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## Original Communications.

### HÆMATURIA.\*

BY WM. BRITTON, M.D., TORONTO.

*Continued from March No.*

As has been said, each portion of the urinary tract, from the malpighian corpuscles down to the meatus urinarius, having its own individual histology and functions, is subject to its own peculiar diseases, and therefore, as hæmaturia may accompany almost any urinary ailment, the first and most important step from this starting point towards a diagnosis is one of topography; and with this object in view, the following data will be useful:—

- 1st. The color.
- 2nd. The degree of coagulation.
- 3rd. If coagula exist, of what form?
- 4th. Relation of the blood to the urinary stream.
- 5th. Condition of the urine as to quantity, reaction and presence of other normal and abnormal constituents.
- 6th. Constitutional symptoms and the history of the attack.

As has been stated, brightness and coagulation of the blood point, as a rule, no farther up than the bladder, unless the renal lesion is much greater than usually met with.

Urethral hæmorrhage is ordinarily normal as to color, and may or may not be coagulated; and if so, coagula that have formed in its outer part are moderately small in calibre and elongated, while those of a deeper origin, in the neighborhood of the bulb may be much larger. It usually precedes the flow if near the meatus; and if more deeply situated, it either flows unmixed by the sides of the urinary stream or comes afterwards.

\*Read before the Ont. Medical Association, June, 1891.

It does not always follow, however, because urethral disease exists, that the hæmorrhage has its origin at that point. A tumor or stricture may so occlude the passage as to produce atony and congestion of the bladder; and in this instance the bleeding would be vesical.

The same rule will also apply to all pathological states of the prostate, causing hypertrophy and obstruction.

An exception to this rule of exceptions occurs when the prostate is in a highly congested condition, for extravasation may occur backwards from this gland into the bladder, which would apparently render the hæmorrhage vesical in character.

As a general rule, the prostate and urethra being excluded, if the blood is bright, clotted, not intimately mingled with the urine, and increasing in quantity towards the end of micturition, it is derived from the bladder.

An exception to this would occur in case it was poured down rapidly from the ureter or kidney.

Occasionally a difficulty in diagnosis may be experienced when bladder hæmorrhage is slow, for free admixture would take place, coagula would be broken up by prolonged contact with urine, and, if marked acidity exist, the color would be considerably darkened.

Sir Henry Thompson advises as a means of elimination, the collecting of the urine drop by drop, through a retained catheter after thorough washing. If in those circumstances it still appears mixed, uncoagulated and darkened, the presumption as to its renal origin would be tenable.

The most frequent sources of vesical hæmorrhage, are wounds, contusions, stone, tumors, malignant or papillomatous, and inflammation.

There is nothing special to be said of the connection between this symptom and wounds of the organ.

In cases of stone the bleeding is irregular in its occurrence, often very slight in proportion to the magnitude of the other symptoms, and much aggravated by exertion.

Cystitis, if productive of hæmorrhage, is apt to be severe in character, and therefore the strangury as well as the constitutional symptoms, are extreme. The presence of pus or abundant mucus, with perhaps alkalinity and phosphates in the later stages, will settle the matter of origin.

Malignant tumors ordinarily cause more hæmorrhage than stone; and, further, the constitutional symptoms as well as the signs of enlargement, elicited by palpation per rectum, together with negative results on sounding all point in the same direction.

There is a variety of bladder bleeding which is perhaps, peculiar. For days together, the urine has a dull red color, and is liable at times to contain large quantities of coffee-ground sediment; at any time an extraordinarily violent contraction of the bladder produces a sudden and considerable increase of blood discharge. This is most frequently a complication of papilloma, and the last mentioned feature is produced, it may be presumed, by the undue and forcible compression of the fragile growth by the contracting organ.

The ureter cannot always be distinguished from the kidney as a source of hæmorrhage; and in cases of impacted calculus when the blood might be fairly thought to proceed from this tube, I have not always been able to find the vermiform coagula that are said to form in the ureter.

Perhaps the most common local cause of renal bleeding is calculus, in the pelvis of the kidney; and of such concretions, the urate being the roughest, and the phosphatic the most irregular in contour are productive of most hæmorrhage; but the extent of lesion, size of stone, and amount of bleeding are not always in proportion.

Two of the most instructive cases of hæmaturia I have seen, because they required most patient investigation in order to arrive at a solution of the cause, and in which hæmorrhage was obstinate and extreme, arose solely from that complex condition lithiasis. In both instances repeated attacks occurred, closely resembling a fit of the gravel. Extreme pain was felt along the track of the ureter, strangury and partial suppression of urine, followed by a free urinary flow, well charged with blood, in part fluid and partly coagulated. Soundings were made repeatedly but without discovery of stone. The first urine voided after a subsequent attack was carefully washed, and considerable quantities of fine sharp sand found. Measures were now directed towards the faulty liver, the real cause of the trouble, and with the happy result of a marked amelioration of the symptoms. Such a state of affairs I have found in infants as well as in octogenarians. It may be

asked how could the passage of sand, almost as fine as an impalpable powder, be productive of so much bleeding and pain. The crystals form in the straight kidney tubules occlude them, and are only carried into the pelvis by the *vis a tergo* of the accumulating urine. Consequently as there are possibly hundreds of such sharp crystals the vascular lesions are many, and bleeding being consequently profuse, large clots form, which in traversing the ureter, excite pain, often as excruciating as that due to calculus. I do not think this form of trouble appearing in young infants is sufficiently emphasized; for before I had given the matter some special thought I had seen several cases which I looked upon as varieties of other disorders, a very hazy explanation of which I had to satisfy myself with, but in the light of the pathology of lithiasis they are easily explicable.

That peculiar disease urethral fever, when accompanied by hæmorrhage is worthy, in this place, of special consideration on account of the apparent disproportion between cause and effect. For example the catheter is used dexterously and with antiseptic precautions, for the relief of retention, caused by senile paresis or prostatic hypertrophy; and, although the kidneys have not been found diseased, there may be violent rigors followed by marked constitutional fever, extreme congestion of the renal vessels and profuse escape of blood.

The connection appears to be, that during retention the pressure of the pent up urine supports the distended and attenuated capillaries, and this external support being withdrawn, miliary extravasations occur. An analogous state of affairs not infrequently follows the tapping of a hydrocele or the operation of thoracentesis.

A description of the treatment of hæmaturia would necessarily involve that of all the diseased conditions giving rise to it, and therefore must be omitted with reference to one or two particulars.

1st. In hæmorrhage of renal origin, rest is perhaps the most potent factor in the way of restraint, and with this may be combined the use of such astringent remedies as tincture of iron, the iron alum, mineral waters, sulphuric acid, matico and ergot.

2nd. In case of bladder hæmorrhage instrumental interference is to be avoided as far as possible, lest the irritation excited still further complicate

the matter, and be productive of increased flow. 3rd. The tendency is for clots to be broken up by the urine, and unless the disease giving rise to them also produces obstructions sufficient to ordinarily necessitate the use of the catheter, they had better be left alone; but if the contrary condition exists, the urgency being extreme, they may be gently broken up with the point of a double channeled catheter and lavement resorted to, perhaps after suction has been employed. Opium as an adjuvant, will not be out of place, as it will keep the bladder in a state of rest.

4th. There is much conflict of opinion as to the efficacy of cold externally as a hæmostatic for the bladder. Sir Henry Thompson asserts that no amount of cold applied to the hypogastrium affects the temperature of the bladder, and, therefore, used in that way it is quite impotent, although, perhaps, it is more effective when applied per rectum.

Many cognate matters have cropped up in dealing with the subject under discussion, and time being limited, statements may have been made in so brief a manner as to be necessarily without sufficient qualification to save them from the opprobrium of dogmatism, therefore, I have to crave the indulgence of this meeting.

#### ACUTE NECROSIS OF GROWING BONE.\*

BY GEO. A. PETERS, M.B., F.R.S.C., ENG., TORONTO.

(Continued from April No.)

*Diagnosis.*—The early diagnosis of this disease has such an important bearing upon the line of treatment to be adopted; and the frequency with which it is mistaken for typhoid fever, rheumatism, or an acute specific fever, is so great that one may dwell with profit on a few of the points involved in its detection.

The early symptoms of chill, followed by fever, vomiting, with more or less obscure pains in the back and limbs, are common to this and many other diseases of childhood, and accordingly do not aid us much in arriving at correct diagnostic conclusions. The malignancy of this disease, however, is such that even in the early stages the rapid depression of the vital forces is perhaps greater than in any of the other diseases of child-

hood. Symptoms of great depression then should lead us to make a careful examination of all parts of the body, and I would suggest that in all cases of disease in growing subjects, attended with grave symptoms, acute necrosis is one of the diseases which should be borne in mind in summing up the whole clinical aspect of the case preparatory to making a diagnosis. It must ever be remembered that young children are frequently conscious of extreme pain, and yet have only a vague idea of its exact localization, and so pain in an epiphysis might readily be referred to an adjacent joint. Again, cases of multiple acute necrosis have been described by Senn.\* Such cases—particularly if complicated with synovitis of the neighboring joints, as may be the case—would be distinguished from acute articular rheumatism with the utmost difficulty. Moreover, the case related in this paper substantiates the observation of others—that the two diseases may be present in one individual.

Under the heading of the Diagnosis of Rheumatism, Fagge† refers to several cases of acute necrosis which were treated for rheumatism, the mistake not being discovered till the patient came to the *post-mortem* table. The most reliable points in the exclusion of rheumatism are the absence of the characteristic sour acid sweats, the great depression which is present, and the localization of the pain and tenderness—not in the joint but near it. In fact, if I were asked to name a crucial point in the diagnosis of this disease, I should say the presence of acute pain and excessive tenderness in the vicinity of an epiphyseal line. In a very early stage, even before the periosteum is affected to any extent, a very distinctly circumscribed tender spot may be found. At this time, as there may not be any affection of the periosteum, there will not necessarily be any increase in the circumference of the limb, but when a collection of pus occurs under the periosteum there should be no longer any difficulty in arriving at a diagnosis. Even at this stage, however, it has been mistaken for cellulitis or phlegmonous erysipelas, but these conditions are rare in childhood.

From the acute specific fevers and typhoid fever the disease will be distinguished by the local

\* Op. Cit. p. 236.

† Fagge's Practice of Medicine, Vol. II., p. 566.

\* Read before the Ont. Medical Association, June, 1891.

manifestations which usually obtrude themselves upon the observation during the first week. As before remarked, in doubtful cases the tender spot should always be sought.

*Treatment.*—Though this is probably at first a local disease, constitutional treatment must not be by any means neglected. The alimentary tract being one of the channels by which infection undoubtedly occurs, free purgation is in order, and no drug may be more fitly used than calomel, given in say half-grain doses every half-hour, until liquid evacuations are produced. Kocher advises salicylate of soda in large doses, and the exhibition of this drug might act beneficially both as an antipyretic and as a disinfectant of the bowels. Stimulants are often required early and freely, and the giving of nourishment in an easily assimilable form must not be neglected.

The importance of local treatment can not be too strongly insisted upon. The application of iodine blisters and liniments is not only useless but hurtful, as these tend to obscure the symptoms, and mislead the surgeon, while they lead the patient and his friends to believe that some good may be done by external application, and thus dispose them to be less willing to allow surgical interference. I am most strongly of the opinion that nothing will do the least good, short of a free incision down to the seat of the disease whether that be in the periosteum, in the cancellous tissue of the end of the shaft, or in the medulla. And I am fully in accord with Tubby and Senn, in urging that this should be done at the earliest possible moment after a diagnosis has been made. Frequently the friends will raise strong objections to an operation for which they can see no indication; but this is one of the cases in which the surgeon must assert himself very forcibly, and so far as possible use his authority in order to carry out what he well-knows to be essential to the welfare of his patient. The operation should be performed by Esmarch's bloodless method, if the nature of the part will permit of this, but the limb should be exsanguinated by simple elevation, without the application of a bandage, thus avoiding the risk of pressing clots, pus, or germs into open veins or lymphatics. In this way a deliberate dissection can be made down to the diseased tissue, and even if the periosteum be found apparently healthy the surgeon should not falter, but should unhesitatingly

drill or chisel the bone on the shaft side of the epiphysis, and if pus is found the opening should be enlarged so as to afford free drainage. It may be necessary to chisel away one wall of the medulla to a considerable extent, and this should be done with extreme care, lest the shaft be driven away from its epiphyseal attachments which are loosened by the inflammatory process.

If the operation is not done until a late stage, when the periosteum is raised by pus, for some distance along the shaft, and when a considerable portion of the medulla is affected, it will be necessary to make several openings into the medulla at various intervals. These should be made by means of separate incisions through the skin, so as to avoid inflicting one large wound, which might destroy important structures. The affected medullary tissue should then be scraped out with curettes bent at various angles as required. Every part of the abscess wall should then be brought into contact with a powerful antiseptic solution, such as corrosive sublimate 1-1000, or chloride of zinc 40 gr. ad. ℥j. An iodoform-glycerine emulsion 10 per cent. strength, may then be introduced, and a bulky antiseptic dressing applied. If the wound is large and likely to give rise to extensive capillary oozing, it would be advisable to pack it with iodoform gauze, which should be removed at the end of 24 hours. The subsequent treatment would consist in thorough irrigations at such intervals as the condition of the wound would suggest.

In dealing with the results of the disease it is necessary to remember that all *bare* bone is not necessarily *dead* bone, and accordingly the part of the bone which perishes should not be removed until its limits are clearly defined.

It is impossible in a paper of this length to deal with the subject in its entirety, and I will close by saying that the hiatus left after removing the dead bone should be treated on general principles, viz., either by the implantation of new living bone by filling with Senn's decalcified bone chips, or with desilicated sponge.

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NOTE the pupil in chloroform anesthesia. When the pupil dilates, the cardiac respiratory centers are beginning to be inhibited.

## THE PHONOGRAPH FOR DEAFNESS.

BY DR. MURRAY M'FARLANE, TORONTO.

Late Clinical Asst. Throat, Nose and Ear, N. Y. Polyclinic.

A new method of treatment of deafness, which promises to be of great utility is the use of the phonograph, which can be used as follows: Specially prepared wax cylinders are used, in which depressions have been made at intervals, by means of a stylus, the result of each depression being a sound shock of varying intensity, according to the depth of the mark made, and the number of revolutions made by the cylinder. Thus the sound is intrinsic, and not derived from outside sources. It acts by focussing the rhythmic sound shocks upon the membrana tympani; acting as a message to the aural conducting apparatus, breaking down recent adhesions, and is seemingly very beneficial. The writer made a number of experiments last week, and demonstrated to a number of medical gentlemen, the utility of this method of treatment. The Edison Phonograph Co. kindly placing one of their instruments at his disposal, six patients underwent the process, five expressing themselves as being benefited.

*Mr. W.*, otitis med. cat. chronica, of 6 years standing, both ears watch heard; 2 in. right ear; 4 in., left ear; after 15 minutes listening to the phonograph, right ear, watch, 6 in.; left ear, 7 inches. This was without inflation.

*Mr. M.*, O. M. C. acuta, left ear, watch heard, 1 inch., after treatment watch heard 4 inches, quite a marked improvement. In both these cases the Politzer gave but little relief, etc.

The writer feels confident that there is a great future for the phonograph in the treatment of middle ear affections, and will be pleased to communicate directions for preparing cylinders to any medical man who would like to investigate for himself. This communication is purposely brief as the discovery is in the experimental stage as yet.

THE ODOR OF IODOFORM can be removed from the hands and other parts, it is asserted, by washing thoroughly with linseed-meal water.

## Selected Articles.

### ULCERS OF THE LEG AND VARICOSE VEINS.

The object of this paper is to call attention to a very simple and successful method of treating ulcers of the leg and varicose veins. It has proved, after an extensive trial, very satisfactory in the relief and cure of that rather difficult class of cases.

This method was suggested by a paper of the late Professor Gamgee, of Birmingham, which appeared in the *Lancet* several years ago, on "The Treatment of Recent Wounds of the Leg by Dry and Infrequent Dressings." In substance, it is an adaption of his method to the treatment of ulcers. It is very simple and comparatively easy of application—in fact so simple, that any intelligent and competent person can use it, if the idea is correctly grasped. The advantage of practice is, however, very great, and in every town of any size, a medical man who would devote some little time and care to become proficient in its application, would obtain considerable practice and be the means of giving great relief to many a wretched sufferer. All the cases reported were treated in the city of Manchester, England, but during the last two years many cases have been treated in Canada and the United States, with even more satisfactory results.

