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NOTES ON TWO CASES OF ABDOMINAL SECTION FOR UTERINE MYOMA.

BY A. B. ATHERTON, M.D., L.R.C.P. AND S. (EDIN.), TORONTO.

CASE I.—Oct. 26, 1882.—Mrs. G., aged 40. Married eight years. Never pregnant. Family history good. Has generally enjoyed fair health. Suffered from fissure of the anus and piles some years ago. Was cured by operation. Catamenia always regular, but for the last three years have been more profuse than usual, and accompanied with a good deal of pain in lumbar and hypogastric regions.

Was examined two years ago by Dr. Scott, of Woodstock, Ont., who thought an enlarged ovary had fallen down behind uterus. He introduced one of his pessaries, which she has since worn most of the time, with a good deal of relief both to backache and other discomfort.

While on her way to Yarmouth, N.S., where she now resides, she consulted me a year ago. I found a firm, hard tumor, of about the size and shape of a small orange, lying behind uterus, slightly to the right side. It was freely movable, but seemed attached to uterus. Latter organ was somewhat enlarged, and could be readily felt above pubes. I diagnosed a pedunculated fibroid of uterus, and advised her to continue the use of the pessary, unless it became too troublesome to endure the pain and inconvenience of the disease. In such a case, I told her, it might be removed by an operation.

In July last she went over from Yarmouth to Boston to obtain the advice of Dr. John Homans. He agreed that the tumor was a fibroid of uterus, and she was treated by some modified form of pessary, for a week or two, in hospital there, being advised to return for operation if she did not progress favorably. After arriving home, she soon resorted to the use of Dr. Scott's instrument again, as it seemed to afford more relief than the one with which she was supplied in Boston. As her symptoms, however, continued to grow worse, notwithstanding the constant wearing of the pessary, she decided to be operated upon, and has come to Fredericton for that purpose.

Patient is fairly nourished, and strength and appetite moderately good.

Oct. 27, 12m.—Bowels having been moved last evening and this morning by enemata, chloroform was given, assistance being rendered by Dr. G. H. Coburn. Median incision made four inches long, between umbilicus and pubes. On opening peritoneum, a loop of small intestine and a piece of omentum protruded. These were pushed back, and hand passed into posterior pelvis. Here tumor was found and withdrawn through abdominal wound. Two steel pins now introduced at right angles to each other, through base of neck of tumor, close to uterus, and beneath them a medium-sized rubber drainage tube was wound around two or three times and tied. Tumor cut away by a wedge-shaped incision, so as to leave two raw surfaces to be united face to face, which union was effected with catgut sutures passed

through and through, from one side to the other. After removing pins and rubber tube, I found that there was some bleeding from one side, and I therefore put a double silk ligature around whole stump, which was about three-fourths of an inch in diameter. This proved effectual in checking all flow of blood. Abdominal wound closed with deep silver and superficial catgut sutures.

Operation done under carbolic spray, and antiseptic dressing was applied.

Patient to have iced milk and lime water, in small quantities. One-third of a grain of morphine administered hypodermically.

7 p.m.—Some vomiting. Pulse 80; temp. 98° F.

Oct. 28, 9 a.m.—Slept part of night. A good deal of vomiting. Pulse 88; temp. 99.3°.

9 p.m.—Ate a little rice and milk to-day. Vomits less. Passes urine freely without use of catheter. Has had a suppository of half a grain each of morphine and ext. belladonna, just before visit, for pain. Pulse 96; temp. 100.4°.

Oct. 29, 9.30 a.m.—Slept five hours. No vomiting. Pulse 72; temp. 99.5°.

5 p.m.—One or two visitors clandestinely got into patient's room to-day and she seems rather nervous this evening. Pulse 84; temp. 100.4°.

Oct. 30, 9 a.m.—Used one suppository last night. Was easy, but did not sleep much. Pulse 76; temp. 99.5°.

Oct. 31, 9 a.m.—Dozed three or four hours yesterday, and slept four hours last night. Used one-half of a suppository during night.

5 p.m.—Wound redressed for first time, spray being used. Only a slight bloody stain on gauze.

Nov. 4.—Has continued pretty comfortable without opiates, since last report. Bowels moved freely this morning from cathartic pills and enema. Wound redressed. Some suppuration along lower two-thirds of incision. This, I think, may have been due to patient's loosening lower edge of dressing a day or two ago, and thus permitting entrance of air to part. Two or three sutures removed.

Nov. 6.—Remaining sutures all removed. Some suppuration going on beneath bridges of

catatrix along the lower line of wound. Probe, however, does not enter deeply at any point.

Nov. 7.—As wound was gaping, I dressed it with strips of adhesive plaster. Pulse 96; temp. 100.5°.

Nov. 8.—Catamenia have appeared. Patient required two or three opiates during the last day or two, which, as well as rise of temperature, has probably been largely due to approach of menstruation.

Nov. 10.—Pulse 72; temp. 99.5°.

Nov. 13.—Bowels moved by enema. Wound gradually healing. Pulse 70; temp. 99°.

Nov. 15.—Bowels moved naturally last night. Pulse 68; temp. normal. Eats a little meat and potatoes every day now.

Dec. 6.—Catamenia again appeared to-day. Wound all healed a fortnight ago, but patient has seemed weak and nervous, with some dyspeptic symptoms. Is taking a quinine tonic.

Dec. 15.—Left to-day for the country, to visit some friends.

Jan. 11, 1883.—Has rapidly improved since leaving town. Weighs 15lbs. more than before, and feels much better for operation.

CASE II.—June 26, 1883.—Miss T., aged 35. Patient sent to me by Dr. Nevers, of Hartland, N.B. Family history good. Patient had bilious fever at 17 years; also diphtheria pretty badly five years ago. With these exceptions, health good till present trouble began. Catamenia first appeared at 14, and have been always regular, but painful. A tumor first noticed three-and-a-half years ago in left inguinal region, and it has gradually grown to its present dimensions. For the last eighteen months there has, at times, been dysuria. A year ago, was one day suddenly seized with severe pain and soreness in left inguinal region, running down groin and inside of thigh and leg. Kept bed for ten or twelve days. During this time the "cords" on inner thigh were hard, swollen, and tender. Also the whole left limb was swelled very much, and remained more or less so for two months.

Present condition.—Patient is pale and emaciated. Pulse 96, feeble. She can walk about pretty well, but must move slowly, and is easily fatigued. Has the appearance of a woman larger than at full period of gestation.

The abdomen is filled by a hard and somewhat elastic tumor, whose surface is smooth everywhere except at one point, two or three inches below umbilicus, and to the left of median line. Here there is felt a rounded prominence, about half the size of an ordinary pear. Per vaginam, the finger impinges against a large mass, pressing well down into posterior pelvis. This had a similar feel to the tumor in abdomen, and is apparently one with it. Cervix uteri cannot be reached by finger, but sound, passed up just behind pubes, can be carried to a point a little to the inside and below the prominence on tumor above-mentioned. Its end can be distinctly felt by hand on abdomen, apparently close beneath the surface.

Diagnosis.—Fibroid of uterus. After clearly stating to the patient the risks of an operation for its removal, she decided that she would rather die than continue to drag out a miserable existence of suffering as at present, and requested me to proceed with it at all hazards.

4.30 p.m.—Operation. Ether given. Assisted by Dr. G. H. Coburn, of Fredericton, N.B., and Messrs. Owens and Sury, my medical students. A long incision, made from near epigastrium to pubes. On opening abdominal cavity, an enlarged Fallopian tube was seen running transversely across tumor from the above mentioned prominence; also another enlarged tube extended from the left of this prominence outwards and downwards. Sound could, with some manipulation, be now passed up into this projecting portion, which was therefore proved to be the fundus and upper portion of body of uterus. Two ligatures were now placed on each side below ovaries, and the vessels between them divided. The tumor was then partly lifted out of abdomen, and two common knitting-needles passed at right angles through its base as low down as possible. A considerable portion of the tumor was, however, bound down firmly in posterior pelvis, completely filling that part of cavity, and thus preventing the application of the rubber cord as low down as was desirable. The diameter of mass pierced by needles was six or seven inches. After winding an ordinary rubber tourniquet two or three times around below the needles, I attempted to secure its ends

in its wooden fastener, but finding them inclined to slip, they were held taut by an assistant, while I proceeded to slice off, in several different portions, the superfluous mass, including, of course, the fundus and body of uterus. After getting well down to needles, I enucleated gradually the part of tumor which adhered to the posterior pelvis, using chiefly the fingers for that purpose, and taking care to keep sliding the rubber tourniquet well down as I proceeded, so as to guard against hemorrhage. Care was also taken during the operation to avoid wounding the ureters or bladder, by occasionally passing a catheter to ascertain more exactly the position of parts. The raw surface at point where I finally amputated was made of such a shape as to permit of the two sides being brought together somewhat after the fashion of a limb stump, just as in Case I. The sutures or ligatures used for this purpose consisted of silk and catgut, and were tightly and firmly tied. Anteriorly, the peritoneum was included in these; but posteriorly, the central portion of peritoneal flap was not long enough for this, on account of the large gap which had been left by the portion of tumor enucleated from the pelvis.

Up to this step of the operation very little blood had been lost, but on now loosening tourniquet a free flow occurred, mostly apparently coming from the free edge of cut peritoneum posteriorly, and from the raw surface left in pelvis region. This was, after a time, controlled by pressure and ligature of the peritoneum.

The symptoms of shock were considerably increased by this hemorrhage, and twenty minims of sulphuric ether were therefore administered hypodermically. Also some brandy was given per rectum.

A glass drainage-tube put in at lower end of abdominal wound, and latter brought together with silver sutures. Usual dressing of carbolic gauze and strapping, with cotton wool and flannel bandage outside.

Operation lasted about three hours, during three-fourths of which time the carbolic spray was used. Tumor weighed 19 lbs.

June 27, 9 a.m.—Rested pretty well during night. Had quarter grain of morphine hypo-

dermically, and also two or three half-drachm doses of tinct. opii. Has swallowed a small quantity of iced brandy and milk, and has had brandy and oatmeal gruel (strained) per rectum. Pulse 144, feeble. Extremities fairly warm. Urine drawn; is smoky. As there was some show of discharge on dressings, these were changed under spray. Also vagina was washed out with 1 in 40 of carbolic acid solution, there having been some bloody serous flow from that part. Quarter-grain of morphine given hypodermically.

11 p.m.—Has had a good deal of eructation of wind and vomiting through the day. Three or four enemata of brandy, with beef tea and gruel alternately, have been given. Pulse 148. Another quarter-grain of morphia as before.

June 28, 8 a.m.—Rested pretty well. Urine has been natural in color since first passage after operation. Some slight bloody discharge continues from vagina. Pulse 148; temp. 100.5°.

6 p.m.—Severe vomiting began at 9 a.m., and continued every few minutes up to the present. Vomited matters presented the coffee-ground character. Patient is very restless, and countenance is somewhat hippocratic. Not much pain. Had quarter-grain morphine subcutaneously about 3 p.m. Pulse 152.

Thinking that some benefit might accrue from transfusion, I cut down upon left median cephalic vein, and, after isolating it, it was raised upon a probe and a small trocar thrust into it through the canula, of which 14 oz. of the following solution was introduced:—

Chloride of sodium	6 parts.
Carbonate of sodium	1 "
Distilled water	100 "

This, after having been filtered, was heated in a clean bottle to 110° F., and then conducted through clean rubber tube of aspirator, by force of gravity, into vein—care, of course, being taken to have no air in tube. Immediately after the transfusion the pulse improved in strength, and fell to 136 in the minute.

June 29, 2 a.m.—Patient felt more comfortable for three or four hours after transfusion, but since then vomiting and distress have returned as bad as ever. Only one or two

nutrient enemata have been administered during the last twenty-four hours, as they seemed to produce quite severe pain. Pulse very rapid and feeble. Glass drainage tube removed and rubber one substituted.

3 p.m.—Countenance grows worse. Considerable swelling of abdomen. Pulse 144; temp. 102°. Dressing changed. Abdominal cavity washed out with 1 in 40 solution of carbolic acid.

June 30, 3 p.m.—Vomiting continues, though nothing is now taken but small bits of ice. No enema since last report, because it causes much increase of pain. One-sixth grain morphine hypodermatis is required twice a day for relief of pain. Wound dressed. Considerable dirty watery discharge, having a gangrenous odor. Pulse scarcely perceptible.

July 1, 3.30 a.m.—Patient died.

11 a.m.—Autopsy. Small intestines found considerably distended, but not much inflamed. There were one or two dark, gangrenous patches on the sigmoid flexure and rectum. The whole raw surface of posterior pelvic cavity was dark and foul-looking, while the free cut edge of peritoneum near this part presented the same appearance. The uterine stump looked well, and no hemorrhage had occurred from it.

Remarks.—There are several points of interest in the last case reported which are worthy of notice. It will be observed, in the first place, that no hemorrhage of the slightest consequence occurred while the elastic cord was held tightly around the stump of tumor. It is therefore evident, I think, that, seeing it was so efficient in the case of a tumor with so large a base, it will prove in all such operations equally successful in controlling bleeding. The fact that so much blood was lost before the completion of the operation was undoubtedly my own fault, in not making sure of the peritoneal wound at least, near posterior pelvis, before relaxing the constricting rubber. I may say, however, in slight extenuation of this error, that in loosening the tourniquet, the edge of peritoneum slipped rather suddenly and somewhat unexpectedly from beneath the grasp of the rubber coils.

