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THE CANADA LANCET.

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MEDICAL AND SURGICAL SCIENCE,
CRITICISM AND NEWS.

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Original Communications.

LAPAROTOMY AND INTESTINAL SUTURE.*

BY JOHN A. WYETH, M.D.,

Professor of Surgery in the New York Polyclinic, Etc.

Leah R., † Russian, fifty-six years old, housewife, was admitted to Mt. Sinai Hospital on October 9, 1886, with the following history: For ten years she had had a swelling in the left groin, which would disappear when she lay down and return when she was standing erect. She had not worn a truss. Two weeks before admission she discovered that the tumor no longer disappeared upon going to bed, but became painful, tender and more swollen. She had not vomited up to the time of arriving at the hospital, but there had been no evacuation of the bowels for six days prior to her admission.

On admission, a swelling as large as an ordinary fist was found occupying the inner aspect of the left groin and thigh. The skin over the tumor was red in color, tender and doughy to the touch, and fluctuation was evident. The tissues around were slightly emphysematous. The patient's appetite was gone; she was emaciated, having lain in present condition ten days in a tenement-house without proper care. The temperature was normal.

A diagnosis of strangulated femoral

* Read before the Section in Surgery of the New York Academy of Medicine, March 14, 1887.

† I am indebted to Dr. Rich, of the house-staff of Mt. Sinai Hospital, for the notes of this case.

hernia was made, ether administered, and the tumor incised. Several ounces of foul pus mixed with intestinal matter were discharged. No trace of a hernial sac or of intestinæ could be discovered, such was the gangrenous condition of the mass. Upon introducing the little finger into the femoral canal, a slight opening into the intestine could be felt. Into this a closed dressing forceps was introduced, and the opening dilated by separating the jaws of the instrument. This was intended to secure the freer exit of ingested matter from the upper portion of the occluded gut.

A loose dressing of iodoform gauze was laid over the wound. The patient improved in condition after this operation, under mild stimulation and liquid diet (milk, beef-tea, beef-juice, whisky, sherry, etc.). Only a small quantity of ingested matter escaped when the gauze dressing was changed on every second or third day.

On October 22d, thirteen days after the first operation, with ether narcosis laparotomy was performed. The patient was placed upon the back with the pelvis elevated upon a firm cushion. With Volkmann's spoon the granulation tissue was first scraped from the walls of the abscess, the hole into the intestine plugged with a pellet of iodoform gauze, the cavity of the abscess irrigated

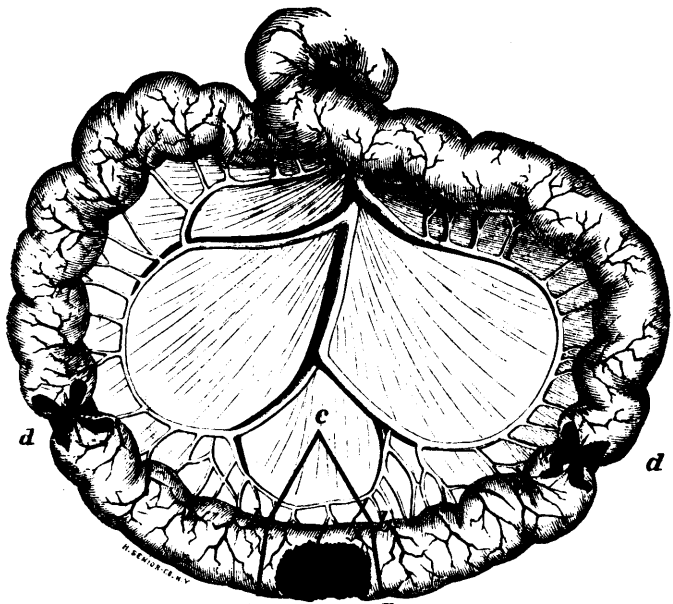


FIG. 1.—Loop of small intestine. *a b*, lines of section through the gut, removing the gangrenous portion; *b c*, same through the mesentery; *a a*, gangrenous portion of illum; *d d*, occlusion of the afferent and efferent tubes by tape ligatures.

with 1 to 1000 sublimate, and then tightly packed with iodoform gauze.

The integument about the femoral canal was washed thoroughly with soap and warm water, cleanly shaved, washed with ether, and finally with 1 to 1000 sublimate solution. Towels wrung out of hot sublimate solution (1 to 3000) were laid over that portion of the body near the groin, leaving only a spot exposed measuring six by four inches.

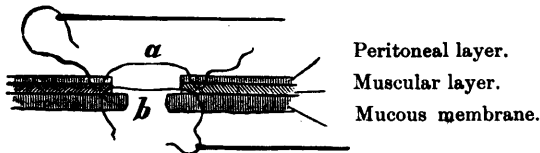


FIG. 2.—Schematic. *a*, Lembert's, and *b*, Czerny's sutures.

An incision four inches in length was made parallel with the outer border of the rectus muscle, the lower end being over the femoral ring. All bleeding was arrested, so that before the peritoneum was opened the wound was absolutely dry. Juniperized catgut ligatures were employed. Great care was observed to keep to the inner side of and away from the epigastric vessels, which were exposed in the dissection. The parietal layer of the peritoneum was picked up with a fine forceps, opened, and further divided upon the finger as a director.

Upon looking into the abdominal cavity, one or two loops of normal small intestine were seen, and upon displacing these upward, a third loop was seen to be imprisoned in the femoral opening. That part of this loop above the constriction was slightly distended, while the part on the side nearest the rectum was contracted until it was about two-thirds of the diameter of the upper segment. The obstruction of the intestinal canal at the ring was complete. A soft flat sponge taken from a warm Thiersch solution (boric acid, gr. iv; salicylic acid, gr. j; water, ʒj) was placed beneath the imprisoned loop in such a manner that it held the loose loops of small intestine back, and was ready to receive any foreign matter which might escape from the gut when it was divided.

Two long-jawed scissors-forceps (used as clamps) were then placed so as close the loop of gut which was caught in the ring. One of these rested against the inner surface of the ring and the other only sufficiently removed from this to permit of a division of the intestine between the forceps.

As soon as this was effected, the loose end, with one pair of forceps attached, was brought out through the abdominal wound and placed in a warm Thiersch towel. As the forceps which constricted the ring of gut attached to the femoral canal was removed, a tuft of sponge was tightly packed into this ring to prevent any infection from the abscess with which it communicated.

Of the loop which had been liberated, about ten inches (five above and below the point of occlusion) were drawn out of the abdomen, flat Thiersch sponges carefully placed so as to close the wound and prevent any escape of matter into the peritoneal cavity, and the exposed gut protected by covering with warm towels. A piece of cotton tape one-fourth of an inch wide was then tied four inches above and below the limits of the gangrenous opening, so as to completely occlude the lumen of the gut (*dd*, Fig. 1). These tapes had been well soaked in a 1 to 3000 sublimate solution. When the forceps-clamp was removed, the opening into the intestine was seen to occupy two-thirds of the circumference of the canal. The gut was then cut across at a right angle to its axis by a single stroke with the straight scissors (*ab*, Fig. 1). These lines of section were well out in sound tissue. The piece of intestine removed measured two inches and a half. A triangular piece of the mesentery was also removed (*bcb*, Fig. 1).

The bleeding from the mesentery was profuse, requiring a dozen catgut ligatures. From the ends of the intestine only a slight oozing occurred. The cavity of the gut from the tapes to the openings was carefully emptied of all matter and



FIG. 3.—Schematic. Shewing the inversion of the peritoneal layer by tying Lambert's suture, and of the mucous membrane by Czerny's suture.

washed out with Thiersch's solution. Nothing escaped from the lower end.

The edges of the divided mesentery were first united by eight interrupted catgut sutures, about one-fourth of an inch distant from each other. When the intestine was reached, the mesenteric attachment of each end was carefully brought into apposition and the work of stitching the ends of the cylinders to each other begun.

In doing this, three forms of suture were em-

ployed: 1. A suture through the mucous membrane alone, or *Czerny's suture*. 2. That through the peritoneal coat alone, or *Lembert's suture*. 3. One which pierces the peritoneal coat, and, passing along with the muscular layer, comes out on the free border of the divided gut, the *intermediate suture*.*

In Fig. 2, which represents a longitudinal section through the ends to be approximated, is shown at *b* the Czerny suture as it is passed through the mucous layer of the gut from the inner surface of the canal, while at *a* the method of introducing the Lembert suture through the peritoneal layer is shown.

When a gut is cut across, the longitudinal muscular layer retracts, carrying the peritoneal layer with it and leaving the thick mucous membrane projecting about one eighth of an inch. The object of the Czerny suture is to bring the mucous membrane and the connective tissue upon which it rests together, and thus strengthen the line of union after adhesion occurs. If this is not done, the slight adhesion between the peritoneal surfaces obtained by the Lembert suture might give way under the strain of distention of the intestine by gas or ingested matter. The objection to passing a suture entirely through the wall of the gut and thus approximating all the coats at once, is the danger that the perforation may be followed by escape of gas or other contents to either side of

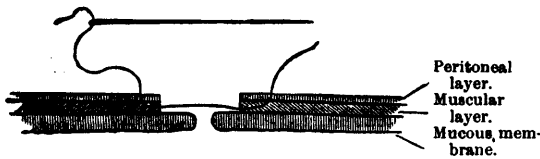


FIG. 4.—Schematic. Showing the route of the intermediate sutures.

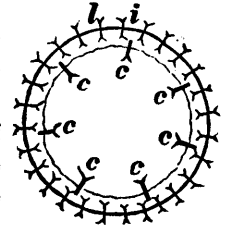
the line of adhesion between the ends. The inversion of the mucous membrane by Czerny's suture and of the peritoneal layer by Lembert's suture after the threads are tied is shown in Fig. 3.

The mechanism of the intermediate suture is well shown in Fig. 4. This suture adds strength to the union by taking in the muscular layer and connective tissue of the mucous membrane, to-

gether with the peritoneal covering. Applied after the Czerny suture, there can be no danger of escape of intestinal contents through the wound.

In suturing the intestine, the very finest black (iron-dyed) silk, and a delicate, perfectly round needle, should be used. The straight needles are preferable to those which are half or full curved. The thread should be made aseptic in sublimate solution (1 to 3,000), and it and the needle taken from a 1-to-20 carbolic-acid solution as they are used.

In commencing the sutures, first insert one Czerny suture just over the mesenteric or attached border of the intestine, and tie this, the knot, of course, coming within the lumen of the gut. The needle should pass from within through the mucous layer at a



distance of about three-sixteenths of an inch from the free border (Fig. 2), out along the border of the same end, alternating; *c*, Czerny sutures. (Natural size.)

the opposite end, should be made to enter below the muscular and mucous layer, and to emerge through the mucous layer three sixteenths of an inch from its cut edge. A Lembert suture should be next inserted just at the edge of the mesenteric attachment, as follows: * The needle is made to enter the peritoneal coat one-eighth of an inch from the edge, and, passing between the serous and mucous coats, is again brought through the peritoneal layer about one twenty-fifth of an inch from the edge (Fig. 2, *a*). At a point exactly opposite, the same stitch is passed through the peritoneal layer of that side for the same distance, and this thread is tied. In knotting all of these sutures it is a wise precaution to use the *double or friction* knot for the first trying, for by so doing

* When the peritoneal surfaces of the intestine are held in apposition by this suture, adhesion occurs in remarkably short time. In January, 1887, I was called in consultation in a case of suspected volvulus. Upon opening the abdomen, it was found impossible to untwist the loop without puncture and evacuation of the contents of the greatly distended gut. The opening, one fourth of an inch long, was closed by four Lembert sutures at 11.30 a. m. At 3 p. m. the patient died. On autopsy, not only had well-marked adhesion taken place, but the silk threads were with difficulty recognized, being hidden beneath the inflammatory exudation.

* Dr. Sutton, of Pittsburg, employed this suture in a case which ended in a good recovery. I saw the line of union in this patient about two years after the operation, through the courtesy of Professor J. B. Hunter, who was performing a second laparotomy.

there is no danger of the suture slipping and the parts separating as the second turn is being made. A second Lembert suture should now be inserted on the other side of the mesenteric attachment, and an *intermediate* suture passed between these, through the substance of the mesentery and down into the strip of intestine which here is uncovered by peritoneum. Extra care must be taken to see that this part of each end of the cylinder is in perfect coaptation. The sutures are now inserted for the remainder of the apposing surfaces. The Lembert and intermediate sutures alternate through the entire circumference, and should be one-eighth of an inch apart. The mucous or Czerny sutures

All of these threads should be cut off close to the knot.

In this operation I had to leave the space between the sutures on the upper end of the gut a little wider than on the lower, for the diameter of the efferent tube was considerably smaller than that of the afferent portion. The intervening space was a flush one-eighth of an inch on one side and a scant one-eighth of an inch on the other. When the sutures were all in, the constricting tapes were removed. The gut immediately filled with gas. To the surprise of all present, the intestine below the line of suture instantly expanded to a size equal to that of the portion above the line of union. That the wound was tightly closed was demonstrated by forcing the contents of the intestine from opposite directions towards the sutures. No gas escaped.

