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## Original Communications.

### CORTICAL EPILEPSY—A CLINICAL LECTURE.

BY DAVID INGLIS, M.D.

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The patient whom you see before you presents, in a typical form, the group of symptoms which, in the past few years, has come to play a very important part in the study of the nervous system. I refer to the condition known as cortical or Jacksonian Epilepsy.

The patient is the wife of a man of an exceptionally irascible temperament, for within two weeks after the time of her marriage, she tells me that the honeymoon was interrupted by her husband beating her. This pastime seems to have been continued regularly, for fourteen years ago while she was just about to be delivered of a child, her husband knocked her down with a chair, which stunned her for some time. The child was born three days after. Again, at Christmas time, in 1886, she was struck on the left side of the head by a chair. You can see to-day the scar upon the temple which marks the place of the gash made by the blow. Such has been her domestic history; and both the blow on the left side of the head and the wearying effect of many years of such an existence, may well have acted together to bring about the symptoms to be noted later. Continuing her personal history, I may tell you also that, married at the age of 17 years, she has had seven children, of whom three are now living. Has, besides, had several miscarriages. Her labors were easy, but she never was able to nurse her children. One child died at the age of six weeks, one was still-born. But while these facts hint at

the possibility of specific taint, yet we can elicit no history of syphilis either in her person or in that of her husband. The family history throws no additional light upon the case, for the various members of the family seem to have been free from neurotic tendency with the single exception of her mother, who died of apoplexy at a fairly advanced age.

In person our patient is rather tall, not stout, but strong; naturally of a fresh, florid complexion, one can yet detect a certain anæmic pallor, especially in the color of the lips. Let me suggest to you, gentlemen, this point in regard to your examination of your patients. One of the most difficult, and yet one of the most essential things for you to learn is, that "seeing ye shall see." I will remember how, in early years, this Biblical phrase seemed to me a meaningless repetition. One naturally thinks that "seeing ye shall see" of course, but it is not "of course," quite the contrary, for we see continually a multitude of things which we yet do not perceive. Your clinical training ought to help you to learn to see. Now, the color of the skin depends not upon one fact alone but upon several—the thickness of the epidermis, the abundance and calibre of the capillaries, the color of the contained blood, and the color of the skin. You will see anæmic girls with thin clear skins and dilated capillaries, whose beautiful cheeks would deceive the very elect with their color. You must learn not to be deceived. So our patient is one of that class of people, commoner in Scotland and Ireland than in America, who have large and abundant capillaries near the surface. A little, even pale blood, makes a good deal of a show with such persons.

To return to our patient, we learn that on April 1st, 1887, about four months after the Christmas festivities, she had a miscarriage which caused an excessive, evidently dangerous hæmorrhage. Four weeks later she tells us that she suddenly lost the power of speech, as she puts it, "could think of things but couldn't say them." This condition lasted an hour and a-half, when she had a convulsion upon the right side of her body. At her next menstrual period, about a month later, the same phenomenon was repeated. The convulsions then began to recur with increasing frequency, coming about once in two weeks, but not in any regular connection with the menstrual

times. In December, 1888, she first came under my care, and when put upon treatment she managed to go along for five months without a convulsion. As to the convulsion itself she sometimes does not lose consciousness at all, more often experiences, just at the height of the seizure, a momentary unconsciousness. She is therefore able to describe her symptoms very intelligently. She feels first a curious sensation in the little finger of the right hand; this sensation or aura then spreads to the hand and is followed by a contraction of the fingers; then the hand, the forearm, the arm and neck, and right side of the face become involved; with this she loses her ability to speak. The attack soon passes off, but for a little time her speech is confused; she finds difficulty in getting hold of the right word. I should state that she has a pretty constant headache, which has lasted since May, 1887, and is always in her right temple. Also, in September, 1888, she noticed that she saw double, and thereabouts she noticed that she began to squint. The convergent strabismus of the right eye seems to be due to a paresis of the right abducens.

Such, gentlemen, is the clinical picture. Now let us see what it illustrates: It is not many years since the brain was regarded as a very mysterious, but single organ. To it were, indeed, attributed certain special intimate relations with thought, sensation, motion; but the first attempts to, in any way, analyze the functions of its complicated component parts, led off into the vagaries and futile fancies of phrenology. The absurdities of this system as has too often been the case with other and better systems entirely overshadowed the single germ of truth; so it happened that with the chaff we threw away the wheat. One solitary fact persisted. Broca had followed up the pathology of certain cases of loss of the power language, until he had established the fact that a small area just above the beginning of the fissure of Sylvius, the posterior part of the third or lower frontal convolution, just where the folds join in the beginning of that long ascending convolution which runs up in front of the fissure of Rolando, known as the ascending frontal, he had distinctly proven that there was a relationship between this area and an affection of speech now known as aphasia. He further recognized the fact that the lesion which gave rise to this affection

was to be found on the left hemisphere. It is not necessary to-day to enter into a discussion of the discoveries which have since been made in regard to aphasia, which in themselves constitute a marvellous demonstration of the constitution of the cerebral mechanism, which show curious relationship within the brain, between the eye, the ear, the memory, the voice and the muscles used in gesticulation. It is enough that Broca's *fact* proved two things: first, the existence of what we now call a centre, a portion of the brain-substance set apart to be in distinct relationship with certain fixed parts of the body, to have a distinct relation with the performance of certain functions. The other fact was, that while the two halves of the brain look alike, yet it was evident that they do not *necessarily* act together.

Now, if one portion of brain matter were thus set apart to control one function, the further step was natural; it might well be that other functions might be found to depend upon other portions or centres, and the course of experimental and pathological study has gone on on these lines, making progress with constantly increasing rapidity until to-day, the doctrine of cerebral localization has reached an accuracy, a certainty, which so short a time ago as the year 1881, would have been deemed incredible. Not only have we widened our knowledge as regards the centres for speech, but a whole area has been mapped out under the name of the motor area, from which proceed the motor impulses to the entire body. The centres for the special senses afford still a subject for further discussion and investigation. Considering the manifold relationships between the special senses themselves and between them and all the finer mechanisms of the body, it is not surprising that many puzzling elements remain; yet it is safe to say that the principle of special centres applies equally to special and general sensation as well as motion. Again, while the problem of the relation of the mysterious phenomena which we call thought, consciousness, will, with the material substance of the body remain as inscrutable as ever, yet the principle of cerebral localization has made its way some few steps further into the darkness of the problem than was formerly possible. We know at least that the anterior convolutions of the cerebrum stand in close relationship with the processes which we designate as mental

or intellectual. In short, we are following out the almost necessary consequence of Broca's one fact, to wit.: that if one function be isolated in connection with one centre, then the others must be also.

Do not misunderstand this isolation of functional connection. The simile has been well used that the skull contains, like the abdomen, not one organ, but many; yet the fact should not be lost sight of that these many organs are related to each other in the most intimate manner. Consider the enormous mass of white matter which a transverse section of the brain just at the level of the corpus callosum shows; this white matter represents an infinite number of nerve fibres, of connecting paths; a moment's consideration will prove to you that only an insignificant portion of these paths can be for the purpose of conducting impulses either from the cerebrum to the body, or from the surfaces of the body to the cerebrum; for, note, what a little mass of white substance is revealed in a cross section of the medulla oblongata. Now, this mass of white substance called the centrum ovale represents the enormously complex means by which the various centres are related each to each other; so that while we rightly designate certain tracts as motor, others as sensory, or others as psychic or mental, yet each centre acts, influenced by some other, in a greater or less degree.

When the burned child dreads the fire, his mental condition called "dread," involves the centres of sensation which were once so pungently excited by contact with the stove, the centres for sight still retain the impression of red-hot iron, and the motor centres, I doubt not, retain enough of memory that they would on a second occasion withdraw the hand more rapidly than on the first occasion. All of these centres and more, are probably bound together when the child dreads the fire.

These preliminary thoughts upon cerebral localization lead, not unnaturally, to the subject in hand, that of cortical (or, as it is often, and, as I conceive, unfortunately, called Jacksonian) Epilepsy. Various experiments had led up to a very exact localization of the centres for the arm, hand, leg and face, and these experiments, necessarily performed upon the lower animals, awaited further proof before the results could be held true of the

human brain. The proofs were soon afforded by pathological experiment. Nature performs the experiment which we could not at first do. If along the fissure of Rolando, in man, there are motor centres like those proven to exist in the monkey or dog, then if these isolated areas are diseased, we should find corresponding evidences of alteration of function; or if destroyed, a corresponding loss of function. A mass of such evidence demonstrates the truth of the theory. The especial characteristic of cortical Jacksonian Epilepsy is this, that the convulsion is a partial or local convulsion. (The term epilepsy is here restricted to its original meaning of a motor disorder.) In some cases the convulsive movement is, and remains limited to a small group of muscles; the convulsions recur after the periodical manner of epilepsy; they are frequently preceded by a sensory discharge or aura, as in ordinary epilepsy, although the sensory discharge like the motor in such cases, tends to be of limited area; consciousness is frequently unimpaired, so that the patient is an interested and intelligent spectator of his own involuntary performance. Such is a typical limited cortical epilepsy; from this there are all grades in the extent of the symptoms up to a complete epileptic seizure with general convulsion, total unconsciousness and subsequent transient coma. It is both interesting and instructive to note how in some individuals the convulsions, may vary. For instance, a robust young woman under my care has at times, a convulsion in her leg only. If the discharge is more severe the convulsive movements of the leg are more pronounced, and the arm of the same side is involved; if still more severe, the opposite side of the body is involved; there seems always to be a proportion between the intensity of the discharge and the extent of brain matter involved; but even in severe and widespread seizures it can be distinctly traced how the convulsion always begins in the same leg.

Here let me give you, in passing, this suggestion; you will constantly see in your medical journals, and will, I have no doubt, yourselves, publish curious, rare or unusual facts which come within your observation. It is quite right and helpful that these "curiosities" should be recorded, but always remember that it is not simply because a thing is strange, or, according to a favorite phrase, "unique," that it deserves publication,

but because the strange or uncommon phenomenon may throw a flood of light upon other related facts. You yourselves will miss the value of your curious fact unless you seek to discover its relation to other facts which may be of common occurrence and yet not fully understood.

Now, the observation of such a case of partial or local epilepsy, of how the various groups of muscles are, one after another, thrown into convulsion, has a value far greater than merely to record a curious fact.

In the first place, it throws light upon the nature of other and severer forms of epilepsy. When you witness an ordinary general epileptic convulsion, the general tumult is so great that it becomes quite impossible to unravel the tangled skein of symptoms, here are tonic and clonic convulsive movements, all the muscles of the body seem involved, we can tell nothing of the sensory conditions, for the patient becomes totally unconscious, in short, motion, sensation and intelligence are so profoundly involved that one cannot, by separating the symptoms, come at any fair explanation of the nature of the phenomenon. But in a case of limited epilepsy we see, in miniature, the process going on, the patient being conscious can give an account of the sensory condition, we can watch the character and progress of the convulsive movements and we see this fact first of all, that the motor disturbance is not set up by an effort of the will, but rather in spite of it. Here, to begin with, is a demonstration of the fact that motion may be set up independently of the mental control, a fact which bears out the theory of separate functions for separate parts of the brain.

Our patient with limited epilepsy, very commonly, but not always, has an aura, a sensory disturbance just before the convulsive movement, and usually felt by her as being in or near the member involved in the convulsion. If there be sensory as well as motor centres, then we should expect, from the common necessities of use, that the respective centres for the same part should be in habitual close connection. For instance, it is essential that the sensations affecting the right hand and arm should very readily bring about motion of the same parts, otherwise the sensations would fail frequently to protect the arm from injury or enable it to perform work required of it. This aura preceding the cortical convulsion, tends

to prove the existence of precisely this arrangement.

One can imagine that the sensory centre for the arm being diseased and carrying on its functions irregularly, should send to the motor centre for the same arm a rush of orders all at once, setting the motor centre into confused activity and thus setting up a convulsion limited to the arm.

That some cases of partial epilepsy are thus due to disorders, not so much of the motor centres in the first place, as of the sensory centres, seems probable from such facts as these. We know that in some cases, some local irritant at a distance from the brain, by sending in continual irritating impulses, can and does cause epilepsy. The proof is found in the cessation of the epileptic seizures upon the removal of the cause. Here let me again give you a practical point. You will frequently be warned to look out for these sources of reflex irritation. Naturally you will look for some spot distinctly painful, some irritation of which your patient *complains*, but if you stop here you will rarely find the point of reflex irritation. You will constantly miss your opportunities. The fact is, that the irritant does not usually cause a distinct pain, a *conscious* sensation, but that from some point a series of slight but steady irritant impulses are being constantly sent in which ultimately wears out the sensory centre.