It would have probably been better to have dissected back a longer flap of peritoneum pos-

teriorly, so as to have been able with it to have covered in completely the uterine stump, and thus shut off more perfectly the general peritoneal cavity from the extensive raw surface in posterior pelvis. In that case it would have been advisable to have drained latter by an opening into vagina, no tube being used for abdominal wound.

As to the general question of the advisability of operating in these cases, there can, we think, be no valid objection raised when the tumor is pedunculated, and is the cause of severe pain or other serious inconvenience. In those, however, in which the uterus and its appendages must be sacrificed, and that, too, at very considerable risk to the life of the patient, it is, of course, incumbent upon us to weigh well the reasons for such a procedure before it is undertaken. No doubt individual minds will be more or less influenced in deciding as to their respective action by the existence or otherwise of a surgical tendency. Some men are, probably, too ready to submit patients to an operation; while others shrink, improperly, from its performance. Some there are who seem to doubt whether a woman ever flows to death from a fibroid of the uterus, and they would apparently teach that *no* case should be submitted to hysterectomy, no matter how large the tumor or how much the system is suffering from its presence. The latter will, of course, rely upon rest and palliatives of various kinds; while an attempt may be made to produce absorption of the growth, by means of bromide or iodide of potassium, ergot, or electrolysis. I have never seen the last used in this disease, but, judging from the reports of others, it would seem that its remedial effects are somewhat doubtful, while it, like the hypodermic injection of ergot, must be anything but agreeable to the patient. I have seen a very serious abscess follow a deep injection of ergot into the buttock, and I am quite sure that few persons on this side of the Atlantic, whatever they may do in Europe, would readily submit to a course of treatment involving much pain, and extending over a period of several months, with the doubtful prospect of some slight decrease in the size of the tumor, or even the exceedingly rare chance of a cure. If a

few weeks of such treatment fail to produce a manifest improvement, I think there are few patients in this country who would persevere in it. Besides, we must not forget that there are periods of quiescence in the growth of these myomata, and sometimes even a spontaneous cure of them without the use of any drugs at all. We must not, therefore, on the *post hoc ergo propter hoc* principle, conclude that every change for the better is due to the concomitant administration of some medicine, or to the use of some other means of cure. This fact may, of course, be fairly employed as an argument against a too hasty resort to the knife in these cases. But, we think, it is now fairly agreed, that when a patient is afflicted with a large tumor in the uterine wall, which gives rise to severe and persistent hemorrhage, or, in other ways, brings about great cachexia of the system, and in which oöphorectomy and other more ordinary means have failed to procure relief, it is but right that she should have the option of the major operation of hysterectomy, a fair and candid statement being made, of course, as to dangers attending it.

As to the fatality of such cases, when left to nature and medicinal treatment, I may remark that, judging from my own small experience, it is very considerable. In a limited field of observation, I have known of six deaths, the ages of the patients ranging from 30 to 35. I am therefore strongly inclined to advise an operation for removal in all cases where the general system shows much evidence of breaking down from the drain upon it. And it must be remembered, as has often been remarked, that the operation of hysterectomy for fibroids is still in its infancy, and future experience may yet teach us to be able to reduce its mortality to a point approaching that of ovariectomy. There are some circumstances, however, which will probably always make it a more dangerous procedure than the latter operation. Among these may be mentioned the greater shock produced by removal of the uterus and its appendages, the greater frequency of pelvic adhesions, the larger size of the stump and the consequent difficulty in preventing hemorrhage, and the obstacle presented by an open passage through the vagina to the

stump, and to the securing of an aseptic condition of the latter part.

The first two difficulties in the way of success cannot, of course, be well avoided. In regard to hemorrhage, I have been told that Schroëder has used a small rubber cord as a permanent ligature to the stump with satisfactory results, the ligature being discharged, per vaginam, two or three weeks afterwards. The stump when thus secured is, of course, left within the abdomen. Most operators, however, at the present time, seem to prefer the extra-peritoneal method of dealing with the pedicle, the latter being secured by transfixing needles and a rubber cord, or *Köiberle's serre noeud*. It is to be hoped, however, that (as in ovariotomy) some safe method will yet be devised, if it has not already been so, by which we may get rid of the necessity for a large sloughing pedicle in the abdominal wound, and the consequent tedious healing of that part.

Whether any satisfactory means will be discovered to keep the wounded tissues aseptic is a question of undoubtedly great importance. Iodoform bougies have of late been passed by some into the canal of the cervical stump, and iodoform gauze at the same time used to plug the vagina, in order, if possible, to prevent the admission of bacteria to the wounded parts. I would myself suggest the propriety of closing the cervix by a surgical operation previous to the performance of hysterectomy in all those cases where an interval of two or three weeks exists between the periods of menstrual discharges, and where, of course, the cervix can be readily got at and is not seriously involved in the disease. A period of ten to fifteen days would give time for the healing process to so far progress as that the cervical cicatrix would probably remain firm after the hysterectomy, and thus bar the road to the fresh wound above. Even were it to break down it would not be likely to do so for some days after the major operation, and meantime the peritoneal cavity might have become sufficiently protected, by the formation of adhesions, to prevent the entrance of germs.

Glycerine and syrups, when added to some emulsions, induce separation.

INTERNAL URETHROTOMY.

BY W. BURT, M.D., PARIS.

By way of introducing my subject I shall give you the histories of three cases selected from my note books.

CASE I. H. M., aged 66, born in England. Had swollen testicle when 15 years old, caused, he says, by a strain. Had been working very hard. Says he never had a gonorrhoea. Always had difficulty in passing his water from this time. Married at 18, and has a large family. From the time that he had swelled testicle, when he received medical attendance for a week, until he came to this country at 45 years of age, he never consulted a surgeon. Urination painful at times; drank gin for it; says of late years he would speak to doctors about his trouble and they would tell him to take a good drink of hot whiskey. Acting on this advice he would take a big glass at bedtime to ease him. For a good many years back, would have to rise three and four times during the night, and for a considerable time has had to pass his water every hour or two during the day. It seemed to him that he lived to make his water. For two or three days before I saw him he was nearly crazy, and could not stand it much longer. Says he would sooner die than continue to suffer as he has done for the last two months. Kidneys affected.

On my first visit to him, Nov. 25th, 1877, I found him suffering from retention. After working at him a good while I succeeded in passing a No. 1 E. elastic catheter, and, as the patient stated, it took about three hours to draw his urine off. The stricture was five inches from the meatus. During the following week I got up to No. 4 E.

December 6th. I introduced Maissonneuve's staff, with filiform bougie attached, and passed the smaller knife in my case, which has a breadth of five millimeters. No untoward symptom followed. Three days afterwards I succeeded in passing a No. 10 E. On the 16th of the month he called at my office, and a month later resumed work. From the time of the operation he never could pass his water without the catheter—which he did with comfort three and four times a day—until a year

had elapsed, when he sent for me because he could not pass the instrument. I succeeded after some trouble in drawing his water off, when I passed Maissonneuve's larger blade, slit up, as I thought, the inner wall of a false passage, and passed a No. 14 E. sound. From this time on he passed his water freely without the catheter, using it only once a week, or not so often, as a precautionary measure.

24th April, 1883. Called at my office to-day. For one year says he has not used the catheter. Never has any trouble. Passes his water two or three times a day, and once at night; says he has no pain or trouble of any kind, and has never been as well since he was 16 years old. Have since met him occasionally on the streets, and when asked about his condition has always answered, "First-rate; never was better." I will not say that a radical cure has been performed in this case—although a No. 14 E. passed readily after the second operation, and no complaints of any kind whatever since—until he has been thoroughly tested with the urethrometer and bulbous bougie, which I have not yet had an opportunity of doing. The urethrometer referred to is an instrument devised by Dr. Otis for determining the calibre of strictures and the normal calibre of the urethra. It is impossible to treat strictures rationally without an instrument of this kind.

CASE II. J. V., aged 46, Canadian, consulted me Jan. 15th, 1885. Had gonorrhœa when 15 years old, chancroids and suppurating bubo at 17; at 26 met with an accident—had a fall—after which he passed bloody urine for two weeks. During this time he would try for about two minutes before he could get his urine to start, and then only a small stream would pass. From that day until the present his water has troubled him, and in the fall of 1868 first suffered from retention, but got relief by getting heated up. Between 1868 and 1872 he frequently had temporary attacks of retention, but would generally get relief himself in ten or twelve hours. His urine most of the time dribbled from him. In Feb. 1872 he was operated on by a well-known surgeon in the United States, but states that he passed a No. 10 sound through his anterior stricture, but never could pass one into the bladder. He was

again operated on by the same surgeon, who this time reached the bladder. A No. 14 soft catheter was introduced and allowed to remain three days. After this the patient passed a No. 12 sound for two weeks, but never got into his bladder afterwards. He continued to pass a No. 10 down to the bladder, as he says, but not into it.

In 1882 he applied to another surgeon in the United States, who passed a No. 8 into the bladder after working half an hour. After two years' gradual dilatation twice a week no larger than a No. 10 could be passed. Shortly after this he consulted an electrician. After the first application passed a very large stream; eight days after this no instrument could be passed through the lower one. After two applications he left the electrician. After this, he states, both strictures closed up rapidly, and he could only pass a No. 4 through the anterior stricture until coming to Paris. He has not had an attack of retention since using electricity. Always could make a little stream, but would always have to don his overcoat during cold weather, it took him so long to urinate. Ever since using electricity, however, his water scalded him and the least election would bring on a painful chordee.

My examination discovered a stricture two inches from the meatus which admitted tightly a No. 4. E. catheter. Found another stricture five inches from the meatus through which, after a good deal of manipulation with filiform bougie, I succeeded in passing Maissonneuve staff into the bladder, where it was held quite firmly. The anterior stricture was cut to an undue extent, as quite a bulging took place underneath at the site of the stricture after the withdrawal of a No. 10 sound, which passed quite easily into the bladder. (It is the operation on this case that prompted this paper and from which I wish to draw some practical lessons). Dr. Dickson assisted me by giving chloroform, as the patient would not allow the blade to be passed without, although he stood the previous manipulation very well. Previous to consulting me, says he suffered a good deal from urethral fever, both after his operation and the passage of a catheter. After this present operation a severe attack of

urethral fever set in immediately after passing his water, which he did twice within two hours. The penis and scrotum rapidly became œdematous. After this he had no uneasiness with his water for 24 hours, when I drew it off with a No. 8 catheter. Passed his water occasionally, with a good large stream, from this on, but more frequently he would draw it off with a No. 10. On the fourth day the fever had almost subsided. The catheter was always used when possible, as there was now no doubt that extravasation of urine was taking place from the anterior stricture. Spasms occasionally prevented the passage of the catheter. From this time on he progressed favorably. Deep incisions were made in the scrotum, in the middle line, the central portion of which sloughed. The two halves were brought together and the healing process went on rapidly, leaving a small scrotal fistula when he left for home, nearly three weeks after the operation. At this time a No. 14 E. was passed through the anterior stricture and a No. 10 into the bladder. Every now and again the catheter would not pass through the second stricture on account of spasms. I have received encouraging notes from my patient since he left for his home. He had gradually improved, although the fistula had not quite closed when I last heard from him several months ago.

Before making any comments I shall read you a history of a third case, which is short, and which may assist me in some of my remarks.

CASE III. A. B., aged 36, Canadian, consulted me about the middle of February last. Had gonorrhœa about five years ago; noticed his stream getting smaller the last six years. Began treatment with one of our western surgeons in 1883, and was gradually dilated for one year. Says the process was a very painful one, and would faint almost every time a sound was passed. Said he had two strictures, and that the doctor could get a No. 12 through the anterior one, but not through the posterior one. On the date above mentioned I found him suffering from retention after having a cold ride and a few glasses of beer. I relieved him with a No. 6 E. catheter, the largest that could be passed. I found two strictures, the first one

an inch from the meatus, the second five inches from the meatus.

On March 27th, the day appointed to operate, I could introduce nothing larger than a No. 4 bougie. Maisonneuve staff was then passed and the smaller knife. No anæsthetic; did not complain; no wincing. Says there was very little pain, and not at all to be compared with that attending the passage of a sound intended to dilate. Passed his water just before the operation. Kept it for five hours after the operation, when it was readily drawn with a No. 8 E. catheter. A No. 9. was passed seven hours after this; was told to pass it himself on the following day. There was very little uneasiness after the passing of the catheter. On the 28th he passed his water quite readily, but it caused a good deal of smarting. On the 29th I drew his water off with a No. 10 E. catheter. Passed a No. 10 bougie; both strictures grabbed the instrument. On April 4th a No. 12 catheter was passed, and on the 8th a No. 14 sound was passed through the anterior stricture and a No. 12 into the bladder. The passage of the sound through the anterior one caused a little hemorrhage. Says he makes a good stream now—that there is some satisfaction in urinating. He does it in one-third the time, and there is no dribbling at the last. The bladder is completely emptied, and the act of urinating is that of a healthy urethra and bladder. Called at my office July 17th; has not had an instrument passed for three weeks. Again passed a No. 12 into the bladder and 14 through the anterior one. There is no evidence of the anterior stricture, but on of large calibre is still indicated in the bulbo-membranous portion.

