchinson that she was quite certain of her facts, and had often tested them. She thought that the perspiration was usually of the soles chiefly. Her hands were, she thought, also made cold, but not so definitely as her feet. Mr. Hutcheson says he had long been familiar with the fact that tea made the feet cold, but did not know that cold perspiration attended it. It does not do so in all persons. The coldness is caused, he believes, by contraction of the arteries, for the feet at the same time shrink. Alcohol has usually a precisely opposite effect.—*Med. and Surg. Rep.*

ARISTOL IN THE TREATMENT OF SKIN DISEASES.

In a letter to the *Journal of Cutaneous and Genito-Urinary Diseases*, September, 1890, Dr. L. Brocq, of Paris, communicates some of his results with aristol in the treatment of cutaneous diseases. In his experience the drug acts only as a cicatrizing. In chancroid its use does not seem to exert a favorable influence on the virulence of the disease. In tertiary syphilitic ulceration it apparently hastens cicatrization, provided that appropriate treatment with mercury and potassium iodide is also used. Cicatrization in tuberculous diseases of the skin is also hastened by applications of aristol. Applied to non-ulcerated lupus vulgaris or erythematous lupus, it exercises no useful influence. In tuberculous ulcerations of mucous membranes it is useful, and by means of it Dr. Brocq was able to secure cicatrization of an extensive tuberculous ulcer of the arch of the palate. In superficial epithelioma aristol does not seem to exert any destructive influence on the pathological cells; but, if the growth has been destroyed by caustics, by curetting, or by the hot iron, the drug hastens cicatrization. The author's method of treating this disease is to curette the base thoroughly, and if he believes that the diseased tissue is completely removed, to dress with aristol. If the disease is apparently not completely removed, he applies potassium chlorate, either in powder or solution, for a few days, and then uses aristol.

In the treatment of psoriasis, aristol has given the author scarcely appreciable results. To test its value thoroughly in this disease, he has treated all his cases with aristol on one side of the body; and with the ordinary applications on the other.

In no instance has Dr. Brocq seen aristol produce toxic symptoms.—*Med. News. Lancet-Clinic.*

POINTS TO BE OBSERVED BY ELDERLY MALES.

1. To avoid being placed under circumstances when the bladder can not be emptied at will. Nothing is so bad for a large prostate, though it may be working satisfactorily, as an enforced retention. It is often the first cause of a permanent atony.

2. To avoid checking perspiration by exposure to cold, and thus throwing additional work on the kidneys. In climates like our own, elderly persons should, both in summer and winter, wear flannel next to the skin.

3. To be sparing of wines and of spirits (if used at all), exercising a marked diuretic effect either by their quantity or quality; select those which promote digestion without palpably affecting the urinary organs. A glass of hot gin and

water, or a potent dose of sweet spirits of nitre, will not do anything to remove the residual urine behind an enlarged prostate.

4. To be tolerably constant in the quantity of fluids daily consumed. As we grow older our urinary organs become less capable of adapting themselves to extreme variations in excretion. Therefore, it is desirable to keep to that average daily consumption of fluids which experience shows to be sufficient and necessary. How often has some festive occasion, where the average quantity of fluid daily consumed has been largely exceeded, led to the over-distention of a bladder long hovering between competency and incompetency. The retention thus occasioned by suspending the power of the bladder, has frequently been the first direct step towards establishing a permanent, if not a fatal, condition of atony or paralysis of this organ.

5. It is important that from time to time the reaction of the urine should be noted. When it becomes alkaline or offensive, the use of the catheter may be necessary. When a catheter is required it is most important that its selection should not be left entirely to the instrument maker. There are other points to be considered beyond the fact that it is to serve as an artificial outlet for the urine from the bladder. An unsuitable catheter in a prostatic case may do much permanent harm.

6. Some regularity as to the time of performing micturition should be inculcated. We recognize the importance of this in securing a regular and healthy action of the bowels, and though the conditions are not precisely analogous, yet a corresponding advantage will be derived from carrying out the same principle in regard to micturition.—*Medical Press and Circular.*

QUADRANGULAR SOUNDS FOR THE TREATMENT OF ORGANIC AND SPASMODIC STRICTURES OF THE URETHRA.

The instruments which I show you are designed to stretch the urethra wherever its calibre is diminished, so that it is incapable of performing its functions normally. I have long felt the need of an instrument, which, when passed into a tight structure, would dilate it without impairing the healthy urethra adjacent to it. I have found, by repeated trials, that this instrument meets my expectations.

All surgeons who have given thoughtful attention to the treatment of diseases of the urethra, have observed the urethra crowding up in front of the usual round sounds, and stretching its long diameter to the limit of laceration, whenever an effort has been made to insinuate one of these round instruments through a tight stricture. No doubt many cases are seriously damaged by the longitudinal stretching with

the sound portion of the urethra receives under these circumstances. Notwithstanding the injunction, "Never use force in passing an instrument through the urethra," the organ is sometimes lacerated in the endeavor to get the sound to pass.

Then the longitudinal stretching does no good; and the round instrument which engages in a stricture develops so much friction by reason of the fact that every part of his circumference impinges on the point of greatest resistance in the stricture, that much force is lost, which, with a rectangular instrument of the same diameter, but presenting less friction surface, could be utilized in stretching the urethra laterally and so gliding through it.

I will not enumerate all the situations in which the round instrument is faulty and imperfect, nor will I say that these rectangular instruments can supersede the round ones entirely, but there are a few points of superiority which may be justly claimed for the rectangular instruments:

1. They present four points of contact with the stricture, therefore less friction than the round instrument.

2. They are grooved between the angles, and thereby insure the presence of the lubricating medium at the points where it will do most good.

3. They provide a mean for applying solvent medicaments to the stricture.

4. They stretch the urethra in its transverse diameter at the point where it is organically diseased or in a state of spasm.—[Wyman, *American Lancet*.