Did you ever undertake to bring up a fairly good but active boy? Well, the boy may not be painfully bad, but he can wear you out. So, for instance, the process of dentition does not cause any very definite pain, but is a frequent cause of convulsions.

Another fact which goes to prove the sensory origin of some cases of cortical epilepsy, is to be found, in a fact occasionally noted that the patient can, at times, block off a seizure by a strong effort of the will. I have, for instance, a patient who usually has her attacks at night, when she is wakened by the aura, she groans. If, now, her husband wakens quickly and gives her a vigorous shaking, she finds that the convulsive movements do not come on; if he is too slow, then the convulsion completes its course. Such a fact seems to show that to the same motor centre, impulses come from different directions, those from the sensory centre tending to start the motor centre into confused activity, those from the psychic or

mental centre tending to control, or, as it is often called, inhibit the motor centre.

In some cases of cortical epilepsy the patient describes no aura whatever. In such a case it is probable that the lesion is purely one of the motor centre. Before leaving this point, however, let me say that the presence of an aura does not enable us infallibly to diagnose the precise locality of the lesion, and this, for the reason, that the relations of sensation and motion are so intimate that we cannot entirely separate them as to cerebral localities and their mutual interaction.

You see, now, that our simple case of cortical epilepsy has considerable importance as one of the proofs of cerebral localization.

Now, let us take up another feature. You remember how I described the convulsions in a certain patient as always beginning in the left leg, if severe, involving the left arm, and if very severe, involving the opposite side of the body. Let us assume that the disturbance began in the leg centre in the motor area of the right hemisphere. Let us then picture what goes on. While we cannot describe what is that mysterious process which goes on in the brain cells when they act, yet we can use a simile to help us. Let us conceive that each brain cell contained a minute quantity of dynamite, the explosion of which caused a muscular contraction in the related muscle fibre (we must also imagine that the brain cell was able to become re-charged after a little time). Now, if the adjacent cells were jarred by the explosion, we could imagine a lot of them going off in rapid succession. It would then be expected that the greater the number of cells involved in, and the more sudden the first explosion, the greater the number of adjacent cells which would receive the shock and be themselves discharged. If the initial explosion in the leg centre were not severe, the leg centre alone would be involved, but if more severe, the adjacent arm centre would be brought into activity, and if the series of explosions were now severe, the cortical matter of the opposite hemisphere would go off or be discharged.

Indeed it seems pretty clear that some such process does occur, and the cortical substance seems to be involved in all directions. It reminds me of a fire in the grass burning rapidly at all points, around the circumference. For instance, my patient with the leg epilepsy, on one occasion,

had a particularly severe convulsion in my office, and not only were all the motor centres invaded, but the mental as well, and for a brief space she had a furious attack of mania, which required the control of four able-bodied men. You see, then again that our limited epilepsy helps us to gain some insight into the processes involved in the ordinary and graver forms. When you conceive that in a general epileptic convulsion, the discharge takes place not at a limited area, but over a large part if not the whole of the cortical substance, at once you can readily understand the wide distribution of the parts involved. Again you can understand why an epileptic falls into a comatose sleep. His cortical cells are all, for the time being, exhausted, and not until the cells have drawn from the blood a fresh supply of explosive material, can the ordinary and regular discharges be again established.

*(To be continued.)*

#### A CASE OF PERIOSTITIS ALBUMINOSA OF OLLIER.\*

BY THOMAS R. DUPUIS, M.D., KINGSTON, ONT.

GENTLEMEN,—The case which I bring before you to-day is one of those diseases which acquire interest by their rarity. Rare diseases when discovered should be brought to light, and exhibited especially before medical associations, for the purpose of awakening attention to their existence. We are so constituted that many things pass us unnoticed every day, and are hence accounted rare, for which, if we were on the look out we should find to be perhaps of very frequent occurrence. It is so with diseases, and with the symptoms of disease; and hence the propriety of noticing many things that in themselves seem trivial. This is my apology for bringing the following case before you.

In May, 1888, there was brought to me from New York State, a young man aged 22 years, to be examined and treated for a peculiar kind of swelling on the middle third of the anterior part of the tibia. The medical gentleman who had attended him there, came with him and stated to me that he was completely puzzled in the case. He had supposed it to be an abscess, and with this

\* Read before the Ontario Medical Association, June, 1889.

conviction had poulticed it for some time and then opened it. His surprise was very great when, instead of an outflow of pus, as he had expected, nothing came but a yellow albuminous fluid almost as thick as the white of an egg. The substance through which he had cut, he said, was a fatty yellowish mass, looking something like the yellow fat sometimes seen in old beef, and at least three-quarters of an inch thick. Surprised as he was, however, he again applied a poultice, but having continued it for a length of time without any definite results, he abandoned its use and applied ung. resinæ, I think, under which the wound healed. For a few months after this course of treatment the young gentleman was better, suffering less pain and lameness, and being able to attend to his employment. But his former symptoms again returning, his surgeon brought him to me, as already stated, to get my opinion on his case, and to treat him if there seemed any prospect of doing him good.

His history was as follows: About a year before the time he had to desist from his regular work (that of a druggist), he had been hit on the shin by a base-ball. The injury at the time was thought nothing of, a lump rising at the seat of injury as one would expect, soreness in the part, and lameness; no pain when quiet and the leg elevated, but intensely painful when standing or walking about. He was, after several days, obliged to "lie up," as the soreness and swelling, instead of subsiding as they should have done, greatly increased, and the pain on moving around—which came on a few days after the reception of the injury—remained constant and unabated. He then consulted the medical friend who brought him to me, and his treatment was rest and poulticing, opening what he supposed to be an abscess, poulticing it again and finally inducing it to heal, as already stated.

When I saw him he was a healthy looking, well developed young man, of about 22 years of age, walking with a limping gait as from a stiff leg. He was very intelligent, and could give an accurate account of himself, and gave me the foregoing history. I need scarcely say that liniments and various other medicaments had been applied to the parts, for this you would all suppose without being told it.

On examination of the leg, I found a swelling

nearly as large as, and somewhat in the shape of, the half of a goose egg, situated on the middle third of the tibia; and which, by its encroachment upon the tibialis anticus and flexor longus digitorum, and by an extension of the inflammation which surrounded the tumor, to these muscles, so interfered with their free motion, as to give him that "stiff-leg" gait which he assumed in walking. The tumor was rather sharply defined, of an elastic resistance, giving almost the feeling of fluctuation; immovable and sensitive to the touch, and seemingly attached to the bone, which could be felt to be enlarged by close examination at the sides of the base of the tumor. The scar was seen upon the surface where the opening had been made, but beyond this there was no marked change in the skin.

Taking the symptoms together, I should have considered it an abscess from periostitis, or, perhaps, osteo-myelitis; but the assurance by his attendant surgeon that he had opened it, and that nothing came from it but a yellow albuminous-looking fluid, and that the cut surfaces from which this yellow matter exuded had the appearance of yellow fat, precluded the idea of either of these conclusions. I was puzzled, and confessed myself so to his surgeon.

I presume, gentlemen, that some of you might have been puzzled also, for such cases are very rare, and in very nearly thirty years' experience, I had never before encountered one.

As there was enlargement of the bone, thickening of the periosteum, and, evidently, some exudate between them, or in the layers of the periosteum, I considered it good surgery to cut down and examine the bone and superposed parts and obtain what information I could, from observation.

The patient was chloroformed, an incision four inches in length made down to the bone, the knife passing through the very same kind of tissue as my friend had described, and from which the same kind of albumino-serous yellow fluid came, as he had previously witnessed. I was now no more enlightened than before. I denuded the bone, from which the periosteum was almost wholly detached, and found it enlarged, white, and exceedingly hard—eburnated in reality.

As there was no exostosis to be removed, nor anything that saw or chisel could take away—it being so hard in fact that none of these instru-

ments would cut it had I wished to use them—I decided on another method of treatment, novel to be sure, but which in this case did much good. I used a Paquelin's thermo-cautère, and with the flat point heated to a bright red heat, drew its sharp edge over the enlarged bone longitudinally, in five or six parallel lines, scarifying it thus from one to two millimetres in depth. I hoped by means of the burning to promote absorption, and I was not disappointed.

This was done on the 16th of May; he progressed favorably without one bad symptom, and on the 4th of June left and went home with the wound entirely healed, the tumor considerably reduced in size, and the lameness almost nothing. I need not speak of the treatment subsequent to the operation, for it was the chloride of mercury aseptic, in common use.

Sometime about the 1st of March, I wrote to Dr. M., inquiring how Mr. W. had got along. He replied that everything had gone on satisfactorily to the best of his knowledge, and that the young gentleman went back to his place to work again shortly after he came home from me. Dr. M. wrote to Mr. W. to ascertain the facts of his condition, and here is the letter Mr. W. sent me:

"DEXTER, April 28th, '89.

"Dr. DUPUIS,—I saw Dr. M. the other day, and he said you had been inquiring about me as to my leg. I went to work last September and felt very well till about Christmas, when I had to work very hard, and my leg began to feel bad again with the same symptoms as before. Instead of keeping quiet, I kept to work till about the middle of January, and at present I am in the same condition as when you saw me. There has been no change in my leg since then, in appearance, and the bunch remains the same (that is, as it was on the middle of January—D.) I have stopped work at present and am going to give it a rest and see what that will do.

"Yours, respectfully,

"E. W.,  
"Dexter, N.Y."

Now, gentlemen, here is my case, but the question is, What is it? That is the question which forced itself upon my mind; and at once I began to search and watch medical literature that I might find something that would satisfy me on the point. Two or three months after Mr. W.'s departure, I found that his disease had been de-

scribed by Ollier, under the title of "Periostitis Albuminosa."

According to Dr. Schlange, of Berlin, Ollier described fourteen or fifteen of these cases—so that, as far as we know, they are the only ones on record—he having collected them from his own practice and the literature of the subject. All the cases described were characterized by the absence of pus, and the appearance of a serous or synovial-like fluid, in connection with signs of inflammation around the bone. "Ollier," says Dr. Schlange, "was the first to point out that inflammation of the periosteum may be accompanied by the formation of a serous fluid, and the name of periostitis albuminosa was applied by him to this special form of periostitis." In all cases observed by him, the accumulation of fluids around the thickened periosteum formed the main change, and deeper lesions of the bone substance were not noted. Other observers obtained the same results, and Cartuffi speaks of the disease as a "periostitis exudativa." Dr. Schlange, from his own observations, differs from the foregoing, regarding the disease as a modification of acute purulent osteo-myelitis, and suggests the name "ostitis non-purulenta" as most appropriate. Some other observations were made, and in every case the citron-yellow granulations were found with an exudation of serous fluid around the seat of disease; in some, the bone was more or less changed, but in none was pus found, the fluid being sometimes almost like that found in old hydrocele, showing that this disease is not osteo-myelitis, although we know not but that the former disease might, under certain circumstances, lead up to the latter.

The affection occurs almost exclusively in young persons, say, from 15 to 22, and the long and tubular bones are chiefly attacked. In eight of the cases, the femur was the seat of disease; in three, the tibia; in two, the ulna; in one, the humerus, and in one, a rib. There is considerable interest attached to this form of periostitis, and if there have been but fifteen cases described, the case of Mr. W. will make the sixteenth. Had the symptoms given by Ollier been written from Mr. W.'s case, they could not have more exactly described it; and it was the exact description of the case that directed my attention to it, and then satisfied me that his was a case of "Periostitis Albuminosa" of Ollier.



To those who would read more on the subject, I may say, turn to page 150 of the *International Journal of Surgery and Antiseptics* for July, 1888, and they will find a fuller description than time and space will permit me to give here. I may conclude by saying that there is nothing there given upon treatment, and each of us for some time to come will have to be an empiric in the treatment of this disease.

### THE RADICAL CURE OF HERNIA.\*

BY ROSWELL PARK, A.M., M.D.

Prof. of Surgery, Med. Dept., Univ. of Buffalo.

(Concluded from July No.)

There are other methods, as is well known, Spanton's for example, but they are practised so sparingly, or else have such evident faults that I do not think it worth while to consider them here. Permit me now to describe a procedure which I have practised frequently, and to which I have held fast, induced thereto by the results of a somewhat extensive experience. Supposing, first, a case of non-strangulated hernia in which we go to work deliberately for the purpose of effecting a radical cure; time, place and surroundings being at the disposition of the operator. The patient is prepared as for any serious operation. After careful shaving and washing of the parts, incision is made over the inguinal canal and external ring, extended as much further downward in either sex as may be desirable. The hernia is at once exposed and search is made for its proper sac; sometimes this is easily found, especially when the hernia is old and large; at other times it may be so incorporated with the spermatic cord as to require a careful search. If the case be not one of congenital origin the sac is carefully isolated and separated from all its surroundings. It is often an advantage, for the purpose of security, to split up the inguinal canal to aid in this search and separation. It is my habit to usually open the sac; if it be found empty there is nothing to do but to ligate its neck as closely as possible to the internal ring. This ligation is made with a carefully prepared catgut strand; if on the other hand, there be found adherent intestine, it is carefully detached

and restored to the abdominal cavity. If adherent omentum be found, I usually slit up the sac so that a ligature may be thrown around the omental mass high up the sac. It is then ligated efficiently, the part outside the ligature divided, the catgut cut short and the omental stump dropped into the peritoneal cavity. The adherent portion remaining is then removed with the extirpated sac.