The chief point which I wish to make is in reference to the use of the different blades of the Maisonneuve instrument. This instrument, or some of the slight modifications of it, I believe to be the most valuable one that has ever been used for strictures of small calibre. I do not believe, however, that the different blades have been used with that precision that they should have been. In fact, I have not seen any directions given that would guide us in their use. Messrs. Buren and Reyer state in their valuable work that the objection to this instrument (Maisonneuve) is that if a large blade be used

the healthy urethra is incised longitudinally, often for its whole length, anteriorly to the stricture; an accident, perhaps, of no great moment, but entirely unnecessary; while if a small blade be used the whole thickness of the stricture is not cut through. Again, Dr. Otis tells us that "It is scarcely necessary to call attention to the *entire incapacity* of dividing or divulsing instruments to deal efficiently with stricture occurring in urethra whose normal calibre exceeds their own measurement." While I would not now use a blade of this width in stricture of large calibre while we have the excellent instrument of Dr. Otis for dealing with them, and which, I believe, is unsurpassed for the precision and thoroughness with which it does its work, I believe it is much less safe in the case of close stricture of the urethra to begin with one of Maisonneuve's large blades. Dr. Otis would have us believe, from the quotation above, that to accomplish our purpose Maisonneuve blades must equal the normal diameter of the urethra. To carry out this idea would, I believe, prove more dangerous, and those who resort to it will, like Dr. Otis, when he fitted a Maisonneuve knife six inches in width to his own instrument and passed it through the deep urethra, perform it for the first and the last time. It is quite evident that all we want is to have a blade with a width equal to the radius of the normal urethra plus the radius of the stricture. To make matters plain, take my second case, where I divided the anterior stricture more than was required, with a blade which, together with the staff, had a cutting capacity of eight inches. The diameter of the anterior stricture was three and a-third inches, the radius one and two-third inches. Take the normal calibre of the urethra to have been about normal, viz., thirty inches, or having a diameter of ten inches, and radius five inches. Now, to cut this stricture we would not be safe in using an instrument with a cutting capacity greater than the two radii, which is five inches plus one and two-third inches, or six and two-third inches; but here I passed a blade with a cutting capacity of eight inches, or one and a-third inches more in width than what seems to have been actually required. However, this need not happen again, as I now hold

that we should never use any other than the small blade, which in my case is five inches in width. With this I do not hesitate to operate on all close strictures through which I can get a filiform bougie and Maisonneuve staff. I believe we can pass a close stricture more readily with a Maisonneuve staff than any instrument I know of, unless it is Otis' dilating catheter, with a whalebone guide, which in some rare instances it may be necessary to precede the staff with. After the passage of the smaller blade of Maisonneuve, a No. 8. E. bougie will pass quite readily, and in a day or two you will have no trouble in passing a No. 10 E. or 19 F. The way is thus paved for further dilatation with bougie in the deep urethra, and for Otis' dilating urethrotome in the anterior position.

Another point, and that is to bring close stricture, anterior to the bulbó-membranous portion, to a calibre of eighteen inches in order that Otis' instrument may be passed. I would use a short Maisonneuve staff with a tunnelled extremity, that would only pass down to the commencement of the deep urethra, for it is in this latter we most frequently meet with spasmodic stricture. I have now but little doubt that the deep stricture in my second case was spasmodic, and that it would have been the best practice to have dealt wholly with the anterior stricture at first, and have restored the anterior portion of the urethra to its normal calibre before dealing with the deeper one; believing with Dr. Otis that many cases of deep stricture are wholly spasmodic, and depending on contraction in the anterior portion. Dr. Otis states that "It is the highest duty of the surgeon in all cases of spasmodic stricture in the deep urethra to ascertain and remove all anterior contraction. After this is efficiently accomplished, and when by healing all irritation from the wounds of operation have passed away, if then an obstruction remains which firmly engages or (if of sufficient size to allow its passage) firmly grasps a small instrument, it must be accepted as a true deep organic stricture." I could give at some length corroborative evidence in support of the rule of Dr. Otis just given, but you will find this part of the subject very fully discussed in Dr. Otis' book on "Stricture of the Male Urethra."

One more point, and that is, where a perineal fistula complicates the stricture, internal urethrotomy is all-sufficient to accomplish a cure in many cases (in support of this I could relate an interesting case, but my paper is already too long) and that perineal section, which it is well for us all to be familiar with—for in certain cases it is imperatively demanded—is the only procedure which will hold out any hope of saving our patient. Cases requiring perineal section alone, or a combination of perineal section with internal urethrotomy, are becoming every day more defined, and occur, I believe, but seldom.

MITRAL STENOSIS.

BY J. E. GRAHAM, M.D.

(Read at Ontario Medical Association, London, June, 1885.)

About fourteen years ago, Dr. Fagge, of Guy's Hospital, wrote a very elaborate paper on "The Murmurs Attendant on Mitral Contraction." I had at that time, through the kindness of Drs. Fagge and Moxon, an opportunity of examining several cases of contracted mitral during life and also of being present at some of the post-mortem examinations. Since then my attention has been drawn to the subject, and all the cases which have come under observation have been noted. The histories of some of them will be given in this paper.

The contracted mitral cannot be said to be a common form of heart disease. At the same time, there is no doubt but that on account of the difficulty of diagnosis many cases are overlooked, and a most serious form of heart trouble misunderstood. As will be seen hereafter, in many cases an accurate diagnosis is impossible on account of the absence of heart murmur. In many others, however, in which the præ systolic murmur is presented, either through carelessness or want of knowledge, it is not recognized.

In the year 1861, Dr. Gardner published an account of the præ systolic, or, as he called it, the auriculo-systolic murmur. This directed

Dr. Fagge's attention to the physical signs of mitral stenosis, and after ten years' study and observation he published in the Guy's Hospital reports the paper already referred to.

In the meantime, articles were written by Drs. Gull Hayden, Peacock, Sutton, and Hyde Salter. The principal object of these papers was to show the connection between the præ systolic murmur and mitral stenosis. Dr. Salter dealt principally with the præ systolic murmur, its character, and its relation to the normal heart sounds. He was of opinion that the præ systolic was one of the easiest murmurs to detect, and went so far as to say that anyone who failed to identify the sound would not only be unfit to hold the place of an accomplished and critical physician, but could hardly be considered a decently informed member of our profession. This is no doubt true in some cases of easy detection. It must be remembered, however, that patients come under observation in whom the irregular action of the heart renders the diagnosis of the sound a very difficult matter.

In French literature we find early mention of this bruit and the lesion which it indicates. M. Fauvel, in 1843, published a short but concise paper in which he described mitral stenosis and the peculiarity of the accompanying bruit. After him several others took up the subject, among whom were M. Bear and Bouillard.

In Germany little attention has been given to the subject. Even Oppolzer, the celebrated clinical teacher, who died in the year 1870, did not seem to have heard of a præ systolic murmur.

Of later years, Dr. Paul Niemeyer wrote a most elaborate paper giving a *resume* of the whole matter. Judging from the conclusion at which he arrived, one cannot help agreeing with Dr. Fagge, that Dr. Niemeyer "must in practice have always mistaken the præ systolic for a systolic murmur."

Dr. Fagge in recording his cases put them under three heads:—

1. Cases in which a direct mitral or præ systolic murmur was heard during life, and in which the mitral orifice was found after death to be contracted.

2. Cases in which the mitral valve, or orifice, was found after death to be narrowed, but in which no præ systolic murmur had been heard during life.

3. Cases in which a præ systolic murmur was recognized by auscultation, but in which no opportunity was afforded of verifying the diagnosis by post-mortem examination.

He gave 6 cases under the first head, 40 under the second, and 19 under the third.

Towards the end of his paper he states that he had collected from various sources 28 cases in which the præ systolic murmur had been heard during life and the post-mortem revealed mitral stenosis. No case had then been recorded in which the præ systolic murmur was heard and contraction of the mitral was not found. It will thus be seen that we can have mitral stenosis without the presence of a præ systolic murmur. On the other hand, however, when that murmur is heard we may almost positively conclude that mitral contraction is present. We should not be misled by the large number (40) of cases which Dr. Fagge gives under the second head. In 15 of these death was sudden, and no proper examination had been made. In some of the remaining 25 the murmur may have been overlooked. It must not be considered, then, that the præ systolic bruit is of less importance as a physical sign because mitral stenosis has been so frequently found in post mortem examination, where its existence had not been suspected.

With this short and imperfect account of the literature of the subject as our introduction, I will now give the history of a few cases which have come under my observation :—

CASE I. Mr. P— came under my observation as an applicant for life insurance. He had a syphilitic history. The disease appears to have run a very severe course, as he was incapacitated for work for fully a year. So far as could be learned, the valvular lesion was the result of syphilis. There was no history of rheumatic fever. He did not suffer from any severe cardiac symptoms, but noticed palpitation on exercise. A distinct præ systolic murmur was heard, which had the usual rough grating character. It could only be heard over a limited space. It is needless to say that

the risk was declined. He has since been married, and is apparently in fair health.

CASE II. Mrs. W—, aged 42, widow, came under my care, April, 1884, when these notes were taken. She has five children, all healthy. The youngest is now 14 years of age. She has had only one severe attack of illness, which occurred after confinement. This was in all probability some form of septicæmia. About a year and a half ago she began to feel poorly. She noticed first a shortness of breathing and a tendency to cough. Her face would become red and puffy when she walked a distance. She had also during the night attacks of difficulty of breathing which resembled asthma. She suffered from these attacks every night for some weeks, during January and February, but they, of late, only come on occasionally. She thinks they are brought on by indigestion, as they often follow the taking of a heavy meal. She has felt very weak and unable to exert herself, and after any undue exertion she has expectorated blood mixed with mucus. She has frequently complained of a fulness in the neck. These disagreeable symptoms were, as a rule, accompanied by palpitation* of the heart.

Present Condition, April, 1884.—Patient is pale and somewhat emaciated. She is very nervous. Pulse weak, and about 90 when she is quiet; bowels regular; urine normal.

Physical Examination.—Lungs healthy. The apex beat of the heart is to the left, but not much lower than normal. Over a space not much larger than a large penny a præ systolic murmur is distinctly heard. It is rough, and stops short just at the turn where the apex beat is felt under the ear. A peculiar impulse, the fremissement cataire, is felt over the cardiac region. Tonics and digitalis were prescribed, and as complete rest as possible enjoined.

During the month of May I was called up at night on two occasions to see the patient. She was at both times suffering from sudden congestion of the lungs. She had during the day exerted herself a little more than usual; had gone to bed at the usual hour, and shortly afterwards the attack came on. I found her sitting up in bed, breathing rapidly, and spitting up large quantities of bloody mucus.

The lungs were to a great extent filled with rales, crepitant and mucous. The pulse was rapid and small. The countenance was dusky and presented a distressed appearance. Ammonia and digitalis were freely given, and mustard applied to the whole surface of the chest. In the course of an hour or two, during which she continued to spit up blood, the breathing became easier, and the next morning she was comparatively comfortable. Rales were still heard in the chest.

The second attack resembled the first, but was not so severe. She had no further onsets of congestion. During the summer she improved somewhat. She went to Muskoka and there gained strength. She was a school teacher, and in the autumn returned to her work, undertaking only as much as she could comfortably accomplish. She continued to enjoy fair health until one day in the month of January. She had attended to her school duties, saw some friends in the evening, and retired as usual. In a short time she began to complain of difficulty of breathing, which rapidly increased, and in fifteen minutes after the first symptom she died. It is probable that this was also an attack of passive congestion due to stoppage of the circulation in the left auricle. I am sorry that I was not allowed to make a post-mortem. From the history, however, I think no one will doubt but that it was a case of mitral stenosis.

It might here be remarked that although the murmur was heard distinctly, the area was so small that one could easily give a cursory examination and altogether overlook it.

It is possible that the lesion in this case may have arisen from an attack of endocarditis following confinement.

CASE III. Mrs. Y—, aged 21, married one year, came under my observation January 1880, and has since frequently been seen by me. At that time she gave me the following history: She has never had rheumatism. About nineteen years ago she noticed first a palpitation and feeling of suffocation when she ran, or went up stairs rapidly. About four years ago she came to me suffering from palpitation and pain in the left side. I did not then make out the true cause of the trouble. The pain disap-

peared and she regained her usual health. She afterwards suffered from congestion of the womb, and has now an attack of bronchitis.

Present Condition.—Patient is pale but not much emaciated. Pulse about 90. She complains of a short dry cough which troubles her very much at night; appetite poor; bowels constipated.

Physical Examination.—Find over both lungs evidences of bronchitis. They are otherwise healthy.

Heart.—On palpation a distinct thrill is felt at each pulsation. The apex beat is in the normal position. On auscultation a murmur is heard over a limited area at the apex. It is rough in character and immediately precedes the systole. The sound is a very loud one, and its rhythm in relation to the normal heart sounds is very marked.

This patient has been more or less under my observation since 1880. She completely recovered from the bronchitis from which she then suffered, and has had one very severe attack of the same disease since. She has never had congestion of the lungs, and has never suffered from those dangerous symptoms which are often observed in mitral stenosis. She can walk a long distance if she does not hurry. I have seen her endure prolonged exertion without seeming to suffer much from it.

In this case, certainly the volume of the limit is not in proportion to the amount of pathological change. The murmur is a very loud one, but the stenosis cannot be very marked. It is probable too that the walls of the left auricle have become thickened and strengthened so as to partly compensate for the obstruction. She has never borne children, which is no doubt a fortunate circumstance for her, as the next case will show.

I had recently the privilege of again examining the patient. Found a presystolic murmur which lasts throughout the interval between the second and first sound. The sound is at first soft but becomes louder and rougher toward the end.

There is increased cardiac dulness over the left auricle as well as over the right ventricle. Patient stated to me that she has had frequent hemorrhages during the winter. These were

the first she has had. She is able to walk a long distance if she walks slowly, and enjoys very good health. She says that worry and excitement will produce distress in the region of the heart more quickly than exertion.