In a short paper like this, it would be quite out of place to give any detailed description of the anatomy of the leg or of the circulation in it. It will be quite enough to notice that in the leg the arterial blood has the force of gravity to help it, and the returning or venous blood has this force to overcome. This is one of the great difficulties in treating diseases of the leg; the other is the injury to the general health ensuing from the enforced rest which is usually taken during their treatment. This injury is most marked in elderly persons inclined to stoutness. In health the disadvantage under which the venous circulation labors is counteracted by the strength of the coatings of the veins and the number of valves placed in them, which cause the contractions of the muscles surrounding the veins to force the blood upward. But when disease and pain occur more blood is carried to the limb by the arteries, and the muscles are used much less freely; the blood in this way overloads and distends the veins, so adding to the existing mischief. In course of time the veins become like India rubber tubing which has been over-stretched and has lost almost all its elasticity.

The method by which the writer has succeeded in many cases in relieving that state of affairs, without requiring any rest in bed or cessation of

work, is extremely simple, nevertheless he trusts that on this account alone it will not be rejected as unscientific. Its action is chiefly mechanical, and consists, in brief, of the application of a perfectly flexible, porous, and absorbent bandage in such a way as to restore the venous circulation to its normal state, absorb and disinfect all the discharges, and permit at the same time free and painless exercise. The change produced in the nutrition and healthy action of the leg is like that brought about by good drainage in an unwholesome swamp.

*Cause of Ulcers.*—The most common predisposing cause of chronic ulcers of the leg is a varicose condition of the veins, but whatever may have been the original cause of an ulcer, in the majority of cases, if not speedily cured, a varicose condition is produced. This fact does not receive the recognition it deserves in the larger works on surgery, but is strongly emphasized by Dr. J. K. Spender, of Bath, in a little book published by him in 1868, in which also the principle of treatment herein recommended is adhered to, though the means adopted differ somewhat. Mr. W. H. Bennet, F.R.C.S., Eng, in some very interesting tables lately published by him in the *Lancet*, gives one hundred and seventy-four consecutive cases of varicose veins of the lower extremity under his care at St. George's Hospital. The percentage of chronic ulcers occurring among them was twenty-eight. Other diseases especially predisposing to ulceration, are erysipelas of the leg, phlegmasia dolens or white leg, syphilis, and acute rheumatism. The reason why the first three should create a tendency to ulceration is apparent, but it is very remarkable that twelve out of the last fifty cases herein reported had suffered from acute rheumatism. The first fifty cases of the series were not questioned on this point. It will be conceded that there is no method of treatment known to the general profession which gives much satisfaction. Most of the great writers on surgery treat the subject in a very cursory manner. There are three essential indications to be fulfilled in order to treat an ulcer of the leg with success. First, to restore the circulation to its normal condition; second, to provide for the absorption and disinfection of the discharges; and, third, to enable the patient to take free and painless exercise. The method here described fulfils these three indications almost perfectly.

The materials chiefly used are stockinette cotton bandages, three inches wide, in rolls of six yards each; Gamgee absorbent tissue, absorbent lint, oiled silk, or gutta-percha tissue, and ointments composed as below:

R. Vaseline . . . . . lb. j.  
 Acid borac. pulv . . . . . ʒ j.  
 Glycerine . . . . . ʒ j. M.

R. Vaseline . . . . . lb. j.  
 Acid carbolic . . . . . ʒ iij.  
 Glycerine . . . . . ʒ j. M.

The boracic and carbolic ointments may be used interchangeably, and will be found very useful in the majority of cases. When the surface of the ulcer is gray, and it is sluggish in healing, carbolic lotion 1 in 80 on lint covered with gutta-percha tissue will be found beneficial; and zinc ointment is suitable in eczematous cases, used alternately with the boracic ointment or acetic acid lotion, 1 in 80, on lint under tissue.

Subnitrate of bismuth, dusted on dry, is useful in many cases.

*Application of the Bandage and Dressing.*—To apply the dressing cut a piece of the Gamgee tissue a little larger than the wound or ulcer, spread over the tissue as thinly as possible some of the ointment thought suitable for the case. The tissue may be split in halves before use, but the gauze side should always be applied to the sore. When there is much discharge two or more thicknesses will be required. The tissue when spread should be laid on the wound, and the first bandage applied as follows: The patient, seated on a seat of ordinary height, should place his foot on a stand of the same height, or on a corner of the chair on which the operator sits, and wherever the wound may be situated the bandaging should be commenced at the foot. The first turn should be made over the centre of the ankle, going under the foot in a figure-of-eight; the second turn should go half an inch higher than the first, again going under the foot, and one turn round the front of the foot close to the root of the toes; the third turn should go half an inch below the first, then under and once round the foot again; the fourth, half an inch over the second, and the fifth, half an inch under the third, each turn going under and round the foot once only for each turn round the ankle, and coming just to the root of the toes. In cases where the ulcer is below the ankle, it is necessary in addition to make two or three turns directly under the heel, coming over the instep in front. The bandage must then be made to ascend the leg by spiral turns of about half an inch each, until the centre of the calf is reached: above the centre the turns should ascend from an inch to an inch and a half each. It is very important to attend to this point, as the bandage exerts all its force at the calf, and if too many turns are put on, the circulation beneath is obstructed. No reverses should be employed. In persons under one hundred and forty pounds weight two rolls of bandage are sufficient; when over one hundred and forty pounds and under one hundred and eighty pounds, three rolls will be required; and when over one hundred and eighty pounds, four rolls. There are six yards in each roll. When more than two rolls are used all but the last should be commenced at the foot; the

last roll in every case should be applied from above downward in inverse order to the first. By attending to this, a stocking can be easily drawn over the bandages without disturbing the folds. For this purpose it is well to use a thin cotton or silk stocking, which should only be changed at the time of dressing, the ordinary stocking can be put over it and removed at bedtime.

In applying the bandages the greatest care should be taken to regulate the pressure in such a way as not to cause stagnation of the venous circulation in the foot. This can be done by always applying rather more pressure to the foot than to the leg. The ideal is to have the pressure graduated in such a manner as to be greatest at the foot, and evenly and gradually less in ascending the leg. The arterial circulation should be almost unaffected, but the stasis in the veins completely overcome by the elastic pressure of the bandages. This is a purely mechanical matter, and is governed by the same laws which regulate the pressure of fluids elsewhere. A varicose leg is like an india-rubber tube, full of fluid, which from over-wear or over pressure has begun to stretch and bulge in places, and in such a tube the greatest amount of pressure would be at the lowest portion.

*Changing the Dressings.*—The dressings should be changed as seldom as possible; three times weekly is about the average number of times required in order to keep the pressure even and the discharges removed. When the discharge is very great it is necessary to change the bandages every day at the beginning of the treatment, lessening the frequency as the leg improves. Some legs hold the bandage in position much better than others. The attendant must use his own judgment. Some do well changed once or twice weekly, others require changing every day. A simple aid to uniformity in putting on the bandages is to make a narrow strip of paper into half inches and lay it on the front of the leg as a guide. If these directions be carefully followed, it will be found easy to reduce almost any kind of swelling in the leg.

*Bandaging after the Cure.*—It is always better to continue the bandaging for at least six months after an ulcer is healed, and in aged persons for a still longer period. This may safely be left in the hands of patients themselves, after explaining clearly to them the method of application. In cases of varicose veins the bandaging must be continued for a still longer time. Two sets of bandages should be used, so as to permit of one set being washed when required. Care should be taken to direct the party who washes the bandages not to disturb the original folds, and in dressing to draw them out sidewise before rolling; on no account should they be stretched lengthwise.

While patients are under treatment they should not be allowed to remove the bandages themselves.

When cured, they should be directed to remove them every night and reapply them every morning. As will be seen by the foregoing description, the three conditions of success spoken of above are almost perfectly fulfilled by this method. The stockinette is wonderfully elastic, and compresses the veins most completely and comfortably. The Gamgee tissue is absorbent to a very high degree, and in conjunction with one of the ointments described disinfects and absorbs all discharges, and the thinness and flexibility of the materials used permit of exercise being taken with perfect freedom.

*Illustrative Case.*—Mrs. T—, aged forty; housewife, with two children; general health good. Ulcer situated just above the inner ankle of the left leg, circular in shape, two inches in diameter, and deep and unhealthy in appearance. She had suffered from it for fifteen years. The leg was much swollen, and the pain "something dreadful." The veins were varicose. The ulcer had been caused by a knock accidentally received. She had twice been an out-patient at Manchester Infirmary, and had been treated by several private medical men. She came under treatment on May 1st, 1884. Two rolls of bandage were used (twelve yards in all) and the ulcer dressed with carbolic ointment and Gamgee tissue as described. The dressing was changed every second day for a week, and afterward every third or fourth day. She experienced immediate relief from all pain as soon as the bandage was applied, and was discharged perfectly well on May 31st, 1884. On making inquiry in April, 1889, she was still perfectly sound, and had never suffered any inconvenience in the interval. No rest of any kind was given, and she did her ordinary work during the treatment.

The medicinal treatment will not be spoken of. Every case must be treated on its own merits. Free exercise should be enjoined and wholesome and nourishing food recommended. It is very important to keep the bowels regular, having a movement at least once each day. Is it safe to heal an ulcer of the leg? Yes, when free exercise is taken during the treatment. In every case treated by myself improvement in the general health took place.

In varicose veins the bandage should be applied as before directed, and will be found on the whole much superior to elastic stockings. In recent wounds of the leg the benefits of this method of dressing are seen to their greatest advantage.

In acute synovitis the equable and constant pressure obtainable in this way often seems to act as if by magic in reducing the swelling and inflammation.

A synopsis of the first hundred cases of ulcers treated was appended to this paper, but is omitted for lack of space. The average period of treatment was about five weeks. Eighty per cent. of



the patients were permanently cured, and in the remaining twenty per cent. the pain was relieved, and the swelling removed in almost every case.—  
W. BREMER, M.D, in *Med. Rev.*

#### DR. LAUDER BRUNTON ON THE TREATMENT OF PILES AND ALLIED AFFECTIONS.

At a meeting of the Medical Society of London, held on March 7th, Dr. Lauder Brunton read a most interesting and useful paper on piles. We are unable to give the paper *in extenso*, but we are sure our readers will appreciate his remarks on the treatment of this painful and at times most obstinate affection. He said:—

“Turning, now, to the treatment of piles, we may consider, first, how we are to keep the liver in such a condition as to maintain a free supply of blood through it. For this purpose, we should insist on moderation in cases where we have reason to believe that either the food or the stimulants taken are in excess of the wants of the organism. The occasional administration of small doses of a mercurial purgative, followed by a mild saline, tends to keep the liver free and to prevent piles, although one may not know the exact *modus operandi* of the mercury upon the liver. Of course the saline ought not to be too violent, or it will tend to cause local congestion and make matters worse. Aloes bears an evil repute on account of its irritant action upon piles, but its effect depends upon the quantity given; and while a large dose of an aloetic pill will almost of a certainty produce rectal irritation, small doses, such as one-tenth grain of aloin three times a day with each meal, will tend to lessen piles by keeping up a gentle peristaltic action and preventing constipation. My friend, Mr. Archer, tells me that he has used with invariable success half an ounce of castor oil given to begin with, and followed up by half a drachm every morning for a month.

“I have already discussed the prevention of portal congestion from chills, but when it has occurred a useful application is a hot water india-rubber bag, with a plush or flannel covering, put under the back of the neck, and a similar one over the liver. These tend to restore the equilibrium of the circulation and lessen portal congestion.

“Exercise is useful in keeping the liver free, but this exercise must be of a certain kind. As I have already said, the liver is a very spongy organ, the blood pressure within it is very low, and the pressure under which bile is secreted is also very low. Both blood and bile, therefore, tend to stagnate within it, but this stagnation is lessened by the liver being rhythmically squeezed, more or less forcibly, between the diaphragm and abdominal muscles. In a person standing or

sitting upright, or lying on either side, this squeezing action is very slight; in a supine posture it is slightly greater. In ordinary walking it is also very slight, but in walking up a hill, and especially in climbing a mountain, the amount of pressure to which the liver is subject is considerable, because the muscles of the abdomen in such exercise are actively contracting, and the movements of the diaphragm during the panting breathing which occurs on exertion are much greater than when a person is quiet. A similar process of squeezing occurs in brisk horse exercise, either trotting or cantering, and thus riding is frequently beneficial for piles, notwithstanding the increased local irritation from contact with the saddle. Another useful exercise is to touch the toes with the fingers, keeping the knees straight, several times every morning.

“A regular action of the bowels is of the utmost importance in preventing piles, because it tends not only to keep the circulation through the liver free, but prevents straining. The different means of securing this regularity of action would require a paper to themselves, but a teaspoonful of compound liquorice powder at night, or confection of senna, either alone or with confection of sulphur or confection of pepper, are perhaps amongst the most widely employed of all the laxatives. No doubt the best times ordinarily for emptying the bowels is after breakfast, but if the piles tend to come down much it is better for the patient to get into the way of emptying the bowels before going to bed, so that he may secure rest in a recumbent position for several hours. Some patients in whom the piles come down easily spend a day of misery if they are obliged to go to the closet in the morning instead of the evening, because the piles tend to remain down all day and worry them.

“The soft unprinted papers which are now commonly sold are a very great improvement upon the ordinary newspapers, but even they sometimes give rise to a good deal of irritation. In cases where piles are very troublesome it is always well for the patient to wash the anus immediately after a motion. It is sometimes impossible for the patient to go from the closet to his bedroom and wash there, and I have found the easiest way of getting over this difficulty is for him to carry to the closet a soft sponge in a small india-rubber bag; an ordinary tobacco pouch is best. If it should be an earth closet, the patient should take the sponge full of water, and, after cleansing the anus gently with paper, he may thoroughly sponge, and then return the sponge to the bag. The anus may then be dried either with the porous paper, or with a small napkin which he carries with him. In the case of a water closet the sponge may be taken dry, and after the closet has been used the plug may be drawn and the sponge dipped in the

clean water which then fills the pan and used in the way which I have just mentioned. The patient should also take with him to the closet a small bottle of some preparation of hamamelis and some prepared wool. This should be sheep's wool deprived of its fat and not cotton wool. The wool thus prepared is quite absorbent and takes up the hamamelis readily. It differs from the cotton wool in one important particular, for it forms a kind of felt, which the cotton does not. A small pledget of the wool about the size of a hazel nut should be dipped in the hamamelis and introduced within the anus, and a similar pledget, likewise soaked in the hamamelis, should be introduced so far within the anus that a few fibres of it at least are caught by the sphincter. The external pledget soon becomes felted together into a regular pad, fitting completely to the anus, and being retained by the few fibres caught by the sphincter it will remain there for twenty hours, while a similar pad of cotton wool might not remain as many minutes. This wool pad not only keeps the hamamelis in constant contact with the piles, but also affords a certain amount of mechanical support. In patients suffering from piles we often notice an almost involuntary tendency to sit on the corner of a table or on the arm of a chair, or to put the hand behind and press upon the anus from time to time; but the woollen pad, by affording a constant support, tends to lessen the necessity for pressure in any of these ways. Where the piles are chiefly internal the hamamelis may be applied in the dose of half a drachm to a drachm, either diluted with water, or, as is sometimes preferable, undiluted, by injecting it within the anus by means of a glycerine syringe. The success of this treatment in stopping hæmorrhage from piles is really extraordinary; within a week I have stopped the hæmorrhage from piles which have been bleeding so profusely that a colleague thought that an operation would be necessary. But not only does the hamamelis stop hæmorrhage, it lessens the uncomfortable weight and aching pain which so frequently accompany piles, especially when they do not bleed; and it will even greatly lessen or remove the pain which occurs in piles when they become inflamed. I have tried various preparations of hamamelis, but I have not found either the tincture or the local extract, both of which are to be found amongst the recent additions to the *Pharmacopœia*, nearly so satisfactory as some of the proprietary preparations.

"The patient requires to be carefully instructed in the mode of using it, otherwise disappointment may ensue. Some time ago a lady who was passing through London on her way to the Continent was seized with a sharp attack of piles. I was asked to see her at an hotel, but, not being able to go for a couple of hours, I hastily wrote

down a prescription for hamamelis and gave it to the maid with, as I thought, definite instructions how to apply it. On going to the lady two hours afterwards, I found that she had used the whole bottle, but with no relief whatever; nor was this to be wondered at, for the piles were internal, and the hamamelis had only been used externally. So satisfactory have I found hamamelis, that I do not now often employ ointments.

"In obstinate cases of piles, great relief is afforded by the anal pad. The simplest is one of india-rubber with elastic straps to hold it in its place, but it does not give, I think, quite the same relief as one in which the pad is pressed against the anus by a spring attached to a metal girdle which passes round the loins.