If, however, we have to deal with a congenital hernia in the male, the sac is separated well down toward the testicle and a second ligature is thrown around it close to that body. By this procedure a shut serous sac is provided which shall hereafter do duty solely as a tunica vaginalis testis. The portion of sac intervening between the two ligatures is then extirpated.

In a case of inguinal hernia in the female the endeavor is made to isolate and extirpate the entire sac, following it into or drawing it out from the labium majus as necessary. The balance of the operation consists merely in the introduction of from two to four silver wire sutures between the columns of the ring and the divided edges of the inguinal canal, by which the parts are brought into close approximation. The sutures are twisted, cut short, their ends turned over and left in such a shape that no sharp ends of wire can press into or interfere with the surrounding parts. The integument is then closed over this wound with catgut sutures. If now the operation has been antiseptically performed, I have found in every instance perfect immediate union within forty-eight hours, without necessity for drainage. I have been led to the use of silver wire by experience. At first I followed Czerny's recommendation and closed the external ring with a shoe-lace suture of catgut, threaded upon two needles. Distrusting the permanency of catgut I then used interrupted sutures of silk and kept up this practice until, in one of my cases, two of the silk sutures were extruded through a minute sinus. The protection seemed perfect, but I did not like to have my sutures thus passed out. Ever since then I have used small silver wire, carefully cleansed before using, and have never known irritation to follow its use nor anything undesirable to attend the same.

The method as above described has to be somewhat modified in the case of femoral hernia. Here one may isolate the sac, return or remove its contents as already described, and ligate its neck,

\* Read before the Ontario Medical Association, June 5th, 1889.

twisting it or not as he may prefer; but he will not find such a complete and accessible canal to deal with as in the case of inguinal hernia, nor any such ring to close. It will be but seldom in these cases that silver wire can be used to any advantage; nevertheless if the sac has been properly disposed of the wound will be filled by a cicatricial plug and the relief will be almost if not quite as perfect.

Upon umbilical hernia one may follow precisely the same general method, only modified as required by the surgical anatomy of the parts. Umbilical herniæ in adults are most commonly found in women with pendulous and very thick, fatty, abdominal walls. In such cases, while there seems to be but little external evidence of a hernial mass, there may yet be found a sac the size of an orange, and I have more than once been surprised to find how small the opening into this sack really was. Opportunity for strangulation is increased rather than diminished by so small a ring, and it seems to me that these require radical relief fully as much as any others. In several of these cases I have cut down upon the sac, which is usually, at the location of the navel, closely adherent to the skin, have separated it from all its fatty and muscular surroundings, have opened it and restored its contents according as they were intestine or omentum, have thoroughly extirpated it, have then brought together the margins of the umbilical ring, whether large or small, with catgut, and have then sewed up the abdominal wound in two or three tiers with silver or silk sutures, and have never seen the slightest disturbance follow. I have operated upon an infant but recently weaned, with rapid recovery; also upon a woman four months pregnant, of which fact I was not cognizant at the time, without the slightest disturbance, or apparent tendency to miscarriage. One remarkable case met with in this city, which I propose at some time to report in detail, occurred in a woman weighing 280 pounds, presenting a large umbilical hernia, whose sac, outside the body, was nearly as large as her head, and so pendulous that when she assumed a sitting posture its lower margin touched the chair before her buttocks did, and which presented in its thickness fibro-sarcomatous masses, that were already ulcerating externally, and were giving rise to great disturbance. I opened the sac, replaced its contents, and extirpated the

balance of the whole mass, without her temperature ever reaching 100°, and sent her to her home on the twelfth day following the operation. This shows what may be done even in such aggravated cases. At first, I used to require my patients to wear a truss for a few months after the operation; at present, unless the circumstances demand it, I advise the contrary, agreeing with Mr. Kendal Franks that the pressure of the hernial pad is more likely to cause absorption of the cicatricial tissue that constitutes a barrier to the return of the hernia, and that it may be an instrument for harm rather than for good. I have, moreover, systematically added to my operations for relief of *strangulated* hernia the procedure above described, by which I endeavor to secure a radical cure—if possible—in every case. It adds an almost inappreciable element of danger, while it very materially enhances the benefit of the operation.

I do not wish to detain you longer and will content myself now with presenting a brief resumé of my personal work in this direction. For the sake of convenience as well as of accuracy I have divided my cases into two classes, one class comprising cases of active and serious strangulation, in which to the operation for immediate relief I have superadded that for radical cure; the other class comprising cases upon which I have deliberately operated at a time when no immediate or urgent symptoms required it. Of cases of the first class I have had twenty, the oldest seventy-eight and the youngest six years. Eleven of these have been males, and five females; Four of these have died, but from causes in no wise connected with the operation, unless the possible element of shock should be taken into consideration. The four were cases of desperate nature in old or decrepit individuals, from whom scarcely anything else could have been expected. I believe that the first of this series of cases in which I had operated had a partial return of his hernia, but I understand that he is now going about as usual, not wearing any truss and not suffering from any hernial protrusion that one can detect. Another case also had a partial relapse.

Of cases of the second class I report *fifty-two*, not only without a death, but without the occurrence of any sign or symptom which has at any time given occasion for alarm. Most of these cases have pursued a course as even and undisturbed as follows

the slightest operation after an anæsthetic. Only once or twice has suppuration occurred, except where a line of granulations might follow the external wound for the distance of a fraction of an inch. Fifteen of these have been in females, and of these fifteen, six were umbilical and two femoral. Of the thirty-seven male cases the hernia was in every instance of the inguinal variety. Of the entire number six have been cases of double hernia, operated upon at the same time on each side. I have no hesitation in operating upon both sides synchronously if the condition of the patient justified operation at all. In one enormously fleshy, elderly man I have made this operation with, if possible, less disturbance than I have seen following a single operation. A few of my cases are in the West, a fair proportion of them live at a considerable distance and perhaps half of them are residents of Buffalo or vicinity. It is fair to suppose that if the condition had returned in any of them I should have had some intimation thereof. Of all the cases that have come under my personal observation, I can say that not in a single one has there been any return, nor has any occurred to the best of my knowledge in any of the others. I can, therefore, claim that to the best of my knowledge and belief, I have made a complete and final cure in every one of these cases. Many of them are pursuing trades or occupations which lead to excessive labor or strain, and it seems to me that the test of final cure in many of them has been as rigid as it ever can be. I desire to conclude simply with the statement, that according to the best light that we have, it appears to me that the common forms of hernia can be now absolutely and permanently relieved with so small an element of danger that it seems as if every person otherwise reasonably healthy could be properly encouraged to undergo the operation; while even a failure, should one result, leaves the patient no worse than before; while the vast majority, if not all of these sufferers, will obtain an ample reward for the trifling danger which they have undergone.

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*The Philadelphia Medical Times, The Medical Register and The Dietetic Gazette* have united, and will hereafter be published as a weekly, devoted to medicine, with a quarterly devoted to dietetics. The Journal will be under the charge of Dr. F. Waugh.

## Correspondence.

### A DEAF-MUTE RACE.

To the Editor of the CANADA LANCET.

SIR,—You have doubtless noticed in various newspapers articles stating that a Deaf-Mute variety of the human race is likely to be the result, in the near future, of the marriage of Deaf-Mutes. From the information I have been able to gather up to this time, I have only heard of ONE deaf child in Ontario (a little boy now about four years of age), whose parents are deaf and dumb. Of the hundreds of children who are now attending, or have attended, this Institution, there is not one congenitally deaf child who has deaf-mute parents. I would like to obtain full and accurate information in regard to this matter, and if you or any of your readers know of any deaf-mute married persons, with or without children, if you or they will kindly send me their addresses, I shall feel obliged.

There are deaf children of school age in the Province that I have not heard of, and I am making an effort to get them into this Institution where they may receive an education that will fit them for the duties of life. The condition of an uneducated deaf-mute is more deplorable than that of any other human being. Will you be kind enough to help me to bring these children to school? You can do more than any other person I might address. The parents of some are not aware that an Institution exists where their deaf children can be taught to read and write. There are others who have heard of the Institution but are probably not acquainted with its real character, or from some causes, fail to send their children to us; these might be induced by a little effort to send them. Deaf children between the ages of seven and twenty are admitted, educated and boarded at the expense of the Province. It is only required that the child shall be of sound mind and that the parents, or the municipality if the parents are unable, pay the railroad fare and provide necessary clothing. Application papers may be had by writing to me at Belleville, and any information required will be cheerfully supplied.

Yours faithfully,

R. MATHISON, *Supt.*

Belleville, July, 1889.

THE MANUFACTURING OF MEDICINES.

To the Editor of the CANADA LANCET.

SIR,—Having been engaged for many years in the drug business, as well as the practice of medicine, and having had occasion to feel the necessity of being in possession of pure reliable drugs for administration, and feeling the necessity a change in regard to the quality of drugs, I deem it prudent to call the attention of the profession to the fact, with the hope, that some one at the head of affairs may take active steps to see that more reliable preparations may be made. Who amongst us has not administered or used certain medicines or drugs, and failed to get the medicinal action from them? Take, for example, cocaine. How provoking, when your patient and everything associated with him is in readiness and you make your application to the eye, for instance, and after waiting due time, to find that you have been applying water or some equally inert liquid. There is no use multiplying examples, for they are numerous as each practitioner knows, but let there be a move at once to endeavor to right the wrong. I would suggest that a company of medical men, endorsed by the body of practitioners of the country, be formed to manufacture medicines, etc., for the use of ourselves, and that as a guarantee for money invested in that way, we give the company our undivided support, and for any doubt of good faith on the part of the company, a penalty be attached. The source of trouble, I believe, is in the fact that there are many manufacturing companies and each endeavors to outdo his neighbor in cutting prices, and in order to not lose money, reduces the standard of the articles manufactured. Now I am not in favor of punishing these manufacturing companies without first giving them a chance to reform, and I would be one of a committee to form notices and note results to such manufacturers. M.D.

Ontario, June, 1889.

THE LATE DR. SMITH.

To the Editor of the CANADA LANCET.

SIR,—Many of the older readers of the LANCET will learn with regret the death of S. F. Smith, M.C.P.S.O., L.R.C.P., last month. He was some eighteen or twenty years ago, a practitioner in

Exeter, St. Marys and Stratford, and those of his confreres who still remember him, must do so with kindest feeling. Energetic, full of love for his profession, he came to England to acquire the degrees of the old land so prized by the Canadians of our profession. After a short stay he became so attached to London, he decided to remain and succeeded in building up a large and lucrative practice. But his field in life extended beyond the pale of actual medical practice, he was known as a man of largely philanthropic views, whose charities reached over a wide area, and there are scores of families, to the writer's knowledge, who have reason to bless the memory of so good a benefactor. He took a lively interest in Christian propaganda; and the hospitals and medical schools of England, and the continent thank him for much good done the medical student by his broad dissemination of Christian literature. The cause of death was syncope, due to cardiac failure. He retired to rest as usual in apparently good health and in the morning was dead. He was a Canadian born, 50 years of age, a student under the late Dr. Rolph, and a graduate of the old Toronto School of Medicine. Among his papers were found some eulogistic recommendations from Dr. H. H. Wright, Dr. James Richardson and the late Dr. Lizars on his application for the House Surgery, of Hamilton Hospital. A mother, eighty-one years of age, a wife and three children survive him.

H. M. COWEN.

London, Eng., July 8th, 1889.

*Selected Articles.*

ON THE DIAGNOSIS AND TREATMENT OF GASTRIC ULCER.

BY WILLIAM M. ORD, M. D.,

Physician to, and Lecturer on Medicine at St. Thomas' Hospital, London, Eng.

In considering this subject from the practitioner's point of view, I shall avoid recondite pathology as far as possible. But as an introduction to the study of the subject, it is necessary to define what may be called the coarse anatomy of gastric ulcer.

I think that all who have given attention to this matter will recognize the occurrence, of at least two popular forms of gastric ulcer; possibly,

quite apart from new growth, there may be other forms; but of the two I may speak with a certain amount of confidence.