The appearance after the tapes were removed is shown in Fig. 6. At intervals of about five minutes during the operation, a small quantity of warm Thiersch solution was poured over the exposed intestine. The warm Thiersch towels upon which it rested were changed every ten or fifteen minutes. No fluid was allowed to get into the abdominal cavity. Finally, the intestine was carefully washed with this solution, and returned into the cavity of the peritoneum.

It was now necessary to deal with the ring of intestine which occupied the femoral opening, and which led from the abscess into the abdominal

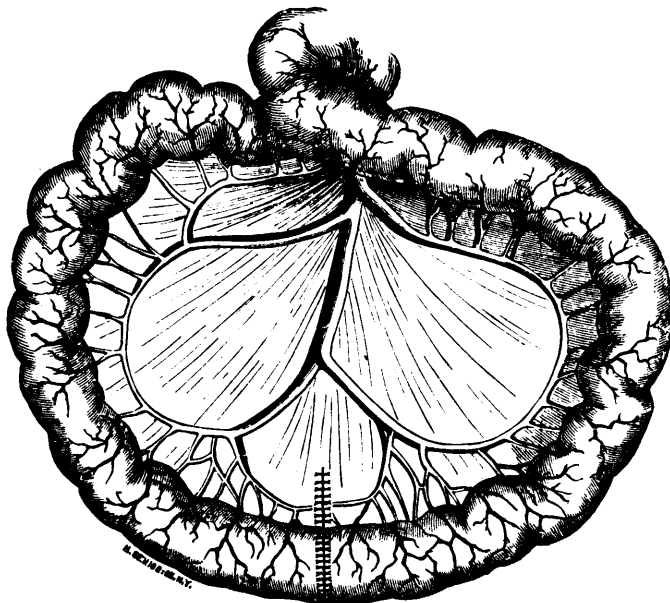


FIG. 6.—Showing the line of sutures in the mesentery and around the intestine.

should be from one-fourth to three-eighths of an inch apart. The relative proportion of these sutures is shown in Fig. 6. It is evident that while the Czerny suture is tied, leaving the knot within the cavity of the intestine for the first part of the operation, the last few threads must be tied leaving the knot imbedded between the mucous and muscular layers of the wall. In applying the sutures the plan followed was first a Czerny, then a Lembert about over this, next an intermediate, another Lembert, and after this a second Czerny suture, and so on. In other words, it was necessary to insert the mucous suture before the superficial sutures had quite reached that point.

cavity. Two strong silk threads were passed entirely through the opposing walls of this rim of intestine and tied so as to bring the edges well together. I then passed a silver probe from the hernial abscess cavity up through the femoral canal, and through the ring of adhering intestine between the two silk threads, until the end of the probe projected a half-inch into the cavity of the abdomen. The ends of both threads were tied to the probe, and this withdrawn, bringing the sutures out through the saphenous opening. By making strong and continuous traction on these, the mucous membrane was averted, the peritoneal surfaces brought in contact, and the femoral open-

ing closed. This procedure effected a radical cure of the hernia.

The wound in the parietal layer of peritoneum was closed by catgut sutures, introduced as in the Lembert suture. The abdominal incision was closed with silver sutures, which included all the tissues down to (but not touching) the peritoneum. For the prevention of ventral hernia after laparotomy, it is very important to include the fascia and aponeuroses of the muscles in the silver sutures. A Neuber's bone-drain was inserted. The abscess and sinus were packed with iodoformized gauze.

The operation lasted four hours. The patient rallied well, and was kept quiet with suppositories of opium. She was kept on the back, and was not permitted to move body, legs, or arms for ten days. The diet was milk, beef-tea, and whiskey in small quantities.

October 23d, 6 A. M., fourteen hours after operation, temperature 99° F. Patient vomited at 4.30 A. M.

24th.—Pulse 120, temperature 99° to 100°.

25th.—Pulse 100, temperature 99.6°. Patient comfortable. Slept well.

26th.—The pulse and temperature were the same.

27th.—Pulse 80 to 100, temperature 98.4° to 99.6°.

28th.—Pulse 100, temperature 99° to 100°.

29th.—Pulse 100 to 106, temperature 99.2°.

On this the sixth day the silk threads came away under the continuous traction of the elastic ligatures attached to them. The wire sutures were also removed. Wound of incision united throughout. Bowels moved; stool of normal consistence.

30th.—Pulse 94 to 100, temperature 99.2° to 100.2° F. Bowels moved again; stool normal. Opium discontinued.

The subsequent history contains nothing of interest. The patient steadily gained her strength. On November 20th she sat up in bed, and on December 3d was walking about the ward. She is now fully restored and attending to her duties. There is no sign of obstruction or interference with the functions of the alimentary canal, and the hernia is at this date radically cured. The great emaciation of the patient at the time of the operation, and the fact that within half an inch of the opening into the abdomen there was a large abscess

cavity, may be mentioned as the two conditions which rendered the prognosis grave.

The treatment of strangulated hernia with gangrene of the intestine may be considered under three methods:

1. Establishing a permanent fæcal fistula at the seat of gangrene.

2. Immediate exsection of the gangrenous portion of the gut, reunion at the ends by suture, and return of the loop.

3. Temporary fistula, followed, after an interval of some days, by laparotomy, excision, and suture.

To the first method may be consigned subjects so feeble that no operative procedure is justifiable.

As to whether exsection should be made at once or postponed after a free discharge through the fistula has been established, must be determined by the condition of the individual at the time of operation. If the patient is well nourished, and if the anæsthetic is well borne, it will be advisable to relieve the strangulation, and through the hernial opening draw out the gut until five or six inches of sound intestine above and below the gangrenous spot are in sight, remove the dead portion, and unite the ends at once. This is a much simpler operation than when an additional opening through the abdominal wall is required.

In most cases, however, it will be found that the condition of the patient is not favorable for immediate exsection. Shock is almost always severe, and not infrequently fatal, when the constriction has been so severe or lasted long enough to produce gangrene. In such cases the plan carried out in the case just detailed should be followed.

Finally, the subject of intestinal suture is one of such vast importance, that too much stress can not be laid upon the necessity for a thorough preparation for the operation. In the careful application of this procedure to penetrating wounds of the intestines, to exsection of gangrenous portions of the canal as the result of hernia, volvulus, intussusception, and in the removal of malignant neoplasms and strictures, many lives may be saved which, under the teaching of former years, were left to die without surgical interference. The difficulties of the operation are great, and the time required in exsection dangerously long, unless the surgeon has had sufficient practice to enable him to work rapidly and safely. I would advise those who are willing to undertake this procedure to

perfect themselves in the various sutures upon the cadaver, or preferably upon living animals. I was deeply impressed with the importance of this in my own case, for, notwithstanding that I had done this operation upon the cadaver about ten times, four hours were occupied in the case which forms the subject of this paper.

VESICO-VAGINAL FISTULA SUCCESSFULLY TREATED BY "KOLPO-KLEISIS."

BY N. E. MCKAY, M.D., M.R.C.S.E., HALIFAX, N. S.

Mrs. D. F., æt. 52, was admitted into the hospital on the 28th of September, 1886, suffering from a vesico-vaginal fistula.

Previous history.—Patient had always enjoyed good health up to the time of her last confinement. She was the mother of eleven children, and most of her labors were very prolonged and difficult. In her last confinement, seven years ago, when the accident occurred which resulted in a vesico-vaginal fistula, she was in labor for nearly three days, and had to be delivered with instruments. Immediately after her delivery, she noticed her urine constantly dribbling away from her by the vagina, which caused her great annoyance and pain. This was the first intimation she had of anything being wrong. Since then her life had been a misery to herself and a source of annoyance to those around her. Two years after, a large tumor gradually appeared in the middle line, a little below the umbilicus, which proved to be a ventral hernia. Patient was bed-fast for nearly seven years.

Present condition.—When admitted, her general health was bad. She was very pale and anæmic, had no appetite, and suffered greatly from obstinate constipation of the bowels. The vulva, vagina, and perineum were extensively excoriated, and the skin and mucous membrane on those parts thick and indurated; the urine constantly ran away by the vagina in dribbles, much to the annoyance of the patient and those around her. Everything about her had a very disagreeable urinous odor. There was a large bed-sore situated over the base of the sacrum, and a large ventral hernia in the middle line, half way between the pubes and umbilicus. On examination per vaginam, the measurement between the two tuber-

ischii was found shorter than the average, and there was a general contraction of the pelvis, either of which conditions would account for her prolonged and difficult labors. There was a large aperture, connecting the vagina with the bladder, which made them appear as if they formed one cavity. The superior anterior part of the wall of the vagina was firmly adherent to its posterior wall, and covered over the os and cervix, so that nothing could be seen except the bright, florid mucous membrane of the bladder.

Treatment.—To improve her general health and sharpen her appetite, she was ordered an aperient pill, to be taken at night, *pro re nata*, and a quinine and mineral acid mixture, *ter in die*; and beside the regular hospital diet, she was given as extras, beef-tea, egg-nog and milk two or three times a-day, with a very moderate amount of stimulant. To obtain a healthy condition of the parts, warm water douches were freely used, per vaginam, four or five times a-day, with injections of corrosive sublimate (1 to 2000) as often. A sponge, soaked in an antiseptic solution, was constantly kept in the vagina, to absorb any urine that might dribble away. These sponges were frequently changed. This treatment, general and local, was continued until her health was good and the parts restored to a perfectly healthy condition, when an operation was determined upon. From the enormous size of the aperture and the great loss of tissue at the base of the bladder, it was evident that an operation with a view simply to close up the fistula would be futile, and that nothing short of complete obliteration of the vagina would succeed in completely and permanently relieving her suffering; and as the patient was past "the change of life," there was no very serious objection to the performance of such an operation.

The necessary preliminaries having been attended to, the operation termed "kolpo-kleisis" was performed on the 17th day of December, in the following way: The patient having been etherized, was put in the lithotomy position, with the pelvis raised on a level with her chest, an antiseptic sponge was introduced into the bladder, and the parts were well held apart by two assistants. A straight staff was introduced into the bladder to press down the anterior vaginal wall. Then the mucous membrane was removed from the anterior wall of the vagina, as near the lower margin

of the aperture as practicable, to the extent of three-quarters of an inch, and also from its posterior wall and its angles on the same level and to a corresponding extent. The vivified surfaces were then brought in perfect coaptation and held there by silver sutures. The operation occupied two hours and a half in its performance. A catheter was constantly kept in the bladder, to draw away the urine as soon as secreted, until union was completed. The vagina was thoroughly washed once a day with a boracic acid solution, and a plug of absorbent cotton wool soaked in boroglyceride was constantly kept in it.

On the 27th day of December, the tenth day, after the operation, the sutures were removed when firm union was found to have taken place. The catheter was left in the bladder for two or three days after the sutures were removed. When discharged on the 5th day of February, she experienced no difficulty in passing water and could easily retain it for from four to five hours at a time. At the time of writing this article, the patient is perfectly well and suffers no inconvenience from her urine.

Correspondence.

FUTURE CANADA MEDICAL ASSOCIATION MEETINGS.

To the Editor of the CANADA LANCET.

SIR,—It is not too soon to bring the suggestions below before the members of the Canada Medical Association, and as doubtless most of the members are readers of the LANCET, if you will grant me space, I should like to submit the following: It has been repeatedly said that something ought to be done with the view of increasing the interest of members of the profession in our Association, and to secure a larger membership and better attendance at the annual meetings, in order as well to promote general good feeling and union for our own strength, as the advancement of the science of medicine. I would suggest that special efforts be made this jubilee year, at the approaching annual meeting, to be held in Hamilton, to accomplish something in the way indicated. At the first possible hour of the meeting of this year, a committee should be appointed to consider the question, report upon it and have it discussed.

The annual meetings, as I believe has been heretofore the case, should be held at a time when medical practitioners could best, and should, take a holiday, of at least a week; as in the summer, when it is too warm to work, but not to travel quietly. It should be so arranged that the gatherings of the members of the profession should partake more of a holiday character, and be made more entertaining and social,—more play, if not less work. More time, not less than three or four days, should be given by all, if possible, to the conference. Greater efforts might fairly be made to obtain from railway and boat managers (who in the end would be gainers thereby) lower rates of travel; and from hotel keepers, by pre-arrangement, good accommodations at more reasonable charges. It would probably be to the interests of the Association never to meet at a point further east than Montreal, nor further west than Hamilton. On occasions, when necessary or admissible, funds of the Association might be used toward defraying expenses of the entertainments. By the careful selection of a small committee of the older and more experienced members for the examination of all papers to be submitted, only a limited number, on subjects of most special and general interest, need be read; and any others could afterwards be read before local society meetings. Certain members might be asked to prepare each a paper on some special, named subject, for the next meeting, which should of course be made known, when members could come more prepared to discuss them.