"Before concluding this paper, I may mention another affection which frequently goes along with the piles, and is most annoying, namely, puritus and eczema round the anus. Both of these affections may be lessened by a simple remedy—eau de cologne applied to the itching surface with a small sponge or a pad of cotton wool. If the skin be at all tender, undiluted eau de cologne gives rise to intense burning pain, but this may be prevented by diluting the spirit before application. The diluted spirit does not have such a strong and permanent action in lessening the itching as the pure spirit, and where the itching is at all great, the pure spirit may be used, notwithstanding the pain it causes, for it converts the intolerable itching into a severe smart, and this may be relieved by diligently fanning the part till the spirit evaporates."—*Hosp. Gaz.*

#### THE PATHOLOGY OF PNEUMONIA.

The pathology of pneumonia is one of the *questiones vexatæ* of medicine. The disease has so many points of resemblance, on the one hand, to the specific fevers, and on the other, to acute pulmonary affections, that the determination of its true pathological relations is a most difficult and complex problem. The question at issue becomes still more interesting when we remember that not only has pneumonia been a puzzle to the pathologist, but its treatment has been one of the great controversies of therapeutics. We naturally turn for light on these subjects to such a work as the exhaustive "Treatise on Diseases of the Lungs and Pleura," by the late Dr. Wilson Fox. "Two opposite theories," the author informs us, "have been advanced regarding the origin of pneumonia, both of which are supported by certain facts and opposed by others—(1) That pneumonia is a 'specific' fever, of which the disease in the lungs is only a local effect; and (2) that it is a purely local disease, of which the pyrexial and other phenomena observed are only the immediate con-

sequences." In favor of the first view are the following facts—(a) negatively, the absence in a large proportion of cases of any discoverable cause likely to excite inflammation of the lungs, and (b) positively, the suddenness of the onset of the disease, its well-defined course, its occasional epidemic and contagious character, the presence of bacteria in the blood, and the frequent appearance of a cutaneous affection (herpes), possibly analogous to the rash of the exanthemata. A point corroborative of the above is the well-known want of synchronism between the clinical progress of the case and the pulmonary condition. Thus, it is very common for the temperature to fall to normal and all the symptoms to abate, while the physical signs of pulmonary consolidation remain practically unchanged. Less frequently, but still not very rarely, the consolidation may show signs of resolution before there has been any abatement of the clinical symptoms."

The above evidence seems strong, and if we confined our attention to it we might conclude with some confidence that pneumonia must take its place among "specific" diseases. But, unfortunately, there are some points of great weight that tell against this view. Thus pneumonia is only very exceptionally epidemic, and its contagiousness, although held by some good observers, is still doubtful. Again, the influence of season is very apparent, the preponderance of pneumonia falling in the months from January to May. It might be urged, in reply to this, that just as pneumonia shows a preference for the late winter and early spring, so typhoid fever inclines to occur as an autumnal disease. But it seems impossible to resist the evidence that the frequency of pneumonia is much influenced not only by season, but by weather, cold winds, and sudden changes of temperature predisposing to it. In this regard, pneumonia shows an affinity with pulmonary disease and other affections that are admittedly due to "chill." Then, again, while there is often a want of synchronism between the physical signs and the symptoms of pneumonia, we have to recognize, on the other hand, such a fact as the greatly increased mortality which attends bilateral, as opposed to unilateral, pneumonia.

In so far as treatment throws any light on this subject there are facts on both sides. The general stimulant treatment of pneumonia, now almost universally adopted, hardly differs essentially from the treatment of the continued fevers, and is obviously adapted rather to the theory that pneumonia is a "specific" disease than to the belief that it is a local inflammation. On the other hand, local applications to the chest in the form of poultices, icebags, etc., have enjoyed much favor, and have been believed by some authorities to influence the progress of the disease. Stimulating expectorants, again, generally play a con-

siderable part in the therapeutics of pneumonia. Summing up the subject, Wilson Fox wrote: "The theory of a 'specific' cause can scarcely be maintained for pneumonia in the same sense as that in which the term is applied for the contagious pyrexial diseases. The causes of pneumonia are manifold, and the disease may originate under such diverse conditions that it seems impossible to attribute it to any single blood poison. On the other hand, the most probable hypothesis to explain its origin is that of an altered composition of, the existence of some morbid material in, the blood, which, from its special qualities, may affect a particular organ, or, as is more probable, may, under local predisposing causes, excite inflammation in that part of the system which in any given individual is the most liable to suffer, as a *locus minoris resistentiæ*." We have no knowledge of the nature of the changes in the blood that predispose to pneumonia. The excess of fibrine that has been described has been shown by Virchow to be the consequence, rather than the cause, of the pulmonary inflammation. In some cases, no doubt, pneumonia is due to septicæmia, but this is not at all probable of the typical acute disease. It is rather a curious circumstance that while theoretical considerations and clinical evidence seem at present inadequate to fix definitely the pathological relations of pneumonia, the response of pathology and bacteriology is also somewhat equivocal. It is true that the researches of the bacteriologist of late years have considerably advanced our knowledge of this part of the subject. From them we learn that the microbe most constantly present in pneumonic exudation, and in that of the inflammatory affections with which pneumonia is often complicated, is the diplococcus discovered by Fränkel and Weichselbaum; whereas Friedländer's bacillus, like some other microbes occasionally found in pneumonia, is of exceptional occurrence. Nor must the remarkable investigation of the two Klempersers upon the toxins of the first-named organism be lost sight of, as affording additional proof of the specificity of the disease. Nevertheless, when all these contributions to knowledge are collated, it would still seem that much remains to be done before we are in a position to conclude that bacteriology has said its last word regarding pneumonia.

According to Wilson Fox, "the disorder which, on a lesser scale, presents the greatest analogy with acute pneumonia is perhaps acute tonsillitis, where we have the same short initial stage, a similar intensity of rigor and prostration, a similar sudden invasion of pyrexia, and a similar rapid decline of this before the local inflammation has shown any signs of abatement. In tonsillitis, also, we have frequently an equal difficulty with pneumonia in verifying a distinct cause, and a certain amount of evidence at least exists in the

case of the so-called 'hospital sore-throat,' that it may also be produced by other poisons than those originating within the system from the impeded exercise of the function of the skin." It will thus be seen that the pathology of pneumonia remains a question *sub judice*, but that the best authorities incline more and more to the specific theory of its origin.—ED. IN *Lancet*.

### ANGINA PECTORIS.

The sufferer from angina pectoris is without warning attacked by a sense of oppression in the precordial region, which is rapidly followed by a well-defined, severe pain, radiating over the left chest, sometimes to the right as well, and from the chest to the left shoulder, whence it extends into the arm and rarely into the forearm, and accompanied by a sense of suffocation. The pain may also shoot up the neck. The arm seems to be of enormous weight, and there is severe pain upon movement. No position in which it may be placed gives relief, while there is a disposition to relax the affected side by an inclination of the body. The face is pale, the features expressive of intense anguish. Respiration is restrained, for movement of the chest wall intensifies the agony; and the heart is either slowed or beats irregularly. The patient attempts to assume a position that will relax the muscles of the thorax and arm, and may either take a sitting or standing posture, being careful, however, to secure support.

Patients are not talkative during a paroxysm, every inspiration required in the act of conversation being accompanied by an acute pang. All movements or jars increase suffering and there is often a strange sensation as of approaching death.

These symptoms, though passing rapidly, sometimes not lasting more than a few moments, may be likened to the slow and easy motion of a train of cars as it leaves the station, but at each second adding to its momentum and intensity, until it is rushing along at reckless speed, pounding, racking, and tearing along, until the patient dreads the next move and fears instant destruction—then, by the same imperceptible change there is a gliding, easy slackening of signs, and soon the countenance itself clears a little, and with a sigh of relief he feels well. Such is the course of symptoms in a well-developed paroxysm. The symptoms may vary; the arm may not suffer; the paroxysm may be so mild as to be almost disregarded.

What is it? For years that question has been asked, and as yet it is practically unanswered. The diversity of opinion as to the nature of the affection is illustrated by the number of names that have been given it, twenty-four in all, based upon phenomena that seemed to be characteristic.

The common name, angina pectoris, is as unmeaning as any.

From a clinical standpoint there seems but little if any advantage in considering the affection under the two forms, true angina pectoris (in which there is disease of the heart) and false angina (in which there is no recognized heart-lesion). I might say that no clinical distinction can be determined; and the pathology of the disorder is at best uncertain. It is true that in some cases in which death has occurred, in one, ossified or obliterated coronary arteries have been found; in another fatty degeneration of the heart; and in another, some other morbid condition; but similar lesions are found in cases in which there had never been attacks of angina. The affection has been considered as a neuralgia, but pure and simple neuralgia it cannot be; for while neuralgia is strictly a nerve pain (and pain enough there is in angina), the pain is so different from the indescribable, agonizing sensations of angina pectoris that the latter must be looked upon as a neurosis; and here we have a clear, decided statement that we are lost. So we accept the neuroses as the category into which angina pectoris falls, and qualify it further by the prefix vasomotor. Some writers prefer to call the disorder angina pectoris when there is recognized organic heart-disease, but under all other circumstances to call it simply a neurosis. This seems like a distinction without a difference, for with or without heart-trouble the affection is a neurosis, the heart-trouble having no clinical significance.

The pallid skin indicative of disturbed circulation, the slowed or irregular heart's action, accompanied by pain in the thoracic respiratory muscles, seem to point more surely to a centrally impeded or deranged innervation affecting the capillaries than to organic heart-disease. With this conception we can understand why the symptomatic phenomena may be irregularly produced, one part affected and another not, accordingly as a greater or smaller number of vasomotor nerve-centers is disturbed. We also find that angina pectoris may result from organic or functional irritation of the terminal filaments of the pneumogastric nerve supplying the heart, lungs, liver, stomach, or intestines, the sense-impressions being conveyed to its nucleus in the medulla and communicated to the vasomotor nuclei. The vasomotor centres being distributed throughout the cord, as well as in the medulla, are irritated, whether from nutritive defect or otherwise, the direct cause being conjectural; the capillaries of those parts or organs from which the disturbance emanates are contracted; the blood-pressure is increased and the circulation is diminished, as indicated by the visible signs. The disturbance of circulation cries for relief, and the excruciating pain becomes a landmark for the location of the organs involved,

and furnishes indications for treatment during the paroxysm, as well as in the intervals between paroxysms.

The means at hand for treating the spasm can now be plainly indicated: Ether, chloroform, morphine hypodermatically, and amyl nitrite. Of these, morphine and the nitrite are pre-eminently the best. Of the latter, from two to five drops may be given by inhalation. Amyl nitrite is rapid in action, stimulating the vaso-dilator centers and causing a flush to appear. With the re-establishment of the capillary equilibrium, the symptoms of the paroxysm subside. It must, however, be remembered, that the nitrite affects the entire vaso-dilator system (especially that controlling the head), and by increasing the circulation in other parts, arm and extremities, sometimes causes a disagreeable sensation of fulness. It is therefore a remedy that must be used with circumspection. If confided to the patient, only a few doses should be prescribed and these with written cautions.

Many of the attacks are so short that the paroxysm may pass before medicinal treatment can be employed. As the spasms are, sooner or later, likely to recur, the case should be under persistent and prolonged treatment during the interval. Should the attack be concurrent with cardiac lesions these should receive due attention and be treated as they would under other conditions; nevertheless a general course of nerve-tonics and such other judicious medication as may be called for will prove satisfactory both to patient and practitioner. It is especially in the form designated false angina that we may hope for some permanent good from treatment. This condition is mostly found in those of neurotic tendencies, of rapid growth, poorly nourished, or suffering from gastralgia, indigestion, hyperæmia and torpidity of the liver. Let us not ignore these cases, but remember that the nerve is simply the means by which the existence of peripheral disorder is communicated to the central organ—the brain.

For the treatment during the interval, arsenic holds a position to the general condition similar to that of amyl nitrite during the paroxysm. For all neuroses, in fact whenever a nerve- tonic is called for, arsenic is a remarkable remedy; but as in the case of the nitrite, it must be used discriminately. In some unknown way, arsenic greatly assists the nutritive processes. According to circumstances, iron, nux vomica and the phosphates, given alternately or with arsenic, may be found necessary.—Dr. Bixby, in *Med. Press*.

## EIGHT CASES OF FISSURE AND ULCER OF THE RECTUM, WITH REMARKS.

Since February 10th, 1891, I have seen eight well-marked cases of fissure and ulcer of the rectum. And yet, in a practice of fourteen years, I can recall only eight or ten cases—previous to the above-mentioned eight—which I have diagnosed and treated as such. I am now perfectly satisfied, however, that during this period I have failed many times to discover the rectal lesion—one or the other, or both, as the cases may have been, for two reasons:

1. Unfortunately, I so often accepted the patient's diagnosis of his or her case, and directed a treatment for hemorrhoids.

2. When I did examine, it was not in a thorough and systematic manner, and I failed to discover the real cause of suffering. Not a few physicians could give the same reasons, as these eight cases will show.

There is very little literature on this subject in the books on surgery. I presume some works devoted especially to diseases of the rectum, treat the subject more fully; though, as I own but one little treatise on the subject, I am not prepared to say how much importance authors give it.

The general impression seems to be that rectal fissure and ulcer is so simple a matter, and the cure so easily effected (which is really true) that we fail to recognize how it wears out the patient's health and strength in a remarkable manner. The constant pain and irritation to the nervous system are more than most persons can endure.

Most of the eight cases I am about to report were non-residents of Norfolk. Two came to me so ill, and suffering such intense pain, that they felt quite sure that they had cancer of the uterus, when in reality they had only a small ulcer of the rectum. The husband of one of these (Mrs. C., aged 44, Nansemond Co.), had been informed by her family doctor that she had cancer of the cervix. I found only a simple erosion of cervix. Both left "The Retreat" entirely relieved of rectal pains, and are now in excellent health, one having gained over twenty pounds in weight.

A third case, Miss W., aged twenty-four, through delicacy of feeling, had for over three years concealed her "uterine disease" from her attending physician. A careful examination of uterus twice (second time under chloroform), satisfied me that the uterus and appendages were normal. On digital examination of the rectum, I at once outlined two polypi—one an inch long, the other not quite so long; then with a speculum I discovered, dorsally, a club-shaped fissure or ulcer, with its apex extending up to the attachment of the longest polypus, which dangled and fitted perfectly in the fissure when the sphincter

¶ THE next International Congress for the study of the question of the abuse of alcohol will be held at The Hague in September.

was closed. This fissure, like some of the others, had a grayish-colored floor, with well-defined hard edges. The young lady had many anomalous symptoms, such as pain and numbness radiating down the leg to her feet; retention of urine; almost constant pain in the back and loins, extending from the time of one defecation to the next. For weeks she had been postponing her bowel actions as long as possible, on account of the intense agony she always experienced when the desiccated and hardened feces passed over this fissure. Her relatives felt sure she was a hopeless invalid. Her mother came with her to "The Retreat," and when I assured her there was nothing like paralysis, as her doctor had suggested, and I felt quite confident that her daughter could be entirely relieved, she was very skeptical. She left in two weeks entirely cured, and now weighs over 140 pounds; is in perfect health.

The next case was a gentleman, a Methodist minister, who had been a great sufferer for ten years. He stated he had "*blind piles*," and that over a dozen doctors had treated him. A close examination of his rectum (the first in ten years), revealed a very insignificant but deep crack situated at the anal orifice over the external sphincter, and involving the skin. I also discovered a small, three quarter inch polypus high up, which gave no pain, though I snipped it off. This patient described his suffering upon defecation as agonizing.

It is very evident why such an insignificant little fissure could so prostrate him and produce such intolerable suffering. It was because of the great mobility of the external sphincter, and because the rectum and anus are abundantly supplied with branches from the sacral and pubic plexus of nerves. The location, therefore, and not the size of a fissure or ulcer, will determine the amount of suffering of a patient. Hence the importance of *close, ocular* examination of the anus, and *never* be content to accept his "*blind pile*" diagnosis and treat it.

My patient was for two years without an examination. I have within the past few days received a letter from this gentleman, from Nansmond Co., consulting me in regard to his *new wife's front passage*, and in this letter he states, "My back passage is in perfect order since the operation."

The fifth case was a noted "Madam," who keeps a house of prostitution in this city. She came to be treated for uterine trouble. She said several physicians here and two in Baltimore had treated her womb. I found a retroverted uterus, chronic cystitis and spasmodic pains in micturition. I thought these sufficient to account for her haggard and wasted condition. I sent her to "The Retreat," and not for ten days after, seeing no improvement, did it occur to me that I had failed to examine the rectum. When I did examine it, I

found a circular ulcer about one inch above the internal sphincter, as large as a silver quarter. I am quite sure the muscular fibers were laid bare in the ulcer. It was exceedingly irritable. I am also sure this was a syphilitic ulcer, as it made but little progress until after she was placed upon iodide of potash and mercury. She left "The Retreat" in four weeks, not entirely cured, but greatly relieved. She comes to my office once a week now for treatment.