The first is the deep perforating ulcer most frequently found in young women: an ulcer which typically has purely erosive characters, presenting round or oval outline, penetrating to various depths through the mucous membrane and muscular tissues, having sharp edges, undisturbed by inflammatory thickening, and crateriform shape. Such ulcer, as it penetrates through the walls of the stomach, may open vessels and give rise to hæmorrhage, or may traverse all the coats, and open into the peritoneal cavity. The term "perforating ulcer" has often been applied to it, and most appropriately. The site of such ulcer varies; but, for the most part, it occupies rather the medium zone of the stomach than either of the extremities; it affects the line of the curvatures, the lesser more frequently than the greater; but it may be found more frequently on the posterior wall of the stomach. Pathological specimens show that such ulcers may heal and leave deep, puckered scars.

The other form of ulcer is diffused, comparatively shallow, with raised or overhanging edges, irregular outline, and uneven surface. It is found more commonly in the right half of the stomach, approaching, in fact, more or less to the pylorus.

The symptoms and associations of the two kinds of ulcer differ in a marked way. The subjects of the first are young women; a very large majority of them, so far as my experience goes, employed in domestic service. As they come before us for treatment they present a curious agreement in their physiognomy. Probably the first thing attracting attention is their anæmia. It is an anæmia not by any means associated with emaciation, rarely associated with pigmentation, and on the whole associated with plumpness and transparency of the skin. A large majority of the subjects are, as regards bulk, well nourished. At the same time a large majority appear to be irregular in respect of their catamenial function, chiefly in the way of deficiency. I think we may take it for granted that menstruation is, as a rule, imperfectly established. It is not unimportant to mention that subjects such as these are, with exceeding frequency, the victims of acute rheumatism.

The symptoms presented by such subjects when suffering from gastric ulcer may be grouped under four principal heads: First, pain; second, tenderness; third, vomiting; fourth, hæmatemesis.

**Pain.** The pain is usually not continuous, but occurs after food-taking, sometimes immediately, sometimes after an interval of half an hour, or an hour, or even more. It is generally of a very acute kind, and recurs at a particular spot after ery meal, being sometimes limited to that spot,

sometimes extending in various directions. Thus, for instance, a pain regularly beginning at a point in the epigastrium will extend to the back and radiate upward over the chest; or beginning in the back may extend upward along the vertebræ, and forward into the epigastrium. During the existence of the pain there is usually much tenderness over the epigastrium, whatever part of the stomach may be exposed to pressure. Should vomiting occur, the pain is subsequently annulled or greatly mitigated. In well-marked cases of gastric ulcer, pressure over the epigastrium and stomach-area usually produces pain at all times, increased, as has been noticed, when internal pain occurs after food-taking. We shall see presently that such tenderness may be determined by two conditions: first, by ulcer; second, by gastritis; but before going further it may be urged that the tenderness of ulcer is much more acute than that of gastritis.

The importance of vomiting as a sign of gastric ulcer has been variously estimated. Some authors would regard vomiting as a more important symptom; some would rely more upon the character and sequence of pain already described. It is certainly true that many variations in the proportion of the two systems are to be observed. But in my experience, vomiting as an isolated symptom, is less decisive than pain. As a conjoined symptom vomiting has an importance often decisive. When pain has, for instance, already occurred, and has lasted for a time proper to the particular case, vomiting takes place and brings immediate relief. It is true that there may be many variations in the severity of the pain and the persistence of the vomiting; but both symptoms being present, the meaning of the succession can hardly be doubtful. The observation of the matters vomited is, of course, an important point in diagnosis. They may consist of food hardly altered; of food partly digested; of food mixed with abnormal gastric juice; of food mixed with mucus in various proportions; and of blood variously mixed. In other words, we may have such irritability of the stomach as determines at once the rejection of what has been received. We may have next, owing either to the position of the ulcer or to impairment of the action of the stomach, rejection of the food at a later stage of digestion; the rejection being determined, in one case by disturbance of peristalsis, in the other, by the irritation of ill-digested matters. The presence of much mucus in the vomit will indicate the complication of gastric catarrh, a subject of much importance in relation both to the diagnosis and treatment of gastric ulcer; a subject which we shall have to discuss more fully later.

The hæmatemesis of this form of gastric ulcer has very distinctive characters. It is very rarely continuous, very rarely small in quantity. Our

general experience is that women suffering from some of the symptoms already detailed will have once, or once and again, or on several occasions, profuse gastric hæmorrhage, bringing them into the jaws of death, but very seldom actually killing them. The blood thus vomited is mostly coagulated, and, by reason of its volume, little affected by the gastric juice. The anæmia of such cases very reasonably leads to the suspicion that hæmorrhage in bulk inadequate to the production of vomiting may have occurred often, and may have contributed to the characteristic anæmia.

With the more decisive signs so far considered, young women suffering from gastric ulcer present many secondary symptoms, such as anorexia, excessive appetite for food, or depraved appetite, particularly for acids; constipation, or, more rarely, diarrhœa; headaches, particularly frontal; neuralgia, shortness of breath, palpitation, undue pulsation of the abdominal aorta, tinnitus, giddiness, and the symptoms which are grouped under the head of hysteria.

So far we have been getting before our eyes a general view of the aggregate of symptoms. But it must be remembered that there are many variations which are to be observed in each and all of them. The pain, for instance, varies considerably as to time, position, and character. In some cases it arises shortly after taking food, or even during a meal. There is every probability that such sudden occurrence is induced by a definite position of the ulcer, viz., of the cardiac end of the stomach. Later occurrence of the pain in all probability marks increasing distance in the position of the ulcer from the cardiac orifice. But while inferences drawn from anatomy have a definite value, we have to take into account the conditions of the stomach generally, and also of the patient.

My experience is to the effect that in not a few cases where the localization of pain is far toward the right limits of the stomach, the ingestion of food excites at once the suffering. There is evidently a hyperæsthesia of the whole organ, which may be simple or dependent upon catarrh associated with the ulcer. Where there are much anæmia and much general nervous susceptibility, we may, on the whole, regard the early occurrence of pain as a mark of simple hyperæsthesia. Should vomiting occur we have an important commentary in the character of the egesta. For instance, the absence, or presence in varying quantities of stringy mucus will help us to understand the meaning of the early access of pain. I do not refer to these varieties in a spirit of curious observations. In my experience they have important relations to treatment with which I shall deal later on.

Under the head of time of pain we must include duration. In gastric ulcer uncomplicated by inflammation of the stomach, the duration of pain is comparatively limited; for the most part certainly

it is not felt when the stomach is empty, or comparatively empty; though I must admit there are exceptions to the rule. A long duration of pain, particularly if it follow vomiting, and, still more, vomiting of much mucus, will mark the existence of much accessory gastric inflammation. The position of the pain varies considerably, sometimes it is in the epigastrium, where a distinct and limited tender spot can be detected by pressure. Often it is felt in the back, so that tenderness is referred to the vertebræ.

The varying conditions of the pain will be, no doubt, generally marks of the position of the ulcer. So, also, will be the attitudes of the patients during the paroxysm. We may well believe that a patient having gastric ulcer will instinctively assume such a decubitus as will obviate pressure of ingested food upon his or her tender point. Accordingly if the ulcer is, as it very commonly is, on the posterior wall of the stomach, the patient will be found lying prone or semi-prone, with the knees drawn up. I have seen several cases in which patients, complaining of violent pain in the back after food-taking assume such an attitude. The limits of my paper are too short to follow out other attitudes, and I will not discuss this point further.

In considering the symptom of vomiting we find, in the first place, that, as in the case of pain, the period at which vomiting occurs may, to a certain extent, indicate the position of the ulcer. Early vomiting after food goes, as early pain, to indicate cardiac position. Late vomiting, and, still more, vomiting occurring after several successive meals, would tend to localize the ulcer in the pyloric end of the stomach. In these latter cases the amount vomited is usually very large, appearing often to be in excess of what has been previously introduced into the stomach. To repeat, the relative importance of pain and vomiting as signs of gastric ulcer is, as I have noted, by no means uniform. On the whole, I should be inclined to attach a higher importance to the pain than to the vomiting, while urging that every case has to be examined by itself in all its bearings.

As regards hæmatemesis, I have already noticed that in this form of gastric ulcer it occurs at long intervals and in large quantity. Here, however, qualifications are needed—hæmatemesis does not occur at all in many subjects of gastric ulcer. The non-occurrence of hæmatemesis, however, does not preclude the occurrence of gastric hæmorrhage, particularly where vomiting is less marked than pain. Several times I have been able to verify the appearance of melæna where no blood was ejected by the mouth. It appears to me probable that melæna is more frequently present than identified, and that it sometimes contributes largely to the anæmia belonging to this class of disease. The occurrence of "coffee-grounds" vom-

iting is decidedly rare in this form of affection, but where vomiting is severe and much mucus is brought up, streaks of blood may be observed in the mucus. These probably belong rather to gastric catarrh than to gastric ulcer itself. In the few cases of "coffee-grounds" vomiting, accessory symptoms are generally present, suggesting deep extension of the ulcer to surrounding organs after the formation of adhesions. Here generally the history of the case elucidates its meaning.

In some cases, after the persistence for a considerable time of the average symptoms, either pain or vomiting or both will become generally more constant and less definitely related with food-taking. The signs of gastric catarrh will be aggravated, and very often strange variations of appetite will obtrude themselves. These generally consist in depravation rather than loss of appetite, and lead us into new ground. I may quote a case in point. A lay-sister in a home presented, for several years, recurrently the ordinary signs of gastric ulcer. At length the pain became persistent, and had constant tenderness associated with it. Vomiting became exceedingly frequent, and blood was often present. The patient steadily developed an inordinate appetite, and a curious predilection for one kind of food. For several years she took nothing but mashed potatoes freely enriched by butter. Feeling pain and craving, she would call for this. She would partake of it freely, and feel for an hour or so, comforted. No other food and no medicine afforded any similar relief. She was in the habit of rejecting this magma between an hour and two hours after taking it. Her distressing conditions at once returned, and she promptly took another instalment. The process was repeated from eleven to fourteen times within the twenty-four hours. Seeing that this patient had, in the earlier stages of her illness, the ordinary signs of gastric ulcer, and investigating her later symptoms, I came to the conclusion that the ulcer or ulcers had penetrated deeply, and had led to adhesions between the stomach and adjoining organs, with the result that the walls of the stomach were prevented from collapsing when that organ was empty. Perhaps one of the uses of a paper such as this is to raise side issues of interest.

Physiological observations and general experience go to show that when the walls of an empty stomach are prevented from coming into contact, sensations of extreme hunger arise. A converse practical illustration is afforded by the fact that a tight girdle placed over the stomach diminishes the intensity of hunger in people who are not able to obtain food. I have seen one remarkable case illustrating, to all appearances, the effects of the impossibility of the stomach to contract during excessive hunger. An elderly gentleman was under my care for several years. He was literally the

shame and opprobrium of his family by reason of his vast and inconsiderate appetite. He was accustomed to eat voraciously of whatever was set before him, with a special selection of the richest possible dishes. That he vomited freely after such indulgence made no difference to him. His one object in life seemed to be to fill his stomach, and to clog it with what might seem to be most oppressive. I had the opportunity of making a "post-mortem" examination, when it appeared that, as a result of an old abscess connected with the gall-bladder, adhesion had occurred between the stomach and all surrounding parts. When the abdomen was opened, the stomach was found to be not a movable viscus, but a large, permanent cavity, firmly bound to the adjacent organs, as if nothing like a peritoneum had ever existed. The smallest diameter of the cavity was at least two or three inches, and no pressure could have brought the mucous surfaces into contact. In the case of the lay-sister I have mentioned no "post-mortem" was permitted; but the two cases were so parallel in their symptoms that I think there can be little doubt of the application.

*Diagnosis.*—In the differential diagnosis of this form of gastric ulcer, at least three or four conditions, producing somewhat similar symptoms, have to be excluded. First, gastritis, acute and chronic; second, malignant disease of the stomach; third, the functional disorders of the stomach comprehended under the term dyspepsia; and, lastly, in a few cases, the acute dyspepsia or gastric crisis of locomotor ataxy.

To compare, in the first place, the signs of gastric ulcer with those of gastritis, acute or chronic, we may notice important differences in the character and duration of the pain. In gastritis we find an epigastric distress of a constant character, markedly contrasted with the evidently induced pain of ulcer. The distress consists in a sensation of oppression, distention, and heart-sinking, of course more pronounced in acute gastritis, the subjects of which complain of a feeling which they describe as "bursting." In addition to these sensations, pain belongs to all three conditions; constant and grinding in acute gastritis, more or less constant in chronic gastritis, though here the milder form of the pain enables us to see that it is aggravated by food-taking. But in either case it is not relieved by vomiting. Vomiting is present in all three; constant in acute gastritis irrespective of food; frequent in chronic gastritis, usually sometime after food-taking; present or absent in ulcer; when occurring therein, giving a relief far more marked than in the inflammatory conditions. The character of the matters vomited will be, in the case of acute gastritis, inflammatory. There will be little food, much tenacious and adhesive mucus; streaks of blood; and as the process advances an intermixture of pus. In

chronic gastritis still much mucus, not adhesive, yellowish or opaque, this either alone or mixed with food. Mucus occurring in the vomit of ulcer will generally indicate the existence of chronic gastritis.