I would further ask permission, even now, to suggest that the meeting of the Association in 1888 be held in the capital of the Dominion, and that it be regarded, under the new order of things, as a special national convention. That early and unusual efforts be made, and which would doubtless be successful, to obtain greatly reduced fares on routes of travel, especially for long distances, as on the Canadian Pacific and Inter-Colonial Railways. That one of the special subjects for the consideration of the Association then, at this Ottawa meeting, be, the best manner in which to secure UNITED ACTION in the profession, amongst all its members, in all questions of public interest, as well as those which relate only to the profession; and another, the formation of a medical benefit and life insurance society for Canada, in

connection with the Association. Not less than four days should be given to this Ottawa meeting, one of which, say, might be pleasantly and profitably occupied by an excursion down the Ottawa, followed by a *conversazione* in the evening. It is not unlikely that quite a number of members of the profession in the neighboring States, and possibly a few from Great Britain, might attend the conference, if invited through the medical press or otherwise. Trusting these suggestions may be favorably considered, and bring out others,

I am, very truly yours,

EDWARD PLAYTER, M.D.

MEDICAL SCHOOL AMALGAMATION.

To the Editor of the CANADA LANCET:

SIR:—The following is the reply of the Corporation of Trinity Medical School, to the report of the Senate of Toronto University, in reference to the establishment of a Medical Faculty in connection with the University.

To the Vice-Chancellor and Members of the Senate:

GENTLEMEN,—At a meeting of the Corporation of Trinity Medical School, held a few days since, the report of the Committee of the Senate of the University of Toronto was, in accordance with the letter of the Registrar (Mr. Baker) accompanying it, laid before the Corporation for consideration. The report was very carefully gone over, section by section, and after mature deliberation regarding the scheme proposed in it, the following conclusions were reached:

I. The proposal to form a new Medical College to be called the "University of Toronto Medical College," which shall be the "Medical Faculty" of the "University of Toronto," is contrary to the policy of the Provincial University, as established in 1853, and would practically destroy its character as a Provincial University, so far as regards medical education, and would reduce it to the rank of one amongst several competing Universities.

II. The scheme submitted, is also, in the opinion of the Corporation, directly opposed to the Government scheme of "College Federation," which does not contemplate the amalgamation of the several federating Colleges—but carefully preserves their identity, and secures self-government to each, whereas, the affiliation of several Medical Colleges with the University, as at present and for many years past, is in harmony with the "College Federation" scheme, and this Corporation cannot understand why there should now, in the department of medicine, be any departure from that policy.

III. That even if, as is not the case, the proposed scheme were practicable in all other respects, it has no satisfactory financial basis to rest upon. Medical professors require to be adequately remunerated if they are to be expected to devote their chief energies to the duties of their respective chairs, and this would not be the case under the proposed plan, since it does not contemplate any provision for Professors salaries beyond fees obtained from students, and in the opinion of the Corporation, so long as Medical Education is dependent for its support on these fees alone, the present is the best system which can be devised, as it is eminently successful—does the country credit at home and abroad and—costs it nothing.

IV. The scheme as set forth in the report, would not promote the interests of Medical Education in this Province. It would not tend to decrease, and would to a certainty increase the number of Medical Schools, while on the other hand the present system gives a healthy stimulus to exertion,—encourages competition amongst the Medical Schools—begets an earnest desire on the part of the respective governing bodies of these, to be first, in efficiency and equipment, and a praiseworthy effort to educate men well, and thus fit them for success in their profession. This healthy rivalry between schools cannot injure the profession or the public, and benefits both, where, as in Ontario, all students, wherever educated, have to be examined by the Medical Council's Examiners, before being admitted to practice. Experience has clearly shewn that in Institutions removed from competition, the teaching is not, as a general rule progressive, nor is the management, always characterized by energy and efficiency.

For the reasons above given, the Corporation of Trinity Medical School is not willing to suspend its charter, and enter into the scheme proposed in the report.

Signed by order, and on behalf of the Corporation,

WALTER B. GEIKIE,

Trinity Medical School,
Toronto, April 6, 1887.

Dean.

To the Editor of the CANADA LANCET.

SIR,—Will you kindly answer, through the columns of the LANCET, the following questions:

1. Should a physician change his clothes after visiting a case of diphtheria, before associating with other people, or visiting other patients? Of course I make exceptions to those cases where, in making an examination of a throat, matter has been coughed on to the doctor's clothing; when such an accident happens, as it not infrequently does, the question must be answered in the affirmative, but I have reference to ordinary visits,

where nothing of this kind occurs. If it is not in the interests of the public generally or his own family, that the outer clothing be changed after visiting an infected house, the average *country* doctor, at least, would be spared no little inconvenience if assured of this fact; while I, for one, would prefer to go clothed in the primitive fig-leaf costume, to running the risk of spreading disease.

2. Will you or any of your readers give your views on the treatment of diphtheria by the internal administration of hydrarg. bichlor.? I may add that a limited experience with this drug has given me a favorable impression of its usefulness.

A COUNTRY DOCTOR.

[It is not considered necessary, in ordinary cases, to change the clothing after visiting a case of diphtheria. Competent authorities deny that the disease is carried in the clothes at all; thus Goodhart (*Diseases of Children*) says: "It is not communicated to other children or patients in a building, or carried about in clothing like measles or scarlatina." His American editor, however, gives a footnote to the above, in which he says: "Many authorities hold that diphtheria is contagious, in the ordinary sense of the term." The question, therefore, as to its being contagious, is an open one].—ED. LANCET.

To the Editor of the CANADA LANCET.

SIR,—I am called to a case of midwifery, and after careful examination, come to the conclusion that it is utterly impossible to save the mother without destroying the child. Two other medical men are called, and they come to the same conclusion. The nature of the operation is explained to the friends, but (being Roman Catholics) they refuse to allow us to proceed. Now what is our duty in this case? Should we allow the woman to die, without any effort to remove the fœtus by means of craniotomy? Would we be in any way responsible, after an operation had been refused?

Yours, etc.,

JUNIOR PRACTITIONER.

[Under the circumstances, cæsarian section should have been performed. This would have given both mother and child a chance of life. There are a sufficient number of recoveries to justify that operation, and when skilfully performed, it is claimed by some good authorities to be no

more fatal to the mother than craniotomy. Among Roman Catholics this is the operation to be performed at all events, whatever may be the practice among Protestants. We are not justified in allowing both mother and child to perish].—ED. LANCET.

Reports of Societies.

OTTAWA MEDICO-CHIRURGICAL SOCIETY.

March 11th, 1887.

A regular meeting of the Society was held this evening; Dr. Sweetland, President, in the chair.

Dr. Prevost read a paper on gonorrhœa.

He commenced by quoting the words of Lisfranc, to the effect that out of 100 individuals 80 have had, have, or will have, gonorrhœa. He then went on to enumerate the seat and characteristic symptoms of the disease, and to show that it was now conclusively established that it was a specific disease produced by the contact of a special virus, and could not originate from ordinary sources of irritation. He observed that, while there were those who still considered it possible for gonorrhœa in the male to originate from excesses in eating and drinking, leucorrhœal discharge and performance of the sexual act with too much violence or during the menstrual period, these could not now be accepted as causes of gonorrhœa—a disease which could only originate from a specific virus and in turn give rise to a specific disease. After taking up each of these supposed causes of the disease, and showing the difficulties pending on the acceptance of them as the true origin of the affection, he went on to point out how gonorrhœa in the female might be overlooked, and the difficulties attending its diagnosis when present.

He stated that the authority of Ricord, Cullerier, Rollet, Lardien, Guerin and Martineau, went to show that spontaneous or traumatic purulent urethritis did not exist in women—and that if with an inflammation of the vulva or vagina there co-existed urethritis, we could affirm the contagious nature of the vulvo-vagino-urethral inflammation. He then went on to give a means of establishing the existence or otherwise of urethritis in the female, as dysuria and strangury were rare as a symptom of that disease in women, which was as follows: The subject for examination being laid on

a bed in a good light, the thighs being flexed on the abdomen and well separated, the urinary meatus and circumjacent parts are dried with lint, and the index finger is introduced into the vagina to the depth of two or three inches, while at the same time the two sides of the vulva are separated by the finger of the left hand, thereby fully exposing the meatus urinarius. The index finger of the right hand, with the palm surface upwards, is made to exert a firm pressure on the urethrovaginal wall from behind forwards along the course of the urethra, this is repeated two or three times, and if any pus exists in the urethra or in the follicle surrounding it, pressure never fails to bring it out, and when perceived to exude from the meatus, there is no further doubt of the existence of a purulent and consequently gonorrhœal urethritis. To avoid any fallacy, care must be taken that no urine has been passed for some three or four hours beforehand. Urethritis in women has been found to be a very rebellious disease, and many authors assure us of having known women who communicated gonorrhœa three or four years after they had the disease, and when they fully believed themselves perfectly cured (Guerin, Gosselin, Martineau).

Blenorrhagia, he went on to show (on the authority of those above mentioned) may remain localized for a long time in the intra-urethral or vulvar follicles, unknown to the patient or even to the physician. Under the influence of oft-repeated intercourse the disease is again lighted up and again transmitted.

The same phenomena have been observed in the man as shown by the following aphorism of Langlebert: "After several attacks of gonorrhœa, or even only one sufficiently severe and protracted, the most simple exciting cause, a muscular fatigue, an excess of coitus or liquor will often suffice to recall the inflammation to the mucous membrane, previously affected." From this he went on to show that blenorrhagia was undoubtedly a parasitic disease, and as such while the active indications of the disease might be dormant for a longer or shorter period, a slight exciting cause might at any time bring on a fresh attack. These facts were brought to light by M. Verneuil in a communication made by him to the Academy of Medicine of Paris during its sitting of the 3rd April, 1886. He showed plainly that our organism could conceal morbid germs capable of sojourning in our

humours, our tissues, or organs, for a longer or shorter period, without betraying their presence by any symptom whatever. This he calls "latent microbical parasitism."

From this he drew the conclusion that the occurrence of a fresh attack of gonorrhœa in a person who considered him or herself cured, and who had not accounted for the origin of the attack from a recent exposure to contagion, was an evidence of the existence of "latent microbes," on one side or the other, as he considered it an established fact that gonorrhœa could not originate except from the specific virus of that disease. Martineau has found that the different secretions discharged from the vulva have not all the same reaction. They are generally alkaline, with the exception of that secreted by the mucous membrane of the vagina which is ordinarily acid. Gonorrhœal fluid is always acid, so that the fact of obtaining an alkaline reaction from any vaginal discharge constitutes a strong presumption against the existence of a virulent affection. With regard to the parasitic nature of blenorrhagia, recent researches seem to have established the fact of its being due to a parasite to which the name gonococcus had been given. While it has long been known that blenorrhagia was inoculable, and therefore the existence of some micro-organism was suspected, it was not till 1862 that anything was proved by investigation.

In 1872, Hulner discovered a micrococcus seated in the intercellular liquid, even in the blood of individuals suffering from gonorrhœal rheumatism. In 1878, Bouchard observed the micrococcus. But to N. Neisser falls the honour of having given in 1879, the first exact description of the gonorrhœal micro-organism. Since then a great many observers have recognized, described, cultivated and even inoculated this organism, and during the session of the Therapeutic Society of the 22nd Oct., 1884, Constantine Paul not only confirmed the truth of previous researches, but even went so far as to propose a prophylactic and curative treatment of blenorrhagia by solutions of corrosive sublimate. These facts are most important with regard to the diagnosis and pathogeny of gonorrhœa. The microscope in revealing the presence of the gonococcus in the discharges from the urethra, will establish in the future in an unmistakable manner the virulent nature of their origin.

The complications which may arise in the course

of gonorrhœa were then entered into. Gonorrhœal arthritis, is common especially among men. In nine years Cullerier observed but two or three cases in women; Guerin met one case in four years; Rollet, Diday, Panas, Martineau, never saw one. Why the affection should be so rare among women is not sufficiently explained.

Gonorrhœal rheumatism is rarely polyarticular; so that if a case of acute articular rheumatism is met with in which but one joint, particularly the knee, is affected, we are justified in suspecting gonorrhœa as a cause. Purulent ophthalmia in the adult is very rare except as a result of gonorrhœal infection.

A case of gonorrhœal arthritis was described, occurring in a young married man, who had a gonorrhœa every year for ten years past, and each time followed by arthritis affecting generally the left knee, on one occasion, all the large joints on the left side, and this year the right knee. The discharge, as shown by Fournier does not cease entirely, though it may diminish when the arthritis is set up. Many theories have been brought forward to explain the appearance of arthritis in connection with blenorrhagia. They, of Brussels, and Guyon look upon it merely as a coincidence, and not as a distinct pathological species. The patient is of a rheumatic diathesis and the blenorrhagia acts as an exciting cause. Hunter and Fournier consider gonorrhœal rheumatism as a mere urethral accident, similar to the articular affections sometimes produced after simple catheterism. Barth considers that the articular manifestations are to be considered as infectious pseudo-rheumatisms, belonging to the numerous class of arthropathies of infectious diseases. Paget and Weiss are of the same opinion.

Gonorrhœal rheumatism is therefore to be classed with the articular manifestation occurring in the course of infectious diseases, such as pyæmia and septicæmia.