THE STOMACH IN DIABETES.

The prominence of gastric symptoms in patients suffering from diabetes mellitus induced Prof. Rosentein (*Berlin. Klin. Wochenschr.*), to carry out observations into the relation of the gastric juice and stomach in ten cases. Of these, the contents of the stomach were normal in four, whilst there was some alteration in six. The results are summed up as follows: In a series of cases of diabetes free hydrochloric acid is absent from the gastric juice during a longer or shorter time, and this failure is to be looked upon as an expression of a neurosis of the stomach. In a number of cases there is extensive atrophy of the mucous membrane, in consequence of interstitial gastritis. Where the absence of free hydrochloric acid is permanent, atrophy of the glandular apparatus arising from interstitial inflammation is to be looked upon as the cause. The secretion-neurosis of the stomach, as well as failure of the knee-jerk and other neuroses met with in diabetes, do not stand in direct proportion to the gravity of the case in so far as it is measured by the amount of sugar, acetone, or diacetic acid.—*The Practitioner*.

TREPHINING IN HEAD INJURIES.

Zeidler (*Amer. Journ. Med. Sciences*) says:

1. Symptoms of cerebral pressure following head injury, indicate trephining only when these symptoms point clearly to bleeding from the arteries of the dura.

2. Simple fractures of the skull, unaccompanied by symptoms of intracranial hæmorrhage, never indicate trephining.

3. Depression of the bone should not in itself be considered as an indication for trephining.

4. The object of primary trephining is asepsis, or the checking of hæmorrhage.

5. Secondary trephining is indicated in cases of beginning meningo-encephalitis.

6. Epileptoid attacks, due to the pressure of splinters of bone upon the brain, should be relieved by removing these splinters.

7. In treating fractures which involve a sinus, the bleeding from the latter should be checked by tamponade, and not by suture.

8. The term *débridement* should be applied to the operative procedures necessitated by a complicated fracture of the skull, trephining being reserved for the formal operation upon the uninjured bone.—*Lancet Clinic*.

CHARCOAL WAFER BISCUITS.

These biscuits, as articles of food, are not, from the nature of the active ingredients which they contain, very attractive in appearance, but they possess a flavor by no means unpleasant. Indeed, it would be difficult to say from the taste alone that they contained charcoal at all. There is, too, no objectionable feeling of grittiness experienced during mastication. They are adapted for use in cases of excessive acidity of the stomach.—*London Lancet*.

THE DIAGNOSIS OF CANCER.

Although the introduction of antiseptics and the progress made in our operative technique have greatly improved the prognosis of cancerous diseases, it must be confessed that our diagnostic means are still far from satisfactory. This is to be the more regretted, since an early diagnosis greatly enhances our chance of effecting a permanent cure in these cases. At the late Congress of the German Surgical Society, Professor Esmarch spoke of the uselessness of statistical studies in affording us information as to the etiology and diagnosis of cancerous diseases. He called attention to the fact that syphilitic tumors, especially of the tongue and throat, are not infrequently confounded with malignant growths, and proposed that the old term, "gumma," be abandoned, since these syphilomata—as he terms them—more often resemble in structure the fibromata and sarcomata. In fact, a large number of the sarcoma

group, especially those of the muscular tissue, are to be regarded as syphilomata, and may be cured by internal treatment alone, whilst some forms of malignant keloid and some of the malignant lymphomata, may also be placed in this class. During the past year, Prof. Esmarch classified all the cases of sarcoma of the muscles occurring at his clinic, and found that at least one-half of them were true syphilomata which promptly responded to specific treatment.

Tuberculous tumors—tuberculomata, the author calls them—not infrequently have given rise to errors of diagnosis, and it should be remembered that masses of pure tubercle may exist for long periods in the tongue, breast, and larynx without going on to ulceration. Of course, in the case of actino-mycosis mistakes are not uncommon, since the disease has been known only for the last ten years.

To avoid these errors of diagnosis, it is plainly our duty to make thorough microscopical examination of the growth before a radical operation is undertaken. For this purpose it may be sufficient to remove repeatedly superficial portions of the tumor, but if the results prove negative, it may be necessary to perform an exploratory operation of magnitude, even laparotomy, laryngotomy, trephining.

In doubtful cases where the microscopical examination shows only granulation tissue and spindle cells, Prof. Esmarch recommends an energetic and long continued anti-syphilitic treatment.

These views of the distinguished author merit serious attention. There can be no doubt that in the case of tumors a positive diagnosis is frequently not made until after their removal, and cases are probably not rare in which a microscopical examination of deeper sections of the growth than have heretofore seemed necessary might have prevented dangerous and disfiguring operations.—*Intern. Journ. of Surg. Cin. Lancet Clin.*

TREATMENT OF ECZEMA IN CHILDREN.

The treatment of eczema is not so definitely settled as to be one for all cases. Every case has its own peculiarities, and demands special attention. Remedies which may be found valuable in one may be found worthless in another. The treatment of the disease, when occurring during childhood, must be different from that employed in adults. Realizing this, Dr. E. Saalfeld, in the *Deutsche Medicinische Wochenschrift*, July 3, 1890, has endeavored to place the treatment of eczema in children upon a rational basis.

The disease in children owes its origin, in many cases, to excoriation or chafings, between the nates, in the bend of the knee, and in the folds of the neck. This is most frequently met with in fleshy children. In eczematous intertrigo,

when the usual household remedies such as salves and powders, have failed to give relief, a careful regulation of the diet and a change of food is primarily indicated. Very frequently diarrhoea will be an accompanying symptom, and this should be checked at once. If the skin is highly inflamed, a cool application of equal parts of a five-per-cent solution of boric acid and leadwater, and the use of a five-per-cent boric acid ointment will be found most beneficial. If the skin is moist, it should be dried with powder, before the ointment is applied. In cases of eczema of the head and face the diet should be very plain and contain as little fat as possible. The bowels should be kept open by means of suitable laxatives. The flakes and scales should be moistened with olive oil and removed. The underlying skin may then be treated with an ointment composed of boric acid, one and one-half parts; oxide of zinc and starch, of each five parts; vaseline thirty parts.