Palpation enables us to recognize very different forms of tenderness; this is considerable and constant in acute gastritis, very light pressure over any part of the stomach-area producing great distress. In chronic gastritis there is diffused but dull tenderness, brought out only by comparatively deep pressure, but sufficient to make the wearing of a closely-fitting dress a cause of considerable discomfort. The more acute and localized tenderness of gastric ulcer has already been noticed.

There are one or two more signs of minor importance. In acute gastritis we may expect to find marked rise of temperature, headache of considerable intensity and constancy, mainly frontal in locality. Thirst as of the desert, a very foul and usually dry tongue, and a fetor of breath almost as proper to the affection as the scent of a particular flower. In chronic gastritis there is rarely pyrexia, headache is common but intermittent, and the other symptoms cannot be spoken of seriously. In gastric ulcer all this group, except headache, are usually absent, and headache, if occurring, is frontal, and coincides in time with the other symptoms.—*Am. Jr. of Med. Sciences.*

(To be continued.)

#### THE TREATMENT OF INEBRITY IN THE EDUCATED CLASSES.

It requires but little reflection to enable one to understand that the treatment of inebriety should be along very different lines according to the varying social conditions of the patient. This is true, indeed, of nearly all diseases the types of which often differ widely according to the surroundings of the patient, but of none is it more true than of nervous affections, and especially, perhaps, of inebriety. The inebriate who has been born and has passed all his life in the slums of a large city is very unlike, in both normal and physical constitution, the well-to-do gentleman, whose surroundings are the most refined, and who deplors his infirmity and shudders to think of the world of his associates becoming sharers in his secret.

The management of cases falling in the latter category is the subject of a communication read before the London Society for the Study of Inebriety, on January 1, 1889, by Mr. James Stewart. The author starts out with the assumption that in every inebriate there is an absolute degeneration of brain elements, and that upon this depends loss of will-function. This being admitted, the treatment should be so directed as to assist nature in

her efforts to regenerate the injured nerve-tissue, to build up again the brain elements through the medium of which the will-power and other functions are exercised. In order to do this, total abstinence from alcohol is absolutely essential, and nothing containing alcohol, not even the lightest wine or beer, is to be permitted at any time, even during the intervals of the drink-craving. The will of the patient being weakened, he must live under the constant supervision of the physician. For this purpose the author advises a residence in the country, in the home of some medical man. The latter should not be in active practice, but should be in a position to devote his entire time to the patients, not more than five or six, entrusted to his care. If there be a greater number of "guests" than this, the domestic family feeling would be destroyed, and the inebriate will come to regard himself as in an asylum rather than a private house.

The life at home is to be made as little irksome as possible, and amusements of various sorts should be provided. The patient, if he have no literary tastes or no hobby, such as painting, wood-carving, or the like should be induced to take up something like photography which will consume much of his time and lead him out frequently into the open air. He should also be encouraged to take up pedestrianism, being accompanied in all his walks, of course, by the physician or his deputy, and should be taken frequently to public meetings, concerts, lectures, cricket-matches, and the like. The physician will be greatly aided by a pleasant and energetic wife, or female members of the family, who may assist in the entertainment of the guest in the home circle during winter evenings and at other times. If the patient is a lady the help of the physician's wife is, of course, absolutely indispensable.

This is briefly the plan of treatment advocated by Mr. Stewart for the intelligent inebriate who is earnestly desirous of overcoming his infirmity and is willing to submit for a period of a year to a moderate degree of restraint, putting his will to a certain extent in the keeping of the physician. But, and especially at the beginning, something more is needed than mere occupation. It is necessary to moderate as far as possible the craving for drink, which returns with almost irresistible force at frequent intervals, and also to overcome the depression from which the inebriate is usually suffering when he first reaches the house. For the latter it will be necessary to administer, at intervals of an hour or two at first, egg and milk, beef-tea, milk and lime-water, soda and milk, and other easily assimilated beverages. The sleeplessness from which almost all inebriates suffer at first is best treated by a draught composed of 20 minims of the solution of bimeconate of morphine with 10 or 15 grains of chloral, alternated for a few nights



with other hypnotics. Sulfonal will doubtless be found very serviceable in such cases. The author protests against the idea that by the exhibition of drugs, such as capsicum, perchloride of iron, or strychnine, the craving for alcohol may be destroyed or kept under. It may perhaps be smothered for a while, he says, but he believes that by this treatment the physician is only substituting one enslavement for another. The same is true to a certain extent in respect to aerated beverages. Without absolutely interdicting the latter he recommends his patients to do without them, and to drink plain water at their meals and take plenty of milk with either tea or coffee, or, as he prefers to either of the latter, cocoa. The diet should be plain and unstimulating, and all condiments should be avoided at meals. If the patient suffer from pain in the stomach after the ingestion of food he should take large draughts very of hot water twice or three times a day. Smoking should be reduced if it cannot be entirely given up.

The author summarizes his conclusions, which he has arrived at as the result of constant clinical study during the last twelve years, as follows :

1. Drunkenness and inebriety ought not to be confounded.
2. Inebriety is a lesion of the brain which has gone so far as to affect the will-power.
3. Successful treatment based on this pathological dictum must include the absolute cessation of alcoholic drinking.
4. There is no danger in the sudden and complete withdrawal of alcohol if the case—no matter how severe—be in the hands of a skilful physician able to personally direct the hourly treatment from the first.
5. The physician undertaking the charge of such cases ought to be a total abstainer, as well as everyone living under his roof, so that normal treatment by example may supplement therapeutic remedies.
6. Permanent recovery need not be hoped for unless both lines of treatment be pursued, systematically, during an uninterrupted period of twelve months in a "Home" from which every beverage containing the smallest quantity of alcohol is absolutely excluded. The first four months barely suffice for the getting rid of the stomach and other troubles which are the result of the alcoholic poison ; at the end of the second period of four months the patient begins to feel less the want of alcohol ; by the end of the third period he has begun, perhaps, to understand that life may be enjoyed and vigorous health secured without stimulants.
7. So called "cures" effected by bark, strychnine, iron, and other drugs have not proved permanent.
8. The permanence of a cure depends greatly on the after treatment pursued subsequently to the patient leaving the "Home."

The family of the inebriate, or the household of which he or she is to form a part, ought all to become total abstainers, no alcohol being allowed under any circumstances into the house except as

a drug prescribed by a medical man and dispensed in a medicine bottle.—*Med. Rec.*

### THE ACT OF MENSTRUATION VIEWED FROM AN INVERTED UTERUS.

During a visit in August to my friend Dr. H., of Warren county, N. Y., I was invited to see a case of inverted uterus which had been under her observation for treatment, a short time before my arrival.

*History.*—Margaret, æt. about 30 years, multipara—occupation a basket weaver, was delivered of a child five months before at term. The placenta was adherent, and the attendant pulled it away, leaving the vagina filled with a mass supposed to be a tumor. When she applied to Dr. H. for treatment she was much reduced and very nervous. Upon examination the uterus was found to be inverted. Proper treatment was given, and when she was able, a reduction was attempted, but failed because the patient refused to take an anæsthetic, and was too feeble to have it done without. She left the place, but returned a few days before my visit. She came to the office, complaining of hæmorrhage. It was found that she had been menstruating for four days for the first time in five months, or before the birth of the child, and that she was flowing more freely than was her normal habit ; had much pain, nervousness and prostration.

Having seen but one case, and that through the courtesy of Dr. Munde, at Mount Sinai Hospital, a few weeks before, I was eager to examine the case and watch the act of menstruation, and settle in my own mind a point which *advanced* gynæcology has been foreshadowing for some time, viz. : That the tubes play the most important part in the act of menstruation.

Upon examination I found the diagnosis of inverted uterus to be correct. The left ovary filling Douglas' cul-de-sac, and the right one lodging above the ring formed by the neck of the uterus. The tubes were dragged down and put on a strain in the sac formed by the peritoneal surface of the inverted uterus. The surface of the tumor was of a dark red color, studded with points of a darker hue and resembled the tongue of a bad case of scarlet fever without the creamy coating. From this surface no discharges, to speak of, could be wiped away with cotton ; but from the tubes a dark healthy menstrual flow passed out drop by drop, and when the tubes were pressed upon would form a stream for an instant.

If the menstrual flow does take place from the tubes, many things will be made plain, which now confuse gynæcological and midwifery practice, and will overturn hitherto preconceived ideas with re-

gard to the functions of the uterus and its appendages.

Dr. Johnston, of Kentucky, the leader in advanced researches on the uterus and menstruation, divided the uterus into two segments, the neck and body—the functions of which differ materially. Again he demonstrates “that the corporal endometrium has an entirely separate nerve plexus, entering it at either cornu, from the centers imbedded in the broad ligaments and tubes” He makes the body of the uterus an entirely separate organ, with its own special nerve supply, and with its distinct function. Again the openings of the tubes of this inverted uterus were dilated, so as to admit the head of a small uterine sound.

Do the tubes dilate during the menstrual flow? If so, cannot treatment be made directly to the diseased tubes in cases where operations cannot be performed, as the urethras are catheterized? And may not tubal pregnancy be more explainable? Mr. Tait says, “All ectopic conceptions are primarily tubal.”

In this case of a healthy woman, the excessive flow was undoubtedly caused by the hyperæmia of the tubes from the dragging strain and the misplacement of the uterus. In Battey's operation, it is proven that the failure to produce the menopause, which sometimes happens, occurs from not removing the tubes close to the uterus. Does the scanty flow of the menstrual blood, which first induces women to seek medical advice, and which often precedes graver diseases, tend to show that the menstrual flow has its origin in the tubes?—*Gaillard's Med. Jour.*

THE ACTION OF OIL OF TURPENTINE IN IDIOPATHIC CROUP.—Lewentaner (*Centralbl. f. klin. Med.*) formerly reported his success with oil of turpentine in the treatment of croup, but there might possibly be a question raised about the correctness of his diagnosis, since no membrane was found expectorated. He now reports two other cases, both of them *in extremis* when the treatment was commenced, and both of which were saved, apparently by the use of turpentine.

The first case was a child of two years, who had exhibited signs of stenosis for several days, and who had reached about the seventh day of the disease. When first seen by the author the asphyxia was extreme, the cough entirely aphonic the face pale and livid, and the pulse scarcely perceptible. No membrane had been expectorated. A teaspoonful of oil of turpentine was administered, and ice compresses put around the throat. The child slept more quietly through the night, received another dose of turpentine on the next morning, and during the day expectorated a portion of membrane of considerable size. Under continued administration of turpentine in smaller doses, improvement steadily progressed.

The second case was that of a child of four years, who had been attacked suddenly with symptoms of stenosis, and was in the eighth day of his illness when seen by the author. He then exhibited extreme dyspnoea, with pale skin, and filiform and scarcely perceptible pulse. There had been no membrane expectorated. A teaspoonful of oil of turpentine was given, and the continuous atomization of a mixture containing turpentine prescribed. Very soon after the ingestion of the drug there was a violent paroxysm of coughing, and a large piece of membrane three to four inches long was expectorated. As it, however, continued to form, the treatment was persisted in, a teaspoonful of the medicine being given twice a day. Membrane was coughed up in abundance, and in a few days the child was well. The author is fully convinced that turpentine has a specific action on the disease. —*Am. Jour. of Med. Sci.*

IMPROVED TREATMENT FOR TINEA TONSURANS.—Although in most cases this disfiguring disease yields readily to one or other of the many applications which are recommended for it, yet in some cases, as the physician knows to his grief, it proves extremely obstinate, and the wisest efforts serve only to suppress it for a time. Some years ago Dr. Harrison, of Bristol, attempted, in a paper before the British Medical Association, to lay down more clearly the principles upon which successful treatment must be based. He showed that two sets of agents were needed: the first, an agent to dissolve the hair and to expose the fungus in its lurking places in the cuticle, hair, and hair-follicles; the second, a parasiticide to destroy the fungus. For the first he recommended a solution composed of liquor potassæ, spirits of wine, and iodide of potassium; for the second a solution of mercuric chloride in spirits of wine and water. By this method, through the softening action of the alkali, the iodide of potassium was allowed to soak into the parts affected, and then the application of the mercuric solution formed the very excellent parasiticide, biniodide of potassium, in and about the tissues occupied by the fungus. In the *British Medical Journal*, March 2, 1889, he presents a simpler plan, in which the drugs are applied in the form of ointment. He finds that patients will carefully rub in an ointment, when they will not take the trouble to properly apply a solution. The ointment which he uses is made as follows: Caustic potash, gr. ix.; carbolic acid, gr. xxiv.; lanolin and oil of cocoa-nut, of each, ʒ ss. The ingredients must be well rubbed together, and a little oil of cloves, lavender, or rosemary may, if desired, be added. A small portion of the ointment is to be rubbed on the affected part, night and morning. The alkali softens the hair, and allows the carbolic acid (it should be remembered that car-

bolic acid is not an acid, and does not combine with alkalies) to reach and destroy the fungus. He thinks it is better not to shave the part, but to leave the hair at least a fourth of an inch long, as the ointment is then kept upon the part.