In fact, as far as regards our knowledge of the pathology of rheumatism, may it not possibly be due to the presence of a microbe? On the 21st Sept., 1886, during the session of the assembly of the German Naturalists and Physicians at Berlin, M. Zimmerman, of Bâle, made a communication in which he held that rheumatism, no matter what its form as the consequence of infection, is amenable to specific remedies. In 1882, Lesitkon ascer-

tained the presence of the gonococcus in the liquid of a gonorrhœal arthritis. In 1883, Petrom made a similar discovery in the purulent liquid of two cases of gonorrhœal arthritis. In 1884, Kammerer found also the gonococcus in the effusion of two cases of gonorrhœal arthritis. Another complication often met with in the course of blenorrhagia is purulent ophthalmia, a formidable affection which may accomplish its destructive work in twenty-four hours, if the disease be not cut short at the outset. Neisser has proved the presence of the gonococcus in the purulent discharge of gonorrhœal ophthalmia. This complication is evidently the result of inoculation of the conjunctiva by the virus, carried by means of the fingers or something which has been contaminated by the gonorrhœal discharge, and the partisans of the theory of metastasis now-a-days but weakly defend this antiquated opinion. De Wecker remarks on the comparative rarity of this complication, in spite of the great frequency of blenorrhagia and the carelessness of many affected with it. Especially remarkable is the immunity enjoyed by women. Martineau assures us that in the hospital of Lorraine he has not observed a single case in seven years out of two thousand women. This is a point very difficult to explain satisfactorily.

With regard to treatment, the following points are to be observed in all cases:

(1) Absolute absence from alcoholic beverages of every kind, and especially gin; (2) Sexual indulgence must be strictly forbidden, and attention is to be paid to the prevention of erections which may be often done by the patient having a dish of cold water by his bedside in which to plunge the penis; (3) No pressure is to be made on the canal in order to discover whether the discharge is completely arrested.

With regard to medicines. Copaiba and cubebs, with sweet spirit of nitre, linseed tea *ad libitum*, and 1 gr. opium, with 2 of camphor, at bedtime.

The first mentioned remedies of course should not be prescribed until the acute inflammatory symptoms have in a measure subsided. Styptic or irritant injections should not be used as long as there is pain. Bichloride of mercury, 1 to 20,000, is the injection of the future. In fact, this drug was made use of in 1865 by Kuss, of Strasbourg, before the parasitic theory of the disease had been discovered. At present, Fanté, in Italy, Diday,

Blondeau, C. Paul, and Martineau, in France, are those who more especially rely on this method of treatment. Martineau has found a urethral suppository containing from $\frac{1}{16}$ to $\frac{1}{8}$ gr. of bichloride very useful in women, and in gonorrhœal vaginitis, a solution of 1 to 2,000. The writer had himself found a most satisfactory result from an injection of 1 to 20,000 in a case of gonorrhœal vaginitis which had resisted a variety of treatment.

MEDICO-CHIRURGICAL SOCIETY,
MONTREAL.

January 28th, 1887.

J. C. Cameron, M.D., President, in the chair.

Laryngeal Cyst.—Dr. Major exhibited a small fibrous cyst removed from the margin of the anterior commissure of the larynx. Before the operation the voice was harsh, rough and breaking from bass to treble during ordinary conversation. Since the removal of the cyst, however, the voice has been gradually improving, until of late it has become almost normal.

Tumor of the Ovary and Fallopian Tube.—Dr. Gardner exhibited a friable, irregular tumor about the size of a child's head, removed by him a few days before from a maiden lady of 43 years. On opening the abdomen, the tumor of the right ovary and tube was found firmly adherent to the intestines, omentum and floor of the pelvis. The operation was a very formidable one. The patient, however, recovered well from the effects of the operation, having experienced no severe shock, and was apparently making a rapid recovery.

Myxœdema.—Dr. James Stewart read a paper on a case of myxœdema.

Discussion.—Dr. R. L. MacDonnell said that the patient had been under his observation in the General Hospital at different times. It was generally regarded there as a case of tetanus. He had never been able to find that the patient had any tetanic spasms in the hospital, though these were carefully looked for. He did not think that the thyroid in the patient was altogether absent. In many it is difficult to make out the gland by external manipulations. Finally, he asked if Dr. Stewart had ever seen the patient in a tetanic spasm.

Dr. Merrill said he had known the patient some years. He had never seen any tetanic spasms,

but the patient had complained about frequent attacks of severe colicky pains. He was always a very badly-nourished, dyspeptic-looking man.

Dr. Shepherd could not agree with Dr. Stewart's suggestion, that the reason myxœdema or cachexia strumipriva follows excision of the thyroid is because of the disturbing damage done to the sympathetic system, as the affection, so far as he knew, never followed extensive operations in the neck (as removal of chains of enlarged glands and tumors), when the sympathetic trunk is quite as much interfered with as in the removal of the thyroid. When no myxœdema follows the operation of removal of the gland, it is supposed to be incomplete removal.

Dr. Reed asked if Dr. Stewart could give the average temperature of the patient.

Dr. Mills said, To believe that any gland or other organ existed to prevent the formation of a substance, whether normal or abnormal, was inconsistent with general physiological principles. True, the removal of certain glands, as the testicles in the young, arrested development, both physical and psychical. In the adult dog, such removal was followed by obesity, which could be largely accounted for by the inactivity of the animal, associated with the psychical shrinkage—the curtailment in the number and variety of the afferent impulses reaching the nerve centres. It had been asserted that after the removal of the thyroid in children there was stunted development, especially intellectually. It is likely metabolic changes follow removal of the thyroid; owing to the influence on the nervous system there is a loss of balance. All healthful life implies balance of function. It was not yet clear how the balance was destroyed by removal of the thyroid; but we were on the way to knowledge, for we had learned, experimentally, that this organ was not a blood-former. If, as had been suggested, the changes following experimental or surgical removal were due to injury to the sympathetic, one would expect to observe vaso-motor symptoms, which had not been the case, though such an objection must not be too strongly urged; for though dilation follows section of the cervical sympathetic, such is not permanent, and if transient, might be overlooked.

Dr. Stewart, in reply, stated that he had seen the patient in tetanic spasms many times. When first seen the patient had an attack. With regard

to the average temperature, it was low—about 97°. The patient always complained of cold. The whole question of the function of the thyroid was still in a very unsettled state. He did not wish to be understood as saying that atrophy or disappearance of the thyroid had nothing to do with myxœdema. There is certainly evidence pointing strongly to both myxœdema and tetany being due to changes in the nervous system.

HAMILTON MEDICAL AND SURGICAL SOCIETY.

April 5th, 1887.

The President, Dr. McCargow in the chair.

Dr. McCargow exhibited a specimen of disease of the vermiform appendix with part of the ileum and gave some history of the case. He also exhibited a specimen of cancer of the penis from a negro æt. about sixty years, of some months' duration, Dr. Malloch removed the penis. In this case the disease had extended high up, and being complicated with a swollen gland in the groin, amputation close to the pubes was necessary. The gland was also removed. To obviate the irritation which would be caused by the flow of urine over the scrotum and adjacent parts, the scrotum was split, the spongy portion of the urethra dissected down to the triangular ligament and brought out in the perineum, the corpora cavernosa cut off close to the bones. The incisions were then brought together with sutures and the necessary dressings applied.

Dr. Malloch also reported two cases of perineal section which occurred during the past week, one from retention due to hypertrophy of the prostate complicated with a false passage. He expressed an opinion in favor of Harrison's method of puncturing the prostate, but not having the necessary instrument, he cut into the membranous portion of the urethra and established communication with the bladder. The second case was one of extravasation of urine, resulting from a traumatic stricture of two years standing. The patient when first seen had not passed any urine for four days. When examined the scrotum was found enormously swollen and the bladder much distended, very little pain was complained of. Wheelhouse's operation was performed. A grooved straight staff was passed into the urethra until it came to the stric-

ture. The incision was then made in the perineum and the stricture divided. The staff then turned so that the knob on the reverse side caught the urethra, and by gentle traction the urethra was put on the stretch; a sufficient opening being made in the urethra, a No. 12 gum elastic catheter was passed into the bladder. The catheter was then bent and the other end passed into the urethra above the stricture and carried up till it appeared at the meatus, the scrotum was then freely incised, to allow the escape of urine, and a large quantity was passed from the bladder through the catheter. The patient is at present doing well.

Selected Articles.

CONSTIPATION.

BY J. J. MILNER FOTHERGILL, M.D.

In the constant round of daily practice the physician commonly encounters cases where the bowels are not properly open. Both sexes and all ages are liable to this undesirable condition. Frequently the constipation is very obstinate, and refuses to yield to the measures employed; or in other cases is only kept at bay by the constant resort to laxatives or even cathartics.

The bowel is not only the recipient of the waste and undigestible matters of our food, but has its own glands, which are not all absorbent. Whether the offensive odor of the fæces is due to mere fermentive or putrefactive change in the contents of the lower bowel, or the glands situated thereon lend some of the fœtor, it may not be easy to perfectly determine; but any one familiar with obstetrics knows how, when the foetal head is distending the perineum, the glands situated near the anus can be distinctly felt like so many small shot, and their secretion is as offensive as it is difficult to remove from the hands. The excreta possess an offensive odor which secures their disposal, and thus one good sanitary end is served by the unsavory secretions of these glands. These glands serve to lubricate the mucous lining of the intestine and thus expedite the passage over it of the contents of the bowel.

Any loss of activity in the muscular movements of the intestine will favor the tendency to a constipated condition. This is met with at all stages of life, but perhaps it is most markedly seen in the case of young females. A natural delicacy impels them to avoid the proximity of the closet, and gradually the bowels are taught to carry a greater and accumulating load. The pouches of the bowel become distended, and the fæces which pass them

are alone voided, and are of more or less fluid consistency; so that a girl may believe her bowels open, or even think herself the subject of looseness of the bowels, when in reality her abdomen is filled with *fæces*. One untoward result of such chronic constipation in young girls is displacement downwards of the ovaries, and these organs may become glued down to their new habitat by adhesive inflammation. Two unfortunate outcomes of this displacement of the ovaries are (1) sterility and (2) irritable ovary. The most marked case of this kind which ever came under my notice was that of an American lady. For the sterility of course nothing could be done, the ova being hopelessly beyond the reach of the fertilizing *zoöperms*. For the irritable tender ovaries something could be done, but the effects of treatment were so little satisfactory that the removal of the offending and useless organs was discussed.

Such a condition of chronic overloading of the bowels is furthered by the lack of bodily exercise during school-life. The school-girl is busy with her lessons and absorbed in her work; she scarcely gives a thought to her bowels, and perhaps is rather glad that they do not force themselves upon her attention. The resultant consequences are that the large bowel becomes distended, while the muscular fibres become attenuated, and the bowel becomes incapable of properly unloading itself when the opportunity is offered. The uterus is forced down upon the floor of the pelvis, and, as we have seen, the ovaries may be displaced. Until physiological aspirations arouse the idea of matrimony, and the marriageable age is reached, little attention is given to the physical state; and then a confirmed condition is discovered and one requiring considerable attention and trouble for its removal.

In selecting remedial agents the choice must be guided by the precise requirements of the morbid condition. To restore the muscular activity is as important as to excite the secretion of the intestinal glands. The ordinary catharsis does both, and so sweeps the contents of the bowels out by the anus. But every physician of experience knows well that the recurrent resort to active purgation gives about as unsatisfactory results as well could be attained. In the first place women of all ages bear active purgation very badly. The griping pains are ill borne and depress very acutely. When the bowels are cleared out by a violent action the process of loading up again sets in immediately, and another catharsis is soon required with all its attendant discomfort. In this respect women are closely approximated by men of feminine type. Active purgation is only well tolerated by robust persons. In others it should only be adopted when there is some distinct end to be served by it.

An occasional clearance of the bowel may be desirable; but the treatment should consist of a small amount of laxative materials, taken with

perfect regularity, persistently and steadily. Two classes of laxative agents present themselves for notice: these are vegetable substances and mineral substances. Frequently they can be combined with advantage. For women the vegetable laxatives are best. As compared to men they do not bear well mineral purgatives, whether as natural waters or artificial solutions. Fortunately vegetable extracts readily lend themselves to pill form. The first laxative to come into general use was rhubarb. But unfortunately rhubarb has a secondary binding tendency following the primary purgative action. Thus, it is unsuitable for habitual use, though this action gives it a peculiar value when the bowels are to be unloaded previous to an operation on any of the contents of the pelvis. (In cases of diarrhœa set up by a railway journey, such use of rhubarb is most excellent). The persons who adopt rhubarb for the relief of habitual constipation are not likely ever to be cured. It has fallen to my lot to see such a case quickly relieved by substituting for the rhubarb some other laxative. Next in frequency of resort is aloes. Aloes acting upon the lower portion of the bowels is in great vogue in constipation linked with amenorrhœa (partial or complete). In consequence of this localized action aloes in full doses are not exhibited in pregnancy, except from ignorance or criminal intent. Fordyce Barker sees a certain utility in this localized action, and has from experience found that the stimulant action of aloes upon the area supplied by the hemorrhoidal arteries is good in the piles of pregnancy. Certainly the use of aloes in small doses, in combination with other laxatives, is rational practice. A certain amount of aloes should form a factor in the remedial agents employed in all forms of constipation in women, whether pregnant or not.

Then, beyond these two familiar laxatives, a host of others, which are more or less in use. *Colocynth*, gamboge, jalap, scammony, *cascara sagrada*, are perhaps those most in vogue. Castor-oil is rarely resorted to for constant use; while croton-oil might be more prescribed than is at present the case with advantage.