As the treatment was different in this case from all others, I will state what I did. I made application of nearly everything I could think of—nitrate of silver, carbolic acid, sugar-of-lead, etc. But repeated curettings did more to break down the well-defined, almost horny edges, than anything else I did. Instead of a twenty-five-cent size ulcer she now has a contracted cicatricial spot, not entirely healed, but healing slowly, and she thinks she is almost well.

I might state just here, that over a month before I saw this patient, a prominent steamboat captain, who has his headquarters in Norfolk, came to consult me about a "terrible case of piles." I found no hæmorrhoids, but the largest fringed margin of the anus I ever saw, and between the external and internal sphincters, an ulcer, if anything larger than the woman's above mentioned. After informing him of his serious condition, and the long time he would probably have to remain quiet, he became alarmed and ran away from me, first to Richmond; and not being benefited there to Dr. Kelsey, of New York. His brother-in-law told me last week he had spent \$1,500, and while greatly benefited and now at home, he was not entirely relieved. I told his brother-in-law before he left me my opinion was that it was a syphilitic ulcer. Dr. Kelsey confirmed this opinion.

This was one of the eight cases of rectal ulcers. The other two cases were fissures. One, a Baptist minister, who had a polypus dangling in the fissure. He had been treated for several years for "*blind piles*;" no examination had ever been made.

The eighth, and last case, was the wife of a prominent merchant of the city, who had been treated for more than two years by a homœopathic with electricity and pessaries for uterine trouble. I found no uterine disease. We had never examined the rectum. It was only necessary in this instance to gently open the anus with my thumb and index finger to see the fissure plainly. When I told her to bear down the pain was so great it would throw the anus into a state of alternate contraction and relaxation. She recognized at once, as I did, that there was her trouble.

*Treatment.*—There is no operation in all surgery so simple as the one for the almost certain cure of fissure. The ulcer is not so easily relieved. If the edges of the fissure are well defined and

hard. I first trim them down with scissors curved on the flat. Now, as to the incision. If it is a case of long standing, and the sides and the floor of the fissure are of a grayish color, and the muscle beneath irritated and hypertrophied, nothing short of complete division of the external sphincter, and then dilatation with the thumbs, obliterate the fissure. I failed to relieve my first cases years ago, because I was too timid, and dilated only, or merely scratched through the fissure with the knife. If only a portion of the fibres of the sphincter are divided, there is danger of too rapid union before the fissure heals, and you may have your work to do over—that is, if the patient will allow you. If you fail to relieve at the first operation, they are apt to run away from you to a specialist.

Six of these cases were entirely cured and remained so. Not one had any incontinence of feces. Of course the incision should be made with a steady hand, and at right angles to the muscular fibers. Such an incision will always heal (except in a tubercular patient), with a nice, narrow scar.

The next most important point is to *compel* the patient to keep the bed until the wound completely heals; for if he gets out too early, the wound may not close, or far worse unhealthy ulceration follow, which will be much harder to cure than the fissure. I place a small piece of fine lamb's wool (not cotton), in the cut for twenty-four hours only. I confine the bowels for three or four days after the operation, when I introduce a suppository of a grain of aqueous extract of opium well up in the rectum, to relieve the throbbing.

My only excuse for reading this little imperfect paper before you, gentlemen, is the hope that it may cause us to examine the rectum oftener and more carefully in the future, and not be content with the diagnosis of this patient, who comes with the statement that he has blind piles and wishes a prescription, as several of these eight told me, and had been telling other doctors for years.

If I learned nothing else from Bantock, of London, and Martin, of Berlin, they showed me the importance of examining the rectum more frequently and systematically than I ever done before.—Lankford, *Va. Med. Monthly*.

#### THE TREATMENT OF SCIATIC NEURITIS BY THE LOCAL ABSTRACTION OF BLOOD.

No physician can appreciate the excruciating pain of a severe attack of sciatica unless he has suffered himself, nor can he feel how grateful the poor sufferer feels for prompt relief unless he has had such relief himself. Therefore, those remedies which give prompt relief in well-selected cases should be known and used by the practitioner. I do not

desire to go into the pathology of the disease, except to say that I believe the great majority of cases of sciatica are due to inflammation of the nerve-sheath, or the nerve itself, and that rheumatism, gout, syphilis, anæmia, etc., have very little to do as factors in the causation of the disease.

The great majority of cases that have come under my observation were healthy males, above the age of twenty-five years, and inclined to corpulency. In nearly every case I have traced the attack either to a direct injury or taking cold, most frequently the former, the most frequent injury being strain or over-stretching of the nerve, by lifting heavy weights from the ground, or remaining in a stooping position, where the nerve is kept continually on the stretch, besides being inordinately pressed on by the overlying muscles. The inflammation may involve a considerable extent of the nerve, as shown by the extreme tenderness on pressure over its course down the thigh. At times it is entirely confined within the pelvis, and I have good reasons for believing that the inflammation may affect any one of the individual nerves composing the great sciatic. Believing that the reduction of the inflammation in the nerve is the quickest way to overcome the disease, I have acted on this principle for nearly twenty years, by using one of the retired methods of treatment,—viz., wet-cupping,—the first subject being myself. I will give a couple of cases from the many I have treated by cupping, which will illustrate its beneficial effects.

CASE I.—This case was myself. In 1872, when I was 26 years of age and in robust health, I rode nearly night and day. My vehicle was a light two-wheeled sulky, which had the seat so much tilted back that I had to lean forward very much, thus keeping the sciatic nerves on the stretch all the time. Besides, there was a wire-railing around the seat just high enough to strike the sciatic nerve a little below where it passes out of the pelvis. This soon had the undesired effect of producing the severest sciatic neuritis imaginable. The pain was principally in the lower lumbar region and the upper third of the thigh. The nerve was extremely tender even to light pressure from where it issues through the great sciatic notch to the junction of the upper and middle third of the thigh. For four weeks nearly every known method of treatment was tried, with but temporary or no benefit. I suffered horribly unless well under the influence of morphine or brandy. Believing in the inflammatory nature of the disease, I had my brother apply fourteen wet cups over the lower lumbar region, on the hip and down the thigh over the course of the nerve. As the blood began to flow I began to feel easier, and, to make a long story short, I suffered no more pain, and took no more morphine or brandy. I

stayed a week in bed, got up, and went to the sgrings to get away from business and recuperate my strength.

CASE II.—Mr. C., a Frenchman, aged 52; has always been very healthy. He eats a great deal of meat and drinks liberally of wine, and has accumulated more adipose tissue than is good for him, weighing two hundred and ten pounds. About December 1st, 1891, he handled a considerable amount of grain in bags and sowed grain for two days, which started a pain in his back and hip. He thinks he also took cold while at work. The pain gradually grew worse. Domestic remedies were tried for rheumatism, and a gout pill was tried. December 20th he was taken suddenly worse, suffering excruciating pain, and his son then came for me. I found him on a "pallet" on the floor, before the fireplace, yelling from pain. The pain was located in the posterior part of the hip, down the thigh for twelve or fourteen inches, and in the lower half of the outside of the leg and foot. The nerve was extremely tender to pressure in its upper part, but nowhere else did pressure elicit any tenderness. I gave him a hypodermic injection of morphine,  $\frac{3}{8}$  grain, and atropine,  $\frac{1}{10}$  grain. Not having eased him in an hour, I gave him  $\frac{1}{2}$  grain, and in another hour another  $\frac{1}{4}$  grain. Besides, I applied several dry cups. I left  $\frac{5}{8}$  grain of morphine, all I had, to be given if pain returned. This was given during the night.

I returned next morning at ten, and found Mr. C. suffering greatly again. I had sharpened my scarifier, and got ready to abstract blood. Having no regular cupping-glasses, I used small tumblers and wine-glasses. I commenced below the crest of the ilium, and followed the sciatic down the posterior part of the thigh, applying six small tumblers and two wine-glasses, and on the calf I applied one large and one smaller glass.

After dry cupping for five or six minutes, distending and paralyzing the capillaries, I scarified deeply, and succeeded in drawing about ten ounces of blood. I then wrapped my patient up in thick woollen blankets, and gave him three ounces of whiskey, and left him for an hour. As in my own case, he began to get ease as soon as the blood began to flow, and when I got through cupping, he felt only a slight pain in the outside of the foot. When I returned he was enjoying his pipe and was as happy as could be. I ordered him to keep between blankets, not to move for anything, and to use a bed-pan when his bowels moved, so as not to put the nerve on the stretch in sitting on the ordinary chamber. I also gave him the following prescription:

R.—Extract. gelsem. fluid. . . . fʒii.  
 Potass. iodidi. . . . . ʒiii.  
 Potass. acetatis. . . . . ʒvi.  
 Aquæ, q.s. ad. . . . . ʒvi.—M.

Sig.—Two teaspoonfuls four times a day in half a glass of water.

He was kept a week in bed, and then allowed to get up. He suffered from some pain on the outside of the ankle for three days after cupping. His wife applied mustard, which was left on till it produced some vesication. This removed the pain; since then there has been no more pain.

I have been induced to write this article for three reasons,—first, I know of no standard work which says a word about this method, and I have not seen anything concerning it in any of the journals which I have taken for twenty years; second, in well-selected cases, and taken before permanent pathological changes occur, I believe there is no remedy that will act so quickly both to relieve the patient and to bring about so rapidly a subsidence in the inflammatory process; and, thirdly, it is the most rational treatment and the most prompt remedy we have in the purely inflammatory types of the disease. When one cupping does not have the desired effect, I do not hesitate to repeat it once or even twice. The patient should be kept in bed, between blankets, and perspiration encouraged. The limb should be kept absolutely quiet, but I do not believe in the straight splint. I have suffered many times with the disease since 1872, but never very severely, and my experience is that the easiest position of the limb is to have the thigh slightly and the leg considerably flexed. Under these circumstances the patient can lie on his back or either side, which is a great comfort to him. The use of adjuvants may be necessary or advisable, such as circumstances may suggest. I would especially advise the use of morphine and atropine for a few days if there is any remaining pain after cupping.

Before discharging the patient he should be fully advised to be careful in the future not to strain the sciatic or expose himself to "catching cold."—Dr. Gundrum, in *Therap. Gaz.*

#### PRACTICAL TREATMENT OF ECZEMA.

A long experience teaches me that the more strictly I conform in the treatment of eczema to the principle that the disease is of parasitic and infectious origin and nature the more successful will be the results of my therapeutic agents. Mere blandness of character of local remedies, while it may tend to lessen pruritus, exerts but little power as a curative means.

This is equally true of local remedies designed to lessen irritation and inflammation. We will find that notwithstanding the industrious use of this class of agents the disease is not lessened or cured, but that there is something back of simple irritation or inflammation, some specific influence in operation, that refuses to yield to our simple remedies. Just as in the case of syphilis, we may give all kinds of simple remedies, while the march of the disease continues on until we adopt the



specific antidotes, when the infection immediately succumbs. Thus I regard eczema as a disease arising from specific parasitic infectious causes, and not a simple irritation or inflammation that can arise from any passing irritating influence.

Furthermore, I am impressed with the conviction that this specific parasitic cause must be destroyed by appropriate antidotes. There is a very large group of anti-parasitic agents in our materia medica. Among those for local purposes are sulphur and its compounds; coal and wood-tar and their numerous derivatives; mercury, iodine, boracic acid, bromine, etc.

In relation to prophylaxis, I am convinced that the leading hygienic measures are absolutely necessary to the prevention of the extension of the disease. These are isolation of the infected persons and cleanliness. I have so often seen the spread and radiation of the disease from a central point of infection that I cannot doubt its contagious character.

During the recent war inveterate eczema was exceedingly prevalent in the Confederate Army. When a case of eczema came into a tent or company of soldiers, that other cases would follow was almost a certainty. Then again, when a soldier would return home and occupy the same bed with his wife, his brother, or a friend, the companion would almost surely contract the disease.

In the past year or two eczema has been somewhat prevalent in this community. A child belonging to a family in this town associated with another who had the disease. The child contracted eczema, went home and imparted the infection to two other children and the father. These are only a few instances given as evidence of the contagiousness of eczema.

Impressed with this idea, I believe that isolation and cleanliness are the chief prophylactics and that anti-parasitic agents are the most efficient curative remedies. In the acute stages of eczema I am in the habit of ordering the skin to be bathed at least twice a day with a lotion composed of sodii hyposulphit.  $\bar{z}$  i, sodii borat  $\bar{z}$  pss, aquæ  $\bar{z}$  xij. This is a good anti-parasitic and anti-pruritic. In these early stages I begin the treatment by a moderate course of mercurials, grain j of hydrarg. chlor. mit., and an equal quantity of blue mass, until the secretions of the alimentary canal are well established. Then an alkaline course, consisting of liq. potas. citratis  $\bar{z}$  ss, potas. bicarb.  $\bar{z}$  ss, after each meal. These remedies in a certain proportion of cases will result in subduing the disease in the early stages, but not in all.

In inveterate eczema of the scalp a different treatment is necessary. After experimenting with a variety of local agents, I have found the following lotion by far the most certain :

R—Ol. ricini, . . . . . f $\bar{z}$ iv.  
 Bay rum, . . . . . f $\bar{z}$ ij.  
 Acid salicyl. . . . .  $\bar{z}$ ij.  
 Resorcine, . . . . .  $\bar{z}$ i.  
 Quinin. sulphatæ, . . . . . grs. x.

This very active parasiticide is to be applied over the scalp night and morning and rubbed into the skin. I believe that perseverance in the use of this remedy will not only relieve most cases of of this kind but will promote the growth of the hair.

Then, again, in the advanced stages of inveterate general eczema, a modification of treatment becomes necessary. The chief internal remedial agents in this class of cases are arsenic, sulphur in some form, iron, and iodine; the sulphide of arsenic,  $\frac{1}{100}$  grain, three times a day, or the sulphide of calcium, 1 grain, three times a day. But I usually precede these medicaments with sulphur sublimat,  $\bar{z}$  ss, potassii bitart.,  $\bar{z}$  ss, divided in chart No. x; one after meals. I feel sure that sulphur is one of the best of germicides and that the system should be saturated with the agent.

In chronic eczema, when the general health is below par, and there is a tendency to anæmia, the tinct. ferri chlor., in appropriate doses, and Fowler's solution, will be of service.

In one of the most inveterate cases of eczema that I ever saw, of the face, in an adult, a teaspoonful of the syrup of hydriodic acid, three times a day, with local treatment, eradicated the disease. The local agents in these inveterate cases that have given me the most uniform satisfaction compose the following combination :

R—Lanoline, . . . . .  $\bar{z}$ j.  
 Albolene, . . . . .  $\bar{z}$ j.  
 Sulphur sublim. . . . .  $\bar{z}$ ij.  
 Aristol, . . . . .  $\bar{z}$ ij.  
 Ungt. picis liq., . . . . .  $\bar{z}$ ij.

The faithful application of this ointment night and morning has served in my practice in the past few years to cure more cases of inveterate eczema than any other local remedy.

In treating parasitic disease of the skin, our germicide agents often destroy the parasite only, and do not reach the ova or germ itself. This explains why we so often relieve the local affection temporarily, apparently curing it, and after suspension of treatment the disease returns. To eradicate the disease, our agents must kill the ova as well as the parasite.

Itching is one of the most annoying features of eczema. This symptom is one of the most common results of parasitic action on the skin. The bite of the innumerable varieties of fleas, of the mosquito, of the gnat, of the flea, of the numerous

species of insectile parasites that infest and attack the human skin, and the movements of minute creatures that imbed themselves in the substance of the skin, as the acarus, all produce the sensation of itching. It is not the simple penetration of the skin that causes itching as any sharp instrument that penetrates, as the needle or pin, does not produce itching, but pain. It is the irritating poisonous matter deposited by the insect that acts on the nerves of the cutis vera.

We can with equal reason assume that the deposit of the microbic organisms causing parasitic disease of the skin, as eczema and analogous affections, cause the itching peculiar to these diseases; and the best anti-parasitics will be found in the germicides to destroy the parasites. For instance, in the case of the common acarus we may use all the anti-parasitics possible without effect until the insect is destroyed by the appropriate germicides. It may be that certain parasites or microbes are only susceptible to the destructive action of certain agents. Sulphur will destroy certain species; mercury another; arsenic, iodine, resorcine, carbolic acid, salicylic acid, naphthalene, others.