CASE IV. Mrs. N—, aged 25, married; two children, one 3 years and the other 15 months old. Patient was first seen December 1884, when the following notes were taken: She suffered from rheumatism when she was 19 years of age. The attack was not very severe, having been confined to her bed not more than two weeks. Shortly after she was married she caught a severe cold. She was not aware that her heart was affected until her first confinement. The labour was a long, tedious one, and afterwards patient was seized with congestion of the lungs, which lasted some hours, during which she was in very great danger. She has since been troubled with attacks of congestion, but none of them so severe as the first.

Her second labor was short and easy, so that it was not followed by the same difficulty as the first one.

Present condition.—Patient has a delicate appearance. She complains of palpitation even on moderate exertion. Pulse about 90, small and compressible. Heart enlarged. The position of apex beat is lower and a little to the left of normal.

A præstolic murmur is heard over a very limited space at the cardiac apex. The space was so limited that one could easily have examined the heart and not heard it. The murmur was not loud but quite characteristic and distinct. The patient was put on iron and digitalis. She has somewhat improved by the treatment, but still suffers from the palpitation. She is in dread of becoming pregnant again on account of the danger of labor. It is a question as to what advice to give in such a case. On this point the case is of interest when taken in connection with the following one:

CASE V. Miss M—, aged 25. Patient consulted me with reference to the propriety of her getting married. She had been warned by her regular medical attendant not to marry on account of heart trouble, and she came to me thinking that possibly I might hold a different opinion. She had been fairly healthy until

four or five years before the time of my seeing her. She then complained of weakness and difficulty of breathing when making any extra exertion. She was then told that she was suffering from heart disease. Since that time she has had several attacks of cardiac trouble, but has recovered to a certain extent. She did not at any time suffer from pulmonary congestions.

Patient was somewhat emaciated. The area of cardiac dulness was increased, particularly over the left auricle. The position of the apex beat was normal, or nearly so. Over a limited space, near the apex, a loud and distinct bruit was heard. It took place before the systole and ceased at the moment of the ventricular systole. The murmur was not heard over the inferior angle of the scapula or behind. An aortic regurgitant murmur was also heard near the base. About half way between heart and apex, where both sounds could be heard, one could notice a distinct pause between the two sounds. There was no interval between the præstolic beat and the first sound.

I have seen two or three other cases, but did not have an opportunity to take their history.

Of the five cases whose histories I have read, it will be noticed that all were females but one. The mitral lesion could be distinctly traced to rheumatism in one case; in another, syphilis appeared to be the cause. In the other three the condition had apparently originated from primary endocarditis. In all the cases the præstolic murmur was heard right up to the commencement of the systole. I could not detect the interval between the murmur and the systole which Dr. Fagge speaks of.

It will also be noticed that all the cases come under the third head of Dr. Fagge's classification, viz., those in whom the præstolic bruit was heard during life, but in whom the diagnosis was not verified by a post-mortem examination.

I might here mention a case, the history of which was kindly given me by Dr. Richardson. A prisoner in the Toronto Jail, an old woman, was known to have frequent attacks of asthma. Her heart had not been examined. She went to her cell in fair health and was

found dead in the morning. A post-mortem was made and the specimen was kindly given me by Dr. Richardson. It is a very typical case of mitral stenosis. The origin of mitral stenosis, as in the case of other valvular lesions, may be traced to endocarditis in some of its forms, either occurring in connection with rheumatism or syphilis, or as an independent disease. It is generally, however, the result of the more chronic form of inflammation. The condition may also be congenital. The margins of the valves unite and become very much thickened, assuming the shape of a funnel. The opening may not be larger than a shirt button-hole. Cartilage is sometimes found in the segments.

I wish, however, particularly to speak of the diagnosis of this condition. Is it possible in all cases where it exists to diagnose the presence of a contracted mitral? This must be answered in the negative. There are cases in which it is not possible, by any means at present at our disposal, to make out this lesion until we find it in the post-mortem room. There are, however, many cases in which the lesion is overlooked, either from carelessness or ignorance on the part of the examiner. It may be stated as a general rule that in all cases where the præ systolic murmur is present there is contraction of the mitral valve. The exceptions have been so few that they do not invalidate the rule.

If the præ systolic murmur is present, can it be easily distinguished from other heart murmurs? In the great majority of cases it can be easily made out. Its peculiarities are, 1. The roughness of the sound; 2. Its being heard over a limited space at the cardiac apex; 3. Its relation to the ventricular systole; 4. The peculiar thrill which frequently accompanies it. It is distinctly præ systolic in character, and ceases at the commencement of the systole. This can be proven by placing the finger on the carotid artery, when it will be found that the sound ceases at the moment the pulsation is felt. In some cases the sound ceases before the ventricle systole, and there is a distinct interval between the two sounds.

Some authorities, Guttman for instance, makes a division of the murmur into two

parts. The one which terminates before the beginning of the systole he calls the diastolic; that portion of the bruit which ends at the commencement of the first sound he calls the præ systolic. When the murmur begins shortly after the end of the second sound and leads up to the first, it is termed the diastolic præ systolic. In most cases a difference in quality is noticed between the diastolic and præ systolic portions, the latter being much harsher and louder than the former. Both portions are louder and more distinct when the force of the heart's action is increased.

Various explanations have been given of the mechanism of this sound. The firmitus which generally accompanies this murmur is explained by Dr. Fagge in this way:—"The jet of blood in which the murmur is generated, entering the flaccid empty ventricle impinges on its inner surface at a point which must be very close indeed to the part of the ventricle which strikes the chest wall and produces the heart's impulse. The physician may thus almost be said to receive with his finger the full shock of the sonorous jet propelled into the left ventricle through the narrowed mitral orifice."

It is probable that the sound itself is produced partly by friction of the blood with the walls in passing through a narrowed orifice, and partly by valvation of the segments of the valve.

The other phthisical signs of mitral stenosis are dependent on the changes which take place in the heart. These changes are dilatation of the left auricle and hypertrophy of the right ventricle. As a result we have the area of cardiac dulness increased upwards, and to the left side as well as to the right side. These percussion signs may be of service in cases of mitral stenosis without præ systolic murmur.

There are two principal points to be attended to in treatment, first, the avoidance of severe exertion. On account of the obstruction the greatest work is thrown upon the walls of the left auricle, and if time is not allowed a compensatory increase of muscle fibre, rapid dilatation takes place which soon brings about a fatal result. If, on the other hand, there is an increased strength of the auricle walls, sufficient force may be supplied to compensate for the abatement.

On the same principle, digitalis is of great value. Its well-known action as a cardiac tonic would recommend its use in this condition. It was given with benefit in all the cases which I have treated. In combination with ammonia, it is of great service in cases of sudden congestion of the lungs.

Selections.

THE TREATMENT OF ACUTE RHEUMATISM.

Prof. Pepper, in a clinical lecture on Acute Rheumatism, concluded with the following remarks upon treatment:—

In regard to remedies. If the tongue is heavily coated, urine very dark, bowels constipated, and anorexia or even nausea present, we should give a short course of calomel and soda. This should be continued for a couple of days, until the bowels have been moved once or twice. If this is not called for, the patient should at once be put on full doses of salicylic acid or salicylate of sodium. Ten grains every three hours during the day and night would represent about the average quantity (sixty to ninety grains in the twenty-four hours). If the fever were high and the symptoms violent, we should give twelve or fifteen grains every three hours. This treatment should be continued three or four days, and if it is to do good it will do it in that time. Some cases will not yield to it, but in many instances it acts like a charm, and the value of this remedy in acute inflammatory rheumatism is positively established. It is not a specific and not universally valuable, but it does relieve a considerable proportion of cases far more rapidly than any other drug. If, before its administration, we place the digestive tract in a good condition, the proportion of cases in which it does good will be further increased. In the present case salicylic acid acted very nicely. The drug rarely does any harm. If it should irritate the stomach, it must be stopped.

If the salicylate has been given for several days and the fever does not subside, the pain does not pass away, and the joint inflammation is not improved, we should stop it; for, if con-

tinued, it is more apt to irritate the stomach and depress the patient than do other alkalies, and under these circumstances it is only doing the work of an alkali. We should then change to the bicarbonate or acetate of potassium, giving these in such doses and with such frequency as are indicated by the condition of the urine and the state of the stomach. Five grains of the bicarbonate with ten grains of the acetate of potassium may be given in water every three hours, and continued until the urine is more copious, lighter colored, and neutral. If a reasonable course of this treatment, continued for a week or ten days, does not cause a subsidence of the rheumatic symptoms, I abandon specific treatment and direct attention to the condition of the patient, giving quinine, strychnine, nitro-hydrochloric acid, and pepsin, to render primary assimilation as vigorous and perfect as possible. If we know anything about rheumatism, we know that it is connected with weakening of the power of assimilation. There is produced some irritative matter which, entering the system, produces these symptoms. If the derangement is so serious that the remedies I have recommended do not enable the system to react and throw off the disease, I abandon them and administer nerve and digestive tonics to improve the condition of primary assimilation. I have secured excellent results by this change of treatment in cases where, week after week, the salicylic acid and alkaline treatments have been pursued without positive benefit.

During this treatment the patient must be relieved of pain and enabled to sleep. Opium is the only drug which positively effects this. It is to be given in such doses as the state of the stomach and the intensity of the pain indicate. Very often a small hypodermic of morphia gives a longer and more complete relief from pain than opium by the mouth. Suppositories of opium may be used with advantage, as they do not injure the stomach. In many cases ten grains of Dover's powder will exert a relaxing, tranquillizing, and sedative effect, which is exceedingly happy. If the case proves at all obstinate, we should never use the hypodermic injections, from the dread that the patient may become addicted to their employment.

I never resort to hypodermic medication for the relief of pain except in the crises of acute disease, and I disguise the form of opium so that the patient may not be able to trace the relief of pain to any special drug. Subacute rheumatism is one of the affections which I have known frequently to lead to the opium habit.

We now come to local treatment. Of late years I have always begun the treatment of rheumatism with the application of a blister to the præcordia, allowing it to remain seven hours, following it with a poultice, and dressing with a simple unguent. I do this, in the first place, as a preventive measure; and, secondly, I think that I have noticed that it modified the general symptoms. I think that I have seen amelioration of the symptoms follow the application of a blister to the præcordia, even when there was no recognizable affection of the heart. I also apply small blisters, one inch by a half inch, over the affected joints, applying them to the different joints in succession. I also apply chloroform-liniment, and cover the part with oiled silk. If I do not use blisters, I rub an ointment of veratrine and iodine of mercury over the inflamed joint. The ointment may consist of thirty grains of veratrine and forty grains of the protiodide of mercury to the ounce of cosmoline.

If endocarditis appears in the course of rheumatism, I abandon whatever treatment I may be employing and again apply a blister to the præcordia, if that is not still sore. Internally I administer calomel, opium, and digitalis. When I have given as much calomel as I think proper, I substitute iodide of potassium and digitalis. The relief of the cardiac inflammation and the preservation of the integrity of the heart are of vastly greater consequence than the mere control of the joint-trouble; in fact, the patient has to remain quiet so long, until the heart has entirely recovered, that it makes little difference whether or not the joint remains inflamed a few weeks longer.—*Med. Times.*

The story comes from the West of a man so tenacious of lucre, that when he swallowed a five-dollar gold piece, the stomach pump could only bring up \$4.50.—*Boston Med. and Surg. Jour.*

TREATMENT OF LACERATIONS OF THE OS AND CERVIX UTERI WITHOUT SURGICAL OPERATION.

Dr. B. Brown, of Alexandria, read a paper with this title, at the recent meeting of the Medical Society of Virginia, and said that the value of Emmet's operation was acknowledged, although it was sometimes risky; but many women were so situated that they could never enjoy its benefits. Ten or twelve years' experience with some twenty cases had convinced Dr. Brown that these patients could be cured, without a surgical operation, by a simple, painless, safe, and easy plan of treatment which could be used by any practitioner. The nature of his cases had varied from trifling fissures to the most severe lacerations, and sterility had invariably co-existed. Many cases were complicated by cellulitis, localized peritonitis, subinvolution, metrorrhagia, displacements, proctitis, etc. In every case the general health was impaired. There were peculiar neuralgic pains in all those nerves coming within the circle of sympathy of the exposed and lacerated nerves of the os uteri. Thus, the great lumbar plexus manifested its sympathies in the form of constant aching pain in the base of the sacrum. Ovaralgia on the side of injury, or on both sides, if the injury was double, was almost invariable. In a few cases the development of sciatica indicated reflex sensation on the part of the sciatic nerves. Neuralgia of the crural nerves and their branches was common. These pains extended to the patella, and even down to the dorsum of the foot. Dr. Brown had healed several cases of laceration by first intention in the acute stage by means of absolute rest, disinfection, and cleanliness. If lacerations failed to unite immediately after labor by first intention, they never united spontaneously by second intention. Local treatment then became necessary. Dr. Brown always examined the womb, etc., for lacerations as soon as labor was completed; and, if found, he began, after the first twenty-four hours, a systematic course of treatment with a view to absolute disinfection and cleanliness. Warm douches of solutions of borax, boric acid, and carbolic acid were gently used two or three times daily, and the patient was kept in

the recumbent position for two weeks. If healing did not occur by that time, it did not occur afterward spontaneously. Eight or ten weeks later, in such cases, he proceeded to procure union by the second intention. For this purpose he had used carbolic acid, chromic acid, Battey's solution of carbolic acid and iodine, solid nitrate of silver, and even nitrate of mercury, but without favorable result. The nitrate of silver increased the inflammation, pain, and tendency to hæmorrhage. He then adopted graduated solutions of crystals of nitrate of silver with the best of results. Solution No. 1 was as follows :

R Argenti nitratis, cryst., ʒ ss. ;
Aquæ destillat., f ʒ j. ℥.