In general eczema, especially of a scrofulous origin, the constitutional treatment plays a most important part, and should include a careful regulation of the diet, the administration of cod-liver oil in connection with phosphorus and arsenic internally. The local treatment of these cases should consist merely in the application of vaseline and subsequent powdering.

Naturally, before any treatment for general eczema is instituted, a careful examination of the skin should be made, in order to exclude the possibility of the disease having been caused by the presence of parasites.

In conclusion, Saalfeld warns against the use of tar, since it is very irritating to the skin of children. Its place may, however, be ably filled by an ointment composed of white precipitate of mercury, one part; balsam of Peru, five parts; and benzoinated oxide of zinc ointment, thirty parts.

Naturally, the hygienic surroundings of the patients is very important; well-ventilated rooms, fresh air and scrupulous cleanliness, all contribute largely to a rapid recovery.—*Medical and Surgical Reporter.*

BLOODLESS TONSILLOTOMY.

Prof. J. Toison, of Lille (*Rev. de Ther. Med. Chir.*, October 1), discusses the various methods of reducing or removing enlarged tonsils. He begins by saying that excision of the tonsils with the bistoury or the guillotine is gradually losing favor among surgeons on account of the risk of hemorrhage. Ignipuncture with the thermo-cautery or the galvano-cautery is often useful, but should be reserved for cases in which the tonsils are only moderately enlarged, and can be sufficiently reduced in one or two sittings, and for cases in which some anomaly of shape in the hypertrophied glands makes it difficult to remove them with a cutting instrument. For

ordinary cases; Prof. Toison uses a new snare of his own invention, which, according to him, effectually obviates all danger of bleeding. The apparatus consists of a *serre-nœud*, the metallic loop of which, instead of being free, is fixed by three silk threads to a blunt ring fixed to the distal end of the instrument. The ring is passed over the tonsil, which is then seized with forceps; the wire loop is next pulled home in the usual way, the traction being sufficient to snap the silk threads which fix it temporarily to the ring. The tonsil is thus cut through without bleeding. Prof. Toison has performed this operation several times since last April; in no case has there been any hemorrhage.—*British Medical Journal*.

CHRONIC, SO-CALLED RHEUMATIC AFFECTIONS.

When the term of chronic rheumatism is used, it should be limited to those cases in which the joints are painful but not swollen, or in which there is a neuralgia or an arthralgia associated with myalgia or apart from it; or in which the fasciæ are affected, or in which there is a general neuralgic condition supervening on an acute attack of rheumatism. This is what we prefer to call "chronic rheumatism." But in speaking of the symptoms of rheumatoid arthritis, I will make reference to those symptoms which are sometimes put down as common to both. Let us imagine two patients sitting side by side, one with chronic rheumatism, and the other with rheumatoid arthritis. Now, what do we see? In the rheumatoid arthritis case the first thing that strikes us is most probably the pallor of the patient, as compared with the chronic rheumatic. We look a little closer, and the next thing we perceive will most probably be the joints. The patient with the chronic rheumatism will present in this feature little or nothing; whereas, on the other hand, the rheumatoid arthritis patient will be more or less crippled. There will be a distinct muscular atrophy in the rheumatoid arthritis case, and the complexion will present the pallor mentioned before, showing on closer inspection yellowish tinges on the face, neck, and perhaps elsewhere. If we ask both patients if they ever had rheumatic fever, they will probably say no; but further inquiry will elicit the probable fact that the family history of the patient with rheumatism will be a good one, or perhaps at the most a rheumatic one, while the rheumatoid arthritis patient, in most cases, gives or shows a strumous taint. It is upon the basis of this strumous taint that we feel we must look for further assistance to guide us in the treatment of this terrible crippling malady. It is nearly always present more or less. We are aware that this strumous history has not been particularly referred to in other descriptions of the disease. Its being the almost

invariable accompaniment has induced us to bring the matter forward. In fact, to look upon struma and rheumatoid arthritis as cause and effect has seemed to us the one plain characteristic in our investigations.—*Lane, London Lancet. Pract. and News.*

THE DRY TREATMENT OF CHANCROIDS.

It is generally conceded that if chancroidal ulcers can be kept perfectly dry, a great step has been taken toward their rapid healing. With this view, the following procedure has been used to some extent in the surgical divisions at Bellevue Hospital, New York: A small roll of absorbent cotton about one-half an inch in diameter and long enough to surround the penis just behind the corona, is put in that position after the prepuce has been well retracted. A rubber thread band is slipped over this ring of cotton in order to hold it in its place. By this means the sulcus behind the glans is obliterated, which is especially liable to retain the secretions, and the prepuce is held back from contact with the ulcerated surface. The cotton absorbs the exudation from those surfaces almost as soon as formed. The dressing is light, is easily handled, and may be renewed as often as needed to keep the parts in a dry condition. In addition to chancroids, herpes preputialis and venereal warts have been found to heal rapidly under the use of this dressing; sometimes no other treatment has been found necessary for these local lesions.—*Weekly Medical Review. Am. Pract.*

THE REMOVAL OF FRECKLES.

The Pharmaceutical Record quotes the following prescriptions for removing freckles.

| | | |
|----------------------|------|-----|
| White precipitate, | } āā | 3j; |
| Bismuth subnitrate, | | |
| Glycerite of starch, | | |

Apply every second day. Or,

| | |
|--------------------------------|-------|
| Sulphocarbonate of zinc, | } 3j; |
| Glycerin, | |
| Alcohol, | |
| Orange-flower water, | |
| Rose water sufficient to make, | |

Apply twice daily.