One matter, especially with female patients, must never be forgotten, and that is, to diminish as far as possible the griping pains which activity in the muscular fibre of the intestine sets up. When the vermicular action is roused, violent contraction produces a griping pain very commonly; yet the muscular activity is essential to cure. To prevent this griping it is usual to add carminatives to the laxative; black pepper, cayenne, and the essential oils all possess the property of taking away to a great extent these painful contractions, and so can be incorporated in the pill with advantage. One point must be borne in mind about the griping pains produced by the exhibition of laxative medicines, and it is this: griping may be due to violent contractions of the muscular fibre, which,

however, may be ineffectual and then the remedy is to increase the dose, when effectual efforts bring with them the desired relief. When the patient complains of griping pains it becomes necessary to ascertain whether the bowels are freely open or not; if not, a larger dose must be given. But if the bowels are freely open then the dose may probably be reduced with advantage.

In order to secure more energetic action in the muscular fibre of the intestine it has become usual to add a little strychnia to the habitual laxative; and a very good practice it is. The steady use of such a compound pill will be found in time to put the bowels in a more desirable condition. But—in my experience at least—persons who suffer with habitual constipation lack perseverance. They either contrive to forget their medicine, or they give it up as soon as they are partially relieved, and do not continue it (in lessened doses) until the new order of things is firmly established. And if the palate is offended by the medicine, abandonment of it prematurely is almost certain to happen. Consequently humanity has declared for pills as the form of remedy *par excellence* in constipation.

A good combination would be provided by something of this kind for habitual use:

- Strychniæ, gr. i.
- Pulv. aloes, ʒ i.
- Pulv. piper. nig., ʒ i.
- Ext. cascara sagrad, ʒij.

In pil. xxiv div. l bis. indic.

When the bowels have become more regular then instead of a pill night and morning one at bedtime alone would be sufficient; and after a time the pill might be given up entirely, having fulfilled its purpose. If something more potent is required then half a drachm of croton-oil may be added to the pill mass.

Some practitioners are fond of giving hyoscyamus to relieve griping.

Where the condition is not very pronounced a laxative pill at bedtime once or twice a week is sufficient. Where the patient is of a rheumatic nature, or there are deposits in the urine, it is well to add a mercurial to the laxative. Something of this kind would be found serviceable:

- Calomel, ʒ i.
- Ext. hyoscyami, ʒ iss.
- Pil. coloc. co., ʒ i.

In pil. xii div. l p. v. n.

When such a pill is found not quite potent enough it may be well to assist its action by a draught of cold water on getting out of bed next morning—often itself very efficacious. Or some form of purgative water may be preferred, or a seidlitz powder, or some effervescing preparation, of which the name is legion.

If one line of attack fails, then try another. Some victims to constipation try a variety of com-

pounds before they find what they desire. In one case it is a proprietary medicine, in another an orthodox prescription. One old lady who for half a century had been in search of a remedy paid me the compliment of asking me what I could suggest. It was in my early days, and the range of my knowledge was limited, but I hazarded the suggestion that a draught of cold water on rising often proved a very good remedy. She adopted the suggestion with the most satisfactory results, and prophesied a career of usefulness for me.

When something is taken in the morning it is uncomfortable, and for business men in cities well-nigh impossible to have the bowels acting during the day. To secure prompt action it is well to take the dose of purgative water (or its equivalent) with hot water, or tea, or other warm vehicle. This will usually produce the desired effect; and, if taken on getting out of bed, secures the desired operation by the time breakfast is over. When a pill has been taken previously at bedtime the bowels are usually ready to operate soon after the morning draught is taken; and then a motion before breakfast, followed by a second when that meal is over, fits the bilious business man for his day's work. Where a person is depressed and liverish, to sweep all spare bile and all offensive matters out of the intestine is to give a mental cheerfulness which contrasts with the gloom which reigned before.

Where children are subject to constipation something palatable is required. Children, even more than adults, resent what has an objectionable taste. Castor-oil is detested in the nursery, and not without reason. Tincture of senna in a little tea is preferable. But of all forms of laxative a sweet ginger biscuit or cracker containing a few grains of jalap is the least repugnant to the childish palate. It should not be too hot, else the ginger offends. If such a toothsome sweetmeat be granted as a reward for good behavior the ruse will usually be successful; but if a shadow of a suspicion be excited that medicine lurks in the sweetmeat a new line of attack at once becomes necessary. In other cases a little oatmeal or maize porridge to breakfast is enough. At other times some stewed fruit, as figs, French plums, or even ordinary garden fruit, is found efficacious.

With many adults some treacle on whole-meal bread relieves the condition which renders life a burden. The mechanical irritation set up by the particles of bran excites the vermicular action of the intestine, and all is well. Brown bread eaters are common everywhere. When travelling such persons are liable to the presence of their bane because brown bread is not always to be had. It will be well for these individuals to lay in a stock of pills in a travelling medicine chest or the now fashionable compound liquorice powder, or a bottle of some granular effervescent preparation.

When constipation is—as it very commonly is—linked with inadequate action of the liver, the pure laxative should be linked with a hepatic stimulant. In the second edition of my *Practitioner's Handbook of Treatment*, many of the prescriptions were altered, and the sulphate of soda substituted for sulphate of magnesia; the latter being a pure laxative, while the former possesses also a distinct action upon the liver. A certain very august personage is said to repose unlimited confidence in sulphate of soda, and certainly time has fully justified that confidence and demonstrated that it has not been misplaced. Others again find that phosphate of soda, familiarly known as "tasteless aperient salts," meets their requirements. Carlsbad salts also are in vogue.

The administration of an habitual laxative and the decision as to what agent or combination of agents and what doses shall be employed is one of the trials of prescribing. If the dose agrees at first, in a week or a month it is either too potent or it loses its effect, and then an alteration of the dose or the employment of some other agent or combination of agents becomes imperative. Some persons have to keep "ringing the changes" and going a certain round, once more reverting to some compound that had lost its effect in past times. When a laxative has to be combined with tonics (or any drugs which have to be taken for some time) it is often well to give two prescriptions, one more laxative than the other, and then let the patient arrange the doses as he or she requires. If this gives the patient a little trouble—well, the patient after all is the person who is benefited, and the trouble brings with it its own reward.—*Med. Register.*

THE TREATMENT OF COLDS.

Of all disagreeable constitutional tendencies, the tendency to "catch colds" is one of the most disagreeable to the individual, and besides the unpleasantness there is always the danger that a catarrh may outstep its usual limits and develop into some grave inflammation.

Is the nature of common catarrhs generally understood? To a certain extent I think it is, but not fully. Let me enunciate the broad characteristics of colds. Catarrhs are excited *de novo* by exposure to wet, cold, and draughts. This is a truism. Most frequently they develop in delicate and in highly neurotic individuals, in fact in the classes which furnish martyrs to common neuralgia. I believe moreover that when once a catarrh is properly established the affected person's breath is infectious, in the acute stage of the disease at least. What then is the nature of the affection? (1) Is it a specific poison comparable to that of the infectious fevers? (2) Does the affection start as an idiopathic inflammation and develop a specific poison which is given off by the

breath? (3) Is it of nervous reflex origin purely?

Bürger has discovered micrococci in catarrhal secretions, and they are possibly factors in the affection. Let us suppose that these micrococci or their spores are distributed nearly universally in the atmosphere, and are carried in fomites. Let us suppose them in their usual state to be unable to attack the healthy buccal, nasal or other mucous membranes. Let us presume that there is a condition in which the trophic nerves of those membranes become depressed and lose their tonic action by the action of poor blood, or from the periodical neurasthenia of hereditary neurotics. Here the result of section of the trigeminus on the eye is recalled to one's mind, and the fact pointed out by Snellen that ophthalmia did not ensue if the eye was carefully covered with cotton-wool, thereby to a great extent excluding microorganisms, before the nerve section was made. Let us suppose that by feeding in such pastures, the progeny of the attacking catarrhal micrococci becomes so virulent as to be able to attack successfully the healthy membranes. We know by Pasteur's experiments the extensive effects of culture on some micro organisms. On these not unreasonable suppositions, then, all the peculiarities of catarrhs are explainable.

Influenza epidemics may be explained by supposing that with large tracts of country all catarrhal micrococci became suddenly virulent, owing to some climatic or telluric fostering cause, or to some law of heredity or evolution of the organisms themselves. This would account for the extensive and sudden outbreaks which, on first view, seem so surprising.

The usual "coddling" treatment of colds, except the very old, very young, or very delicate, is a mistake. A person suffering from a catarrh should certainly be warmly clothed and avoid draughts; but by shutting himself up in a warm room, by taking warm air baths and lowering medicines, he only promotes the development of the exciting cause of the affection.

"Feed a cold, starve a fever." There is a deal of wisdom in the first part of this advice. A person with a catarrh should take an abundance of light nutritious food, and some light wine, but avoid spirits, and above all tobacco.

Now as to medicines. All depressants should be avoided. For some time I was in the habit of taking a mixture recommended by Dr. Jukes Styrap, composed of minute doses of morphine, antimonial wine, and potassium citrate. This beyond doubt always subdued the acute inflammatory stage, but I have no hesitation in saying I was depressed by its action, and rendered liable to relapses and renewals. Personally, I have found the large dose of an opiate in the early stages, as extolled by Sir Thomas Watson and Dr. George Johnson, very unpleasant and of but little use.

Trying to avert an attack by a large dose of potassium iodide failed in my hands. The bromides were useless through all stages. Antiseptic inhalations and spraying afforded temporary relief from the distressing symptoms, but failed to cure.

Belladonna, quinine, and arsenic I have found useful when given separately—not so much in large as in small doses. When combined I believe them to be nearly specific—prophylactically and therapeutically, if I may so speak.

The formula I invariably use is as follows:—

R Quinina sulphatis, gr. xvij.
Liquoris arsenicalis, ℥xij.
Liquoris atropinae, ℥j.
Extracti gentianaë, gr. xx.
Pulveris gummi acaciae q.s. ut fiant pilulae xii.

Sig. One every three, four, or six hours, according to circumstances.

If these pills be commenced in the early stage of a common cold, *i. e.*, when the affection is as yet confined to the nose and pharynx, the affection will be nipped in the bud. At starting, one pill should be taken every three or four hours, and later on every six. If a catarrhal subject has a box of these pills always at hand, he has, I believe, a weapon wherewith to meet and defeat his enemy. The longest time I have seen a cold last while the patient was fairly taking these pills was three days. How the remedy acts I do not know, except it be as a powerful nerve and general tonic, bracing the patient's tissues up to resist the attacks of the exciting cause of the affection.—
J. H. Whalen, M. D., in *The Practitioner*.

MEDICAL NOTES.

Prof. Bartholow states that styptic collodion is an efficient application to *bleeding hemorrhoids*.

Prof. Brinton is fond of small copper wire coated with silver for *sutures*, especially in parts exposed, as the face.

In *fatty hearts*, with occasional attacks of pseudo-apoplexy, Prof. Da Costa prescribed gr. 1-40 strychnine, three times a day.

In watery, *colliquative diarrhoea*, Prof. Bartholow claims that no remedy is more valuable than sulphuric acid, to which opium may be added if necessary.

In *cardiac asthma* arising from dilatation and pericardial adhesions, Prof. Da Costa, after alluding to digitalis, adonis and the sulphate of sparteine as also appropriate remedies, prescribed five drops of the fluid extract of convallaria, which was gradually to be increased to ten or fifteen drops three times daily.

For local use in *chronic eczema*, Prof. Da Costa prescribed the following:

R Ung. hydrarg. oxidi rubri, ʒij.
Unguent. sulphuris, ʒij.
Acid. carbolic, gr. ii.
Unguent. simplicis, ʒss. M.

Sig.—Apply to affected part.

Progressive muscular atrophy, occurring in a patient having fatty heart, was treated by Prof. Da Costa with—

R Strychninae sulph., gr. ʒ/6
Ferri carbonatis, gr. iij. M.

Sig.—Ter die.

Prof. Gross states that he would treat *pneumonia* thus: If seen early, he would bleed the patient until the pulse became soft, and follow this by aconite, veratrum, or gelsemium. He would give an active purge, perhaps of the compound infusion of senna—four ounces. Would combat the hyperpyrexia with quinine or antipyrin, and would place poultices to the chest.

Prof. Bartholow still continues to advocate the use of carbolic acid in *typhoid fever*. He states that no form of treatment has, in his hands, been so successful. It modifies the disturbances of the intestinal tube, reduces temperature and promotes quiet. Two drops of a solution consisting of equal parts of carbolic acid and Lugol's solution may be given every three hours.

Hydrastis canadensis (fluid extract) is an excellent local application in *cervicitis*, *endometritis* and *vaginitis*, the one great objection to its use being its straining properties. In gonorrhoea, the fluid extract mixed with mucilage as thick as can be used by injection, is of much service. It should be retained in the urethra for some time, and the urethra should have been previously cleansed with water or a solution of sodium chloride.

A case of *sciatica*, originating by strain, having persisted for four months and resisted iodide of potassium and colchicum, and having been only temporarily relieved by atropine and morphine, was finally made to succumb to gr. ʒ/60 of aconitia three times daily, prescribed by Prof. Da Costa. The patient became almost immediately much better, the pain disappeared and improvement continued. After a week the remedy was given but twice daily and gradually withdrawn.