This solution was to be applied to the interior of the cervical canal freely, down to the os incernum, as the cervical canal was always involved in the rent and was left in a diseased condition. Solution No. 2 was :

R Argenti nitratis, cryst., ʒ ijss. ;
Aquæ destillat., f ʒ j. ℥.

This solution was to be applied with a camel's-hair brush freely over the entire external surface of the os and cervix, including the fissure of the laceration, until a uniform white coating was formed, thick and tenacious, almost resembling a coat of paint. This gave immediate protection to the supersensitive extremities of the exposed nerves and tender granulations, and acted as a sedative application—allaying irritation, redness, inflammation, and engorgement rapidly, stimulating new vital action and healthy growth of granulations which filled up the fissures or cavities of the lacerations, and accomplished the healing of the wound by second intention. This coating, in the meantime, formed an impervious barrier to the further absorption of septic matter from the discharges, and in this way relieved pelvic cellulitis. The healing process and reduction of hypertrophy of the cervix and inflammation progressed rapidly. The process of absorption was stimulated in a wonderful manner, and the process of involution was also promoted in proportion. In simple fissure of the cervix, extending through the mucous membrane and fibrous tissue only partially, solution No. 1 should be applied

thoroughly in the groove of the fissure, so as to reach its very bottom, and thus induce healing from the lowest depths of the wound ; otherwise the object would be defeated. Solution No. 3 was :

R Argenti nitratis, cryst., ʒ jss. ;
Aquæ destillat., f ʒ j. ℥.

This solution was only to be applied to the external surface of the cervix in the event hypertrophy and induration remained after the lacerations had healed ; otherwise, if left in that condition, it formed a basis for the renewal of inflammation and re-opening of the wound. After treatment, the cervix became naturally soft and normal in dimensions. The os was not only not contracted by the application, but returned to a perfectly healthy condition. A great majority of females thus treated had since borne from one to three children, and had been entirely free from all uterine troubles. In three patients—one having borne three children, the second two, and the third one child after treatment for previous lacerations—the os uteri was found perfect as to softness, dimensions, and freedom from disease. Concealed fissures were often found after labor in the mucous membrane of the cervical canal, and caused an infinite amount of local disease, such as endocervicitis, hypertrophys of the adjacent tissues, inflammation of the fibrous tissues of the cervix, leucorrhœa, and often painful menstruation. A favorite locality for these fissures was at the internal os. The mucous membrane and sub-mucous tissue were split through, and then the rent remained a source of trouble for years. The No. 1 solution of nitrate of silver reached these wounds admirably, and would surely heal them from the bottom.—*N. Y. Med. Jour.*

MENTAL ALIENATION IN FEMALE PHYSICIANS.
—According to the *Lyon Medical*, the number of women practising medicine in England in 1881 was twenty-five. From 1880 to 1884 eight had been placed in Asylums, and at the end of last year three were under treatment. In the same country one out of every seven hundred physicians or clergymen became insane. Among lawyers the proportion was one in a hundred.

R. Z.

A CASE OF HYSTERECTOMY IN WHICH
REMOVAL OF THE APPENDAGES
HAD FAILED TO ARREST THE
HÆMORRHAGE OR GROWTH OF
THE TUMOR.

BY LAWSON TAIT, F.R.C.S.

Mrs. A. P., aged 40, was placed under my care by Dr. Lycett, of Wolverhampton, in January, 1882. She had a large myoma, which caused persistent hæmorrhage. For its treatment, I proposed the removal of the appendages, and proceeded with this operation on January 4th, 1882. I removed the left tube and ovary, as I thought at the time, completely, but the right tube and ovary could nowhere be found, although I extended my incision to the extreme length of eleven inches and a half, and pulled the tumor right out of the abdomen. Still, I could not find any trace of the ovary or tube on the right side. I replaced the tumor, and the patient made an admirable recovery. But neither the growth of the tumor nor the recurrence of menstrual hæmorrhage were in the least degree affected by that operation. In March, 1884, she again came under my care for the purpose of having the tumor removed. It had increased to quite three times the size it was in 1882, and her condition was that of extreme debility and anæmia from hæmorrhage. I opened the abdomen on March 25th, for the purpose of removing the tumor; but the hæmorrhage was so terrific from the adhesions which had to be separated, that I desisted, and closed the wound. The patient went home in about three weeks, with no other hope before her than that of a speedy death. She was one of the thirteen cases of which I spoke to the British Gynæcological Society a few months ago, which then were known to me to be in progress of death from bleeding myomata. The only remaining interest which I had in the case was the expectation of having a *post mortem* examination, to discover, if possible, why my original operation had failed.

One day early in August, I happened to be in Wolverhampton, and called to see how the patient was, and, to my surprise, found her still alive, and able to get about in a sort of fashion, with the hæmorrhage still going on,

and certainly no kind of improvement effected in her condition. The tumor had grown until it occupied the whole abdomen, and interfered very much with her breathing. The patient was extremely thin, and of a most ghastly white color. She is a woman of remarkable pluck, and when I suggested to her that, if she liked, I would try the operation of removal of the tumor once more, explaining to her that I would complete the operation, no matter what it cost, she yielded a ready consent. Therefore, again on September 5th, assisted by Mr. J. W. Taylor, I succeeded in removing a tumor somewhere about forty pounds in weight. The adhesions were all in front on the line of the old incision. The tumor itself proved to be, as I had all along suspected, one of the large soft œdematous myomata, occupying the anterior wall of the uterus, the cavity of the organ lying quite behind it, and measuring nine inches long, and three and a half inches wide at the base. After removal of the tumor, about four quarts of serum exuded from it in the course of a few hours. The pedicle was broad, but easily secured by a clamp. The patient has made a rapid and easy recovery.

Very careful examinations of the tumor were made independently by Mr. Taylor and myself, and we came exactly to the same conclusions, which are as follows: That there was no aperture on the right corner of the uterus, and that there was no trace of the right ovary or tube. The aperture on the left corner of the uterus was large enough to admit a No. 5 catheter, and there was no more than two inches of the left Fallopian tube outside, which had not been removed at the original operation. No trace could be discovered of the left ovary. This ovary, fortunately, I had preserved, and, when I re-examined the organ which had been removed on January 4th, 1882, I found that its removal had been quite complete, but that only about one inch of the outer part of the Fallopian tube had been removed with it. Here, then, we have an extremely curious condition. The appendages on the right side were congenitally absent. The failure of the removal of uterine appendages to arrest the growth of this tumor had always been regarded by me as due to the fact that the tumor was one of the soft œde-

matous myomata, and the case is alluded to in my recent paper in the *British Medical Journal* as No. xxv., and as being the only real failure in my experience up to the time included in that paper. Now, the evidence is to the effect that the failure was due, not to the peculiar nature of the tumor, but to the fact that I did not completely remove the only Fallopian tube which the woman possessed. In speaking of cases of myoma, I have repeatedly alluded to three cases in my experience where I have failed to arrest the growth of the tumors by removal of the appendages. In all three cases, I have regarded the reason of this failure as being due to the nature of the tumour, that of the œdmatous myoma. In this, the first of the three cases in which I have had an opportunity of verifying the accuracy of my opinion, my view of the tumor has been correct, but it seems to me far more probable that the failure of my first operation was due to the incomplete removal of the tube, than to the intrinsic quality of the tumor. I need not point out that this case goes a long way to show that removal of the ovaries has nothing to do with the brilliant results of these operations for bleeding myoma. As I have often said, in many cases I have deliberately left the ovaries, and yet success has been perfect. In this, the ovary was absolutely removed, and the operation failed. This case is one of thirteen patients who were in the process of death from myoma, to whom I alluded in a speech made to the British Gynecological Society. I hope to be able still further to reduce the list after such an encouraging experience.

I have just received a letter from my friend Dr. Keith, in which he tells me, to my intense delight, that he has been able successfully to remove another from this list of impending fatalities. I have not the slightest doubt that, in every one of those thirteen cases, if the operation were done under the improved methods of Dr. Keith, we should have a successful result. But, unfortunately, the patients shrink from the proceeding from which alone they can derive any prospect of benefit.—*Brit. Med. Jour.*

IRREGULAR SEXUAL DEVELOPMENT.

Two recent studies in our German exchanges give much food for reflection to the physiologist and the social philosopher.

One of these is by Dr. Geigel, and has for title, "The Variability in the Development of the Sexual Organs in the Human Species." The other is an opinion by Dr. Scholtz, of Bremen, in the case of a middle-aged man, who had long been subject to abnormal sexual desires.

Dr. Geigel has once more subjected the growth of the fœtus in utero to a careful study, with the view of ascertaining what it is that decides on the sexuality of the child. His results are in certain respects negative. His conclusion is that there is no room for a simply mechanical explanation of the fact of sex. He says: "We must content ourselves with saying that in every embryo there is an inherent tendency, the plus or minus of which decides its sexual evolution."

But there is one new fact which he brings out strongly, and that is the slow and imperfect manner in which in some cases both the sexual organs and their correlated sentiments are developed, not only in the fœtus, but in after life. "The whole term of life," he remarks, "is often insufficient to develop the sexual contrasts which theory demands." Some men remain largely women, some women largely men, their whole life through. There is an emotional and intellectual hermaphroditism where there is no physical one.

At this point we may turn to Dr. Scholtz. In his specialty of medical jurisprudence he explains the perversity of the sexual instincts in certain cases by this undeveloped sexuality. "My observations have convinced me," he writes, "that in such cases the crime of pederasty is not merely a disgusting habit, or the refinement of debauchees, but a congenital abnormality of the sexual instinct; an abnormality which very often is revealed in a general physical condition approaching that of the female type."

Such cases he would consider as of inborn mental alienation, and thinks their proper place is in the wards of a hospital, or under medical

FLATULENCE.—Bartholow states that hysterical flatulence can often be promptly relieved by 5 to 10 drops of ol. cajuputi.

surveillance, rather than in the criminal dock.

Doubtless, their scientific aspect is such as he describes. But the social economist may well inquire whether a criminal punishment even in such cases is not better, as the fear of it will serve to stimulate the weak will-power of the feeble-minded, and will also be more of a terror to the deliberately perverse. For ourselves, we think it would be better, here as elsewhere, to punish the insane than to afford the sane an excuse to escape the proper chastisement for their crimes.—*Medical and Surgical Reporter*.

ATONIC DYSPEPSIA IN BALTIMORE POLYCLINIC.

BY G. J. PRESTON, M.D.

The service at the Polyclinic has been quite large during the past few months, and a number of interesting cases have presented themselves. Of course in a general dispensary there are certain diseases which become monotonously frequent, and it is necessary for various reasons to adopt a certain standard treatment for them. With this view various experiments have been made in the treatment of Atonic Dyspepsia, which is by far the most common form of indigestion met with at the Polyclinic.

The alkaline treatment, even in cases where acidity was marked, was soon discarded as being only temporary. Sometimes the combination of a simple bitter, as tincture of columbo with soda bicarbonate, acts well for a time. Pepsin has proved of little value in adults unless given in quantities larger than most dispensaries can afford, or than a patient will take.

The most generally useful drug is strychnia in the form of tincture nux vomica. This can be given in much larger doses than it is prescribed. For many of the cases the initial dose was gtt. x to xx t. i. d. with as much acid hydrochlor. dil. This given before meals in cases where the normal acid is in excess, and after meals where it is deficient in quantity is of inestimable service. It is by no means a new treatment, but after a somewhat careful and extensive experience with it, it has proved the most satisfactory.

In some of these cases where, in addition to

the ordinary symptoms, there is pain, a very good plan is to add to the above, m i to iii of acid hydrocyanic, dil.

This drug seems to have a peculiar sedative action upon the terminal nerves of the stomach, and will be found useful in various painful affections of this organ.

Many of these cases improve rapidly on iron and the best way to overcome the unpleasant effects which often prevent its use is by combining gr. x of pot. brom. with gtt. x to xx of the tincture of the chloride. — *Maryland Med. Journal*.

A DANGER FROM DRAIN VENTILATION.

Although sanitarians thoroughly realise the danger from this source, yet the average physician is very apt to overlook it. Hence we reproduce the remarks of Dr. John C. Thorowgood from the *Lancet*. He says:

"Not long ago, when attending a young lady with ulcerated throat, I heard of a family several members of which were for a long time ill with troublesome ulceration of the throat, the cause of which was for a time a mystery. It was at last found out that the ventilating pipes in connection with the drains of an adjoining building were not carried up above the roof, the result of this arrangement being that sewer gas found its way into the dwelling of the patients by the upper windows. Now, when so much is being done in the way of drain ventilation, it becomes obviously a most important matter for the ventilating shafts to be carried well above all windows that may be in proximity. In the heavy air of a town it is especially important to let the gas escape at an altitude where there is some air current to blow it away." — *Medical and Surgical Reporter*.

THE USE OF VAGINAL INJECTIONS AFTER NORMAL CHILD-BIRTH.