WHOOPIING COUGH.

(Germain See, in *Jour. de Medicines*):

| | |
|---------------------------|----------|
| Powdered belladonna root, | gr. 1-5; |
| Dover's powder, | gr. ss; |
| Sublimed sulphur, | gr. iv; |
| White sugar, | gr. x. |

M. Sig: Take in one dose from two to ten times a day, according to age of patient and effect produced.—*Am. Pract.*

In a severe case of acne associated with rosacea, Shoemaker advised and prescribed as follows (Times and Register): Wash the face in hot water, as hot as can be borne. Drink a cupful of hot water upon retiring and upon rising. Have the pustules punctured by a physician; the incision thus produced will not cicatrize, whereas, if they are squeezed, they heal with a scar. Take internally :

| | | |
|--------------------------|------|-----------------|
| Liq. potassii arsenitis, | } āā | gtt. lxxij ; |
| Tr. nucis vomicæ, | | |
| Aloini, | | gtt. ij ; |
| Aq. menthæ pipe, | | q.s. f̄ij iij ; |

M. Sig: f̄ij ter in die.

Apply externally :

| | |
|-------------------|----------|
| Acidi borici, | Ḑj ; |
| Lanolini, | ʒij ; |
| Ol. eucalyptol, | gtt. v ; |
| Ung. zinci oxidi, | ʒj ; |
| Bismuthi subnit., | ʒj. |

M. Sig: Ft. unguentum.

For a case of herpes induced by a remote traumatism, Shoemaker prescribed, internally :

| | |
|-----------------------|--------|
| Ext. malt, | f̄ij ; |
| Elix. ferri lactatis, | ʒss. |

M. Sig: This quantity thrice daily.

Externally, to allay the inflammatory action of the integument :

| | | |
|-------------------|----------|------|
| Cocainæ, | gr. ij ; | } āā |
| Sulphuris subl., | gr. x ; | |
| Zinci carbonatis, | ʒj ; | |
| Marantæ, | ʒj ; | |
| Pulv. camphoræ, | gr. x ; | |
| Ung. aquæ rosæ, | ʒss. | |

M. Ft. ung.

—Pract. and News.

Castor Oil is a drug which has not yet been and is not likely to be, altogether supplanted by its more modern rivals, says the British Medical Journal; nevertheless it has been found that patients often decline to take it, and choose some more palatable, but less efficient substitute. The best way of taking castor oil is thoroughly to mix the dose with about four times as much hot milk; that is most effectually, accomplished by shaking the two together in a bottle which they do not more than half fill. When taken as above directed, the activity of the oil appears to be increased, and, being rendered very limpid by the hot milk, its oily nature is not perceived. Children take it very readily in this form, in which indeed it is scarcely distinguishable from rich milk.—Am. Pract. and News.

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MONTREAL, MARCH, 1891.

SHOULD A POOR MAN STUDY MEDICINE ?

The above question is the subject of an editorial in a recent number of one of the leading New York journals, and one which is answered in the negative. He holds that not only is a thorough medical education becoming very expensive, but the young graduate has to contend with such keen competition, not only with long established practitioners and a host of other graduates, but what is much worse he has to compete with the hospitals and dispensaries at which the rich specialists not only see their patients for nothing but give them medicine besides. The lot of the young city doctor without private resources is indeed a hard one. But this editorial brought out several replies, showing that while these remarks were true in the large cities they did not apply to the country districts where there was still room for many hundreds of physicians who would receive a moderate fee for every consultation. One correspondent blames the hospital physician for not excluding from his clinic not only the well-to-do but also those who could afford a very small fee. But we think the hospital and dispensary physicians are not alone to blame for the difficulty the young physicians have in obtain-

ing a practice. When the young practitioner charges fees altogether beyond the means of the masses of workmen to pay, and sends them to a drug store where fancy prices are charged, he must not complain if those who should be his patrons fall back upon charity for the services they cannot afford to buy. Very few patients indeed would endure the hardships they do endure in the outpatient department of a hospital or at a dispensary if they could afford to go to a doctor's office and afterwards purchase their medicine. We venture to say that notwithstanding the too abundant facilities for gratuitous treatment in the city and the consequent abuse of charity that follows, any hard working and well educated young physician can be earning his own living at the end of two years on condition, first, that the cost of his services and medicines be within the means of the masses to pay, and secondly that he conducts the financial part of his professional work on business principles, or in other words that he insists on being paid cash. The young practitioner who expects workmen with large families living on a total income of twenty-four or thirty-six dollars a month to pay him the same fees as are received by his older professional brother, from the well-to-do and wealthy, is hardly entitled to much commiseration. There seems to be an idea in the minds of many young practitioners that it is *infra dig.* to charge less than a dollar a visit. With this we do not agree. While we think that twenty dollars a visit is the very least that should be charged a millionaire in receipt of fifty thousand dollars a year, to charge a dollar a visit to a laboring man with an income of two or three hundred dollars a year is cruel and extortionate. According to the writer in the *N. Y. Medical Record* above referred to, there is an immediate living waiting for every graduate who is willing to begin practice in the country, while those who elect to start in the city must be prepared with private means to support them during the years of waiting for their turn. As we

have already said, there is an almost immediate living for a great many more in the city if they are prepared to begin by serving the honest poor who are even more willing than the rich to pay in proportion to their means.

A UNIVERSITY OF CANADA.