Clemen's solution of bromide of arsenic, said by Prof. Bartholow to be the best remedy brought forward for *diabetes*, can be prepared as follows: Boil in eight ounces of distilled water 57½ grs. each of powdered arsenious acid and carbonate of potassium. When cold add sufficient distilled water to make eleven and one-half Troy ounces, and in this dissolve 115 grains of pure bromine. This will need occasional strong shaking for the

first week, and the solution will not be perfect or clear for three or four weeks, when it will then be ready for use. The dose is one drop three times a day.

When stimulus fails to maintain the pulse and heart's action in *typhoid fever*, Prof. Da Costa states that cocaine has given him most satisfactory results. It will sometimes establish convalescence rapidly when, under stimulus, the cases seem to be rapidly failing. A case shown at the Pennsylvania Hospital, which was receiving $\bar{3}$ xij of whiskey in 24 hours, and with no response, began at once to improve on gr. $\frac{1}{4}$ of cocaine every two hours, afterward increased to gr. $\frac{1}{2}$ every third hour; the whiskey at the same time being kept down to $\bar{3}$ viij.

Prof. Gross's favorite prescription for *secondary syphilis* is—

R Hydrarg. iodid. viridis, . . . gr. $\frac{1}{4}$
 Antimonii et potassii. tartrat,
 Morphine sulphat, aa . . . gr. $\frac{1}{4}$. M.
 Ft. pil.

For a cure, take one after each meal; after two days, take two pills after dinner; in a few days, if no bad symptoms arise, increase to three pills after dinner and two after breakfast. Increase until it is found what patient can tolerate; five pills a day about the usual amount. This should be persisted in until all symptoms disappear; then cease for a short time, and then renew with $\frac{2}{3}$ dose. With intervals of a few weeks every two or three months gradually reduce the dose. After two years in this way we may then cease, but keep the patient under observation for eighteen months longer.—*Coll. and Clin. Rec.*

HYDRASTIS CANADENSIS IN UTERINE HEMORRHAGE.

The recorded experience in the use of *hydrastis canadensis* covers more than one hundred cases. Before adding my own, I would state that metrorrhagia especially and menorrhagia have been the determining symptoms for the use of this drug. I would define menorrhagia as a condition of menstruation when the flow, previously normal, becomes profuse, or has always been profuse, when compared with that of women of the same station and time of life, and is evidently too great a loss for the patient to bear. Although nothing, so far as I know, will conceal its unpleasant taste, yet I have given only the fluid extract, in doses of twenty drops three or four times daily in a wine-glass of water, in cases of fibro-myomata, sub-involution, and hemorrhagic endometritis continuously, in other cases of ten days before and during the menstrual period. I have never used *hydrastin* or the other alkaloids, because of the great variations in their strength.

I have used *hydrastis canadensis* in three cases of uterine fibro-myomata.

My conclusions in these and the subsequently enumerated cases are supplemented by the results of treatment in the observations of the writers whom I have already mentioned. *Hydrastis* checks the bleeding from uterine fibro-myomata by the production of persistent anæmia, unaccompanied by the distressing cramps of ergot or the flooding from the alternate contractions and relaxations. So in the cases of small fibroids it is preferable where their expulsion would probably be attended by hemorrhage or septicæmia. We all know that enucleation by the spoon-saw is frequently followed by death, that removal of the ovaries (castration), or removal of what has been termed, curiously enough, the uterine appendages, is generally unnecessary and contra-indicated, aside from the great danger to life, on both social and moral grounds. In face of the experience of the various observers above enumerated, every man, before resorting to abdominal section, should consider that he may needlessly sacrifice a human life.

Of hemorrhagic endometritis I record seven cases, five being cases of endometritis fungosa.

In *hydrastis*, then, we have a sovereign remedy, in endometritis fungosa, even when curetting has failed to arrest the bleeding. I have seen a fatal result from the apparently simply operation of curetting. That there is danger attested by the number of so-called antiseptic curettes to be found in the market. When the use of *hydrastis* no confinement to the bed is necessary.

Sixteen cases of subinvolution of the uterus have been treated by *hydrastis*. All of these patients were examined, and in many instances the uterine cavity measured from time to time. The average duration of treatment was about that of preparation for the operation of closure of the cervix. Had these patients come under my observation a few years before, I should have undoubtedly operated upon the greater portion of them. *Hydrastis canadensis*, then by its faithful use, will often render Emmet's operation unnecessary. We see the uterus becoming smaller, the leucorrhœa diminishing, the erosions healing, the displacements becoming rectified. Apparently it is to this class of cases that Shvestizeneff refers, although he does not apparently recognize a lacerated cervix.

I have treated successfully five cases of climacteric hemorrhage with *hydrastis*. The results obtained in these cases I regard as admirable, and believe we have a valuable remedy in the class of cases, which sometimes are very difficult to relieve. It is only fair to say that I have also used the bromides sparingly and arsenic somewhat vigorously, but I feel positive that, in removing one cause of general anæmia, *hydrastis* has been of great benefit.

Nine cases of pelvic inflammation have come

under my care which have been treated with hydrastis. The more accurate diagnosis will be given with each case. Since I have been using hydrastis in these cases I have abandoned the use of iodine, to some extent that of hot water, and in a measure local treatment. I should even be inclined to use this remedy in pyosalpinx, because by it we can reduce the hyperæmia without producing contraction of the tubes. I have seen too many healthy tubes removed, to operate before having exhausted medical therapeutics, and, further, I have found postmortem that even pyosalpinx can become quiescent, the pus becoming cretaceous, the whole process apparently never having given rise to any symptoms.

Three cases of congenital antelexion have been treated with such marked relief of symptoms that I report them here. In this flexion of the uterus, producing what has been called obstructive dysmenorrhœa, although the worst cases as regards pain and intractability, have been cases with a patent uterine canal, the artificial anæmia has not failed to relieve the cramps, the pain, and generally the nervous symptoms as well. This drug also obviates the necessity of having recourse to the operation of posterior section, which is ordinarily one of the most fatal of all the minor operations. In these cases, if hydrastis is employed, local treatment is entirely unnecessary. I would even go farther and say that, in many cases, an examination can be dispensed with. The only interest that the patient has is that her symptoms shall be relieved; that is the only interest that the physician should have, and, if it can be accomplished without an examination, I regard an examination as entirely unnecessary. I am prepared to say even more, that I would have it the established rule that no examination of an unmarried woman should be made unless with the unanimous decision of a consultation, one of the physicians, at least, to be a general practitioner.

In this paper I have aimed to show that results can now be satisfactorily attained by medical means which were formerly reached only by surgery. I regard every step in this direction to be a decided advance, because it brings gynæcology into the hands of the general practitioner to a greater and still greater extent. To do this is, I maintain, the first duty of the specialist. Before closing, I wish to remind you that disputed questions have never been settled by the specialists and rightly so. They come for their final verdict before the jury composed of general practitioners. The gynæcological question of to day in this: Shall we lead the revolt against needless operations, dangerous mutilations, and unnecessary and debauching examinations, or shall we wait to be driven into line by the outraged sentiments of the profession at large?—Dr. R. W. Wilcox in *N. Y. Med. Jour.*

PROFESSOR VIRCHOW ON CHARCOT'S JOINT-DISEASE.

At the meeting of the Berlin Medical Society, held on November 17th, a most interesting discussion took place on the joint-affection peculiar, as is generally assumed, to tabes dorsalis. The subject elicited a speech, which amounted to an address, from Professor Virchow. The debate was opened by Herr Rotter, who began with these questions: 1. Is the joint-disease (occasionally) found in tabetic subjects a special arthropathy different from all other joint-affectations? 2. Is this joint-affection only indirectly connected with the tabes, or is there an intimate causal connection subsisting between them?

Clinically considered, this (Charcot's) joint-disease, said Dr. Rotter, was peculiar in the following respects: Its appearance in a definite stage of the tabetic disease, the so-called prodromal stage; its sudden onset; the absence of inflammatory signs; the analgesia of the deep parts, especially of the bones; the peculiar swelling of the soft parts; and, lastly, the rapid destruction of the joint.

Pathologically, it differed from arthritis deformans, inasmuch as ulceration of the intra-articular structures was enormously in excess of new growth, while the reverse was the case in the latter disease, especially as regards extra-articular bony growth. But this does not necessarily constitute a specific difference, for many authors refer the peculiar character of the tabetic joint-disease to analgesia of the bones, and the want of regulation in the loads they bear, the result being increased liability to injury. Others, again, consider the disease to be a special nervous affection, because, in the first place, it usually precedes all ataxic phenomena; secondly, the process may occur in the upper limbs, which have no abnormal weight to bear; and, lastly, it may attack bedridden people. A specific joint-disease, from direct nervous influence, is here assumed to exist, the affected bones being supposed to have an abnormal liability to fracture and lessened resisting capacity, and the bony alteration being strictly limited to circumscribed parts. This liability to fracture is assumed upon the following grounds: 1. Intra-capsular spontaneous fractures are not seldom found in this disease (the diaphysis being in this case affected, instead of the epiphysis): 2. Microscopical and chemical examination have revealed corresponding changes in the bones; microscopically, a rarefaction commencing centrally, and advancing to the periphery; and, chemically, a decided lessening of phosphorus and calcium carbonate, and an increase of fat. These latter changes are considered primary, and due to special nervous influence, and not merely secondary to the joint-disease. Other joint-diseases in tabetic subjects run their usual course.

Such is the case ably presented by Herr Rotter on behalf of a specific arthropathy in tabetic people. Virchow opposed this view. There was no doubt at all in his mind that the usual causes of joint-affection—mechanical and thermal causes—sufficed to explain the disease. He could not understand how a nervous (trophic) influence, starting from a diseased spinal cord, could be so entirely limited to a single joint. As to the early appearance of the joint-disease, that was both difficult to prove, and also a suspicious statement. Some cases—notably one of hip-joint disease, as to which he had differed in opinion from Westphal—were doubtless due to congenital luxation, or luxation soon after birth. Again, in some cases, disease of the knee-joint followed upon fracture of the femur in the lower third. Others, said to be tabetic, were plainly syphilitic. Indeed, a large proportion of cases assumed to be tabetic had been proved to be due to syphilis. But lastly, there was no doubt that arthritis deformans was the disease to be kept the most in mind. Even the advocates for a tabetic arthropathy allowed that the process was at first one of proliferation, to which a regressive stage (of loss) succeeded. The only peculiarity lay in the quicker course of affairs, and the more startling results produced.—*Brit. Med. Journal.*

DURATION OF THE SYPHILITIC CAPACITY IN RELATION TO MARRIAGE.

In a paper read before the N. T. County Medical Society, February, 1887, Dr. P. A. Morrow formulates the following conclusions on the above subject:—

1. The facts of every-day observation show that there is nothing constant in contagion, nothing certain in heredity. Many men marry with a syphilis in full activity of secondary manifestation and never infect their wives or transmit the disease to their offspring. These negative observations are, however, entirely valueless as a basis for estimating positive results.

2. The modern division of syphilis into secondary and tertiary periods, based upon anatomical forms and processes, does not furnish a safe criterion for determining the contagious or non-contagious character of the lesions.

3. The chronological completion of the secondary stage does not always mark the definite disappearance of the virulent principle; clinical experience shows that late lesions are exceptionally, but none the less certainly, the source of contagion.

4. While in the immense majority of cases the contagious activity of syphilis and its susceptibility of hereditary transmission cease after the third or fourth year, yet well-authenticated observations prove in the most positive manner that these qualities sometimes continue in force much longer

and may be manifest in the fifth and sixth year of the disease, and even later.

5. The aptitude of syphilitic parents to procreate diseased children may persist after the cessation of all specific manifestations; the contagious stage of syphilis is not, therefore, the exact measure of the duration of hereditary influence.

6. The precise date in the evolution of the diathesis, when the syphilitic organism undergoes that radical transformation which marks the limit of its contagious or transmissible power, does not admit of mathematical expression.

7. It is probable that this limit varies in different cases and that many circumstances contribute to advance or defer it.

8. The type of the syphilis, the constitutional peculiarities of the patient, the character of the treatment, the presence or absence of certain conditions which are recognized as factors of gravity in syphilis, all exert a modifying influence.

9. All these elements should be taken into consideration in deciding upon the admissibility of a syphilitic man to marriage; each case should be studied upon its individual merits.

10. The direct paternal transmission of syphilis, without preliminary infection of the mother, may be classed among the most conclusively established facts of medical science.

11. It is, therefore, a dangerous doctrine to teach that the sole risks a syphilitic man introduces into marriage consist in the contagious accidents he may bear upon his person.

12. The arbitrary designation of a limit of three, or at most four years, as perfectly safe for a syphilitic man to marry, with or without treatment, irrespective of the actual existence of specific lesions, is unwarranted by science or the teachings of experience.

The conditions of admissibility to marriage formulated by Fournier are much broader, more scientific, more safe. These demand a mild or medium type of the disease, an advanced age of the diathesis, three or four years at the minimum, and a prolonged immunity, eighteen months to two years, from specific accidents; if these guarantees of safety are further fortified by sufficient specific treatment, a reluctant consent is given; marriage is tolerated rather than advised.—*Jour. Cutaneous and Genito-Urinary Diseases.*

INFANTILE DIARRHŒA.