Dr. Simon Baruch, who has studied this question very thoroughly, thus concludes an article in *Gaillard's Med. Jour.*:

If the obstetrician will never introduce an examining finger into the parturient canal without brushing the nails and washing the hand

with an antiseptic solution—if he will be careful to make his examinations rarely—if he will *express* the placenta completely by Credé's method and *extract* the membranes without haste—if he will ensure complete expulsion of all coagula and tonic contraction of the uterus—if he will *see to it* that the vulva has been well cleansed of all clots and stains by an antiseptic solution (not with a sponge), and that it continues to be kept clean—if he will have clean napkins, sprinkled on the outside with some strong antiseptic solution, placed upon the external genitals, and if the nurse's hand be strictly kept out of the vagina, the demands of modern midwifery will be fulfilled, and "all will go merry as a marriage bell," so far as puerperal fever is concerned.—*Medical and Surgical Reporter.*

GALL STONES.—Dr. Quisling states (*Tidskrift for Prakt. Med.*), that in seven cases of gall stones—two men and five women—he has seen good results follow the use of Martin's elastic bandage. Its action depends on the immobilization of the abdominal organs, by which the calculus is prevented from irritating the mucous membrane, and from causing reflex contractions of the muscular wall of the bladder. The bandage is applied rather firmly over the upper edge of the hepatic dulness, as far down as the crest of the ilium, a piece of flannel being placed under it. It may be removed at night, if desired, by the patient. Its use should be persisted in until the patient appears to be definitely cured.—*London Med. Record.*

ICE TO THE SPINE IN OBSTINATE VOMITING.—Dr. Wm. L. Davis reports a case of vomiting in typhoid fever, in which every remedy, even pellets of ice, was rejected by the stomach. He applied ice to the lower part of the spine in considerable quantity, and the vomiting instantly ceased and a profuse perspiration followed. The use of ice was only persisted in when indicated, and cool sponging was instituted with marked benefit, so that the ice was only occasionally required. Recovery in the average time took place.—*Mississ. Valley Med. Monthly.*

HYDROCHLORATE OF COCAINE IN THE VOMITING OF PREGNANCY.—Weiss, of Prague, has used this remedy successfully in a case of vomiting of pregnancy which had resisted all previous attempts at relief. The patient was weak and anæmic, of a nervous disposition, and had suffered in three previous pregnancies with persistent vomiting: in her present pregnancy her condition was serious. Weiss prescribed:

℞ Hydrochlorate of cocaine gr. ii.

Alcohol, enough to dissolve.

Water ʒv.

Sig.—One teaspoonful every hour.

After the sixth dose three tablespoonfuls of milk were well borne: after the eighth, a cup of broth with egg, without vomiting. After the sixteenth dose the patient ate with relish chicken broth, slices of white chicken-meat, and drank a glass of wine, without vomiting. The drug was then withdrawn for a time, owing to an increased frequency of pulse and respiration; but hourly doses were subsequently given with the result of entirely checking the vomiting and enabling the patient to regain her former strength.—*Boston Med. and Surg. Jour.*

Therapeutical Notes.

IODOFORM AGAIN.—One-third of its weight of powdered coffee is said to effectually disguise the odor of iodoform.

FOR ULCERATED ZONA.—

℞. Liniment, oleo-calcaire 500 gr.

Acid boric o.g. 50c.

Skullcap (*scutellaria*) is highly recommended by Dr. Wimmermark, in the *New York Record*, for enuresis. To a child, aged twelve, he gives ʒi of fluid extract t. i. d.

The *Lancet* says that iodoform may be rendered inodorous by adding 1 part of sulphate of quinine and 3 parts of charcoal to 100 parts of iodoform.

OINTMENT FOR PHLEGMASIA.—℞. Pure lard, 30 grains; extracts of opium belladonna, hyoscyamus and conium, of each 3 grains. Mix. Rub over the inflamed veins.—*Bullet. Gén. de Therap.* R. Z.

NASAL ASTHMA.—Dr. G. Hunter Mackenzie, in the *British Medical Journal*, finds nasal bougies containing one-twelfth to one-sixth of a grain of extract of belladonna the most efficient remedy. He applies one night and morning.

FEVER THIRST.—Surgeon-Major S. K. Cotter, of the Indian service, recommends painting the tongue with glycerine in cases of typhoid fever with dry and parched tongues covered with sordes.

FOR BALDNESS.—Bartholow uses :

Ext. pilocarpī fl. ʒi.
Tinct. cantharid. ʒss.
Lin. saponis. ʒiiss.

℞. Sig.—Rub into scalp thoroughly daily.

CODEINE AND ITS SALTS.—Schencider recommends large doses, a grain and a half to three grains, to produce sleep and as a substitute and palliative for morphine habitues. In these cases he gives a grain and a half every three hours. —*Northwestern Lancet.*

FOR IMPOTENCE. (Bartholow).—

℞. Ext. cannabis ind gr. x.
Ergotin (aq. extr.) ʒ ii.
Ext. nucis vomica gr. x.
Ft. pil. No. xx.

Sig.—One morning and evening.

SPECIFIC CATARRH. (Bartholow).—

℞. Sod. Iodid gr. x.
Syr. picis ʒii.

Sig.—Ter die.

Et. ℞ pil. ferri iod. (U. S. P.)

Sig.—One daily.

Bartholow states that he has better results from the combination of potassium, bromide and digitalis in the spermatorrhœa of plethora than from any other remedies. (Wouldn't ʒi magnes. sulphat, three times a day, be efficient?—ED. PRACTITIONER.)

LUBRICANT IN OBSTETRICS.—Dr. S. H. Owen recommends the following as an antiseptic lubricant for fingers and instruments in midwifery:

℞. Hydrarg. Perchlorichi gr. ij.
Olei eucalypt ʒi.
Adipis benz. ʒi.

LOTION FOR ERYSIPELAS. (Rothe).—

℞. Carbolic acid, tinct. iodin. and
alcohol āā ʒ gr.
Spirit turpentine 10 “
Glycerine pur. 25 “

℞. Apply every two hours with a soft rag or sponge.

IODOFORM POWDER FOR CANCER.—

℞. Iodoform 18 grains.
Quinine sulphate 3 “
Essen. Menth 40 ℞
Charcoal powder 15 grains.

℞. Apply to the ulcerated parts.

TO DISGUISE THE TASTE OF MEDICINES.—Bitter and nauseous salines are best taken simply diluted with ice water. A mouthful or two of iced water, before or after the dose, to blunt the sense of taste, and the dose between them in a wineglassful of iced water, renders it easily taken by most people.

FOR BUBOES. (Taylor).—

Cryst. carbol. acid gr. vii.
Distilled water ʒi.
Alcohol q. s. to dissolve.

Ten to twenty drops are injected deep into the bubo, whether inflammatory or specific. According to the author, pain and inflammation rapidly disappear.

COUGH OF FIBROID LUNG.—Dr. Hawkyard, of Leeds, writes in the *London Lancet*, of Aug. 22nd, that Bonjeau's ergotine ensures a good night's rest with little or no cough, and expectation somewhat lessened, in cases of fibroid lung. He usually prescribes a draught containing four to six grains, or gives two grains hypodermically. All other preparations of ergot have been of little or no use.

SALICYLIC LEMONADE IN FEVERS.—

℞. Fruct. Lincn. No. 10.
Acid Citric ʒ ss.
“ Salicylic 200 grs.
Sacch. alb., aqu. āā q.s.

Squeeze the lemons and put the juice aside; boil the fruit in half or three quarters of a gallon of water fifteen or twenty minutes. After

standing six hours, take out the lemons and again press them before throwing away. Add the juice and citric acid to the liquid, boil five minutes and strain. While hot add the salicylic and stir. Sweeten to taste, and make up to one gallon.

THE
Canadian Practitioner.
 (FORMERLY JOURNAL OF MEDICAL SCIENCE.)

TO CORRESPONDENTS.—*We shall be glad to receive from our friends everywhere, current medical news of general interest. Secretaries of County or Territorial Medical Associations will oblige by forwarding reports of the proceedings of their Associations.*

TO SUBSCRIBERS.—*Those in arrears are requested to send dues to Dr. W. H. B. Aikins, 68 Gerrard St. East.*

TORONTO, NOVEMBER, 1885.

CANADIAN MEDICAL SCHOOLS.

The winter sessions of the Canadian Medical Schools were commenced on the 1st of October, and the regular work has been continued since. On comparing this with former sessions, there is nothing very striking to note. The numbers appear to be steadily increasing from year to year, probably to a greater degree than the wants of the country demand. Many ask, What will become of them all? The question is not very new—in fact, it has been asked so often of late years that we would gladly answer it if we could, to prevent needless repetition. As far as pecuniary considerations are concerned, there is no doubt that the physicians of Canada have fully their share of this world's good things. When we look at other professions or occupations, we can find no one which is more certain to bring in a fair yearly income to a conscientious worker than the practice of medicine. Apart from this aspect of the question, there is much connected with the grand and comprehensive study of medicine which is certain to draw within its folds many earnest students. As medical graduates in the past have, as a rule, succeeded, and attained a position among the most prosperous and influential of our inhabitants, we see no reason why

they should not be equally successful in the future.

As far as medical education is concerned, Toronto holds a very high position in our Dominion. It attracts more English-speaking students than any other of our cities, and the numbers are increasing very rapidly. During recent years both of our schools have been compelled to make extensive additions to their buildings, and yet they are even now full to overflowing.

THE TORONTO SCHOOL OF MEDICINE.

The opening exercises of the Toronto School of Medicine took the form of a conversazione, which was given by the Faculty on the occasion of the opening of the new wing, to which we made reference in our last issue, and was in all respects a successful and brilliant affair.

The opening address was delivered by Dr. W. W. Ogden, and was highly appreciated by those who had the good fortune to get into the overcrowded lecture-room. After the lecture a concert was given under the direction of Professor Theodore Martens, which was all that could be desired.

The various new rooms in the recent additions, which were made unusually attractive by the beautiful decorations which had been arranged by students and ladies interested in the school, were much admired.

The number of freshmen registered this year exceeds considerably that of any former session. Both teachers and students are delighted with the new condition of things. The capacity for laboratory work and practical work of all kinds is greatly increased, and the great utility of such increase, in the light of modern teaching, can scarcely be overrated.

TRINITY MEDICAL SCHOOL.

The opening lecture for the session in the Trinity Medical School was delivered by Dr. Covernton, and well received by the large audience assembled, including the students, among whom the doctor is deservedly popular. A conversazione was also held on the evening of the 1st of October, which was well attended, and was exceedingly successful. The number of freshmen is large, and the school will be very full this session.

THE WOMAN'S MEDICAL COLLEGE.

Dr. Krause delivered the opening lecture for this modest but worthy institution. The number of *Freshmen* is less than that of either of its big brothers in Toronto, but the school is on a firm basis financially and otherwise.

M'GILL MEDICAL COLLEGE.

A large addition was built to the school building this last summer, which was formally opened October 22nd, when Professor Osler, of Philadelphia, delivered the opening lecture. The worthy and able doctor received a hearty welcome from his old students and many friends in Montreal.

A dinner was also given the same evening, which was a very successful and enjoyable affair.

We regret that this excellent institution should have suffered to any extent from such a cause as the existence of small-pox in Montreal, but are pleased to be able to state that it is not affected so much as was at one time expected; and the number of students is about equal to that of last year in the aggregate, while the number of freshmen will be somewhat smaller.

KINGSTON MEDICAL COLLEGE.

Reports from Kingston say the Royal College of that city is in a flourishing condition, and has a large class of students. This worthy old school has had some reverses in the past, but it has come through them all with flying colors, and stands to-day stronger than ever.

THE WOMEN'S MEDICAL COLLEGE OF KINGSTON.

Dr. Anglin delivered the opening lecture for the session, October 11th.

WESTERN UNIVERSITY—MEDICAL DEPARTMENT.

Considering all the circumstances connected with the formation of this school, its success has been very encouraging. The difficulty of giving clinical instruction with an hospital so far removed from the school building is a serious drawback. It has, however, a good staff, and is situated in the centre of a very flourishing country, and must eventually succeed.

MANITOBA MEDICAL COLLEGE.

The opening lecture of the Winnipeg Medical School was delivered, October 1st, by Dr. N. H. Ferguson, Professor of Physiology, who gave a history of the college, with reasons for its establishment, and discussed the present prospects of its ultimate success. In its first session, 1883-84, there were 15 students; last session, 22; and this year there are over 30.

OUR SUPPLY OF VACCINE VIRUS.

The prevalence of small-pox in Montreal has had a good effect throughout the Dominion by showing the great importance of vaccination. As vaccination is not compulsory, in the proper sense of the word, people are very apt to grow careless about the matter until danger grows imminent.

It has become the custom among nearly all physicians in this country to use the bovine to the exclusion of the humanized virus; and, indeed, we have educated the public up to the point of refusing, as a rule, to have the latter used. The question is, however, by no means one-sided, and some arguments may be adduced in favor of using the humanized vaccine, as was the custom a few years ago. We have no intention of entering into a discussion of this subject now; but a few in this city are commencing to think the results were more satisfactory under the old system of vaccination than they have recently proved under the new.

The physicians of Canada have to depend, as a rule, upon the material sent here from various firms in the United States, most commonly on ivory points or quills. The results have generally been fairly satisfactory, while occasionally they have been quite the reverse. The best results have been obtained from the points of the Lancaster farm, and the quills of the National Vaccine Establishment at Washington. Some think the Provincial Board of Health in Ontario should have an establishment under their supervision. Some time ago they had the matter under consideration, but as they thought we could obtain plenty of good virus from the Americans, they decided not to recommend the scheme to the Government. It is not improbable that they may reconsider their decision, and advise the formation of an Ontario vaccine farm.

ENGLISH HOSPITALS.

From the educational number of the *British Medical Journal* we can get a great deal of information about British medical teaching and examining bodies. The fees in some of the London hospitals are high. The composition fee for all lectures and hospital practice required by examining boards in St. Bartholomew's, St. George's, and University College is for each six hundred and fifty dollars. The lowest fee in London is that of the Charing Cross and the London, viz., four hundred and seventy dollars. In all cases the hospital and medical school are under the same management.