During our last visit to England a patriotic Canadian who has risen high in the London medical profession urged upon us the propriety of advocating a single portal to practice in Canada to be called the University of Canada. Great difficulties stand in the way of the realization of this idea, but they are not insurmountable, while on the other hand the advantages would be very great. Our London friend knows that all the medical colleges in Canada, so far, give a thorough medical training, but having in view the state of medical education in the United States where we see at the same time the very best and the very worst medical schools in the world conferring the same diplomas and rights to practice, so that American diplomas are scarcely recognized abroad, he believed that we might by having a single standard avoid the possibility of ever having their reputation lowered by competition. Let us see what difficulties would stand in the way. The principal one would be the vested rights cry of the universities which would have to make the sacrifice of the fees for the degrees. All the medical schools could go on with their work just as they are doing at present, and when at the end of the four years course they felt satisfied that their students had a reasonable chance of passing they would certify them and send them up to the University of Canada for their degree. The University would consist of examiners only, not teachers, who would be elected by the professors of all recognized schools, and who would meet in Montreal during the first week in May of every year. The second objection would come from the candidates who might be in-

clined to place personal convenience before patriotism and the general welfare, and who would be obliged to travel from all the outlying teaching centres to the metropolis for examination. But this would only be once in a lifetime, as the matriculation could be managed by sealed papers entrusted to a local examiner in each city. Some of the candidates who would like to get through easy would of course object, but the profession is already so crowded that it could well afford to keep half educated men out of its ranks. There would thus follow a general raising of the tone of the profession. The University might then undertake the protection of its graduates, which is now very inefficiently performed by the provincial medical boards. There would be also to some extent a saving of expenditure or a concentration of energy, for instead of having eight examining boards, the members of which are necessarily of very ordinary capacity for such work, we would have one examining board composed of the very ablest men in each department. The different local universities might make up for the loss of revenue by raising the cost of teaching, as many are of the opinion that the fees are much too low. We would commend this idea of a University of Canada to our contemporaries so as to elicit an expression of opinion from the profession of the Dominion.

ALCOHOLISM IN THE PROFESSION

Under the above heading we notice an editorial in the *Medical News and Circular* of London, 11th Feb., 1891, in which its writer says: "From time to time circumstances remind us that the vice of inebriety is not confined to the non-professional classes, and sad instances of its ravages occur even among those who have attained to the more serene altitudes of the profession after the usual period of anxious expectation and waiting. It would seem that this period of restless inactivity conduces to indulgence in stimulants if only to drown

care and to enable the unoccupied energies to await the advent of better times." He also notes that general practitioners resort to alcohol as a relief to the worry and strain of practice, and that those who thus use it themselves are too apt to prescribe it unnecessarily for others. Happily the temperance movement which has done so much for the drink-oppressed people of England has made its influence felt in therapeutics, so that the profession fully realize the danger of resorting to stimulants without some very grave reason. We remember that during our two winters spent at Guys and the London hospital we were very much struck by the large number of students who made use of alcohol while the medical journals frequently contained notices of malpractice suits against physicians who, while under the influence of liquor made such little mistakes as cutting off a loop of small intestine instead of the umbilical cord. At that time one of the leading general practitioners of the west end of London informed us that his becoming a total abstainer and ceasing to prescribe port wine unnecessarily, had cost him half his income. Since then, however, things are very different. In this country we are glad to say there is comparatively little drinking either among students or practitioners, one of our medical schools being so anxious for the morals of the young men coming to the city to study, that it provides a large building or *pensionnat* in which the students are boarded at less than cost price, each one having two rooms with board for the modest sum of twelve dollars per month. The doors of the building are locked from 8 p.m. to 8 a.m., large recreation rooms with music and other amusements being provided in the house. This plan has been in operation for twenty-five years with the result that the students are provided with wholesome food, healthy lodgings, proper time for study, and a sufficient amount of sleep, lights being put out at 10.30; while on the other hand they are saved from the temptations of city life,

such as taverns and houses of ill fame; and from entangling relations with the boarding house keeper's daughter so often ending in life-long trouble. We can safely say that what little drinking there is among the profession in Canada is the result principally of habits acquired during student life, which should therefore be guarded by the watchful and loving eye of the Alma Mater.

BOOK NOTICES.

WOOD'S MEDICAL AND SURGICAL MONOGRAPHS, consisting of Original Treatises and Reproductions, in English, of Books and Monographs selected from the latest literature of foreign countries, with all illustrations, etc. Contents: Practical Guide to the Demonstration of Bacteria in Animal Tissues, by Dr. H. Kühne, Wiesbaden; On the present position of Antiseptic Surgery, by Sir Joseph Lister, F. R. S.; Cancer and its Complications, by Charles Egerton Jennings; The Treatment of Epilepsy, by Dr. Ch. Fréré; Handbook to Dr. Koch's Treatment in Tubercular Disease, by Drs. Grün and Severn. Published monthly. Price, \$10 a year; single copies, \$1. December, 1890. New York: William Wood & Co., 56 and 58 Lafayette Place, 1890.

WOOD'S MEDICAL AND SURGICAL MONOGRAPHS, consisting of Original Treatises and Reproductions, in English, of Books and Monographs selected from the latest literature of foreign countries, with all illustrations, etc. Contents: Advances in Bacteriology, by R. Koch, M.D.; Formulary of New Remedies and New Medicinal Preparations, by H. Bocquillon-Limousin; Anæsthetics: a Discussion, by Dr. William Macewen and others. Published monthly. Price, \$10 a year; single copies, \$1. January, 1891. New York: William Wood & Co., 1891.

WOOD'S MEDICAL AND SURGICAL MONOGRAPHS, consisting of Original Treatises and Reproductions, in English, of Books and Monographs selected from the latest literature of foreign countries, with all illustrations, etc. Contents: The Clinical Use of Prisms, and the Decentring of Lenses, by Ernest E. Maddox, M.B.; Electricity in the Treatment of Uterine Tumors, by Thomas Keith, M.D., LL. D., Edin., and Skeene Keith, F. R. C. S., Edin.; Ether Drinking: its Prevalence and Results, by Ernest Hart. Published monthly. Price, \$10 a year; single copies, \$1. February, 1891. New York: William Wood & Co., 1891.