The key to the solution of the problem of infantile diarrhœa lies, I think, in a knowledge of the conditions for the development of micro-organic life. The tissues of infants are of course much more susceptible to the inroads of organic action than those of adults, and we have it on the highest authority that some forms of life are developed in

the intestines as the result of fermentative processes, or at any rate that they are frequently found; and that they are often found in sub-epithelial spaces, and even in deeper portions of the mucous membrane. This, I am of opinion, from my experience in the treatment of children's diseases, will be found to be of much more frequent occurrence in them than in adults.

I divide the diarrhoea of children, as I do that of adults, into the acute and chronic forms. In the acute form a little carbolic acid with spirits of ammonia as a diffusible stimulant, and with or without grain doses of chloral and minim doses of belladonna, will cure the most urgent cases in a few hours. Thus—

- R. Spiritus ammon. aromat. ʒ j.
- Sol. acid. carbol. . (1 to 20), ʒ iss.-ʒ iij.
- Chloral. hydrat, gr. xv.-xx.
- Tinct. belladonnæ ℥ xv.-ʒ ss.
- Syrupi ʒ ss.
- Aquam ad. ʒ iij.

M. ft. mist. One teaspoonful every two hours. This mixture cures by the direct antiseptic or antifermentative action of carbolic acid.

In the chronic forms, *i. e.*, those which have existed for more than a day or two, the employment of a *remote* antiseptic is required, for the destruction of those low forms of organic life which have penetrated into the deeper layers of the mucous membrane of the intestine, and which cannot be reached by the *direct* method.

The biniodide of mercury dissolved in iodide of potassium answers admirably for this purpose. I prescribe as follows :

Remote antiseptic or germicide—

- R. Solutionis hydrarg. bichlor., . . . ʒ iij.
- Potassii iodidi, gr. x.-xv.

Direct antiseptic—

- Sol. carbolic (1-20), ʒ iij.-iij.

Diffusible stimulant—

- Spirit. ammon. aromat., . . . ʒ ss.-ʒ j.

Sedative—

- Chloral hydrat., gr. x v.-xx.
- Tincturæ belladonnæ, ℥ xx.

- Vel.—Tr. camphoræ co. ʒ ss.— . ʒ j—*Sedative.*
- Ferri ammoniæ citratis, gr. xv.—*Tonic.*
- Syrupi ad. ʒ iij.

Misce. Fiat mistura. Signetur : Capiat cochleare unum parvum tertiis vel quartis horis.

I use chloral and belladonna in the more acute cases, and the compound tincture of camphor in those of a very chronic nature, or where there is much pain complained of.

This treatment is also of much service in some cases of diarrhoea in adults, in larger doses and of course with stronger sedatives. I do not at the same time overlook the fact that injudicious feed-

ing of infants is the cause of much mischief. I give instructions in all cases to feed the child at intervals of three hours only, and between the times to give it toast water.—Dr. Illingworth, in *Med. Press.*

HOMŒOPATHY, AS REGARDED BY ONE OF ITS LEADERS.—Jousset, of Paris, is unquestionably one of the lights of homœopathy on the Continent of Europe. His recently published *Leçons de Clinique Médicale* is in some respects a model of its kind. According to this authority, the homœopath of to-day no longer affirms the mysterious potency of the globule, or the all-sufficiency of the doctrine of similars, but claims to be in the true sense of the word, eclectic.

"Hahnemann and his pupils," he says, "pretended that homœopathy was the whole of therapeutics." This is a complete misconception of the case—homœopathy is but a part of therapeutics; this is a truth which has cost us many execrations from men in our own ranks, but is now held to be indisputable.

The fact is that homœopathy cannot take the place of palliative medication: nor of surgical medication; nor of antidotal medication in cases of poisoning; nor of parasiticide medication, wherever clearly demanded; nor of medication by mineral waters, which often cures where other modes of treatment fail; nor of hydro-therapeutic medication; nor of medication by electricity; nor even altogether of empirical medication. Homœopathy is not everything, and liberal medicine must include all collateral modes of treatment.

Jousset repudiates the allegation that homœopathy is a sect, and affirms that it is simply a branch of medicine which has to do with the therapeutics of certain internal disorders, and not even all of these are amenable to treatment by the law of similars (for example, helminthic diseases). The same writer, who seems to have some following in France, and may be said to represent the advanced thought of his school, gives some pretty hard blows at the advocates of infinitesimal doses, who he intimates have brought discredit upon homœopathy, and affirms that "the school of high dilutionists is losing ground every day, and in France, as in Germany and America, the general tendency is to employ the low dilutions."—*Boston Med. and Surg. Jour.*

INFLUENCE OF DRUGS GIVEN TO NURSES ON THEIR SUCKLING INFANTS.—Dr. Fehling (*Les Nouveaux Remèdes*) discusses this subject and says: 1. *Salicylate of Sodium*: Dose varying between thirty and forty-five grains. Whenever the child is put to the breast one hour or less after the administration of the drug, the salicylate of sodium can be found in the child's urine. After the ex-

piration of twenty-four hours, no traces of it can be found in the urine. The elimination of the drug terminates simultaneously in nurse and child.

2. *Iodide of Potassium*: The same results are obtainable. The milk, if analyzed, gives the characteristic reaction. In the child, the elimination lasts seventy-two hours; in the nurse, forty-four hours.

3. *Ferrocyanide of Potassium*: The reaction is very distinct in the urine of the nurse, but never in the child's urine.

4. *Iodoform*: After prolonged application of iodoform upon wounds of the vagina or vulva, iodine can be recovered from the milk and urine of the nurse, but wholly absent in the child's urine.

5. *Mercury*: The transmission of mercury from the nurse to the mother is very slight and inconstant.

6. The influence of the nurse's diet on the child is illusory; nurses can with impunity eat sour articles (lemons, vinegar) without thereby influencing the child.

7. *Narcotics*: (a) Tincture of opium in twenty to twenty-five drop doses. Thornhill claims to have observed a prolongation of the sleep in infants, while Fehling saw neither prolongation of sleep nor constipation resulting from it. (b) Hydrochlorate of morphine. The drug given in medicinal doses does not influence the child. (c) Chloral. Dose, fifteen to forty-five grains. Average length of sleep produced in nurse, two hours. No effects on the child are observable if it is strong and vigorous. If the child is weak and possibly born before the full term, it is advisable to wait two hours after administration of the drug to the nurse before allowing it to suckle. (d) Sulphate of atropine. Injected in the usual doses hypodermically in the nurse, the drug produces very distinct physiological effects in the child. The dilatation of the pupils taking place in the child does not disappear before twenty-four hours; hence, minute doses of the drug exclusively are permissible. —*Therap. Gaz.*

NEW TREATMENT FOR PHTHISIS.—A new method of treating phthisis has been proposed, but apparently as yet but slightly tried, by Professor Kremianski, who read a paper on the subject at the recent Moscow Medical Congress, which provoked a good deal of discussion. The idea is based, firstly, on the fatal effect of the most dilute solution of aniline on Koch's bacillus, and, secondly, on the fact that aniline seems to be but slightly, if at all, poisonous to the human body. Professor Kremianski proposes to introduce aniline into the lungs, and, indeed, the circulation generally, by inhalation, so that the phthisis bacilli should be bathed in a very dilute solution of aniline, wherever they may be. This, he thinks, would kill

them, and render even pulmonary cavities free from bacilli, so bringing them into the condition of healthy granulation ulcers, which may be expected to cicatrize. A committee has been appointed, including Professor Subbotin and Ostroumoff who expressed themselves at the meeting as strongly opposed to the plan, for the purpose of observing Professor Kremianski's proposed experiments in one of the Moscow hospitals. Two cases in which the aniline treatment had been successfully tried were detailed. A lad of eighteen, who had undoubted phthisis, was ordered a four-drop dose of aniline (but took by mistake three times the proper quantity) combined with nux vomica, mint water, and antifebrin, his diet being good, including dried meat, kvas, and oranges. He was also given inhalations of atomised aniline. A remarkable change took place almost immediately, all the râles disappearing; his temperature, respiration, and pulse becoming normal. His skin, however, assumed a slightly blue tinge, but whether this was as permanent as the cure is represented to have been is not stated. The second case was a complicated one, there being tubercular peritonitis and meningitis, together with typhoid fever, present at the same time as pulmonary phthisis. Aniline inhalations, washing out the pulmonary cavities with corrosive sublimate and antifebrin, were employed, together with a special acid diet, as in the other cases. Here, too, the results are said to have been remarkably good, the bacilli disappearing from the sputum, and the patient regaining his health entirely. No mention is made in the abstract published by the *Vratch* of any change of colour in this patient's skin. Amongst the various replies that were made to Professor Kremianski, Dr. Zakrzhevski, of Helsingfors, remarked that, admitting the fact as stated, still there was nothing to show that the aniline had been the cause of the cure. He himself had had surprisingly good results in phthisical cases, the disease becoming completely arrested by simply giving increased nourishment and prescribing antipyrin.

ON THE USES OF BORIC ACID.—Dr. J. T. Searcy, in the *Atlanta Medical and Surgical Journal*, writes enthusiastically in praise of boric acid, which as an antiseptic, he says, is better than iodoform, besides being cheaper. The best shape in which to use it is as an impalpable powder. Open wounds, before they are closed, may be freely dusted over with this powder, and compound fractures may be so treated, with often the happiest results. No application so effectually destroys the offensiveness of foul sores. Cancerous and other ulcers are benefited by boric acid, in combination with iodoform or not. It makes an excellent injection for gonorrhœal inflammations, in the strength of ten grains to the ounce of water for

the urethra, and half an ounce to the pint of hot water for the vagina. Eczema, both in its moist and in its dry stages, is helped by it, as a rule. Dusted finely on itching surfaces, it proves usually a very grateful application. It is almost a specific for ringworm; moisten the surface first, and with the wet hand, or a piece of sponge, rub the powder into the skin firmly once or twice a day. All itching is soon allayed, and the part gradually gets well. Persons troubled with offensive secretions of the axilla or the feet, will find this a very efficient and safe application. A combination of iodoform one part, boric acid two parts, vaseline four parts, makes an excellent ointment for venereal sores.—*Boston Med. and Surg. Jour.*

PERIPHERAL NEURITIS IN TABETIC PATIENTS.—Pitres and Villard. *Neurological Review (Revue de Médecine.)*

1. The peripheral nerves of tabetic patients are very often the seat of neuritis.
2. The neuritis of tabetic patients does not differ in any essential respect from other forms of the non-traumatic affection.
3. Their topographical distribution in the body is variable, for the neuritis may attack the sensitive and mixed nerves and the visceral.
4. In the majority of cases, but not always, the disease begins at the outer extremity of the nerve.
5. Their extent and gravity have no constant relation in respect to age, or the extension or depth of the medullary regions of the locomotor ataxia.
6. It is probable they do not play any part in the production of the specific symptoms of tabes; such as, the lightning-like pain, inco-ordination of movements, abolition of patellar reflex, disorders of the muscular sense, etc. These latter symptoms depend rather upon the condition of the posterior columns of the cord.
7. Certain inconstant symptoms, however, which are added to or complicate the symptomatology of tabes, appear to depend upon the peripheral neuritis; such, for example, as anæsthetic spots in the skin, localized trophic disease of the skin and its dependencies, certain localized motor paralysis, accompanied or not by muscular atrophy, isolated joint affections visceral crises, etc.

THE TREATMENT OF ASTHMA.—If any drug deserves the title of specific in this affection it is potassium iodide. The remedy was first recommended in asthma by Trousseau, but this use of it fell into oblivion for a number of years, to be only recently restored by the publications of Leyden and Germain Sée, the latter of whom recommends its administration with lactucarium. Potassium iodide is of great service, also, in the purulent bronchitis which occurs as a sequel to asthma. In many cases of this condition the

various balsams are efficacious, and Lubinski has observed excellent results from the use of Peruvian balsam combined with myrrh, the former in doses of from a grain and a-half to three grains three or four times a day. If there is really a nasal affection, it should be treated according to its character, and not on any far-fetched theory of its etiological importance. But, in the treatment of asthma, it is of the greatest moment to distinguish true, or primary, asthma—by no means a common affection—from that which is secondary to disease of the heart or lung. We need scarcely say that we have had only the former in view in this writing.—*N. Y. Med. Jour.*

PHIMOSIS IN INFANCY.—In the *Lancet*, Dr. Hett contributes a few remarks on the subject of phimosis in infants. The author suggests the following rule for those who take charge of midwifery cases: To examine every male child within a few days of birth, and if the prepuce can not be retracted by the exertion of a moderate amount of force, to perform circumcision on or about the eighth day after birth. Many an unfortunate little boy is credited with bad temper, and punished for naughtiness, whose irritability is due to neglected phimosis. There is also much reason for thinking that the old habit of masturbation is frequently led up to by a morbidly excitable condition of the sexual organs due to phimosis. Circumcision may be performed by seizing the extremity of the prepuce between the finger and the thumb of the left hand, drawing it well forward, and slicing it off diagonally downward and forward, just in front of the glans. The mucous membrane should then be split along the dorsum, quite up to the cervix, turned back, and retained in position by a narrow strip of dry lint wrapped firmly three or four times round the penis. No sutures are necessary. The lint can be removed in a few days, when generally the wound is quite healed.—*Compend Med. Science.*

TREATMENT OF GONORRHOEA.—(1) Fully explain to the patient the inefficiency of popular remedies, and the dangers attending their use. (2) Secure absolute personal cleanliness, thereby preventing infection of other parts, and insist upon as nearly perfect rest in bed as the exigencies of the case will permit. (3) Soak the penis frequently in water as hot as can be borne, but more especially during the act of micturition. (4) Recommend milk as a diet, and prescribe alkaline diuretics and mineral waters as internal medication. (5) Secure absolute freedom from sexual intercourse and from thoughts associated therewith.