The London Hospital has 800 beds; St. Bartholomew's, 750; Guy's, 695; St. Thomas', 572; St. George's, 351; University College, 200; King's College, 170.

St. Bartholomew's will furnish a fair example of how they are divided. There are 227 beds for medical cases, 353 for surgical, 26 for diseases of the eye, 20 for diseases of women, and 75 in the Convalescent Hospital at Swanley.

The *British Medical Journal* is not satisfied with the position of London as a centre for advanced medical teaching. It says: "There is a constant stream of men still young, or in early middle age, returning to London on furlough. It is, unfortunately, too true that men of this class can find but few openings to turn their leisure to good account." After discussing the matter at length, it closes its article as follows: "Meanwhile, cannot some effort be made to put the advantages which already exist more prominently forward, and to fill up the vacant places? The matter is eminently one for the consideration of the teachers and men of scientific attainments in the various departments. The want of funds is, no doubt, one of great difficulty; but the want of organization and concentration of thought and work is greater. If a satisfactory scheme for the formation of biological laboratories for advanced students were drawn up and put before the profession, there would be a something to point to, and it is quite possible, nay certain, if sought in the right way, that funds would be found."

TESTIMONIALS TO COMMERCIAL ENTERPRISES.

A correspondent in this issue directs attention to the custom of giving indiscriminate testimonials to commercial enterprises, which is becoming far too common. Many practitioners appear willing, through pure good nature, to lend their names to any parties who choose to ask for them. Many think that physicians should not under any circumstances give such testimonials, and make it a rule to refuse all applications for them. These certificates become altogether too cheap when they are to be had simply for the asking. With all due deference to our correspondent, we may say that the custom of refusing them is not so well observed, even in the old country, as it might be.

Apart from the ethical aspect of the matter, the custom appears much worse when certificates are given for articles which are practically worthless. We will not follow our correspondent in his discussion of the value of any particular compound, but have only to add that the possibility of giving a certificate which might deceive the public should put all physicians on their guard in this particular.

MEDICAL EDUCATION IN CANADA.

In many respects we are making rapid strides in improving the character of our medical teaching in Canada. It is becoming more practical in many ways, but especially in the increased amount of work done in laboratories, and the better methods of imparting clinical instructions in our hospitals and dispensaries. The Canadian student who takes full advantage of all the facilities placed at his disposal, sees less that is new to him when visiting foreign countries than he did under the old regime.

At the same time we have to regret that so many men show such an anxiety to complete their course in three sessions in our schools. As a rule the fourth year spent with a medical practitioner is little better than a farce, and the three years students are compelled to resort to a system of injudicious cramming in preparing for their examinations.

The Ontario Medical Council made strenuous efforts to enforce four years' attendance in lec-

tures in recognized schools, but the course adopted by some of the institutions in Great Britain in allowing our three years graduates to go up to their examinations, has seriously crippled their laudable attempts to advance the standard of medical education in this province.

It is a strange incongruity, and a lasting disgrace to the old country, that such a condition of affairs should exist, and we would like to see some of our Ontario universities follow the example of Toronto and McGill Universities in adopting and thoroughly carrying out the four years' system.

ONTARIO MEDICAL ACT.

Dr. Burns, the representative for Midland and York, has called a meeting of the physicians in the Division to be held in the Medical Council Chamber, Toronto, Thursday evening, Nov. 12, at 8 p.m., for the purpose of considering the proposed amendments to the Ontario Medical Act.

It is intended at the same time to have a meeting of the physicians of Toronto and suburbs to decide on a regular tariff of fees to be submitted to the Council for approval, the result of which will be to legalize such tariff.

We have before expressed our opinion on this subject, which is a very important one, and will do no more now than urge the members of the profession to show an active interest in the matter, and we hope there will be a full meeting.

The following are the proposed amendments :

Firstly,—In Section VI., add,—“and provided that said colleges not mentioned in this clause must establish a medical faculty, and give lectures in each department for such a time as may be specified by regulations of the council.”

Secondly,—That all actions brought against medical practitioners for malpractice must be instituted not later than one year from the date of such so-called malpractice.

Thirdly,—In regard to proper payment of medical witnesses when summoned to give medical evidence for any court of law or equity, recommend that they should be properly paid.

Fourthly,—That we recommend the appointment of a medical man in each division to act as taxing officer for all medical accounts in dis-

pute, when so required, with similar powers to those of the taxing officers of the law society.

Fifthly,—That the council shall have power to establish a code of ethics, and in the event of any violation of the code, to punish the offender by suspension or erasure of his name from the register of the college, such action to be proceeded with by examination by the council. The same to have power to examine witnesses on oath.

Sixthly,—Security for cost in suits for damages for alleged malpractice.

The plaintiff's and defendant's private examination might be placed before a judge of one of the superior or high courts, and if the judge thought it doubtful that a conviction would be obtained against the defendant, he might order the plaintiff to give security for costs, so that if the judge at the trial dismissed the suit, or if the jury found for the defendant, the defendant would not in fact be saddled with damages: the damages here of course being his own costs, which too often the plaintiff cannot pay.

At the last meeting of the Medical Council, held in June, 1885, the following resolution was carried :

Resolved,—That the members of the several divisions in Ontario shall bring before their several division associations the amendments sought for by the Medical Council, and endeavor to secure their influence with the members of the local government, by petition or otherwise, and that the registrar be requested to have printed petitions sent to each of the representatives in this Council requesting them to obtain signatures to such petitions, and also to act in accord with the chairman of committee appointed by the council to obtain such legislation; also that a copy of the amendments sought for shall be sent to the representatives of divisions.

MEDICAL SCHOOL RESIDENCE.—The authorities of St. Mary's Hospital Medical School, recognizing the difficulty students find in selecting boarding houses near the school, have established a “residential college” in the neighborhood. This boarding house is placed under the superintendence of Dr. Robert Maguire, who is connected with the school, as warden. Each student will have a comfortable room which he may also use as a study, and he can also have the use of a large public study, a laboratory, and other rooms, together with the assistance of demonstrators of the school.

Correspondence.

To the Editor of the CANADIAN PRACTITIONER.

It has been repeatedly, and unfortunately not without some degree of justification, said that medical men can be induced to give certificates in favor of anything under the sun. The remark is most frequently made, I believe, by our cousins "of the long robe," and though prompted often, perhaps, by *ex parte* malice, the hidden germ of truth, it must be allowed, makes the inoculation rankle. Would it not be well, therefore, "in general honest thought and common good to all," that medical societies and medical schools should inculcate amongst their members the impropriety of giving certificates at all in extra-judicial matters, and more especially in favor of commercial enterprises? This is the rule of conduct in the old country, and, fortunately, is fairly well observed—at all events by the leaders and great teachers of the profession. Judge of my astonishment, therefore, to find, the other day, in picking up, in a drug store, the advertising sheet of a proprietary preparation which bore its condemnation on its face, the names of ten medical gentlemen of this city—some of whom did not hesitate to involve their school and hospital in their own disrepute—appended to certificates as to the excellence and value of "*Permanganate-Phenylene*." Now, sir, when we take into consideration the time and trouble necessary to test the worth or worthlessness of an antiseptic substance in a scientific way, we are led to wonder how those engaged in active general practice can find the time and disinterested zeal demanded by the arduous task of a micro-clinico-chemical-biological investigation of the merits of a commercial disinfectant-antiseptic. Of course these gentlemen must have determined the virtues of this old-new thing, else are the testimonials which they give of little worth, and so is justified the public stricture on the profession quoted in the beginning.

A very good authority—Dr. James A. Russell—has stated, in a scientific publication, that of carbolic acid a solution "1 in 20 is the only one fit for use in disinfection," and Baxter's experiments went to show that "no virulent liquid can be considered disinfected by carbolic

acid unless it contain at least two per cent. by weight of the *pure* acid." Weak solutions may, however, have the very opposite effect to that desired, viz., the preservation, not destruction, of the disease germ, and in illustration of this, Dougall, of Glasgow, has demonstrated that "vaccine, mixed with carbolic acid (1 in 50), regained its effective power (temporarily in abeyance) after ten days' exposure to the air." Of the value of such combinations as permanganophenylene, Dr. Russell thus speaks—and I am inclined to think "a patient study and consulting the best known authors and chemical experts" will corroborate his views:—Carbolic acid "decomposes potassium permanganate, and therefore cannot be used in conjunction with this agent or with chlorine." "Permanganate of potassium," the same authority remarks, "is a true disinfectant, oxidising and destroying contagious as well as putrid matters; but the quantity required, and the price, render its use almost impossible, for enough permanganate has to be used to destroy the medium or vehicle bearing contagion as well as the contagion itself." Moreover, "permanganate has no effect in restraining the appearance of bacteria, or preventing the onset of putrefaction." I have an indistinct recollection of certain experiments made some years ago with permanganate of potash and the stools of enteric fever which went to show that for purposes of disinfection in such cases, nearly, if not quite, equal quantities of stool and this disinfectant, weight for weight, were necessary. Is it reasonable to suppose that permanganophenylene, at fifty cents a bottle, fulfils the requirements? These are statements which, doubtless, the experiments of those who have given testimonials to permanganophenylene will enable them to confute. If not, I fear the currency of their die has been stamped, doubtless through inadvertence and want of thought, upon a scientific (!) falsehood; and their certificates, in place of being regarded, by those whose opinions they will chiefly value, as reliable testimonials to the virtue of a meritorious preparation, will run the risk of being maliciously distorted by the uncharitable into evidences simply of their own ignorance of chemistry and the subject on which they wrote. Apart from the harm which is done to a

confiding public by the sense of security engendered by false reliance on the broken reeds of proprietary disinfectants in times of epidemic, there is a personal and professional aspect to the subject,—but the moral is already drawn. Would that it were true that “a word to the wise is sufficient.”

Yours,

“Without sin” in that respect.

Meetings of Medical Societies.

HAMILTON MEDICAL AND SURGICAL SOCIETY.

At the regular meeting in September, Dr. Case, senior, presided.

Dr. Malloch exhibited a pathological specimen with the following history: He had performed abdominal section in a case of peritonitis with symptoms of obstruction of the bowels, and a history of previous attacks of colic. The colon was so much distended that it could not be returned. To relieve this distension, an opening was made with a scalpel of its own width simply, and the gas pressed out. This wound was then closed with interrupted sutures of the finest catgut. The patient only survived the operation forty-seven hours. At the autopsy, it was with great difficulty that the site of the wound could be found, for the union was so good. There were no signs of inflammation to be found and no adhesions were present about the wounded intestines.

The October meeting was presided over by Dr. White, the President.

Dr. McCargow showed the larynx of a man who was in the city hospital for but a short time. His history was as follows: He was twenty-eight years of age, had been working on the railway and caught cold. When admitted to the hospital was much emaciated; had a cold, enlarged glands, and unable to swallow. He was ill only six months. Family history was good; there was no record of either phthisis or syphilis. Post-mortem, as seen by the members, there was ulceration and partial destruction of the epiglottis. The lungs, which were unfortunately mislaid, were full of miliary tubercles. In the left apex there

was a cavity the size of an almond, and the lung was adherent. There was also softening in the right apex. The other organs were normal. Dr. A. Woolverton had seen the patient during his lifetime and noticed that he was specially anæmic, and had the characteristic appearance but not the physical signs, especially of tubercular trouble, but there was dulness of the left apex. Patient resembled more like one with typhoid fever with a slight cough. Dr. Mullin recollected a case in the hospital that was at first thought to be syphilitic laryngitis, as there was laryngeal trouble, and the patient was an old soldier. Dr. McCargow had seen suppurating kidney in similar cases.

Dr. White remembered a case taken for typhoid fever where miliary tubercles were found in the lungs and kidneys, but no suppurating cavities or foci.

Dr. McCargow then gave the history of two cases he had seen in practice of foreign bodies entering the larynx and being found in the right bronchus. The first case was that of an infant who was playing with some green coffee beans, and had some in its mouth; some one made the child cry, it was seized with an attack of coughing and strangling, and evidently from the history would likely have returns of the cough, and did. Acute bronchitis set in, tracheotomy was advised, but not permitted and the child died in two days. Post-mortem, three green coffee beans were found in the right bronchus. The second case, was that of a boy aged seven, who was running while holding a head of timothy in his mouth; he stumbled and the head disappeared; he was seized with a fit of strangling but rallied. A few days afterwards he was found to have pneumonia of the right apex, active treatment was used and the symptoms would yield and then exacerbations would occur. A cause was sought by Dr. McCargow such as an insect in the windpipe, but nothing of the sort was known of or remembered till suppuration took place and some seeds of timothy came away, the sputa being rigidly examined twice a day, then the mother remembered about the head of timothy which she had tried to remove at the time. A consultation was asked for, and the late Dr. Strange and Dr. Malloch went out to see the patient;

the morning they went to Caledonia (where Dr McCargow then was practising) the boy coughed up a foreign body, apparently the head of timothy. But as there were signs of a cavity and gurgling was to be heard, the prognosis was bad and there was not much improvement though he continued to pass seeds. Two weeks after the consultation, the body actually did come up, quite hard, divested of seeds and not macerated; it was two and a half inches long. The boy was carefully watched by his father, who, however, by mistake on one occasion gave him a dose of tinct. iodi. instead of tinct. opii.; the fetor was then relieved but not the cough, so the dose was increased; the mistake was discovered, but on the suggestion of Dr. McCargow the remedy was continued, and the boy recovered entirely.