ILLINOIS STATE BOARD OF HEALTH.—Seventh Report on Medical Education, Medical Colleges and the Regulation of the Practice of Medicine in the United States and Canada, 1765-1891. Medical Education and the Regulation of the Practice in Foreign Countries. By John H. Rauch, M.D., Secretary, 1891. For the first time in its history the Report on

Medical Education, issued by the Illinois State Board of Health, embraces the medical institutions of the whole world. This is a feature that will be an assistance to medical boards that have to determine the value and validity of a medical diploma.

As regards medical education in the United States, the Report shows the marked changes for the better that have taken place in the past ten years, and it is seen that more progress will be made within the next two years. Most of the changes for the better that have been made in this century have occurred since 1881, when the first number of this Report was published, and since 1882-83, when the schedule of minimum requirements of the Illinois State Board of Health went into effect. In 1882 only 45 Colleges in the United States and Canada required educational qualifications for matriculation; now the number is 129. Of the 148 medical colleges 123 now teach hygiene and 119 teach medical jurisprudence. In 1882 these branches were taught in 52 and 61 colleges, respectively. In 1862-83 the average length of the lecture terms was 23.5 weeks; the average is now 26.3 weeks. There are now 111 colleges that have lecture terms of 6 months or more, while in 1882-83 the number was 42. A table shows the results of the examinations before the State Boards of Medical Examiners of Alabama, Minnesota, New Jersey, North Carolina, South Carolina and Virginia since the dates of their organization. Another table shows the results of the Prussian State Examinations in 1890.

Special attention is called to the fact that in some of the largest universities in this country courses preliminary to the study of medicine are now offered—the University of Pennsylvania, Cornell, Yale, Princeton, Lake Forest and Northwestern Universities, Johns Hopkins and the University of Wisconsin, while Harvard has made arrangements by which those intending to study medicine can take a special A. B. course in three years. The course offered by the University of Wisconsin is fully outlined, as is the one that was proposed by the Medical Department of the University of Michigan, but was rejected by the joint faculties. The Report shows a marked increase in requirements as to preliminary education during the year 1890. It shows also that the movement for four years' study and three courses of lectures is an assured success, and a list is given of the colleges that have adopted or will soon adopt the requirements of longer terms of study.

Several State boards, having authority similar to the Illinois Board, have already adopted the requirement in this respect, and those that have not already done so, will in a short time co-operate in the movement. The potency of this factor will be appreciated when it is considered that these boards directly control the recognition of diplomas embracing about 41,000,000 people, and indirectly in almost the entire area of the United States; and that a number of them exercise jurisdiction in the new States and Territories.

It is suggested in the Report that, with four years' study and three courses of lectures assured, the boards of medical examiners and the colleges should co-operate in establishing a system of registration of medical students before they enter college, in order that the requirement of one year of study outside a college may not be mere form.

A correct resume of the medical practice acts in the different States and Territories is a valuable addition to the Report. Comprehensive tables show the progress made towards higher medical education in the past ten years, with the numbers

of matriculates and graduates for each year, and the percentage of graduates to matriculates. These tables show the effect of the schedule of minimum requirements of the Illinois Board after the session of 1882-83. In 1882-83 the total number of medical students in the United States was 12,274, while in 1884-85 it was 10,987; and the 12,000 mark was not reached again until 1887-88. The percentage of graduates to matriculates in the United States has fallen from 35.8 in 1881-82 to 21 in 1890. The percentage in Canada has not reached 24 in ten years.

That portion of the Report devoted to institutions and regulations in foreign countries contains in full the requirements of the examining boards in Great Britain, with the names of all the medical schools and of all the hospitals in which instruction is given. The requirements as to preliminary education in foreign countries are given for purposes of comparison, as well as the requirements for graduation and for the license to practice. The course of study and the semesters in which the various subjects should be taken up, as advised in the German universities, as well as a description of the German method of examining for the license to practice, are given in full. In addition, the correct names and locations of foreign medical institutions are given.

THE JOHNS HOPKINS HOSPITAL REPORTS.—Report in Gynecology, I. By Howard A. Kelly, M.D. Contents: I. The Gynecological Operating Room and the Antiseptic and Aseptic Rules in Force; II. The Laparotomies Performed from October 16, 1889, to March 3, 1890; III. The Report of the Autopsies in Two Cases Dying in the Gynecological Wards without Operation; IV. Composite Temperature and Pulse Charts of Forty Cases of Abdominal Section; V. The Management of the Drainage Tube in Abdominal Surgery; The Gonococcus in Pyosalpinx; VII. Tuberculosis of the Fallopian Tubes and Peritoneum—Ovarian Tumor; VIII. General Gynecological Operations from October 15, 1889, to March 4, 1890; IX. Report of the Urinary Examination of Ninety-one Gynecological Cases; X. Ligature of the Trunks of the Uterine and Ovarian Arteries as a Means of Checking Hemorrhage from the Uterus, etc.; XI. Carcinoma of the Cervix Uteri in the Negress; XII. Elephantiasis of the Clitoris; XIII. Myxo-Sarcoma of the Clitoris; XIV. Kolpo-Ureterotomy—Incision of the Ureter through the Vagina, for the Treatment of Ureteral Stricture; XV. Record of Deaths following Gynecological Operations. Baltimore: The Johns Hopkins Press, 1890.