The germicidal line of treatment in my experience, is the only method that gives permanent success. But there is an important principle involved, even in this, that is necessary to success, and that is a firm and steady perseverance in the application of our therapeutic measures. The successful treatment of inveterate eczema requires all the firmness and perseverance of our character to accomplish it.—BEDFORD BROWN, M.D., in *Maryland Med. Jour.*

## ON THE MEDICAL TREATMENT OF CYSTITIS.

Acute cystitis is far less commonly met by the physician than the chronic form, while its treatment is far simpler, and, I may add, more satisfactory, at least so far as the removal of the acute symptoms is concerned. Rest in bed is a primary and essential condition. Leeches to the perineum should be applied more frequently than they are. A poultice to this same region and over the abdominal region is always useful, while a brisk saline cathartic should never be omitted.

As the feverish state which always accompanies cystitis is more or less constantly associated with a scanty urine, concentrated and irritating to the inflamed mucous membrane, it is desirable at once to increase the secretion, and thus dilute it. Copious libations of pure water, to which the citrate or acetate of potassium is added, in 15 to 20-grain doses for an adult, should be allowed. The ordinary spirits of nitric ether in 2-drachm doses every two hours is an admirable adjuvant, and may be combined with the officinal liquor potassii citratis,

which contains about 20 grains of citrate of potassium to the half ounce. Formerly the mucilage of flaxseed or flaxseed tea was much used as a diluent menstruum for the diuretic alkalies indicated, but I am doubtful whether it is any more efficient than a like quantity of water.

Where there is much pain and straining, as is often the case, especially where cantharides is the cause of the inflammation, opium is indispensable, always in the shape of a suppository, half a grain to a grain of the extract being thus administered, or a proportionate amount of morphine. Iced water injections into the rectum, or pieces of ice similarly applied, are very efficient in allaying the pain and irritation where additional measures are needed.

The successful treatment of chronic cystitis is a much more difficult task for three evident reasons: (1) the constant presence in the bladder of the urine with its irritating qualities, especially to an inflamed mucous membrane; (2) the difficulty in getting remedies to reach the inflamed surface; and (3) the pent-up inflammatory products, which in their decomposition often make the urine still more irritating by exciting in it ammoniacal changes.

1st. The irritating qualities of the urine may be diminished by the use of diluents, as already recommended in the treatment of acute cystitis. When it is proposed to go farther and add to the efficiency of diluents, mistakes are often made, for in the chronic form the urine is already alkaline, or becomes so on the slightest addition of alkalies to the blood. Such alkalinity in turn favors decomposition, the effect of which is to convert the pus, if present, into a tenacious, glairy fluid, which the bladder cannot evacuate. The indication under these circumstances is to render the urine acid, if possible, although this is very difficult to accomplish.

Benzoic acid will probably do this in 5-grain pills, at least six a day.

The second indication is to medicate the inflamed surface. Two ways, of course, suggest themselves: (a) by the internal administration of drugs; (b) by the injection of medicated liquids into the bladder.

The best of these is the oil of sandal wood in 10-minim capsules at least eight a day, two before each meal and two at bedtime. The preparation known as Santal Midy is better borne than other specimens of the oil.

The application of remedies to the bladder by injection can be conveniently considered in connection with the third indication—the getting rid of the products of inflammation, the pus and mucus, and the compounds resulting from their decomposition. Tepid water should be at first used, and the injection made through the soft catheter, four ounces at a time. After a few in-

jections with tepid water he adds a solution of salicylate of sod. in the proportion of one drachm to a pint. He also refers to boric acid, alum, and bichloride of mercury, beginning with 1 part in 25,000.

Where there is greatly enlarged prostate catheterizing is indispensable, and is often attended by most happy results.—Dr. Tyson in *N. C. Med. Journal*.

### THE TREATMENT OF ASTHMA.

The questions as to the etiology and pathology of this strange affection have been so thoroughly discussed by clinicians, physiologists, and pathologists that there is little more to be said, unless something definite can be stated in place of the numerous hypotheses which each writer has advanced. The truth is gradually dawning upon many in the profession that asthma is a symptom, not a disease, a manifestation of functional or organic disturbance in the nervous system, in the upper air passages, in the gastro-intestinal canal, or even in the kidneys, bladder, or uterus. As a result of this conclusion physicians no longer rest satisfied with simply prescribing for the asthmatic attack, but endeavor at the same time to discover and remove the cause which, however remote it may be, can generally be discovered by careful investigation. It is not the purpose of this article to call attention to the methods by which we proceed in the discovery and treatment of the exciting causes of asthma. Regarding the treatment of the case as consisting in a double line of procedure, we shall devote ourselves to the consideration of the care of the patient during the paroxysm, or just when a paroxysm is feared to be approaching.

It having been proved by C. J. B. Williams that the minute bronchial tubes contain as many, if not more, muscle-fibres as the larger ones, the question as to the possibility of there being a distinct contraction of the air-passages is assured. Stoerk and other clinicians have found that hyperæmia of the bronchial tubes is always present when asthmatic attacks occur, and still others have demonstrated the fact that the muscles in the walls of the tubes and the blood-vessels of the mucous membrane are governed by the anterior and posterior pulmonary plexus, which are made up of branches of the pneumogastrics, recurrent laryngeals, spinal nerves, and ganglia from the sympathetic system. Branches from these plexuses form a network about the bronchioles and contain ganglia. Reflex activity can therefore play an important part in the causation of asthma, and those remedies which decrease reflex activity and depress the vagus nerve or its terminal branches are nearly always indicated. It is for these reasons that belladonna has been so long a favorite drug for the relief of asthmatic attacks, since it depresses

the power of the vagi. In a similar manner is relief brought about from the administration of lobelia.

Within the last two years another remedy for asthma has been introduced into medicine,—namely, *euphorbia pilulifera*, the mode of action of which is almost unknown. Empirically, however, it has been found of service in asthma, and it may be employed along or in combination with several of the depressants to the pneumogastric nerve, in a prescription made up as follows, which is most readily given in a compressed pill or capsule :

R.—Extract. *Euphorbiæ piluliferæ*. ℥ iii.  
Nitroglycerin . . . . . gr. ʒiʒ.  
Sodii iodid. . . . . gr. ii.  
Potassii bromidi. . . . . gr. ii.  
Tr. lobeliæ . . . . . ℥ii.—M.

Sig.—To make one dose, which may be doubled or tripled, and used three times a day.

It will be seen that in this prescription we have the new antiasthmatic *euphorbia*, and in addition that powerful depressor of the vagus nerves, nitroglycerin, which at the same time tends to relax muscular fibres which are contracted in spasm. The lobelia has a similar effect on the vagus, and the iodide of sodium exercises the peculiar effect which the iodides possess in altering abnormal secretion, and promoting normal function in the respiratory passages, in so far as secretion is concerned. Finally, the bromide tends to decrease reflex activity and so to lessen spasm in addition to quieting nervousness and relieving insomnia. The nitroglycerin is used in the comparatively small dose, in order to allow of the increase in the dose of the other constituents, without increasing, to too great a degree the dose of this powerful medicament. In obstinate cases, the *euphorbia pilulifera* may be given in separate doses to the extent of half to one drachm in addition to the prescription already named.—*Therap. Gaz*

### THE PATHOLOGY OF VERTIGO.

Dr. C. W. Suckling, in an interesting communication on vertigo to the *Birmingham Med. Rev.*, November, 1891, draws attention to the following points :

Vertigo, is a symptom, not a disease. It results from many morbid conditions. It is more frequently due to functional disorders than to organic disease of the brain. It is the consciousness of disordered equilibration, and is produced generally by a want of harmony in the impressions derived from the senses which subserve equilibration. The senses are : the impressions gathered by the terminations of the auditory nerves in the membranous labyrinth, especially the semicircular

canals; sight, and the muscular sense of the muscles of the eyeballs; touch, especially plantar touch; muscular, and possibly articular and visceral, sensibility. The co-ordinating centre is situated in the middle lobe of the cerebellum. The motor apparatus is found by the muscles of the head, neck, spine, and lower extremities. Derangement of any part of this mechanism may lead to vertigo; but the great organ of special sense for equilibration is formed by the semicircular canals. Vomiting nearly always accompanies intense vertigo, and is not nearly so suggestive of serious disease as it is when it accompanies headache.

Dr. Suckling classifies the forms of vertigo as as: (1) *Aural or labyrinthine vertigo*; (2) *Ocular*; (3) *Vascular*; (4) *Dyspeptic*; (5) *Nervous*; (6) *Epileptic*; (7) *Due to Organic Brain Disease*; (8) *Toxic*; (9) *From Reflex Irritation*.

The first variety (Mènière's disease) is by far the most important variety, though cerebral anæmia and brain exhaustion are the most common causes of vertigo. Mènière's disease is characterized by three symptoms:—vertigo, which is severe and paroxysmal; tinnitus; and deafness. All these symptoms may be paroxysmal, but usually deafness and tinnitus are constant, though much increased during the paroxysmal attacks. Mènière's disease is rare under twenty, more common after forty, and especially found during the degenerative period of life. The bromides hold, in Dr. Suckling's opinion, the first place in the treatment. In ocular vertigo, some error of refraction is usually present. Vertigo from disturbance in the blood-supply to the brain is of frequent occurrence; it is as a rule continuous and paroxysmal. Some authorities deny that gastric vertigo exists, deeming all such cases to be really aural. Vertigo occurs as an idiosyncrasy in some people after eating certain articles of food. Nervous vertigo is produced by cerebral exhaustion; and it requires to be treated by rest, change of air, alcoholic stimulants, iron, and strychnine. Epileptic vertigo requires a continuous treatment with the mixed bromides. Vertigo from organic disease may result from tumors situated in any part of the encephalon, but it especially occurs in tumors or lesion of the cerebellum and its peduncles, and of the pons. Under toxic vertigo we may include the vertigo of uræmia, gout, specific nerves, tobacco, alcohol, and drugs. In giddiness, convulsions, or other nervous disturbance in children, worms should always be suspected.—*Practitioner*.

#### PROPHYLAXIS AGAINST NEPHRITIS SCARLATINOSA.

—Dr. Ziegler (*Berl. kl. Wochenschrift*), refers to the value of milk diet in the treatment of nephritis, especially in its acute form, and that in children it is very easy to carry out this line of

treatment. Hensch, Senator, and Baginsky are each quoted in support of this treatment. Dr. Ziegler gives the results of his experience and observation for a period of six years as physician to the Military Orphan Asylum at Potsdam during nine epidemics of scarlet fever. In uncomplicated cases, his reliance was entirely upon a milk diet and rest in bed, in order to avoid catching cold. The favorable results led him to use it as a prophylactic against the development of nephritis during and after scarlet fever. Milk acts as a gentle diuretic and is at the same time a nutritious diet, which can be said of no other means at our command.

His mode of treatment is as follows: At the beginning of the attack, when there is high fever and loss of appetite, the milk is diluted with seltzer or soda water. This, with water gruel, comprises the only treatment in uncomplicated cases. After a few days, when the desire for food returns, zwieback or rolls are given with the milk. The amount of the milk is only limited to the appetite of the patient—sometimes one-and-a-half to two liters being taken in twenty-four hours. The diet is continued till the end of the third week, when other nourishment is gradually added. No statistics from his private practice are given, for the reason that he felt that they would not be reliable, as the patients could not be under absolute control. The study of the orphan asylum statistics covers the period from 1875 to 1892. In the nine epidemics there were 218 cases of scarlet fever; 115 cases occurred before the introduction of the "milk-diet treatment." More than half of these had kidney complication during or following the acute disease. And it is farther recorded that many of these cases were of an extremely light form. In the second category there were many cases of great severity, some of which died in three or four days, but there was no development of renal complication during the stay the patients in hospital.

In private practice he found it difficult to confine patients to an exclusive milk diet, as they soon grew tired of it. In such instances he allowed farinaceous food with the milk.

[I have employed this method in several cases with the most satisfactory results. By combining farinaceous food with the milk early in the course of the disease, as soon as the patient begins to desire to eat, I have not met with difficulty in carrying out the principle. It is advisable to keep the bowels open at least every other day, preferably with small doses of soda and calomel.—F.H.S.]—*Brooklyn Med. Jour.*

URÆMIA.—Many middle-aged men are unwittingly the victims of a mild form of chronic uræmia; going about their daily avocations with heavy heads, hot skins, drowsiness, blurred sight,

shortness of breath, and general feeling of uneasiness, "stupiness," oppression, and malaise. All these symptoms are quite consistent with derangement of the liver and digestive organs, but they are also frequently due to torpor of the kidneys, not yet actual disease, added to a lazy action of the skin. This leads them instinctively to the use of Turkish baths, hot water baths, and other modes of rapid elimination. And they really experience almost magical relief, feeling as though they breathe luxuriously through the skin as well as the lungs, for they have just expelled quite a quantity of pent up poison from their tissues. This poison consists of urea and other nitrogenized constituents of urine; and when a more formidable amount is locked up in the blood, through more urgent failure of the kidneys, headache, vomiting, puffiness of the eyelids and face, ascites, and most alarming symptoms of blood-poisoning develop. The pupils now dilate, the odor of the breath and perspiration become "urinous," the breathing is labored and there is evident cerebral disturbance, leading to delirium, convulsions, and coma. Sometimes an attack simulating epilepsy or apoplexy sounds the first note of warning. These symptoms constitute acute "uræmia," or an accumulation of urea in the blood, though it is just as likely due to other excrementitious products; in fact, in many instances, as in the uræmia of cholera and some hepatic diseases, the vital fluid is singularly free from urea. The diseases associated with acute uræmia include the various forms of Bright's disease; typhus, typhoid, scarlet and yellow fevers; small-pox, pleurisy, and probably diphtheria and acute rheumatism; extravasation and suppression of urine, stone in the kidneys, impacted calculi in the ureters, impassable stricture of the urethra, and cancer of the uterus. The treatment must necessarily be active, but it is far from satisfactory in severe cases. Horizontal posture, with the head raised; cold applications to the scalp; sinapisms to the loins; vapor baths; purgatives; diaphoretics; hot blankets; sometimes bleeding; chloroform or ether; jaborandi; nitro-glycerine; oxygen inhalations; digitalis leaves as poultices to the abdomen; and transfusion of blood. Diuretics are to be avoided when the kidneys are in a state of irritation; and the main channels of elimination shall be sought through the media of the skin and intestines.—Louis Lewis, in *Times and Register*.

"ELIMINATION OF MICRO-ORGANISMS BY THE SWEAT."—Under the above title a short paper appears in *L'Union Médicale* for March 3rd of this year. It commences by stating that it is still an unsettled question as to whether micro-organisms are able to pass through certain vessels and organs, and then be eliminated by means of the kidneys or intesti-

nal canal, when these organs are in themselves perfectly unaffected and in a healthy condition. According to some authorities, amongst whom is Wyssokowitch, such an event can only occur when there is a sanguineous exudation, or the tissues of the kidneys or intestine are diseased. Some observers, on the other hand, deny that such conditions are necessary. Thus Trambusti and Maffucci maintain that they have found anthrax bacilli in the urine and bile when no disease whatever could be found in the kidneys and liver. Baumgarten, again, states that he has seen tubercle bacilli pass from the blood into the tissues when the walls of the vessels were quite healthy. From other authorities we learn, on well-established evidence, that pathogenic micro-organisms can pass into the milk when the mammary glands are unaffected. Brunner investigated this matter from another side, and demonstrated the fact that pathogenic microbes could be eliminated by means of the sweat. This investigation was met with a great difficulty from the outset—namely, that it was not easy to sterilise the skin so as to be sure that the micro-organisms which were found in the secretion, and cultivated in artificial media, were derived from the tissues and fluids of the body, and not from its cutaneous surface. This difficulty was overcome by using animals for experiment which had been inoculated with disease, the pathogenic organism of which could not accidentally have found its way on to the skin. The animal was then made to perspire profusely by artificial means, pilocarpine being usually employed for this purpose, and then further inoculation and cultivation experiments were made with the sweat. Proceeding in this way, Brunner injected a culture of staphylococcus aureus into a hog, one of anthrax into a cat, and one of micrococcus prodigiosus into a sucking-pig. In all three cases the microbes injected were found in the sweat, and also in the saliva. This is an important discovery, from both practical and theoretical points of view. It gives the crises, accompanied by profuse perspirations, which may be produced artificially or occur naturally, a still more important place than they formerly held. It also demonstrates that there may be great danger in allowing a patient who has been sweating profusely to possibly reabsorb the secretion, and that therefore it is a good plan to employ moderate friction with dry cloths when such a crisis occurs, and to subject all linen and clothing capable of absorbing the sweat to immediate disinfection. Another precaution which the investigation indicates is that when an abscess is discharging externally, or when a patient is suffering from erysipelas or other infectious cutaneous affection, there is great danger to the patient himself if the linen, etc., are not changed after profuse sweats, as the micro-organisms may possibly be absorbed by the skin. It is singular, however, that several observers (includ-

ing Mattei, Surmont, and Lille) have failed, after numerous attempts, to find tubercle bacilli in the sweat of phthisical patients; so numerous have such trials been that we may almost consider it as absolutely proved that such migration of the bacilli does not occur.—*Lancet*.