To prevent infection from ringworm of the scalp, he employs an ointment of the following composition: Ointment of boracic acid, and ointment of eucalyptus, of each  $\frac{3}{4}$  ij.; oil of cloves,  $\frac{3}{4}$  ss.; oil of cocoa-nut, enough to make  $\frac{3}{4}$  vj. This, he says, constitutes a very elegant pomade even for general use, and is also an excellent prophylactic pomade. When ringworm makes its appearance in a family, he recommends that this prophylactic pomade be applied daily, not only to the healthy parts of the patient's scalp, but also to the heads of the other children in the family. To test its protective powers he has in three cases placed infected hairs on the heads of healthy children, and then first applied the pomade on the next day. None of the children caught the disease. The great confidence which he feels in the efficiency of the methods described above is founded upon the observation and treatment of more than one hundred cases of tinea tonsurans. —*Med. Rec.*

**CHLOROSIS.**—Dr. Huchard, *Rev. de Clin. et Thèrap.*, points out that it is a mistake to push the ferruginous treatment in all cases of chlorosis. The total amount of iron in the body under ordinary circumstances is not more than a few grammes, and even in chlorosis all of it has not disappeared. Any surplus iron is more likely than not to give rise to gastro-intestinal irritation. He prefers to give the iron in the form of iron filings mixed with chalk, powdered coffee, or rhubarb, in the form of a powder. Vinegar, to which chlorotic patients are often extremely partial, is not to be absolutely forbidden; on the contrary, a draught containing hydrochloric acid, taken after each meal, is a powerful aid to digestion. The constipation should be overcome by means of podophyllin, and the uterine functions should be stimulated at the approach of the menstrual epoch by means of hot baths and an infusion of saffron internally. Massage and general gymnastics are also to be commended as adjuncts. In many cases when iron has failed, arsenical preparations, in conjunction with bitters, are successful, and the binoxide of manganese has given good results when both iron and arsenic had been tried in vain. The binoxide can be given in a powder with charcoal and powdered calumba root, or it may be given in the form of the lactate of manganese, made into pills with extract of cinchona. When iron is well borne he recommends the following formula:—*R.* Ext. cinchonæ, ext. gentianæ, ext. rhei., āā, 5 grammes; ferrum tart., 5 grammes; ext. nucis vom., 50 centigrammes; ol. anisi, ꝑv.; glycerine,

q. s. To be mixed and divided into 100 pills. Two to be taken before each meal.—*Lond. Med. Rec.*

**SALICYLATE OF MERCURY.**—Dr. W. C. Caldwell, of Chicago, Ill., in an original communication upon salicylate of mercury in the *Therapeutic Gazette*, concludes thus on this drug:

"1. Because the salicylate is likely not absorbed from an acid membrane, it will usually produce less derangement of the stomach than the bichloride.

"2. Because the mercury is combined with an organic radical, it will produce less irritation during both first- and elimination-contact actions than the bichloride.

"3. Because the salicylate contains less mercury and acts slower than the bichloride, it has less action on albumen and on bacteria of putrefaction and far less on digestion.

"4. Because the salicylate passes through the stomach to the duodenum and there is dissolved, it appears that exhibited with hydrochloric acid it would be better adapted for an intestinal antiseptic than the bichloride, which probably is dependent mainly on its elimination-contact action in the intestinal canal.

"5. Because the mercury is combined with an organic radical, it should not be prescribed with mineral salts of the heavy metals.

"6. Because iodide of potassium given with it converts it into the biniodide, the salicylate should not be exhibited at the same time, unless it be in small doses.

"7. Because the salicylate is insoluble in acids it should not be prescribed with drugs requiring an acid menstruum for solution.

"8. Because chemical change occurs when combined with muriate of cocaine, they should not be given together,

"9. Because the bichloride is probably more active and effective in syphilis, it probably is the best when it agrees.

"10. Because the bichloride has such marked elimination-contact action, it is the better when such action is desired, as in acute tonsillitis, parotitis, etc."

**CANCER OF THE TONGUE.**—Jacobson (*Am. Jour. of Med. Sci.*) emphasizes the need of recognizing the precancerous stage at the beginning of tongue cancer and the early removal of the growth. The precancerous stage he defines as "a stage in which inflammatory changes only are present, any ulcerative and other changes in the epithelium which may be present not amounting as yet to epithelioma, but on which epithelioma inevitably supervenes." To recognize this stage he considers the duration of the ulcer, its obstinacy to treatment, the age of the patient, absence of duration or fix-

ity, careful scraping of the surface of the sore, and microscopic examination. For the small percentage of permanent cures he blames both the surgeon and the patient for delaying the operation and cultivating the cancer. Even where permanent cure is impossible, not only are months of life gained by the operation, but much comfort, because death from recurrence in the cervical glands is less painful and noisome than from the original lesion.

He considers four methods of operation—Whitehead's, Syme's, Kocher's, and that by means of the *écraseur*. Of these he prefers Whitehead's, of which he has made some modifications. He prefers to perform a preliminary laryngotomy and to plug the fauces in cases where the growth extends back into the posterior third of the tongue, when the surgeon is doubtful regarding his ability to control the hæmorrhage, and when the floor of the mouth is at all involved. He also splits the tongue before removal, because it is then easier to control hæmorrhage, and in certain cases it may be safe to leave half of the tongue. He combats the opinion that leaving half of the tongue is useless, and maintains that, on the contrary, the patient has most serviceable control over the half which is left. When the disease is very far back and unusual difficulties are present, he slits the cheek as far back as the anterior border of the masseter. He does not approve of preliminary ligation of the linguæ.

A brief description is given of Syme's and Kocher's methods. Both are severe and should be reserved for cases in which Whitehead's operation would be insufficient to remove the disease on account of the involvement of the floor of the mouth or of the cervical glands.

The *écraseur* he does not recommend, because, however well behind the disease, the loop is placed, it tends to come forward, as it is tightened closer and closer to the diseased tissue, until, if it does not encroach on this, it may upon tissue in its close contiguity ready to take on disease and also because of its failure to successfully divide the lingual arteries. The galvanic *écraseur* is mentioned only for condemnation.

For some days before the operation Mr. Jacobson makes the patient practise washing out his mouth frequently with Condy's fluid, sitting up, with the head alternately dependent on either side. Also he makes the patient accustomed to feed himself with a tube attached to a feeder-spout and passed by himself to the back of the throat. After the operation he brushes over the surface with a solution of zinc chloride, gr. x to ʒj. or of iodoform ether. Morphine is given freely, and ice to suck. Food is administered by means of a soft œsophageal tube.

The causes of failure as he enumerates them are: Septic diseases of the lungs, hæmorrhage,

cellulitis, erysipelas, pyæmia, exhaustion, more rarely shock, œdema glottidis, suffocation from falling back of the tongue, and recurrence.—*N. Y. Med. Jour.*

**PATHOLOGY OF CHRONIC ALCOHOLISM.**—The Pathological Society of London has devoted much time recently to a consideration of the pathology of chronic alcoholism. The discussions have been prolonged and very interesting. The following brief review of them, taken from the *Quarterly Jour. of Inebriety*, April, 1889, will prove of interest.

Dr. Payne, in his opening and closing of the debate, insisted clearly on stating his belief that the ordinary pathological conception of cirrhosis needs reconsideration. He demurred to regarding it as a mere inflammation of the interstitial stroma of the liver set up by alcohol introduced through the portal vein, and producing great quantities of new fibrous tissue, which by pressure destroys the hepatic cells. He insisted that the destruction of cells and the hyperplastic inflammation of connective tissue take place concurrently, and in this view he was supported by Dr. Lionel Beale, who held that the essence of cirrhosis is atrophy of cells, and not inflammation of connective tissue. Dr. Dickinson stoutly maintained that the overgrowth of fibrous tissue is the essence of cirrhosis; and Dr. Sharkey showed specimens of apparently healthy liver cells side by side with masses of newly-formed connective tissue even in advanced cases of cirrhosis. He suggests that the liver cells seen in such connection with newly-formed fibrous tissue may be newly-formed cells; his hopeful view of the formation of new cells and new bile ducts is especially noteworthy; in other words, there may be a restoration of tissue in a diseased liver, a possibility supported, as he says, by clinical experience of cases of recovery from grave degrees of hepatic disease.

Not the least interesting part of the debate was that having reference to alcoholic paralysis and other forms of nervous disease produced by alcohol. What is eminently worthy of the attention of practitioners in this connection is the frequency of tuberculous disease in cases of alcoholic paralysis. In fact, the association of chronic alcoholism in all forms, and tuberculosis was brought out by almost every speaker, including Dr. Payne, who said truly that the inaccurate impression that habits of alcoholic excess are in any way antagonistic to tubercular diseases must be regarded as swept away. Dr. Dickinson's investigations into the comparatively much greater frequency of tuberculosis in publicans and others whose occupations and habits expose them to the evil of chronic alcoholism, were the first to open the eyes of the profession to the fallacy that alcohol antagonizes tubercle. Many eminent medical men have

felt with Dr. Dickinson that, as alcohol does so much harm, it surely must do some good. But, so far, the good that it does or the evil that it prevents has not been made very manifest. They need more definition. Dr. Izambard Owen says the statistics of the Collective Investigation Committee show that the consumption of alcoholic liquors appears to check malignant disease. This statement should now be tested very rigidly. Malignant disease is said to be on the increase. We have seen the demolition of the belief that alcohol is a preventive of tubercle; it would be some set-off against the mischief it works if it could be shown seriously to antagonize cancer.

The views and opinions of the many leading men who participated in this discussion were expressed in a scientific spirit, not as absolute or final, but as the most probable facts sustained by our present knowledge of the subject.—*Med. and Surg. Rep.*

**MENIERE'S VERTIGO.**—Brunner, of Zurich, formulates the following conclusions regarding this disease (*Annales des Maladies de l'Oreille*).

1. The name Ménière's disease is no longer applicable to any special and distinct affection, but rather to a complex set of symptoms; hence the name should be changed to Ménière's vertigo.

2. Under this head there should be placed only those cases in which the attacks come on suddenly, without known cause, at distinct and prolonged intervals, without fever, preceded by a more or less intense subjective noise in the ear, and followed by a more or less rapid deafness. This definition excludes vertigo dependent upon mechanical causes in the middle ear, as well as permanent vertigo due to acute labyrinth diseases.

3. Without doubt cerebral lesions, and especially cerebellar lesions, can produce Ménière's vertigo without any positive diagnostic sign. This difficulty does not often occur, because it is rare that such lesions produce deafness, excepting in cases of pressure on the fibres of the acoustic nerve.

4. Ménière's vertigo has generally as a fundamental cause some pathological change, either primary or secondary, in the labyrinth.

5. Nosologically we must distinguish between the grave cases and the light ones, as those consecutive to otorrhœa.

6. Some of the grave ones may be connected with hæmorrhages in the labyrinth; some of the light ones with a vaso-motor neurosis.

7. Generally, Brunner thinks, too important a role is ascribed to hæmorrhage, although many cases are doubtless due to a pathological modification of the blood-pressure in the labyrinth: *an obstacle in the efferent canals of the perilymph and endolymph is an important factor in the pathogeny of this disease.*

8. In favor of the vaso-motor origin of Mén-

ière's vertigo there may be adduced the following reasons: (a) The vertiginous aura preceding the attack. (b) Slight functional troubles show themselves only slowly. (c) A certain regularity in the frequency of the attacks. (d) The effect of quinine or even galvanization of the cervical sympathetic in moderating or arresting the attacks.

9. According to the experience of oculists, large doses of quinine provoke ischemia of the retina, and, as we all know, the labyrinth is also thus congested. We can thus explain the favorable action of this drug in cases of Ménière's vertigo.—*Am. Jour. of Med. Sci.*

**TREATMENT OF JAUNDICE FROM RETENTION.**—Dr. Le Gendre gives (*Concours Méd.*) the following treatment for this affection:

1. *Absolute Milk diet*, consisting of five pints of milk taken pure or in an alkaline medium, in quantities of eight ounces every two hours.

2. *Intestinal antiseptics*, for which the following powders are to be taken:

R.—B. Naphthol (finely powdered), 23 grs.

Salicylate of bismuth, . . . . 15 grs.—M.

Divided into ten powders; one to be taken every time that some milk is taken.

3. *Sponging the body* every morning and evening with cold water, to which the following has been added:

R.—B. Naphthol, . . . . . 1 part.