Dr. Malloch referred to a case where a surgeon had operated in the dark and alone, and effectually, for the foreign body was loosened by the suppurative act and escaped through the opening in the larynx. Dr. Malloch himself had had two cases lately; in one a child had swallowed a piece of almond shell, but operation failed to discover it, bronchitis set in, and the child died. In the second case, the foreign body was not discovered either, but the patient recovered without inflammation setting in.

Dr. Rosebrugh related a case he had operated in. A lad of fourteen was attacked with suffocation every few minutes; the trachea was opened, during the operation he ceased breathing, and it was thought due to the chloroform, but probably was caused by the foreign body, a piece of glass three-quarters of an inch long, which was removed when the trachea was opened, in this case from the left bronchus; the boy recovered all right. He thought inversion often helped the operation.

Dr. Ryall related the case of a boy who had swallowed a piece of nut and afterwards had asthmatic attacks which lasted nine months, and ceased one day after coughing up blood and the piece of nut which was quite smooth.

Dr. Stark remembered a case where a pear-shaped glass ornament was swallowed and the breathing was interfered with, sometimes on the left, sometimes on the right. Tracheotomy was performed and the body was removed.

Dr. Mullin gave some further particulars with reference to Dr. Malloch's second case: The boy was whistling with a whistle made of two pieces of tin three-eighths of an inch square, tied together. Although never found, it had been heard before the operation, and there had been attacks of laryngeal spasm. Although the foreign body was never found, the boy has done well and the wound has healed.

Dr. McCargow called attention to the fact that when a foreign body is loose, there are always attacks of spasm.

Book Notices.

The Innervation of the Heart of the Terrapin. (Pseudemys Rergosa). By T. WESLEY MILLS, M.A., M.D.

This is a reprint from the *Journal of Anatomy and Physiology*, Vol. VI., Nos. 4 and 5, and gives the result of some careful scientific observations made in Prof. Newell Martin's laboratory at the Johns Hopkins University. Our old friend Dr. Mills is worthily emulating his eminent predecessor and teacher, Prof. Osler, in the field of science. We want more of such Canadians.

The Management of Labor and of the Lying-in-Period. By HENRY G. LANDIS, A.M., M.D., Professor of Obstetrics and Diseases of Women, Starling Medical College, Columbus; etc. Philadelphia: Lea Brothers & Co.

Having formed a high opinion of Dr. Landis from his work on "How to use the Forceps," we read this book with considerable interest, but at the same time with a certain feeling of disappointment. The manner of writing is pleasant, and the matter good; but, with the many excellent and complete treatises on obstetrics which are now available at such reasonable prices, we can see no reason for recommending such a work as this.

Poisons: Their Effects and Detection. A Manual for the use of Analytical Chemists and Experts. By ALEXANDER WYNTER BLYTH, M.R.C.S., F.C.S., etc.; Public Analyst for the County of Devon, and Medical Health Officer for St. Marylebone. New York: William Ward & Co.

This work is published in two volumes, form-

ing the June and July numbers of Wood's Library for this year. It is especially intended for the use of expert analysts, and will be found extremely valuable by them. It will also prove useful as a book of reference for all physicians. The *resumé* of the latest methods for identifying blood stains is very satisfactory. There is also added a list of the more common poisons, with directions for treatment, which are, however, too brief to be of any great value.

Acne: Its Etology, Pathology, and Treatment.
By L. DUNCAN BULKLEY, A.M., M.D. New York and London: G. P. Putnam's Sons.

One would think it scarcely possible that a work of 275 pages could be written upon the subject of Acne. When we consider, however, the frequency of the disease, and the unsatisfactory nature of its treatment in many cases, one is not surprised at the amount of attention paid to it by dermatologists. In this work the disease is treated in a most exhaustive manner, and a large amount of original work is shown. The author's reputation as a therapist is well borne out by the thorough way in which the various forms of treatment are given. We would recommend the book to all medical practitioners as one which will prove of great service to them in practice.

Diseases of the Tongue. By HENRY T. BUTLIN, F.R.C.S., Assistant-Surgeon and Demonstrator of Practical Surgery and Diseases of the Larynx, St. Bartholomew's Hospital; etc. Philadelphia: Lea Brothers & Co.

Mr. Butlin is well known as one of England's ablest Pathologists. While thoroughly scientific, he is at the same time eminently practical. During his connection with St. Bartholomew's he obtained a rich field of materials for this work; and he has certainly written a delightful book, and one which will be found extremely useful to general practitioners as well as surgeons.

He treats of injuries, inflammations, dyspeptic excoriations, ulcers, and other diseased conditions, together with tumors of all descriptions.

This work is one of the clinical manuals published by Cassell & Co., of London, and Lea, of Philadelphia, and the copy before us is in every way creditable to the American firm.

Epitome of Diseases of the Skin. By LOUIS A. DUBRING, M.D. Philadelphia: J. B. Lippincott Company.

During the last season Dr. Dubring delivered lectures (sixteen in number) before the graduating class of the University of Pennsylvania. They were reported in abstract form by Dr. Henry Wile for the *Medical News*. These reports have been collected and published in book form. This epitome ought to be of great use to students who have not time previous to their examination to read a larger work. Although the work is small, it contains a short description of all the known diseases of the skin. From the previous reputation of the distinguished author, one would conclude at once that even in a small book he would give a great deal of accurate information. We would advise all medical students to purchase the work.

On Renal and Urinary Affections. By W. HOWSHIP DICKINSON, M.D., F.R.C.P. London. (Miscellaneous affections of the kidneys and urine.) New York: William Wood & Co., 1885. Pp. 337.

This the August volume of Wood's Library, and completes Dr. Dickinson's exhaustive treatise on renal diseases and diabetes. Being issued in England early in the present year it is fully abreast with the times on all renal affections other than the various forms of Bright's disease, which are so ably treated of in Vol. I. issued in 1881. The American publishers have omitted numerous cases cited in detail in the English edition, so as to reduce the size of the work and render it uniform with the series. We regard Dr. Dickinson's works as the best that have been written on renal disease, and in the volume before us nothing appears to have been omitted or overlooked. Abscess, pyelitis-suppurative perinephritis, thrombosis and embolism, renal tumors, tubercle, hydro and pyo-nephrosis, cystic disease, renal calculi, misplacement or mobility, urinary paraplegia, parasites, diseases of ureters and large vessels, chyluria, hæmaturia and intermittent hæmaturia, suppression of urine, excess of earthy salts, and a valuable chapter on "Albuminuria, generally considered in relation to renal and other disorders," are the affections discussed in the twenty-four chapters. Sixty-three wood-cuts illustrate the work. The one hundred pages devoted to renal tumors and renal calculi are of themselves well worth the price of the volume.

Obituaries.

Dr. John L. Atlee, of Lancaster, Pennsylvania, died October 1st, in the eighty-sixth year of his age. He was widely known chiefly on account of his work in ovariectomy with his brother, the late Dr. Washington Atlee.

Dr. Richard McSherry, of Baltimore, died Oct. 7th. He was appointed Lecturer on the Principles and Practice of Medicine in the University of Maryland, in 1865. The *N. Y. Medical Journal* refers to him as a writer of considerable repute, and the author of several medical works.

Personal.

Dr. Fordyce Barker, who was recently ill, has recovered.

Prof. McCall Anderson recently paid a visit to this continent. He left New York for home Oct. 7th.

Dr. Buzzard will deliver the next Harveian lectures on "some forms of paralysis dependent on peripheral neuritis."

Drs. H. W. and W. H. B. Aikins have been appointed assistant demonstrators of Anatomy in Toronto School of Medicine.

Dr. George M. Sternberg, of the United States Army, has been elected an honorary member of the Royal Academy of Medicine, of Rome.

It is reported that Prof. Matthew Hay, of Edinburgh, has been elected Professor of Pharmacology in the Johns Hopkin's School of Medicine.

Dr. Pattullo, of Brampton, and Dr. McMahon, of Fergus, have moved to Toronto. Dr. Cochran, of the Hamilton Hospital, will settle in Toronto in November.

Births, Deaths and Marriages.

SWEETNAM-GOODERHAM.—On the 7th Oct., at the Central Methodist Church, Bloor Street, Toronto, by the Rev. Manly Benson, assisted by the Rev. John Potts, D.D., Leslie Matthew Sweetnam, M.B., eldest son of M. Sweetnam, Esq., P. O. Inspector, to Margaret Victoria, eldest daughter of C. H. Gooderham, Esq., all of this city.

Miscellaneous.

ALIENISTS.—A congress of Russian Alienists is to be held next February.

An assistant in the Halle Clinic was recently found dead in bed from an overdose of morphine, administered hypodermically.

ANIMAL LIGATURES.—Dr. Gross uses the following: Take ʒi. of chromic acid (oriptals) to ʒv. of water; of this solution take one ounce and add to it five ounces of glycerine. In this latter steep the animal ligatures for ten days, then remove and thoroughly dry them. Now for preservation keep them in a five per cent. solution of carbolic acid.

"Fano," in the *Presse Medicale*, reports a patient who put a wineglass up his rectum, necessitating its withdrawal with instruments. The moral of these cases is that people should not use drinking utensils at the wrong end. Query—Will the Scott Act prevent such transpositions?

Dr. Braxton Hicks, in the *London Lancet*, Aug. 15th, 1885, says: "The fact is, it is impossible to give an opinion worth anything as to the uterine age of a child after eight, or even seven and a half months of pregnancy, either in respect of its size or development."

Life, a western newspaper, has discovered why it is that "uneasy lies the head that wears a crown." A newly-arrived chiropodist from the old country announces himself as corn-doctor to the Court of Germany, and tells us that he has removed corns from several crowned heads of Europe.

REMARKABLE SURGERY.—Prof. Bergmann had two cases simultaneously at his clinic, one a necrosis of the humerus, and the other an amputation of the femur. The necrosis of the humerus called for extensive removal of dead bone, which Bergmann supplanted by a large piece from the amputated femoral bone. Perfect success attended this certainly unique procedure.—*Therapeutic Gazette*.

A woman having broken a glass pessary in the vagina, and a severe vaginitis having been set up by the fragments comminuted by the efforts at removal, Dr. Lewis threw into the vagina, by means of a syringe, a mixture of plaster-of-Paris, and after two or three days removed the mass, the solidified mixture having fixed in it the various pieces of glass.—*Coll. and Clin. Record.*

TWO REMARKABLE CASES.—The Denver *Medical Times* reports two cases, one of perityphlitis, in the history of which it is reported:—"Aug. 3rd. Patient keeps up his strength very well and has *no temperature.*" On the next page, in the history of a case of "Epithelioma of Rectum," the following extraordinary proceeding is noted:—"Aug. 9th. *He passes his bowels unconsciously.*"

The Rumford Chemical Works, Providence, R. I., manufacturers of Prof. Horsford's Acid Phosphate, have recently purchased a commodious building and warehouse near their present location, where they propose to move their business a few months hence. This purchase has been necessitated by the demands of their large and increasing business, and it is pleasant to record such an evidence of well-deserved success and prosperity.

SINGULAR ABSENCE OF ADIPOSE MATTER.—Dr. Weir Mitchell reports a case in *American Journal Medical Science*, of a school girl, aged twelve, who began to emaciate after a severe cold lasting three months. This was confined to the upper half of the body—head, neck, arms, and chest. The muscles are normal in the affected parts; the grasp good. Abdomen, buttocks, and legs plump, and present all the appearances of belonging to a well-nourished child.

EMBALMING PROCESS OF M. SAUTER.—Three or four litres of the following solution are first injected: R Carbohc acid, 1 part; glycerine, 10 parts; alcohol, 5 parts; water, 40 parts. This is followed by another abundant injection of a solution of one in three of chloride of zinc in water tinted with fuschine, or with a solution of sulphate of aluminum colored with

cochineal. The surface of the body is coated with vaseline, or a carbolated sandarac varnish. The cavities are filled with sublimated cotton, or tow dipped in carbolated glycerine, 5 per ct.—*L'Union Médicale.* R. Z.

PERSONAL EXPERIENCE OF A PHYSICIAN.—BEEF PEPTONIDS.—YARMOUTH, Nova Scotia, Sept. 3, '85.—For the first three months of current year I was prostrated with gastric trouble, and for seven days, during latter part of third month, found it impossible to retain food upon the stomach. In this exigency Pepsin of various leading brands, as also bismuth (in powder and solution), oxalate of cerium, and ingluvin, were successively tried with no beneficial result. So obstinate and pertinacious indeed was the attack of emesis that indications pointed strongly to fatal result through inanition. At this juncture "Beef Peptonoids" was suggested by Mr. O. C. Richards, a local druggist, as worthy of trial, and was taken up as a *dernier ressort.* Notwithstanding the fact that this preparation is continuously advertised in the medical journals, I had never tested it in my practice, and was hopeless of profit from its use after having failed with all the generally accepted remedies. The result, however, was so markedly beneficial, and the preparation so quick in action, that though ordinarily strongly averse to giving certificate or testimonial, I feel bound to place my personal experience on record.

The first day's use of the Beef Peptonoids gave notable relief and accession of strength on the second day the vomiting was materially reduced, with steady improvement until the fifth day, when this distressing feature was entirely eliminated from my case. Convalescence was rapid under continuance of this treatment.

I need hardly add that the preparation holds high place in my esteem. I have prescribed it in many critical cases, and have no hesitation in testifying to its extraordinary recuperative properties. In dyspepsia I have found it a most valuable agent; as a nutrient after childbirth it has done excellent work in my practice—materially increasing the quality and flow of milk,—and indeed, in all asthenic conditions I have proved it to be a constructive of rare merit.

GEORGE BELL, M.D.