**THE SURGICAL TREATMENT OF TUBERCULOUS CERVICAL GLANDS.**—Owen, in writing on this subject (*The Practitioner*) emphasizes the importance of early operation. The routine treatment of iodine and poultices he considers unsatisfactory, and the administration of sulphide of calcium has been in his hands the "veriest impostor of the Pharmacopœia." Even a visit to the seaside is considered as so much time wasted. Aspiration of a suppurating gland is characterized as a half-way practice. Once a gland has broken down, an operation becomes imperative. If the surgeon does not interfere, Nature performs the work, but at best slowly and imperfectly, and with much greater deformity than after the surgeon's knife.

In those cases which are seen early the operation is a very simple affair, but unfortunately comparatively few consult the surgeon at this stage.

The operation, to be successful, must deal radically with every affected gland and sinus. Due regard must be had for the various important structures of the neck. Of these, the internal jugular vein causes the greatest anxiety, these growths at times being intimately connected with the wall of this vessel, which is frequently seen exposed at the bottom of the wound. The author refers to a well-nigh fatal attack of dyspnoea in a child on removing a sarcomatous tumor of the neck. Owing to the difficulties and dangers of these operations, it is advised to have a skilled anæsthetist and a familiar and trustworthy assistant.

It is considered a mistake to attempt to work through too small an incision or to spare the scalpel at first, though subsequently the more blunt dissection the better. Diseased skin should be sacrificed, and when all is completed the cavity may be filled with powdered boric acid and covered with an antiseptic dressing.

If the wound be a clean one primary union may be aimed at by the introduction of sutures. When the glands are broken down, however, and the curette has been employed freely, the wound should not be closed. Occasionally a second cleaning and scraping is necessary before complete healing occurs.

The author does not consider the risk of general dissemination of tuberculous matter after such an operation to be great, but believes, on the contrary, that the patient has been rid of much of the danger of general tuberculosis. [This is all in accord with modern teachings, and has been especially emphasized by the writer and Mr. Treves.

The one point which seems open to dispute is, as to the value of such measures as change of climate. If the case is seen early and is not rapidly progressive, and if no glands are as yet broken down or caseating, it is unquestionable that sea air or mountain air, cod-liver oil and the iodide of iron, limitation of the movements of the head by means of a collar like an old-fashioned "stock," attention to any defects of neighboring skin or mucous surfaces, etc., may sometimes be followed by resolution. Operation, though advisable, and, indeed, necessary in the great majority of cases, need not be considered the invariable rule.—J. W. W.]—*Am. Jour. Med. Science*.

**THE FUNCTION OF THE HAIR-TUFTS IN MAN.**—In the *Journal of Anatomy and Physiology*, Dr. Louis Robinson formulates a theory to account for the persistence in man of the tufts of hair usually present in the axillæ and over the pubes. These he imagines to be the persistent remnants of hair-tufts developed with reference to the clinging or grasping power of the young, and as a means of enabling them to cling to the parent when he or she, as the case may be, was not in a position to spare an arm without much imperiling the chances of escape or rendering movement difficult. Naturalists have observed that young apes hang beneath the body of the mother and sustain themselves by grasping the hair, and it is stated that certain male gibbons assist in carrying the helpless young. It is an interesting point that in these apes the period of immaturity is prolonged almost as much as in man. Other considerations which Dr. Robinson looks upon as supporting his theory are the appearance of the hair at puberty, its appearance in both sexes, and the fact that it often appears earlier and more plentifully on the female. It also exists in parts where the young of tree-climbing animals could attach their hands without danger of violent contact from obstacles, and Dr. Robinson has ascertained by measurement that in most cases the situation of the axillary and pubic tufts is within easy reach of the hands and feet of infants when their limbs are extended, if the body of the adult is in the position taken by that of an anthropoid ape in climbing. The theory is no doubt ingenious; but objections to it readily occur. Dr. Robinson considers some of the most obvious of these, such as the existence of similar hair elsewhere and the sensitiveness exhibited by the skin when the hair in those parts is pulled. These, of course, are capable of being explained; but the theory would be very much strengthened if any example could be quoted of an anthropoid ape in which these tufts are actually used in the manner suggested by the author. Their development, if the theory is correct, must have been very much greater in his ancestors than it is in man at the present time, to account for their persistence now, not only in the

absence of any use for them for so many ages, but actually in spite of very considerable drawbacks to their existence, such as much exist in the friction to which they are exposed.—*Lancet*.

**THE TREATMENT OF REDUCIBLE HERNIÆ BY THE INJECTION OF ALCOHOL.**—Edward Steffen, of Zurich, during the past three years, has treated 326 cases of reducible herniæ by Schwalbe's method, and has published the results in the *Correspondenzblatt für Schweizer, Aerzte*. In most instances the patients were able to continue their work during treatment. After the injection the puncture was cleaned and covered with mercurial collodion. Notwithstanding, in a few cases, sloughing took place; but this acted rather beneficially than otherwise. The number of injections in a single case varied from 6 to 168, the latter extending over a period of two years and a half. A medium-sized rupture in an adult required from 80 to 100 grammes of alcohol. The author used alcohol 70 per cent. in doses of one to four grammes, substituting in exceptional cases extract of oak bark. Latterly he found the addition of phosphoric acid, in the proportion of 1 to 200, advantageous. In thirteen cases the result of the treatment is not known, in twenty-nine a cure was not possible from various causes, such as obesity or size of the rupture; of the remainder, 245 cases are reported cured and nineteen improved. The longest time taken to effect a cure was four years, the shortest one year. Of 257 inguinal herniæ, 216 cases were cured and 16 improved, with 23 relapses. Of 13 femoral herniæ, 9 were cured and 2 improved, with 1 relapse. Of 19 umbilical herniæ, 17 were cured, with no relapse. Of 4 herniæ in the linea alba, 3 were cured, the other improved. It appears that the more recent herniæ and the younger the patient the more favorable the prognosis, and the ambulant treatment, with intervals of three to seven days between the injections, gave better and more lasting results than the treatment in bed with daily injections.—*Lancet*.

**PUERPERAL SEPTICÆMIA FROM MEPHITIC AIR.**—Guéniot (*Bull. de l'Acad. de Méd.*,) read before the Paris Academy of Medicine on March 1st, 1892, a paper on this subject, which raised a very active discussion. It was based on four cases, in which the mothers all recovered after running great peril; the children were all born alive. The house where the patient lived was in each case malodorous. In the first case, the poisonous air arose from an untrapped sink pipe in a dressing room attached to the patient's bedroom. A similar insanitary arrangement existed on each floor. In the second case, a filthy privy on a staircase close to a large library room was the source of infection; the other side of the library. In both these cases the forceps was used with every precaution; Guéniot

had employed instruments repeatedly without any similar accidents. In the remaining cases, no forceps was required; the mephitic air came from a privy in the third, and from a ventilating pipe connected with a cesspool in the fourth. Free carbolised intrauterine injections and other precautions saved the patients. Guéniot declared that mephitic poisoning during pregnancy occurred in the respiratory tract; after pregnancy it entered through raw surfaces contaminated by liquids and solids already infected by the poisoned air. The septicæmia so produced was not of a suppurative type; its chief focus was the uterine cavity, where the septic vibrios met, in fluids holding the products of mephitism, a first-rate cultivating medium. M. Alphonse Guérin, who claimed to have discovered the germ theory of sepsis many years before the modern antiseptic doctrines were first promulgated, and M. Charpentier alike scouted the theory of infection through the lungs. That way of infection only occurred in paludal fevers. Had the mephitic poisoning occurred through the lungs in M. Guéniot's cases the patients would have been taken ill during pregnancy, not after delivery; and M. Guéniot did not explain how it was that the other inhabitants of the houses where the patients lived managed to escape infection. M. Charpentier considered that injections were insufficient, the curette should be used as well, but M. Guéniot maintained that the curette often made these cases worse. The septic symptoms only appeared after delivery because then a far larger dose of the poison was taken into the system than before.—*Br. Med. Jour.*

**THE SUBSEQUENT RESULTS OF SIMPLE RESECTION OF THE SCROTUM AS A TREATMENT FOR VARIOCELE.**—Wickham, in the *Revue Générale de Clinique et de Thérapeutique*, gives the ultimate results of five cases of this operation. In performing it one should resect, from the parts on either side of the raphe, a sufficient quantity of skin, so that the scar will fall in the median line and appear like a normal raphe. The remaining skin supports the testicles, and presses them up against the external abdominal rings. The operation is easy of performance, but care should be taken to excise a sufficient amount of skin, and a special clamp devised for the purpose had better be used. The first case, aged forty four, for several months had pain while walking for any distance. The operation above described was performed, and three years later the scrotum had not enlarged, but was of normal dimensions. The veins appeared normal to the touch, and all pain had disappeared. The second case, a man, aged thirty-eight years, was also found completely cured after a lapse of three years. Case three, aged twenty-nine years, had a long and flaccid scrotum. Two years after the operation there was no pain, and the scrotum

normal in size. Case four, a young man aged nineteen, had a large varicocele and relaxed scrotum. Nearly four years after he had been operated upon, his condition was perfect. The fifth case was aged thirty-three years, and after three years and a quarter was still found perfectly cured.

These cases show the good results to be obtained by excising a portion of the scrotum in cases of varicocele. While one cannot say the disease will never return, still the statistics compare favorably with those of operations, for the same condition, on the veins themselves; also, as the operation can hardly be deemed other than one of expediency, it has the advantage of not endangering life. There is one contra-indication to its performance, and that is when the pains complained of are increased by the wearing of a suspensory badge.—*University Med. Magazine.*

**CARBOLIC ACID POISONING.**—On December 26, 1888, a child fifteen months old drank some crude carbolic acid from a bottle. Its parents being close at hand, heard its cries, and the father snatched the child in his arms and ran to my house, not more than one hundred yards distant. Probably not more than two minutes could have elapsed between the taking of the poison and the time when I saw the child, and it was then totally insensible.

The pupils were much contracted, the corneal reflex was absent, the breathing labored and noisy, the face pale, and the lips cyanosed where not seared with the acid. The pulse was almost imperceptible and the child appeared to be on the point of death.

I poured an ounce or two of olive oil down its throat at once and injected  $\frac{1}{10}$  gr. of apomorphia into the arm. I then passed a No. 10 gum catheter down the œsophagus, and with a large brass syringe injected four ounces of milk and olive oil. On turning the child on its face with the head lowered, this at once escaped again through the catheter, and in this way the stomach was repeatedly and quickly washed out, the first of the returning fluid smelling very strongly of carbolic acid. Ultimately about four ounces of the oil and milk were left in the stomach. Although the dose of apomorphia was a large one ( $\frac{1}{10}$  gr.) vomiting did not occur for more than an hour after its administration. The milk and oil then expelled had but a faint carbolic odor.

Sensation returned in the cornea after about two hours, the contraction of the pupil passed off, and in three hours from the time of taking the poison the child, in spite of the burnt state of the tongue, was able to take the breast. The tongue, fauces, and buccal mucous membrane were extensively burnt, and externally the burns extended around the mouth, over the chin, throat, chest,

and abdomen almost as low as the umbilicus. The fingers also were burnt, and there were various smears and finger marks over the cheeks and around the eyes. As to the quantity of acid swallowed, I am unable to judge with any approach to accuracy. No convulsions occurred, and the child made an excellent recovery.—*Austral. Med. Gaz.*

**NEURASTHENIA AND HYPER-ACIDITY.**—The *Medicinisch Chirurgische Rundschau* reviews an article by A. Pfannenstill, of Stockholm, in the *Nordiskt Med. Ark*, on the connection between the above-named two conditions. Neurasthenia and nervous dyspepsia are, according to the writer, as frequently seen in Sweden as in other parts of the world. A valuable addition to the etiology of these complaints is that all the cases observed by Pfannenstill belonged to the working classes, so that neurasthenia is certainly not confined to the upper classes of society, who are most exposed to the excitement of modern life. Of both complaints a primary and secondary form can be distinguished; but the latter, which is merely a symptom of other affections, especially hysteria, is much the more frequent. Hysteria is more often observed in connection with a general neurasthenia, in which the functions of the secreting nerves are always disturbed, and we may find in consequence hyper-acidity and hyper-secretion, or subnormal acidity, or even an entire absence of acid. The hyper-acidity is entirely due to an increase of hydrochloric acid. Pfannenstill considers that this hyper-acidity is the result of an increase in the quantity of the gastric juice, and not merely of the hydrochloric acid, and that there is no decrease in the power of absorption. Increased secretion of gastric juice is probably the source of hyper-acidity in other affections of the stomach, and the reverse is probably equally true.—*Lancet.*

**SIR GEORGE HUMPHRY ON "NIPPING."**—Professor Sir George Humphry, F.R.S., in addressing the Cambridge Temperance Association this week, took occasion to protest against the common form of intemperance in drinking, which was short of drunkenness, but which, as it was more general, was more prejudicial, and was doing more damage than actual drunkenness. This was the habit of "nipping"—taking a glass now, a glass then, and a glass often; in the morning (which was worst of all), at the midday meal, in the afternoon, and in the evening. Even more than drunkenness, this was terribly damaging to the system; it made men soddened, and was evinced in a general shakiness of the hand, sometimes of the step, and above all of the tongue—in fact, a general shakiness of all the organs. The "nippers" succumbed to slight accidents, slight illness, or slight shocks of any kind. Prick them, and the life, as it were, ran out of them. They said, "My work is hard," and they



took the very means which unfitted them for good and prolonged work. By temperance in drink, he meant that nothing should be taken whatever under any conditions except at meals, and very little then. Those who could not be absolutely temperate, and content with moderation, should become total abstainers.—*Br. Med. Jour.*

**TREATMENT OF DYSENTERY.**—Drs. Lardier and Pernet strongly recommend the use of salol and iodoform in the treatment of dysentery. Salol, in four-grain doses suspended in mucilage, acted in a most salutary manner; but iodoform—from four to six grains daily, combined with opium—gave the most beneficial results. The iodoform was given in capsules, each containing three-quarters of a grain of iodoform and a quarter of a grain of opium, to be taken five or six times during the day. The pain and tenesmus were relieved by warm boracic acid enemata, and in obstinate cases by a suppository containing hydrochlorate of cocaine and opium. In addition to this treatment great cleanliness was observed, the patient being washed daily with a saturated solution of boracic acid or with a solution of corrosive sublimate of the strength of 1 in 500.—*Lancet.*

**COMMON SALT FOR FACIAL NEURALGIA AND ALLIED NEUROSES.**—Take chloride of sodium finely powdered and perfectly dry, use as a snuff in the nostril of the affected side. The best results are obtained when the salt is administered through an insufflator. An insufflator holding four or five grains is sufficient. As the powder is blown in the nostril ask the patient to inhale through the nose, that the remedy may be thoroughly distributed over the membranes. The application will cause but little pain or discomfort, and often a single treatment will immediately inhibit a neuralgia, especially when it is recent and located in one branch of the fifth nerve. In other cases, where the disease has been protracted and extensively distributed, the insufflation may be repeated every one-half to one minute for five to ten minutes. This novel treatment has given satisfaction many times, and may also be used for odontalgia, cephalgia, bronchial asthma, etc.—*Medical Free Press.*

**ON THE TORSION OF ARTERIES.**—In connection with operations for excision of tumors, and other excisions of a like character, Jonathan Hutchinson remarks as follows: "I may mention that for many years I have quite ceased to use any other means for arrest of arterial bleeding than torsion. In excisions of the breast, for instance, I do not think that I have during the last fifteen years ever used a ligature. The torsion is always effected by a pair of Wells' clamp-forceps, now in such universal employment. I am always extremely careful to close all vessels, keeping the wound exposed for a considerable time for that

purpose. Very seldom, indeed, have I encountered any secondary hæmorrhage."—*Archives of Surgery.*

**CONSTIPATION OF INFANTS.**—Karnitsky's method of treatment by abdominal massage was used by him in twelve cases of chronic and twelve cases of acute constipation in children from eight to eleven years of age. The following are his conclusions:

1. Abdominal massage may produce effects upon the alimentary tract, in connection with digestion, which are not inferior to those produced by purgatives.