Water, . . . . . 5000 parts.

Heat and dissolve, filter and allow to cool.

4. *Purgatives* of a sodic base (such as sulphate of soda, etc.), to be taken every third day.

5. *Inhalations of oxygen*, or air baths, if circumstances permit.

Although insomnia is often a troublesome symptom in this affection, it is best not to give any hypnotics, especially not morphine. Sleeping can frequently be induced by calming the troublesome itching with the following lotion:

R.—Sublimate, . . . . . } āā 5 grains.  
Chlorhydrate of ammonium, }  
Camphorated alcohol, . . . . . ʒj.  
Cherry-laurel water, . . . . . ʒiixss.—M.

—*Rev. de Thérap., Med. News.*

**CHLOROFORM IN DYSPEPSIA.**—Chloroform administered in the various forms of dyspepsia overcomes fermentation and flatulence; it is best given in one of the following formulas:

1. Method of Dr. Wilson.—From ten to twenty drops of chloroform, to be taken in a few spoonfuls of sweetened water, in flatulent dyspepsia. After a few minutes eructations occur, followed by improvement.

2. Method of Dr. Huchard.—Administer before each meal one dessert-spoonful of the following:

R. Chloroform water, 150 parts; mint water, 30 parts; water, 120 parts.—M.

Or, from eight to ten drops of the following mixture in a wineglass of water: R. Tincture of nuc. vomica, tincture of gentian, tincture of anise, āā ʒ j.; chloroform, gtt. xx-xl.—M. An appropriate diet and oxygenated waters at meal times form part of this treatment.

3. Methods of Drs. Regnault and Leseque.—This treatment applies particularly to painful dyspepsias with dilatation of the stomach: R. Chloroform water, 150 parts; orange flower water, 50 parts, water, 100 parts.—M. One dessert-spoonful to be taken every fifteen minutes, until the pain ceases.

Or the following for the same affections: R. Chloroform water 150 parts; tinct. anise, 5 parts; water, 145 parts.—M.—*Revue Gén. de Clin. et de Thérap.*

IGNIPUNCTURE OF THE TONSILS.—Dr. Wilhelm Roth, of Fluntern, finds that in order to reduce the size of the tonsils without risk of troublesome hæmorrhage, which is not uncommon, especially in young subjects, the best plan is to employ ignipuncture, as has been recommended by Krishaber, and more recently by Verneuil. The tonsils and neighboring parts are first brushed over with a ten to twenty per cent. solution of cocaine. The finest point of the thermo-cautery, heated to redness, is then inserted to a depth of about five millimetres in three or four spots a few millimetres apart from one another on the tonsils. The instrument is not allowed to remain more than one or two seconds in the tissue. The whole operation, including both tonsils, can be performed in a very few minutes without any bleeding and with scarcely any pain. It must be repeated four or five times at intervals of two or three days, and this is usually sufficient to cause the tonsils to return to their ordinary condition.—*Lancet.*

DANGERS OF CHOLOROFORM IN LAPAROTOMY.—Professor Zweifel, of Berlin, has remarked several times that pneumonia has occurred after laparotomy has been performed under choloroform, either at night or on dark days when gas has had to be used. In some cases which were done in a small, badly ventilated room, where a good many bystanders were present and two or three Argand gas burners were in use, a peculiar cloud of partly decomposed choloroform vapour was very noticeable, not only to the eye, but by the effects produced on the respiratory organs of the operator and his assistants. When ether was used instead of choloroform these effects were not observed. Pending the establishment of the electric light, Professor Zweifel commences with a mixture of alcohol, choloroform, and ether alone, the patient being put under the influence of this in another

room, ether being subsequently used during the operation.

BELLEVUE REMEDY.—The following is the prescription for an expectorant mixture much used in Bellevue Hospital:

R.—Ammonii carbonatis, - - gr. xxxij.  
 Extr. senegæ fluidi,  
 Ext. scillæ fluidi, - - - āā f ʒ j.  
 Tr. opii camph, - - - - f ʒ vj.  
 Aquæ, - - - - - f ʒ iv.  
 Syr. toltan, - - - q. s. ad f ʒ iv.—  
 Dissolve and mix. Dose, a teaspoonful.

As a gargle for inflammatory troubles, Dr. Abraham Jacobi's "Special" is used:

R.—Potassi chloratis, - - - gr. lxxx.  
 Tr. ferri chloridi, - - - ʒ clx.  
 Glycerini, - - - - - f ʒ ij.  
 Aquæ, - - - - q. s. ad f ʒ viij.

Dissolve and mix. Used as a gargle and internally in doses of half ounce.—*Med. & Surg. Rep.*

TREATMENT OF ANAL FISTULA WITHOUT OPERATION.—Fistulæ which do not cause pain should not be operated upon. The clothing should be soft and smooth, and extreme cleanliness should be observed, the general condition of the patient should be attended to, and of systemic remedies a mixture of the bromides and iron is especially valuable. The following is an excellent remedy: Bromide of potash, 10 grams; citrate of iron, ammoniated, ½ gram; syrup of bitter orange peel, 190 grams. Tablespoonful should be taken morning and evening.

Topical appliances should be made after each stool. Here is a good formula for suppositories: Iodoform ʒ i gram; extract of belladonna ʒ i gram; cocoa butter, q.s. This should be applied after each defecation and on going to bed.—*Professor Guyot, Jour. de Méd.*

AN UNUSUAL ACCIDENT ATTENDING TOOTH EXTRACTION.—To the record of the numerous casualties which may follow tooth extraction Mr. Ackery, at the Odontological Society of Great Britain, has added another probably unique case. A molar was extracted from a patient while under the influence of nitrous oxide gas; the apex of one root, however, was left behind. A sinus subsequently appeared, and this did not heal upon the removal of the remaining portion of the tooth. Eight years after the original operation a substance was discharged from the sinus, which proved upon examination to be the point of one of the jaws of a tooth forceps, which had doubtless been broken and left in the alveolar process at the time of the endeavor to extract the tooth.—*The Lancet*, February 9, 1889.

**THE CHOICE OF A HYPNOTIC IN INSOMNIA.**—Chloral has fallen into disfavor of late years, and deservedly. It weakens the heart's action, lowers the powers of self control, and creates a craving for its continued use. The depression and general disturbance of function produced by opium contraindicate its use in a large majority of cases. The bromides are useful as a sedative, but loss of bodily weight and blood impoverishment follow their frequent exhibition. Sulfonal has been hailed as the hypnotic *par excellence*, and certainly it has given satisfaction in most cases; but there are instances where it is slow in its action or contrary in its effects. These objections can be urged, however, against every known remedy, and should not detract from the value of this new sleep-producer. Dr. Clouston (*Am. Jour. of the Med. Sciences*, April, 1889), throws the weight of his authority in favor of the claims of paraldehyde as the best hypnotic. It is so valuable, he says, so reliable, so free from risks, that it cannot be too widely known by the profession. It acts so quickly that the patient is often asleep in five minutes after getting the dose. After a paraldehyde sleep there is no headache, no lassitude, no loss of appetite, no disagreeable feelings. It restores the sleep habit of the brain in many cases. As to the dose of paraldehyde, begin with forty minims or a drachm, and go up to two, three, or even four drachms, if necessary. Give it mixed with tincture of quillaya in cinnamon water. Its bad taste cannot be got over.

**CONSANGUINEOUS MARRIAGES.**—The author of a recent work on this subject calls attention to the curious ideas which have been generally received in reference to the infecundity of, and physical degredation consequent on, consanguineous marriages. So far as the data given may be trusted—and it is hardly to be supposed that the author holds a brief on the opposite side—there is absolutely nothing to show that marriages between near kinsmen are lacking in fertility, or that they are peculiarly liable to give issue to deformed or diseased offspring. There is no lack of instances of enforced consanguinity, in the matter of marriage, in isolated communities, according to M. Huth, to disprove the assumption that physical degeneration is likely to result from the practice. An investigation into a number of unions between uncles and nieces, nephews and aunts, and cousins in the first and second degree, give an average of children rather above than below the general average, though this is attributed to some extent to the comparatively early age at which such unions are generally contracted. Breeders inform us that the results are markedly in favor of consanguineous unions between healthy well-bred animals. Unions between men, or animals, of widely different varieties, on the other hand, have a de-

cidely injurious effect on the offspring, and beyond a certain limit are almost absolutely sterile. Mulattoes and the half-breeds of India and America are striking examples of the deterioration to which such racial disparity gives rise. The great point to bear in mind is that the union of individuals with the same morbid tendencies intensifies the taint, and that, too, quite irrespective of any consanguinity. The moral, according to the author, is that the reasons which have led to the prohibition of marriages within certain degrees of relationship are social, and not physiological.—*Med. Press and Circular.*

**DYSMENORRHOEA**—William Wiles, M.D., Snaresbrook, Essex, says: I used Aletris Cordial especially in a case of severe dysmenorrhœa of considerable standing. The first period that occurred after taking the Cordial was passed through with considerably less pain than usual. The patient took the medicine for a week before the menstrual period was expected for six months. At the end of that time no difficulty or pain was experienced. So that, considering the time the patient had been suffering before, the benefit was very marked.

**TREATMENT FOR CATARRHAL AFFECTIONS OF THE THROAT.**—Dr. G. B. Hope, 34 W. 51st Street, New York, Attending Surgeon Metropolitan Throat Hospital, and Professor Diseases of the Throat, University of Vermont, says: "For a long time I have been employing Horsford's Acid Phosphate as a constitutional treatment for catarrhal affections of the throat. I consider it to be among the very best tonic excitants of the vocal organs, and particularly applicable in relieving the fatigue and huskiness of voice incident to those who pursue a professional career of actor or vocalist, and far preferable to the various forms of wines now so generally recommended for this purpose. I have seen no other allusion to its employment in this direction, which I believe you are perfectly safe in recommending both from a theoretical and practical point of view."

**POWDER FOR OZÆNA.**—Cozzolino (*Jour. de Méd.*) gives the following:

R.—Salol	. . .	5 grams.
Boracic acid	. . .	2 "
Salicylic acid	. . .	0.50 centigrs.
Thynol	. . .	0.20
Powdered talc	. . .	10 grams.—M.
S.—Snuff frequently.		

**CALOMEL** with digitalis succeeds well (*Schwass*) in removing ascites following hepatic cirrhosis, especially when the patient comes under treatment early in the disease.

# THE CANADA LANCET.

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

*Communications solicited on all Medical and Scientific subjects, and also Reports of Cases occurring in practice. Address, DR. J. L. DAVISON, 12 Charles St., Toronto.*

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

TORONTO, AUGUST, 1889.

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

## THE CARE OF THE INSANE.

The ponderous mechanism of the existing laws for the admission of an insane person into one of our asylums, has been dwelt upon at considerable length at various times, in both the professional and lay journals of Canada. That the present methods are not as facile as they should be, or as indeed they might be, is evident to anyone who has had the painful experience of committing a patient suffering from mental alienation. But great bodies move slowly, and the amount of conservatism displayed by our legislators in this matter compares favorably with that of the old-line Tories, who would gravely discuss for hours the advisability or not of changing the number or style of buttons on the soldier's coat, or the regulation length of his hair. And this weary delay of the law exists, notwithstanding the fact that the medical profession is, and has always been well represented in our legislative halls. It would have been reasonable to suppose that some one of these legislators, who belong to our profession, would long ago have succeeded in sweeping away some at least of the old-time barriers, and making the sad road to the asylum as short and as little unpleasant as possible.

It would seem that the present methods are intended to protect the individual. But it should be remembered that the community also has rights to be considered. Insanity means danger to the community, and while the individual should be protected to the fullest extent, the community

should also be so guarded, that the terrible consequences of alienation in the individual may not endanger life or property.

The difficulty seems to lie in the magisterial supervision of those held to be insane. The question of sanity or insanity is surely a medical one, no layman, be he judge or magistrate, being considered competent to pass an opinion as to the fact. So that the medical testimony is, after all, the only one which has weight. Why then should there be so cumbrous a method of committal? Have we not all seen the evil results of the delay in treatment in certain cases demanding prompt attention by experts? The month, or perhaps more, during which the unhappy lunatic lies in jail, may be so many days spent with the worst possible surroundings, during which the chances for his eventual recovery become greatly lessened.