This small work of 250 pages marks a new era in the literature of hospital reports. As will be seen by the perusal of the table of contents, an immense amount of interesting and valuable material is introduced under one heading or another. One of the most interesting chapters is the illustrated description of the operating room, which is acknowledged by all who have seen it to be as nearly perfect as ingenuity and money can make it. One can see in reading this chapter that Dr. Howard Kelly of Baltimore is thoroughly imbued with the spirit of Dr. August Martin of Berlin, under whom he has recently studied. As he says, the working rules are antiseptics up to the beginning of the operation, aseptics throughout the operation and preservation of the aseptic state after the operation. After describing the building and the room, he mentions one thousand and one details which are

essential towards attaining these ends, details, we may add, which owing to their cost have hitherto rarely if ever been attainable in any one institution. More dependence is placed upon sterilization by heat than upon disinfection by chemicals, in the preparation of the patients, instruments and dressings, while soap and water and the nail brush used during ten minutes at least are depended upon to a great extent in the preparation of the operators and the patients. The abdominal sections are beautifully tabulated, so that one can see at a glance the age of the patients, the nature of the disease, the kind of operation, including the difficulties encountered, whether a drainage tube was used, how long, time consumed by the operations, the temperature if over 100, whether there were any stitch hole abscesses, and whether the patients recovered or died. Following the tabulated list is an analysis of cases in which the peculiarities of each case are briefly but thoroughly gone into, and the practical deductions are given. The careful perusal of this chapter by every abdominal surgeon cannot fail to be of the greatest possible value. The chapter on the temperature charts and management of the drainage tubes are also intensely interesting. In the former we see that the temperature after the simplest and most uncomplicated cases is always higher than in health, while after the removal of pus-tubes it may remain as high as 101° to 102° without causing anxiety. The rest of the report is equally interesting, and we trust that Dr. Howard Kelly will continue from time to time to disseminate the valuable experience he acquires, and thus save other operators from purchasing their experience at the price of human life.

PRINCIPLES OF SURGERY. By N. Senn, M. D., Ph. D., Milwaukee, Wis., Professor of Principles of Surgery and Surgical pathology in the Rush Medical College, Chicago, Ill., etc. Illustrated with 109 wood-engravings. Philadelphia and London: Z. A. Davis, Publisher, 1890. Price \$4.50 in cloth; sheep, \$5.50.

After perusing this work on several different occasions we have come to the conclusion that it is a remarkable work by a man of unusual ability. We have never seen anything like it before. As the author says, the recent great discoveries relating to the etiology and pathology of surgical diseases have made the text books of only a few years ago old and almost worthless. The author has devoted a large part of his work to the study of bacteria, giving them their true place in the causation of surgical diseases. The work treats exhaustively of the pathology, etiology, and treatment of the surgical germ diseases, but does not touch upon fractures, dislocation, etc. In other words it is a work on the principles but not on the practice of surgery. It embraces inflammation, necrosis, suppuration, septicemia, pyemia, erysipelas, tetanus, hydrophobia, surgical tuberculosis, actinomycosis, anthrax, and glanders. Many of the references and illustrations are taken from German authors which are not readily accessible to English speaking students. These subjects are handled by the author as we have never seen them treated before, so that this work is more suitable for the professor than the student. The author seems to have had a very large personal experience, which is freely made use of in the text, besides which he is familiar with almost all that has been written in English and German on the above topics. We con-

gratulate Dr. Senn upon the manner in which he has accomplished his task.

A MANUAL OF MODERN SURGERY. For the Use of Students and Practitioners. By John B. Roberts, A. M., M. D. Philadelphia: Lea Bros. & Co.

This handsome volume on practical surgery fully supplies the want which the author had in view when he wrote it, namely, to be a book of ready reference for the young surgeon, as well as a text book for final year students in this branch. The reading material is so put together as to make its perusal pleasant, and the various subjects are briefly and concisely gone into, yet by this brevity it in no way loses any of the explicitness of more ponderous works. In its pages many of the more minor details of the various operations are fully described with great clearness. The illustrations are of the very best, and they are selected in a manner that indicates the author is fully abreast of the times, and possessed of the keenest judgment. It is a book that one delights to read, study and consult. The letter-press and paper are excellent and the general appearance of the volume would make it a handsome addition to any practitioner's library.

A TEXT BOOK OF PRACTICAL THERAPEUTICS, with especial reference to the application of remedial measures to disease, and their employment upon a rational basis. By Hobart Amory Hare, M. D., (Univ. of Pa.) B. Sc., Clinical Professor of the Diseases of Children, and Demonstrator of Therapeutics in the University of Pennsylvania, Secretary of the Convention for the revision of the U.S. Pharmacopœia of 1890, etc., etc. Philadelphia: Lea Brothers & Co., 1890. 8vo., cloth, pp. 632.

We have purposely withheld our comments on this work, till the present in order to permit of a thorough perusal of its contents. Having now done so we can fully assure our readers that the task (if we may express it) has been a most pleasant one. The author's ideas in the general construction of the material are thoroughly original, and the work is designed for the use of the student as well as the medical practitioner, and a successful endeavor has been made to combine science with practice by placing this most difficult subject on a rational rather than an empirical basis. It is essentially a work on practical therapeutics. The arrangement of the drugs is alphabetical and the volume is quite abreast of the times and the newer drugs, e.g., acetanilide, are spoken of at some length. A point which is of much importance to Canadian readers is the embodiment of the *materia medica* of the *British Pharmacopœia*. The first part of the work treats of the remedies employed in modern practice and the latter part is devoted to a description of the treatment of the various diseases. In the appendix is found a full table of doses; also a complete index of remedies and diseases, making the work as a whole a very acceptable text book for the student, as well as a volume for reference or the busy practitioner.

SOUTHERN ENTERPRISE.

It appears, from a pamphlet we have received, that Pine Bluff, Moore County, North Carolina, is an El. Dorado for patients suffering from lung diseases. In order that the merits of the place may be investigated, the management of the location have made the very generous offer to the Editor of this journal to provide a free pass from New York there and back, between the 8th and 15th of April; or, if the Editor is unable to go, the offer holds good for some other member of our staff. As we are rather short handed at present, we are unable to accept the invitation, but we are prepared to engage a reporter for the special work, without salary, to whom we will give the free ticket offered us, and who would no doubt come in for a good time among the hospitable denizens of Southern Pines, the new health resort. Any of our readers desiring to take this journey should apply at once to the Managing Editor of the RECORD.