2. Habitual constipation may be easily cured by massage without the aid of purgatives.

3. The younger a child is the more readily can the constipation be cured.

4. The younger a child is the milder should the manipulations be, and the shorter the séances.

5. The duration of the séances should be from three to ten minutes, according to the age of the patient. Longer séances are inadvisable, and may even be harmful and aggravate the condition of the patient.

6. Abdominal massage may be regarded as the best means of treating constipation in children. Purgative should only be used in exceptional cases.

THERE are some women of the brunette type, usually with an olive skin, sometimes with a fair skin, who have the misfortune to bear upon their upper lip or on the sides of their face, just in front of their ears, a growth of fine, dark hair. The hair is of the lanugo variety, and is noticeable only on account of its dark color. The application, by means of a camel's-hair brush, of hydrogen peroxide, will bleach the hairs, and render them invisible except on very close inspection. As a preliminary measure, it is well to wash the growth with a solution of powdered borax in water, to remove the grease which adheres to every hair. The application should be made several times a day until the hairs are thoroughly whitened, and after that as often as is necessary to maintain the color.—*Maryland Medical Journal.*

**GOITRE AND CRETINISM.**—A recent discussion on goitre and cretinism in Paris revealed the fact that there are now, in thirty departments of France, no less than four hundred and twenty thousand persons suffering under the former malady, while cretinism is becoming more common in the Pyrenean and Alpine valleys. It was proposed that the government should be asked to provide funds for the draining of the soil of the districts chiefly affected, and that steps should be taken to supply the inhabitants with filtered water. For the treatment of cretinism it was suggested that some of the old transport ships might be converted into naval hospitals.—*N. Y. Med. Record.*

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## CANTHARIDES INTERNALLY ADMINISTERED.

The *Therapeutic Gazette* for March, '92, contains an interesting article upon the internal uses of this drug, so commonly used externally, and so little internally. The key-note to its use—the general principle underlying its exhibition, is the stimulating effect it has upon epithelial cells. This stimulation, of course, if allowed to go too far, readily becomes irritation. Apart from its external use as a blister, irritative action should always be avoided, as the therapist will defeat his own ends by securing more than a stimulating action. The epithelia readily subjected to its action, are two, that of the skin and that of the genito-urinary tract, the latter being subdivisible into the three areas, renal, vesical and urethral. Bearing this anatomical division of our subject in mind, we may intelligently proceed to our therapeutics. No one is likely to use cantharides for its local effect upon any part of the alimentary canal. Its action is secured only after the entrance of its active principle cantharidine into the blood. First as to its action thereafter upon the skin. Eminent French dermatologists have highly recommended it in psoriasis, eczema, lichen, and prurigo. The dose should be cautiously begun at half one drop three times a day, and the urinary secretion watched. It need not be persevered in if good results do not follow from a dose of two or three drops at most.

Secondly, as to the effect of cantharidine when

excreted by the renal epithelium. Its action will be exerted here first on the renal epithelium itself. If in sub-acute or chronic Bright's, following on an acute parenchymatous attack, the urine remains albuminous or bloody, or is scanty, minute doses may be given, 1-2-3 minims of the tincture three times a-day, or every four or six hours, and the good effect is often very prompt. Ringer recommends it highly, and says that while the urine becomes less albuminous the controlling influence of the drug over the hæmaturia is much more marked. In the passive congestions, accompanied by albuminuria, which result from circulatory or pulmonary disturbance, such as cardiac asthma, valvular incompetency, or portal obstruction, the drug often acts well, by "stimulating the depressed and inactive secretory epithelium of the kidney to increased action." Its use is recommended both in the fatty kidney of parenchymatous nephritis, and in the chronic contracted kidney with œdema and threatening eczema or ulcer of the legs, its action on the latter condition being two-fold, both local, and through the medium of the kidneys, by stimulating them to increased and derivative action. If small doses, say two drops three times a-day, are not effective, they need not be increased, or harm will be done, as "there is the danger of inflaming the secreting cells in an injured kidney, and so disabling the entire organ temporarily or permanently."

Following the excreted cantharidine down with the urine, we find that in certain forms of urinary incontinence, depending mainly upon want of control of the vesical sphincter, it is of great service. The partial incontinence that often follows childbirth, or is due to debility following prolonged illness, characterized by the escape of a few drops of urine on any sudden movement, singing, laughing, etc., or the same incontinence sometimes accompanying chronic bronchitis, is often much benefited by cantharides. Ringer says that it is even of service not infrequently in incontinence due to paralysis, and sometimes in the enuresis of children, though belladonna is usually better in the latter case. The *rationale* of its action in these forms of atonic incontinence is that its stimulant effect upon the vesical mucosa is reflexly felt by the spinal centre, which is urged to resume control of the situation. It may be employed with good results in cystitis, sub-acute, or

chronic, with urine still acid, the latter point being carefully noted, and its reason evident. Also in gonorrhœa in the third stage, or in gleet, its action being just that of copaiba and the similar oils in ordinary use in such cases. The latter field of action is the last, according to the anatomical basis laid down for our guidance in the consideration of the subject. The familiar aphrodisiac action of the drug depends upon its effect here, and if combined with iron, phosphoric acid and strychnine it is often of service in impotence, whether due to old age, self-abuse, or sexual excess. As an abortive it is very dangerous.

### VALVULAR HEART LESIONS.

A question that not infrequently arises to confront the conscientious medical man, who has discovered a cardiac murmur in the course of a physical examination, is, whether or not it is his duty to inform the patient that he is suffering from "heart disease." For there can be no doubt that many subjects who present what are called murmurs, live out the allotted span of life, or die of some inter-current affection having no connection with the heart; and the cruelty of damning some young man's career, by hanging the sword of sudden death over him, will be apparent to any thinking man. When students are learning auscultation at the bedside, it would be well if at the same time, they were informed that the presence of a valvular lesion, does not necessarily indicate that treatment is called for. Indeed as treatment, even when indicated, is usually of little avail, it is seldom necessary to inform the patient of the existence of a lesion, for the information cannot have other than an extremely prejudicial effect upon his peace of mind, and will tend to increase his trouble, if he has as yet complained of any. In many cases not presenting acute symptoms, it would be well to keep in mind the old adage, "Where ignorance is bliss 'tis folly to be wise." As Sir Andrew Clark sententiously remarked on one occasion, when the prognostic value of valvular lesions was under discussion. "It is quite early enough to tell a patient that he has disease of the heart," when the results are beginning to make themselves felt."

In addition to this, he told the story of a certain hospital secretary, to whom it became necessary

to insure his life at a time when he was making all the arrangements for getting married.

On undergoing the examination, he was rejected upon the ground [that he was suffering from a serious form of heart trouble, which, upon further pressing, the doctor opined would prove fatal at some undetermined, but in all probability not far distant, period.

The result was the breaking off of the matrimonial engagement, and as the authorities of the institution didn't like the idea of their secretary suddenly dropping dead about the premises, he was pensioned off on full pay, on the tacit understanding that he was not going to live long. That gentleman, though willing to be obliging under ordinary circumstances, lived long enough to be examined by Sir Andrew, a decade or two later, for some totally distinct affection. The writer knows of two young medical men suffering from valvular disease, accidentally discovered while practising auscultation in college days, who live lives of constant misery and dread, ever on the outlook for some symptoms of active trouble. Instances such as these could be multiplied *ad infinitum*, and serve to point out the necessity of great caution upon the part of physicians, who may, by a needless word, blast a promising career forever.

We must not forget moreover, that valuable as are the indications derived from auscultation, they are by no means absolute, and in order to make a correct prognosis, it is necessary to take into consideration the effects of the supposed lesion, as evidenced by the symptoms. In a certain proportion of the cases in which there is evidence of "something wrong with the heart," no symptoms of any kind are produced. Sometimes this is due to the fact that the lesion is due to a malformation, which has been fully compensated in the course of development, and entails no physical incapacity so far as the integrity of the circulation is concerned. In other words the abnormality may have become normal. Then too, we all are aware that the lesions which give rise to signs, most easily recognized by means of the stethoscope, are frequently of small importance intrinsically; indeed, it is an axiom that the most serious lesions are often the least obvious, and conversely.

We must be guided then in these cases by the amount of physical disturbance present with the

valvular disorder, for by no other means are we able to make any prognosis of the probable outcome of the trouble.

So long as physical equilibrium is maintained, and the functions appear normal, there is no reason for any alarming prognosis, nor restraining treatment.

But when the physical signs and disturbance of equilibrium render it obvious that disease is advancing apace, then it becomes our duty to inform the patient as to the true aspect of affairs; and to enter upon an active course of treatment.

Coming to a question of treatment, much good work has been done lately to show that in certain selected heart cases, graduated exercise gives excellent results.

Oertel's name has come into prominence as the originator of a method of treating degenerated heart muscle, by carefully graduated "cardiac gymnastics," which have given much satisfaction, and has restored to comparative health, a large number of persons, otherwise doomed to a life of hopeless invalidism.

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#### ONTARIO MEDICAL ASSOCIATION.

We would earnestly call the attention of our readers to the announcement of the programme for the meeting of the Medical Association in June. This is the one opportunity in the year afforded to our profession for a common meeting-place, and we would like to see the great bulk of provincial physicians availing themselves of the privilege—for such they should deem it.

The programme always provides abundance of food for thought and discussion; entertainment, public and private, is not wanting, and those questions which affect the profession, as a whole, are frequently threshed out.

Those physicians who do not enrol themselves in the membership, fail to make use of an organisation of great pleasure and profit both from a professional and social standpoint.

The programme this year affords a new feature, in the symposia upon topics of leading interest. The titles of the papers promise good things, and the discussions will be fought out upon real live subjects.

#### ONTARIO MEDICAL ASSOCIATION.

The 12th annual meeting will be convened in Toronto at 9.30 a.m. on Wednesday, June 1st, and continue to the evening of Thursday, June 2nd. The following subjects have been selected by the Committee on Papers for the final discussions:

"Diphtheria."—Discussion led by Dr. A. S. Fraser, Sarnia; assisted by Dr. W. Britton, Toronto; Dr. T. S. Harrison, Selkirk; Dr. H. P. Wright, Ottawa.

"The Present Status of Antiseptics in Surgery."—A discussion led by Dr. R. B. Nevitt, Toronto; assisted by Dr. J. K. Holmes, Chatham; Dr. N. A. Powell, Toronto; Dr. Geo. A. Peters, Toronto.

"The Third Stage of Labor."—A discussion opened by Dr. A. H. Wright, Toronto; assisted by Dr. H. S. Griffin, Hamilton; Dr. J. M. Cotton, Lambton Mills; Dr. N. W. Meldrum, Ayr.

"The Therapeutics of Constipation."—A discussion led by Dr. J. C. Mitchell, Enniskillen; assisted by Dr. A. McKinnon, Guelph; Dr. J. J. Farley, Belleville; Dr. Geo. Acheson, Toronto.

"Hay Fever."—A discussion led by Dr. D. G. Hodge, London; assisted by Dr. G. R. McDonagh, Toronto; Dr. A. B. Welford, Woodstock; Dr. W. J. Wilson, Richmond Hill.

A Symposium upon "Hip-joint Disease."—(1) "In Early Diagnosis." (2) "The Expectant Treatment." (3) "The Operative Treatment," by Dr. I. H. Cameron, Toronto; (4) "The Mechanical Treatment, before and after Operation," by Dr. A. McKay, Ingersoll.

A Symposium upon "The Pneumonias of Children."—(1) "Differential Diagnosis of Lobar and Lobular Pneumonia, and of Pneumonia from Bronchitis," by Dr. H. J. Machell, Toronto; (2) "Diagnosis of Lobular Pneumonia, Acute and Chronic, from Tuberculosis;" (3) "Diagnosis of Pneumonic Consolidations from Pleural Effusion," by Dr. W. H. Henderson, Kingston; (4) "Prognosis in Pneumonias Generally," by Dr. Allen Baines, Toronto.

The President's Address—Dr. R. A. Reeve, Toronto.

"On Chloroform Inhalation"—Dr. A. B. MacCallum, London.

"Acute Suppurative Pleurisy," A case—Dr. H. S. Clerks, Lucan.

"Brain Injuries"—Dr. J. Olmstead, Hamilton.

"Ventral Hernia," The flap-splitting operation—Dr. H. Meek, London.

"Otitic Cerebral Abscess"—Dr. G. Sterling Ryerson, Toronto.

"Diphtheria"—Dr. W. J. Wilson, Richmond Hill.

"Disinfection after Infectious Disease"—Dr. W. J. Greig, Toronto.

"Angina Ludovici"—Dr. G. L. McKellcan, Hamilton.

"Ocular Paralysis from Basal Lesion"—Dr. D. J. Gibb Wishart, Toronto.

Report of three cases of congenital malformation of the female sexual organs, with remarks—Dr. A. Vanderveer, Albany.

"The Dressing of the Wound after Supra-Pubic Cystotomy"—Dr. A. Groves, Fergus.

Dr. Sangrill, Osweton; Dr. Welford, Woodstock; Dr. Harvie, Orillia; Dr. Gibson, Belleville; Dr. Lett, Guelph; Dr. Howitt, Guelph; Dr. Clark, Kingston; Dr. Brown, Owen Sound; and Dr. Saunders, Kingston, have also expressed their intention of reading papers.

The following are the officers for the meeting: *President*, Dr. J. A. Reeve, Toronto; *Vice-Presidents*, Dr. F. le M. Grasset, Toronto; Dr. A. Grover, Fergus; Dr. H. J. Saunders, Kingston; Dr. G. I. McKeough, Chatham; *Secretaries-General*, Dr. J. Gibb Wishart, Toronto; *Assistant*, Dr. F. P. Cowan, Toronto; *Treasurer*, Dr. E. J. Barrick, Toronto.

The chairmen of the committees are requested to organize their committees and have their reports in readiness for the meeting.

If any member desires to present a paper or a case, the title should be in the hands of the Secretary by the 10th of May at the latest.

Candidates for membership require to present nomination papers signed by two members.

Delegates travelling to this meeting will obtain tickets for one fare and one-third by applying to the station agent at the starting point.

DR. J. GIBB WISHART,  
*General Secretary.*

April 25th, 1892.

## MEDICAL EXAMINATIONS.

TRINITY UNIVERSITY.

### *Primary Examination.*

Class I.—A. L. Danard and R. King (æq), silver medallist and certificate of honor; C. D. Parfitt, H. R. Frank, L. Lapp, B.A., T. G. Devitt, G. H. Field and F. C. Harris (æq); J. L. Bradley, J. D. Windell, J. Semple, A. K. Ferguson, H. E. Armstrong are awarded certificates of honor. The following are also placed in the first class:—H. Livingstone, P. D. White, A. R. Colvin, T. Kerr, W. H. Scott, C. M. Kingston, C. H. Thomas.

Class II.—F. G. Storey, E. L. Proctor, G. Alexander and J. M. Jory (æq); T. A. Manes, M. Baker, A. McKay, A. G. A. Fletcher, Miss J. S. Shirra and J. T. Somerville (æq), J. S. Matheson, J. C. Hay.

Class III.—Miss G. W. Hulet, F. S. Nicholson and D. Thomson (æq), W. W. McQueen, T. N. Insley, and Miss R. Pringle (æq), M. F. Lucas, F. N. Henry, J. W. White.

### *Final Examination.*

Class I.—H. B. Anderson, gold medallist and certificate of honor; A. S. Tilley, W. E. Sitzer, H. C. Parsons, H. L. Barber, R. M. Mitchell, R. N. Fowler, F. Fenton, and Miss J. Gray (æq), D. McEachern, C. McPhail, are awarded certificates of honor. The following are also placed in the first class:—W. E. Potter, W. E. Mathew, A. P. Chalmers, J. J. Thompson, T. B. Scott, B.A., J. W. Bryen, A. M. Cleghorn.

Class II.—J. A. Kemp, G. J. McPhee, R. M. Curtis and A. W. Allingham (æq), D. A. McPherson, T. M. Williamson, G. K. McDowell and D. A. Beattie (æq), B. G. Coates, Miss E. R. Gray, E. B. Blain, A. Flath, N. Anderson, M. Ferguson, E. O. Bingham and Miss B. Dymond (æq), W. Reid, J. J. Roach and W. E. Ogden and H. J. Orchard (æq).

Class III.—E. F. McCullough, T. M. Allan, F. N. Henry, J. A. Mitchell, Miss A. Chambers, W. J. Proctor, W. M. Anderson and J. W. Wheeler (æq), H. Morell, A. L. Murphy, W. C. Belt, H. J. Denovan, E. W. Goode, A. P. McLaren, M. F. Lucas, J. W. White.

TRINITY MEDICAL COLLEGE.