There can be no doubt that the "painful and harassing procedures," now necessary for the admission of a patient to the asylum, are the cause of the retention at home of many lunatics who, both for their own, as well as their relations' sake, would be much better under the special environment and treatment of an asylum. But parents and friends hesitate to open up the case of a son or daughter who begins to show symptoms of mental derangement, or of a wife suffering from, say, puerperal mania, to the magisterial function of their neighborhood, and thus many valuable days are lost for early treatment. Days which can perhaps never be recalled, and which may, by their inactivity, doom the unhappy sufferer to a life of alienation, which might, with early special treatment, have been averted. There certainly exists a strong prejudice in the minds of a majority of the community against sending a relative or friend to an asylum. This prejudice is no doubt the result of the education of generations regarding the insane, heredity, etc. It should be the duty of the profession to do battle with such prejudice, and educate the laity up to the idea that insanity is a disease requiring prompt and special treatment by experts, with proper environment, and that the so-called kindness of keeping a dement at home is, in nearly every case, an absolute injustice, not to say cruelty to the sufferer, as well as fraught with danger to all those with whom he comes into contact.



## DIPHThERITIC PARALYSIS.

The cause of this frequent sequela of diphtheria is not well understood. It is most probably a *neuritis migrans*, as Fagge called it. This theory would go to show that a morbid process, starting in the part most affected by the diphtheritic poison, travels along the fibres until the centres are reached. Trousseau pointed out that when the disease was cutaneous, the limbs were affected as early as the fauces. As against the theory that it is due to a general systemic poison, we have the fact that faucial paralysis is the rule, and true paralysis has been known to follow an abscess of the tonsil, as also a case of parotitis. Some authors assert that the paralysis occurs after the primary disease has ceased; but this is certainly not true, although in many cases it does not show itself till the patient is thought to be well. It not unfrequently begins, says Sanné, on the fifth or sixth, or even as early as the second day from the beginning of the diphtheria,

It has been all along looked upon as having a favorable prognosis. But recent observation would go to prove that it is a very serious matter. The staff of the Great Ormond St. Hospital have concluded that, in children especially, it is attended by dread possibilities. The organs supplied mainly by the pneumogastric and phrenic nerves, viz., heart, lungs and larynx, are the ones through which danger comes to the sufferer. Cases of heart failure or paralysis; of pneumonia whether from disturbed innervation or from the irritation of the lungs by inhaled matters, the larynx having lost the power of properly protecting these organs, are frequent, and extremely dangerous. The muscles of respiration are sometimes attacked, giving a panting, difficult breathing as the result. Death may come on by more or less slow degrees in this way, accumulation of mucus from want of functional activity of the lungs, cyanosis and asphyxia. When the heart is the seat of the trouble, there is, says Duchenne, a sense of cardiac oppression and distress; small, slow, irregular pulse, becoming at times thready and imperceptible. The cardiac lesion is perhaps the most serious of the whole series, for though it may be cured, death is the usual result. Sometimes this organ is alone paralyzed.

The treatment which has so long been followed

in this form of paralysis has not been materially changed. A few years ago, the necessity of injecting the strychnia into the tissues was urged, but it is doubtful if the benefit derived from this drug is much if at all increased by this method of administration. Perhaps the syr. ferri, quin. et strychniæ phosphat. is as useful a preparation as any, combining as it does the specific action of the strychniæ with the useful tonic action of the other ingredients of the syrup.

Oertel objects to the use of either strychnia or nux vomica, depending upon ferruginous and other tonics; but the consensus of opinion is strongly against him. Massage of the limbs, stimulating baths as of warm salt water, and electricity are all useful in their place. The patient may have to be fed for weeks through the stomach-tube or per rectum, the most perfect nutrition possible being *a sine qua non* in the management of such cases.

## THE VIRTUE OF THE PROFESSION.

The men of the medical profession are rarely credited with the virtue that their conduct entitles them to; there is no profession or occupation beset with so many temptations and opportunities as ours. The doctor is made the repository of the family secrets and the misdoings of the patients. With closed doors and drawn window blinds in the doctor's private office, the lady patient describes her symptoms and relates in detail any circumstances that may stand in a causative relation to a disease peculiar to her sex. During a long course of treatment there springs up, by gradual growth, a simple familiarity which may ripen into an admiration on the part of the patient, encouraged by the kind and gentle treatment and sympathetic manner of the benevolent physician. With this state of facts, which are not in the least overdrawn, it is highly creditable to the profession that so few violate their trust and take advantage of the weakness of the gentler sex under these circumstances. We do not pretend to say that the physician is purer by nature than men of other professions, but through their special education, and the sense of honor inherent in every right-minded man, they learn to exercise self-denial with those whose physical welfare is committed to their charge. Opportunities for blackmail are fruitful under the above conditions, yet few are improved.

The clergy, we are sorry to say, suffer tenfold more scandals than physicians, notwithstanding that they are the physicians to the moral and spiritual being. They assume to build up what, sad to relate, some of them destroy by a single misdeed. When we pause and look into the retrospect, and compare the moral conduct of the medical man towards his clients with other professions and occupations in life, we are proud to announce our profession as a *physician*.

CANADIAN MEDICAL ASSOCIATION.—The following are the papers promised for the meeting of C. M. A., at Banff, August 12th, so far as heard from :—

The Endemic Fern of the North-West Territories (Mountain Fern), Dr. A. Jukes, Regina, N. W. T. The climate of South Alberta, with special reference to its advantages for patients with pulmonary complaints, Dr. G. A. Kennedy, McLeod. Traumatic Inflammations of the eye and their proper treatment, Dr. John F. Fulton, St. Paul, Minn. Hæmatoma of the Vagina and Vulva, Dr. A. W. Wright, Toronto. A case of Empyema successfully treated by free incisions, Dr. James Ross, Toronto. The early recognition and treatment of Epithelioma, Dr. L. Duncan Bulkley, New York city. The relief of pain in Eye and Ear affections, Dr. R. A. Reeve, Toronto. Sulfonal, Dr. James Stewart, Montreal. Nephrolithotomy, Dr. F. J. Shepherd, Montreal. Vertigo, an eye and ear symptom, Dr. J. W. Stirling, Montreal. A Resumé of a few surgical cases, Dr. E. A. Praegu, Nanaimo, B. C.

SULPHONAL AS A HYPNOTIC.—The Swiss correspondent of the *Br. Med. Jour.* says that Drs. Paschoud and Claret read a paper on the use of sulphonal in insanity, in which they stated that the drug is of great service, especially in maniacal excitement, and in the insomnia of melancholia, as well as in every kind of sleeplessness of nervous origin. When given in a dose of 2 grammes (which, if necessary, may be safely repeated once or twice in 24 hours), sulphonal produces calm and refreshing sleep, lasting from 4 to 5 hours. The remedy caused no digestive, respiratory, or vascular disturbances, nor any unpleasant subjective sensations on awakening.

QUININE IN PREGNANCY.—The idea that full doses of quinine are liable to produce abortion seems to be no longer held. A writer to the *Br. Med. Jour.* says, "I have frequently, both at home and abroad, administered large doses of quinine (10 to 20 grains) to pregnant women suffering from malarial fevers, and never observed the uterus at all stimulated by it. I do not know of any drug that will cause, when taken internally, the expulsion of the contents of the pregnant uterus."

FOR TAPE-WORMS IN CHILDREN.—The *Lyon Méd.* gives the following formulæ as effectual and agreeable :

I.

- R.—Oleoresin of aspidium . . . . . ʒj to ʒijss.
- Peppermint water . . . . . f. ʒss.
- Essence of anise . . . . . gtt. x.
- Chamomile water . . . . . f. ʒj.
- Syrup of sugar . . . . . f. ʒv.
- Syrup of bitter orange-rind . . . f. ʒv.

II.

- R.—Oleoresin of aspidium . . . . . ʒj.
- Calomel . . . . . 6 grains.
- Sugar . . . . . ʒij.
- Gelatine . . . . . q. s.

Make into the consistency of jelly, and administer as a confection.

CALOMEL AND DIGITALIS IN ASCITES (in dropsy from hepatic cirrhosis).—Schwass (*Centralbl. f. klin. Med.*) advises the use of calomel and digitalis as follows :

- R.—Calomel . . . . . 2 grains.
- Digitalis . . . . . ¼ grain.—M.
- S.—Every three hours for a week.

The diuretic action of this combination is far greater than that of either drug alone and can also be tolerated longer and better than either drug when taken by itself.

PROLONGED GESTATION.—Dr. Mans (*N. Y. Med. Jour.*) gives a case of prolonged gestation which he thinks can be authenticated. The period of pregnancy, calculating from the time of last menstruation, was 334 days. At the end of this time the patient bore a healthy male infant weighing nine pounds. This almost breaks the record, though Simpson mentions a case in which delivery occur-

red 336 days after menstruation ceased. Playfair places the extreme limit at 295 days.

**PRINTER'S ERROR.**—In the Announcement of Trinity Medical College, just issued, the reference to Dr. Spilsbury's course of practical instruction in diseases of the throat and nose (at page 19) is marred by the accidental introduction, by the printer, of the Dr.'s name before the word "*instruction*." Any one can readily see that it is a printer's blunder. That the teaching will be good and practical, the students will soon discover, Dr. Spilsbury's protracted training in Europe for his work having specially fitted him for this post.

**WOMAN'S MEDICAL COLLEGE, TORONTO.**—The following gentlemen have been appointed to positions upon the staff of this institution: Dr. Atherton, Lecturer on Principles of Surgery; Dr. Powell, Associate-Lecturer on Practice of Surgery; Dr. B. G. McKenzie, Lecturer on Orthopædics and Surgical Anatomy; Dr. R. S. Tyrrell, Lecturer on Jurisprudence; Dr. L. M. Sweetnam, Lecturer on Therapeutics.

**FOR TONSILLITIS.**—Dr. John Aulde recommends (*Med. Reg.*) the following as a useful medicine and gargle in this troublesome complaint:

R.—Tr. guaic. ammoniat.	.	.	.
Tr. cinchonæ comp.	.	.	āā f̄iv.
Potas. chloral.	.	.	ʒij.
Mel. desp.	.	.	f̄iv.
Pulv. acaciæ	.	.	q. s.
Aquam.	.	.	q. s. ad f̄iv.

M. Sig.—Use as a gargle, and take a teaspoonful every two hours.

**ATROPINE IN HÆMORRHAGE FROM THE LUNGS.**—Dr. Stirling says the *Therap. Gaz.* relates a case in which hæmorrhage from the apex of the left lung was entirely uncontrollable by ergotin, and all the other remedies usually prescribed. He administered  $\frac{1}{16}$  grain of atropine, hypodermically, with the result that the bleeding was at once stopped. He found that when the drug was stopped the bleeding recommenced, to be controlled by a further use of the atropine.

The name of Dr. Buller, of Montreal, was inadvertently omitted in our last number from the list of those attending the Ontario Medical As-

sociation. The doctor read a paper which will appear in a subsequent issue of this Journal.

**HONORS TO RICHARD QUAIN.**—The Queen has been pleased to appoint Richard Quain, M.D., LL.D., F.R.S., Fellow of the Royal College of Physicians, to be one of Her Majesty's Physicians Extraordinary.

### Books and Pamphlets.

**WOOD'S MEDICAL AND SURGICAL MONOGRAPHS.**—Consisting of original treatises and complete reproductions in English, of Books and Monographs selected from the latest literature of foreign countries, with illustrations, etc. Published monthly at \$10 per year. Single copies \$1.00. New York: William Wood & Co., 56 & 58 Lafayette Place. Toronto: Vannevar & Co.

In our March issue we noted the January and February volumes of these *Monographs*. We have lately received the March, April, May, June and July numbers. We can only reiterate what we then said as to the character of these productions; their excellence is made the more manifest, as they continue to appear, while their cheapness and attractiveness are undoubted. The contents of the various numbers are as follows: March—Neurasthenia and its Treatment; Antipyresis and Antipyretic Methods of Treatment, by Dr. H. Von Ziemssen; the Tongue, as an Indication of Disease, by Dr. W. H. Dickinson; On the Treatment of Cystic Goitre, by T. M. Hovell, F.R.C.S.; New Remedies from 1878 to 1888, by Dr. C. Cauquil. April—On Diabetes and its connection with Heart Disease, by Jacques Mayer, M.D.; Blenorrhœa of the Sexual Organs and its complications, by Dr. Ernest Finger. May—On the Preventive Treatment of Calculous Disease and the use of Solvent Remedies, by Sir Henry Thompson, F.R.C.S., M.B., London; Sprains; their consequences and treatment, by C. W. Mansell Moullin, M.A., M.D. Oxon. June—General Orthopædics, including Surgical Operations, by Dr. August Schreiber, Surgeon-in-Chief to the division of the Augsburg Hospital. 388 illustrations. July—Cancer and Cancerous Diseases, by Sir Spencer Wells, Bart., F.R.C.S.; Cardiac Dyspnoea and Cardiac Asthma, by Dr. S. Von Basch; The Influence of Menstruation and of the Pathological Condition of the Uterus on Cutaneous Diseases, by Dr. L. Grellety; Tension as met with in Surgical Practice, Inflammation of Bone, Cranial and Intracranial Injuries, by T. Bryant, F.R.C.S.; Antisepsis and its Relation to Bacteriology, by Dr. J. Neudorfer.