NEWS ITEMS.

The *University Medical Magazine*, of Philadelphia. We have much pleasure in calling the attention of our readers to a new departure which this excellent journal is making. The method adopted is as follows: a corps of young medical men make extracts from all the leading foreign journals; these extracts are then submitted to the chief of each department who selects the most important ones, which present in the most satisfactory manner the current literature of the day. When we state that these departments will be under the personal direction of such men as Pepper, Agnew, White, Wood, Goodell and Hirst, we need hardly state that the result of their labors will give the greatest satisfaction. We trust that the enterprise of the publishers will be rewarded by a largely increased subscription list, the price remaining as before, only \$2.00 per annum. The journal has long been one of the most welcome among our list of exchanges.

Men who Advertise and need a new idea now and then, or who have not always the time or inclination to prepare their advertisements, will find a valuable assistant in the novel book of "Ideas for Advertisers" just published by T. D. Mallett, New Haven, Conn., and sent on receipt of \$1.00, post-paid. He also publishes a tasty pamphlet called "When," (price 25c.) a treasury of good advice to business men. Descriptive circulars of both these new books can be obtained upon request to the publisher.

Reprint from the Kansas City Medical Record.

THE ACTIVE PRINCIPLES OF PARSLEY
IN AMENORRHEA AND DYS-
MENORRHEA.

Various methods for the extraction of the active principle of parsley have been proposed from time to time, but there has been always a want of uniformity in the therapeutic results obtained with the so-called Apiol preparations, hitherto found in commerce.

With a view to obtain a reliable product, M. Chapoteaut recommenced a study of the plant and finally adopted a new process for the extraction of a thick, reddish liquid boiling at 275° C. (527° F.) specific gravity 1.113.

This is a product totally different from true Apiol (Von Gerichten), since the latter is a solid melting at 30° and boiling at 300° C., and different from the Essence or Oil of Parsley, boiling at 160° C., while its reddish color indicates that it cannot be confounded with ordinary so-called commercial Apiol, which is a yellow or green liquid having an approximate specific gravity of 1.07.

This new substance therefore has been named *Apioline (Apiolinum)* by M. Chapoteaut, and clinical experiments show it to be the true active principal of the plant.

Dr. Laborde* has made an exhaustive study of the action of apioline and its derivatives, cariol, etc., on animals, which indicates that it stimulates the circulatory system of the intestines and genitals, causing vascular congestion of the uterus and ovaries and exciting contraction of the smooth muscular fibres of the genital organs, especially of the uterus and ovaries.

Experiments made on female guinea pigs and dogs demonstrated this special action in a very decided manner and corresponding genital excitement was also observed in males.

These results have been remarkably confirmed by their therapeutic application in the French hospitals.

Apioline Chapoteaut administered in spherical capsules 20 centigrammes each, always relieved the pain in spasmodic and congestive dysmenorrhea, cases in which principal reliance should be placed on equalizing the circulation and increasing the power of the ovarian nissus.

In amenorrhea, where the menses had been suppressed even for a considerable length of time, the flow promptly reappeared.

In fact, all cases depending on uterine troubles amenable to internal treatment, and where a correct diagnostic of the symptoms had been made and suitable hygiene and treatment observed, this drug relieved the suppression, regu-

lated and prevented or removed the accompanying pain, and proved to be the most powerful emmenagogue with which we are familiar.

In cases of scanty or deficient menstruation with pain, etc., one capsule can be given after meals, thrice daily for a week before the expected period, as recommended by Dr. Fordyce Barker.†

R *Apiolini* grm. IV. (about 3i)
ft. Capsule No. xx (Chapoteaut).

Sig.: Take three each day during the week preceding menstruation.

It is especially appropriate when amenorrhea depends upon anemia. The same authority suggests the administration of aloine or podophyllo-toxin when amenorrhea and dysmenorrhea are complicated with constipation. Although apioline is looked on as a specific for menstrual disorders by many gynecologists, it must not be forgotten that these troubles are often subordinate or associated with a general atony of the system, which requires tonics, hematics (Ferrum Sanguinis) and suitable hygienic agents. Finally *Apioline Chapoteaut* cannot be expected to remove dysmenorrhea depending on mechanical obstruction of the cervical canal—causes of failure which are sometimes overlooked.

Dr. Vadeboncoeur, after a series of trials with *Apioline*, writes: "I have obtained excellent results in painful cases of dysmenorrhea. One lady patient who was an hysterical subject, and who was obliged to use injections of morphine to relieve the pain, has found this unnecessary since I prescribed *Apioline*."

Dr. C. Hewson Bradford, of Philadelphia, November 21, 1890, reports: "I have used it successfully in amenorrhea. Miss H., æt. 19 years, had always been irregular; her menses were always scanty and for the last two months they had been absent.

She expected her menses on November 17th, so on the 12th inst. I gave her the *Apioline* Capsules and requested her to take one morning and evening until after her sickness had appeared—to-day I visited her and found her much improved. She stated that menstruation had begun early on the morning of the 18th inst.

* J. Laborde, directeur des Travaux Physiologiques à la Faculté de Médecine de Paris.—*Tribune Médicale*, January 8, 1891.

† See Shoemaker's *Materia Medica and Therapeutics*. Vol. II. page 447.

PERSONAL.

Dr. Charles E. K. Vidal (Bishop's '90) who for nearly a year past has been one of the resident house surgeons of the Montreal General Hospital, has resigned this appointment to accept the position of assistant to Dr. P. E. Menburn, residing at Lethbridge, Alberta, N. W. T. We wish him all possible success in his new undertaking.