### *Primary Examination.*

Examinations for the fellowship degree, certificate of honor for standing in the primary branches.—Candidates who obtained 75 per cent. and over:—A. L. Danard, C. D. Parfitt, H. R. Frank, F. C. Harris, A. K. Ferguson, H. E. Armstrong. Class I.—70 per cent. and over:—H. Living-

stone, P. D. White, T. Kerr, C. H. Thomas' Class II.—60 per cent. and over :—R. L. Proctor, T. A. Manes, A. G. A. Fletcher. Passed—F. S. Nicholson, D. Thomson.

*Final Fellowship Degree.*

Certificate of honor, for standing in final branches. Candidates who obtained 75 per cent. and over :—A. C. Parsons, F. Fenton, R. V. Fowler, B.A., C. McPhail, J. W. Brien, H. B. Anderson, A. S. Tilley, R. M. Mitchell, and R. M. Curts. Class I. 70 per cent. and over—George K. McDowell, D. McEachern, H. L. Barber, J. J. Thompson, James G. McKee, A. P. Chalmers, H. J. Orchard and H. Morell. Class I. 60 per cent. and over :—A. M. Cleghorn, D. A. McPherson, A. Quackenbush, W. E. Ogden, Edward Blake Blain, E. O. Bingham, N. Anderson, A. L. Murphy, B.A., F. N. Henry, A. W. Allingham, and B. O. Coates. Passed—H. J. Denovan, E. W. Goode. Special prize for the highest standing in physiology for first year, value \$25—Fred Parker, standing 95 per cent ; Dr. Ryerson's special prize given this year. For the highest standing in medicine and surgery taken together, value \$25—Fred Fenton.

*Scholarships.*

The 1st first year's scholarship, \$50, standing 471 out of 530 marks, J. C. Hutchison, B.A. The 2nd first year's scholarship, \$30, standing 463 out of 530 marks, Frederick Parker. The 3rd first year's scholarship, \$20, standing 459 out of 530 marks, Carlton Shaw. The 1st second year's scholarship \$50, standing 420 out of 460 marks, A. L. Danard. The 2nd second year's scholarship, \$30, 401 out of 460 marks, C. D. Parfitt. Medals—The second Trinity silver medal, standing 299 out of 360 marks, Richard Victor Fowler, B.A. The first Trinity silver medal, standing 302 out of 360 marks, Frederick Fenton. The Trinity gold medal, standing 307 out of 360 marks, Harold Campbell Parsons.

QUEEN'S UNIVERSITY.

H. R. Adamson, J. Adams, G. T. C. Adams, T. A. Balfe, A. E. Barber, W. J. Belton, Miss M. E. Bermingham, F. H. Bermingham, T. C. Bourns, J. Bissonette, B.A.; H. H. Denaut, H. E. Douglas, J. C. Gibson, W. G. Hare, Miss Mabel Henderson, Allison Jamieson, J. J. Kelly, B.A.; J. Kirk, B.A.; E. J. Lent, A. Lockhart, E. J. Melville, F. J. McCammon, B.A.; R. R. Robinson, T. B. Scott, B.A.; D. V. Sullivan, B.A.; Miss Nellie Skimin, G. W. H. Smith, N. T. Stevens, Miss Agnes Turnbull, H. E. Tuttle, W. B. Thompson, J. W. Wheeler, Isaac Wood, B.A.

WESTERN UNIVERSITY.

Honors: Gowan, H. McDonald, McGregor, Gubbins, Shaw, Hughes, McGinnis, F. Fraleigh,

McEwen, Burkholder; Pass: Cook, Halliday, McGuffin, Patrick, Nixon, Hall, Wood, Johnson, F. Noyes, Parker, H. Noyes, Banting, McIntosh. Medals, Gold medal: H. F. McDonald; silver: L. J. Gowan.

M'GILL UNIVERSITY.

G. A. Brunette, G. A. Berwick, J. E. Binmore, G. A. Bowen, B. F. Boyce, F. W. A. Brown, J. E. Brouce, D. A. Bruce, H. B. Carmichael, J. L. Chabot, R. J. Chipman, A. R. A. Day, O. W. Guilleston, R. F. Glendenning, W. C. R. Graham, H. A. Grant, Y. Halliday, P. O. Hayes, J. Hogg, H. J. King, F. A. Long, A. F. Longley, A. E. A. McCann, D. Y. McKay, J. E. McKenty, R. F. McKenzie, O. Y. McKinnon, H. A. McMally, A. W. Muir, C. F. Martin, T. H. Martin, W. B. H. Massiah, J. Peak, E. D. Phelan, B. E. Robinson, W. Rodger, W. H. Smith, W. M. Taplin, T. T. Taylor, J. N. Taylor, J. Thompson, A. S. Wade, W. E. Walker, W. G. Walker, H. G. Wasson, Honor list on final subjects: Jameson, Henderson, Massiah, Day, C. F. Martin, Wasson, Hayes, J. T. Taylor, Chabot, Chipman, Walker, Wade, Bowen, Berwick, Boyce. Prize list: Holmes' medal, Thomas Jameson. First prize, James Henderson.

BISHOP'S COLLEGE.

*Final.*—Wm. Burnett, Montreal; John W. F. Purvis, Lynn, Ont.; F. J. Hackett, M. Goltman, Montreal; Ewing R. M. Brant, Georgetown, British Guiana, South America; Arthur J. Richer, Montreal; Frank Sylvestre, Cazaville, Que.; Alex. Blanchette, Worcester, Mass.; Duncan Crevier, St. Anicet, Que.; James L. Warren, Murray Bay, Que.; S. W. Outwater, Plainfield, Ont.

*Primary.*—David Primary Silver Medal, W. E. Wilson; Wood Final Gold Medal, J. W. F. Purvis.

GOLDEN RULES OF SURGICAL PRACTICE.—*Continued.*—(*Times and Reg.*):—BONES.—Always hesitate to diagnose in an off-hand way "rheumatic" pain in young children. Remember acute periostitis simulates acute rheumatism closely.

Never delay in acute periostitis in cutting freely down to a bone as soon as the nature of the case is detected. Every hour of delay will need a month to repair.

Do not forget the three golden rules in acute periostitis:

1. Prompt incision.
2. Free incision.
3. Free drainage.

Remember secondary abscesses may form in acute periostitis. Be on the *qui vive*.

Do not fret if, on making incisions to the bones, you evacuate but little pus in periostitis. It makes no matter, the relief afforded is often the same.

Remember the golden rules of removing segments from long bones after necrosis :

1. Do not wait for the periosteal sheath (new bony sheath) to have acquired strength enough to preserve the continuity of the limb.

2. Always remove the sequestrum as soon as possible, for it is :

(a) A permanent source of irritation.

(b) A danger to the adjacent parts.

3. Do not leave any dead bone behind.

4. Always splint carefully and bandage to maintain the parts in apposition and prevent fracture.

Never forget that there is no periosteal sheath in the necrosis of the popliteal space, and that the exfoliated bone lies close under the popliteal artery.

In removing such avoid four things :

1. Joint.

2. Artery.

3. External popliteal nerve.

4. Rough manipulation.

Scratch with finger nail and handle of knife.

Do not use the knife.

**BREAST.**—Never forget that a "tumor" in a young woman's breast is not usually a *chronic* abscess.

Never procrastinate about a tumor of the breast in a female over forty.

Never excise a mammary tumor of doubtful character before cutting it across.

Never remove a true carcinoma of the breast without clearing out the axilla.

Never be too anxious to make your flaps meet, and look well in removing a cancer of the breast. Your vanity will often tempt you to leave a flap in which cancer may lie concealed.

**BURNS.**—Do not neglect opium for the shock of burns in children, but use it cautiously ; afterwards do not stint fresh air, food or warmth.

Never give a hypodermic in burns of children ; you cannot recall it. Give it by mouth.

Beware of strong application of carbolic oil in burns, and if it be used at all, watch the urine for absorption signs.

Do not dress too often ; but never let the dressings foul.

Never uncover the entire wound at once ; do it piecemeal.

Never omit chloroform or opium in the first dressing of extensive burns.

Always have the tracheotomy instruments at hand in burns or scalds of mouth, because of œdema of glottis.

**CHEST.**—Do not be very solicitous in obtaining crepitus of a fractured rib. Treat it as such.

In manipulating either side of a fractured rib to obtain evidence of undue mobility, do not handle portions of two different ribs.

Never forget that all penetrating wounds of the chest, not involving fracture, should be closed at once.

Do not forget that it is a good practice in severe cases of fractured ribs, and those in which the lung is wounded, to strap the chest and apply ice externally.

[Bandage is said to be contra-indicated if there is much comminution or tearing of the parietes of the chest ; or :

1. If dyspnoea increases, on its application.

2. If pain is caused by it.]

Do not strap or bandage if there is much surgical emphysema.

Always regard rib injuries in old people with anxiety.

[There may be, and usually is, pre-existing emphysema and bronchitis, which will hamper the breathing greatly.]

Never tap a chest in paracentesis without making certain, by auscultation and percussion, that you are on the right spot.

Do not neglect to secure your drain tube from slipping into the thorax. Let it be sufficiently, and only sufficiently, long to enter the cavity. Longer is needless.

Always use an exhaustion syringe in tapping the chest.

Never forget in this, as in all other aspirations, to run some carbolic or hydrarg. perchlor. solution through your canula and exhaustion bottle before operating.

Always use an exploring syringe first, if you are in doubt.

Do not forget your landmarks (upper border of lower rib).

Always remember that you aim at the lung ris-

ing up and taking the place of the fluid you evacuate. If the lungs are bound down by adhesions and attempts are made to exhaust the fluid with considerable force, rupture and hæmorrhage take place.

Do not forget, also, that too forcible a suction applied to the vascular false membranes, which often occupy the pleural cavity, may give rise to hæmorrhage into the pleura.

Always stop if pain is complained of.

(To be continued.)

LOSS OF SIGHT DURING LACTATION.—Mr. Nettleship, in the last number of the *Ophthal. Hosp. Rep.* (*Glasgow Med. Jour.*), gives several curious cases of loss of sight, in some cases amounting to blindness, during the period of lactation, from which amaurosis the patients recovered. The curious fact is, that in most of the cases ophthalmoscopic changes after restoration of sight are wanting. While pointing out that frequently during pregnancy there is loss of sight from retinitis associated with albuminuria, still no traces of such a condition can be seen in the cases under discussion. Nor does amaurosis after hæmorrhage explain matters, for that was not a feature in these cases. Nettleship attributes them to a neuritis which has subsided without leaving any permanent destruction of nerve fibre.

THE POSTURE OF THE PUERPERAL PATIENT.—Duke (*Med. Press. Am. Jour. Med. Science*), considers the usual custom of keeping the puerperal patient upon her back for a long time after labor to be most injurious. He claims that drainage of the birth-canal is least thorough in this position, and that retro-displacements of the uterus frequently result from this custom. He favors the semi-recumbent position upon the hip or the sitting posture for a few moments after the first twenty-four hours. These positions favor involution and promote the action of the bowels. The best posture to favor the delivery of the placenta is the prone position, and the puerperal patient should assume this posture for a short time daily.

A MILITARY MEDICAL ASSOCIATION.—It is proposed to form an Association of Medical Officers of the Militia of Canada, having the following objects: 1. The bringing of medical officers in

closer personal relation, and the development of a departmental *esprit de corps*. 2. For discussion of matters relating to the Medical Department of the Militia. 3. For the discussion of military matters from a medical point of view. 4. For reading of papers on Military Medicine and Surgery, Hygiene and Equipment. A meeting for organization will be held in the Canadian Military Institute on Monday, May 9th, at 8 p. m.

ANTIPYRINE IN WHOOPING-COUGH.—Dr. E. Feer (*Ibid.*), believes that this remedy should have the first place in the treatment of whooping-cough. Eighty cases were under observation and the dose was in the proportion of that of fifteen grains for a ten-year old child, given morning and evening. When several children in the family were affected with this disease the results were not so good (mutual reinfection—Professor Hagenbach). The remedy was beneficial in four-fifths of the cases. It cannot be ascertained whether it acts as a germicide or as a sedative—very likely the latter, as Demme and Sée have proved that it has a direct restrictive influence upon the reflexes.

ANTIPYRIN TO DRY UP MILK SECRETION.—Guibert (*Archives de Tocologie—Univ. Med. Mag.*) found incidentally that the administration of antipyrin, in doses of thirty grains a day, distinctly diminishes milk secretion by the second day. He tested the drug in nineteen cases. In seven cases the women nursed their children for several days, in the remaining cases not at all. Guibert found that in all cases the milk disappeared in several days.

SALICYLATE OF SODA IN PLEURITIC EXUDATION.—Dr. Oerl has, *Hosp. Gaz., Med. Zeit.*, during the past five years, treated nine similar cases of pleuritic effusion with salicylate of soda, after other remedies, such as phenacetin, pilocarpine, etc., had failed, and with the exception of two instances the results were favorable. In these two the resorption was only partial. The author concludes: 1. Serous pleuritic exudations of long standing may be removed by the administration of the salicylate of soda. 2. The salicylate has in exudative pleuritis, just as in polyarthritis, an apparently specific effect. 3. The fact that, so far as experience with this remedy has gone, no new collection of fluid is observed, makes surgical



interference in serous pleuritic exudation not only not imperative, but, indeed, puts operative procedures in the background.

**COLLAPSE AND DEATH AFTER POST-PARTUM INTRA-UTERINE IRRIGATION.**—P. C. Larsen reports the case of a woman who was in her third childbirth. After delivery and manual separation of the placenta an intra-uterine irrigation was made with a 3% solution of phenol, when the patient suddenly became collapsed and died in a few minutes. There was no rupture of the uterus but a mitral insufficiency.

**TRINITY MEDICAL COLLEGE.**—The summer session at Trin. Med. Coll. commences May 2nd, and will continue till July 1st. Drs. Meyers and Millman have been added to the staff of summer session lecturers.

We are pleased to note that Dr. C. A. Temple, late interne assistant in the Toronto General Hospital has been appointed surgeon to the *Empress of India*, one of the new C.P.R. steam ships, *vice* Dr. Gordon, invalided.

A German edition of the second revision of Gowers' book on the Nervous System has just been published by Cohen of Bourse, and we understand that an Italian translation is also nearly ready.

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### Books and Pamphlets.

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**A TREATISE ON DISEASES OF THE NOSE, and its Accessory Cavities.** By Greville Macdonald, M.D., London. London and New York: MacMillan & Co., Toronto, Carveth & Co. Price \$2.50.

The second edition of this excellent treatise upon Diseases of the Nose, and Accessory Cavities, has been received; and the fact that the first edition of this book was exhausted in a little more than a year, is sufficient to indicate that it was needed. Several additions have been made, among the most noteworthy being articles on croupous rhinitis, and cysts of the middle turbinated bone, which were imperfectly treated in the former issue. The chapter on nasal respiration, which commences the treatise is most thorough and scientific, presenting

many new points for consideration, elucidating by practical experiments, many features of nasal breathing hitherto unknown, or shrouded in doubt. The classification of chronic rhinitis is excellent, and will do much to educate the masses of general practitioners into a proper comprehension of true hypertrophy of the turbinated tissue as distinguished from vascular tumefaction of the erectile bodies, an error into which many specialists have frequently fallen from want of proper consideration of the subject.

In discussing the etiology of nasal polypus, the author differs in his views from many observers, notably Woakes, who believes that polypus is always indicative of caries of the turbinated bones. McDonald holds this view erroneous, and we think correctly so. In the chapter on nasal neuroses, the author's views on idiopathic rhumorrhœa, and hay asthma are given in a masterly manner, and from the large clinical advantages at his disposal, are entitled to the greatest possible consideration. Other parts of the work highly to be commended, are the chapters devoted to the study of chronic rhinitis as affecting the ethmoid bone, and diseases of the accessory cavities of the nose, including empyema of the antrum. On the whole, we are disposed to consider this work as one of the most complete and masterly expositions of nasal disease ever published, and take great pleasure in recommending its careful perusal to the general practitioner and specialist, who will find embodied within its covers the scientific views of probably the ablest rhinologist in Europe.

**THE MEDICAL ANNUAL AND PRACTITIONER'S INDEX, 1882.** Toronto agents: Carveth & Co.

This publication has been ten years in existence, and fills a place previously vacant in medical literature. The size of the volume is necessarily increasing year by year, as new facts are added to the store of medical knowledge. The compilation of matter contained in these volumes is done by experts, who boil down the various articles contributed during the year. The reference system to preceding numbers of the *Annual* makes the reading of the essentials of any case easy, and fairly complete. We commend the series and the 1892 volume to our readers as of much practical, every-day use.