Perfect faith in, and obedience to these simple formula, he insists, will insure a successful ending of all uncomplicated cases before the beginning of the seventh week.—Dr. Otis, in *Med. & Surg. Rep.*

PAPINE.—Dr. Thos. Little, of Spirit Lake, Iowa, in comparing Papine with other forms of opium, says: "I have been using Papine for the past two months. It meets the requirements of a class in which opiates are indicated, but in which the 'remedy is worse than the disease.' One case in particular has given me a great deal of trouble for years. I have tried opium in every form, and many other narcotics, alone and in combination; but constipation, nausea and nervous prostration have been the invariable results. Some two months since I obtained some Papine and commenced on this case with the happiest effect; no nausea, no constipation, no prostration. I have been prescribing it in my practice since with the greatest satisfaction to myself and my patients."

HOW DR. OLIVER WENDELL HOLMES RELIEVED HIS ASTHMA.—In the first instalment of Dr. Holmes' entertaining article in the *Atlantic Monthly* for March, giving an account of his trip to Europe, the experiences of the writer in overcoming his attacks of asthma are related. All kinds of prescriptions were showered upon him, but Dr. Holmes announces that nothing did him so much good as a certain patent asthma-cure made in Providence, R. I. The composition of this is said to be:

R Pulv. lobelia,
Pulv. stramonie fol.,
Pulv. potas. nitrat.,
Pulv. black tea āā 3 ij

M. and sift.

Some of this is burned and the smoke inhaled.—*Med. Record.*

SALICYLIC ACID AND IRON IN RHEUMATISM.—Dr. George L. Peabody treats his cases of acute articular rheumatism in N. Y. Hospital with the following combination:

R. Acidi Salicylici gr. xx.
Ferri pyrophosphatis gr. v.
Sodii phosphatis gr. v.
Aquæ 3 ss. M.

The dose which is described in this formula is given every two hours until improvement justifies diminution in the frequency, or until constitutional effects are pronounced.—*Epitome*

INEBRIETY.—The French Journal of Hygiene estimates the probabilities of life for moderate drinkers and total abstainers as follows: A moderate drinker at twenty years of age may expect to live about fifteen years; at thirty, twelve years; at forty, ten years; at fifty, eight years. The hope of a total abstainer is, at twenty years, forty years of life; at thirty, about thirty-six years; at forty, about twenty-eight years; at fifty, twenty-one years; at sixty, fifteen years.

BISMUTH SUBIODIDE.—This is intended to replace iodoform. Iodine fused with bismuth forms bismuth iodide. Boiling the latter with water leads to the precipitation of the subiodide as a fine powder. It, like iodol, is said to be inodorous, and yet to be equally as effective as iodoform as an antiseptic.—*London Lancet.*

AGARICIN FOR NIGHT SWEATS.—Young recommends the following combination: R. Agaracini, gr. viij; pulv. ipecac et opii, gr. cxx; althæ pulv., and mucilag. acacia, āā, gr. lx. M. et div. in pilnæ, No. 100. S. One or two to be taken at night.

In the Bellevue Hospital the following combination has been used with excellent results: R. Agaracini (Merck's) gr. x; Atropinæ sulph., gr. i; acidi sulph. arom. M 1200. M. et filter. Dose, 10 minims contain $\frac{1}{10}$ of a grain of agaricin, $\frac{1}{10}$ of a grain of atropine sulphate, and 10 minims of aromatic sulphuric acid. To be given in syrup or simple elixir.—*American Druggist.*

SIR Henry Thompson appeals to the medical public in protest against the use of his name in the advertisements of Friedrichshall mineral water, which he named once in a lecture, twenty years ago, with approval. This was when there were only one or two laxative mineral waters in England, and he no longer endorses the original statement. But the advertisers persist in the use of his name, and he cannot help himself except by an occasional disclaimer in medical journals.—*Boston Med. and Surg. Jour.*

DUJARDIN ON AN EYELASH IN THE ANTERIOR CHAMBER.—The patient had received an injury to the eye and a woued of the globe. By oblique illumination a foreign body was seen directed vertically in the outer part of the anterior chamber of the left eye. The upper end of the lash was slightly curved. The author could find but twenty-nine such cases on record.—*Jour. des Sci. Med. de Lille.*

PRESS me closer, all mine own,
Warms my heart for thee alone.
Every sense responsive thrills,
Each cares my being fills;
Rest and peace in vain I crave,
In ecstasy I live thy slave;
Dower'd with hope, with promise blest,
Thou dost reign upon my breast;
Closer still, for I am thine,
Burns my heart, for thou art mine,
Thou the message, I the wire,
I the furnace, thou the fire;
I the servant, thou the master,
Roaring, red-hot mustard plaster.

—Burdette.

THE CANADA LANCET.

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

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

TORONTO, MAY, 1887.

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

DEATH FROM CHLOROFORM.

How often we hear the remark, when a fatal result has taken place in the administration of an anæsthetic, that "such a small quantity was given." It is a matter of surprise to the public at large, and we believe to not a few in the profession, that "only a few whiffs" are sufficient to produce death. Now, that such ideas hold their place among the laity is not to be wondered at, but when medical men speak, and even write with the idea that small quantities of an anæsthetic are safer for an operation than profound anæsthesia, it is desirable that a clearer comprehension of the danger of anæsthesia in operations be generally had. Much has been said of the relative safety of the two agents, chloroform and ether. Statistics, as commonly given, do not take into account the fact that chloroform is so much more frequently employed than ether, in Europe at any rate, and the bare fact that a certain number of deaths from each occurs during a stated period of time gives the reader little insight into their relative safety; but of this we have no occasion to speak now.

Our object is to make clear the fact that for the simplest operations, even for the extraction of a tooth, complete anæsthesia should always be induced.

The danger of anæsthetics are chiefly three, viz: paralysis of the respiratory centre, from an overdose, paralysis of the heart, from a too concentrated chloroform vapor, and a "combination of chloro-

form narcosis and shock." As to the first two conditions, they should never occur, and in reality we believe the third is the true cause of the great majority of fatal cases. Now this condition of shock is caused commonly by *incomplete anæsthesia*, and the fatal issue is the result, not of the too liberal use of the anæsthetic as is commonly supposed, but of its too sparing use.

When a painful operation is performed without any anæsthetic at all, the irritation being reflected through the pneumo-gastric tends to cause stoppage of the heart, and a consequent condition of syncope, while at the same time, the same irritation causes, also reflexly, contraction of the arterioles. This raises the blood pressure and thus counteracts the tendency to syncope, caused by the action of the vagus.

Now chloroform does not paralyze all the reflexes at the *same time*, the centre for the arterioles being affected early in the administration, and sooner than the vagus. When a small amount of an anæsthetic has been used then, the reflex centre for the arterioles is paralyzed while the vagus is not affected, or is at any rate but little affected, and the consequence is that the balance between these two counteracting nervous mechanisms is lost, and under the influence reflected through the still vigorous vagus, the heart tends to stop, and not being spurred on by the increased blood pressure, syncope occurs, which may or may not prove fatal. When, however, complete anæsthesia has been induced, the irritation of the sensory nerve, by the operation affects neither the pneumo-gastric nor the centre for the arterioles, both these reflexes having been abolished, and herein lies the safety of complete anæsthesia, namely, the absence of any such untoward effect upon the heart as has been mentioned above, that is the absence of shock. This being understood it is clear, why, even in the most trivial operation, the anæsthesia should be perfect. Not even the extraction of a tooth should be attempted while the patient is only partly anæsthetized. As a matter of fact a large proportion of deaths from chloroform occur during the extraction of teeth, for which short and simple operation, complete anæsthesia is not considered necessary. Ether seems less dangerous than chloroform, when used sparingly, a fact which may be accounted for by its more equal action upon the centres, all being paralyzed by it more nearly

at the same time, and in the same degree than is the case with chloroform.

If then all anaesthetists would insist upon complete anaesthesia before even the simplest operation was proceeded with, we should hear less frequently of the fatal results of "a few whiffs," when death is not really due to the use of the anaesthetic, but to the shock, consequent upon its not being pushed far enough before the operation was begun.

NEW MEDICAL SCHOOL.

A few remarks as to the proposed new Medical Faculty in Toronto University will be pertinent at this time, though perhaps the profession in the country at large is not so deeply interested as some few in Toronto would have us believe. With two efficient medical schools in full blast, many may think the necessity for the establishment of a third is out of the question. Neither Trinity nor Toronto school seems willing to forego the advantages they now possess, and surely the number of men who are being qualified every year is sufficient. As to the efficiency of the medical schools now in existence here, the rank their graduates hold both in the United States and Britain, is an assurance that they are not inefficient. Canadian graduates are generally looked upon in England and Scotland as being well up in their work so far as college training goes, but as a rule have not the same practical knowledge as their confrères who have spent their entire college course at one of the large hospitals in London or Edinburgh. Now the establishment of a new college cannot, so far as we can see, increase the facilities of our students, for clinical instruction or observation. A considerable difficulty in this matter is, that any such establishment of a medical faculty in connection with the University, would *practically* put an end to the affiliation of other medical schools with that institution, which would we think be a misfortune, as regards medical education in this Province. Again, the proposition that the University shall borrow the funds necessary to equip the new school, will not we fear meet with general approval. With two established schools in Toronto, it would be a long time before such a debt would be cleared off, if the fees of the students were the only means at the disposal of the faculty for that purpose.

The existing medical schools have been steadily improving year by year in attendance and equipment. The members of the Faculty of Trinity Medical School alone have spent ten thousand dollars within a short time, in increasing the efficiency of their school. And other schools have been working in the same spirit, so that, to-day, medical education in Ontario is, to say the least, on a solid basis, and such as we need not be ashamed of:

The number of students in medicine, presenting themselves for degrees at Toronto University, has been comparatively small of late years. But this is due largely to the fact that certain subjects are required by the University, which are not in the curriculum of the Medical Council. Any one who knows what the burdens of a medical student's life are, will readily understand, that few indeed are the individuals who will add to their own burdens, or will shoulder those which may be avoided. Comparative anatomy is all very well, and the more a man reads the broader will be his field, but we hold that the mass of medical students in Canada are not in a position to read science for the sake of science, and that the time now required to be spent on biology might be better spent in, say, human anatomy, as indeed it is so spent by all other students than those whose love for Toronto University impels them to accept this additional work, for the sake of possessing her degree, a number, which we are sorry to say, is very small. It is easy for those who have not gone through the work required of a medical student, to philosophize and point out the advantages and beauties of science, etc., but those who have gone through the said work *know*, that with such students as are now coming up for medical education, it is not wise to require this additional work. Let the Senate assimilate the Medical Curriculum of the University to that of the Medical Council, and continue to examine as heretofore in medicine; and there will be no lack of students from every affiliated school, who will be only too glad to present themselves for her degrees in medicine.

CONSERVATIVE SURGERY.

Conservative surgery has been the text for many editorial sermons, and yet it is a fit subject for the pen. Verily there are surgeons and there are sur-

geons. Since our advent into the profession, we have found that there are two schools of surgeons. One in which the underlying principle is the welfare of the patient first and always, without regard for anything else, and certainly far removed from mercenary motive. The other is characterized by what is commonly called bold, daring surgery. Its members being men who look always to their own interests, who have more consideration for the fee than for the welfare of the patient. We have witnessed these so-called surgeons perform operations, which were totally unjustifiable, and often uncalled for. We have known operations to have been undertaken when there was not the slightest possible chance for the patient to be benefited. In these cases the operation was performed in order to obtain the fee, and to impress the laity with the boldness and fearlessness of the surgeon. There are cases occurring every day in which limbs, eyes and lives are sacrificed because the surgeon in attendance was desirous of operating, and shut his eyes to all methods of treatment other than the knife. That such things as these are wrong, and that they are detrimental to the whole profession and science alike, there is no doubt. We take it that a surgeon should not be bold and daring. Let him rather be timid. Let him have a due regard for the feelings of his fellow man, and hold at as high a price the lives and limbs of his patients as he does his own. Let him be slow to mutilate by the removal of a member, and when by all authority, by his experience, and upon his honor as a humanitarian, it is necessary to remove a part, then he can be bold and daring without discredit to his calling. The surgeon who will operate simply to gain the fee and credit for the performance of an operation, when he is not positive that he thereby increases the chances for life, or relieves suffering, is unworthy the name of surgeon, and is a discredit to his noble science.

Professor Verneuil says: "Of one hundred possible operations, twenty are imperatively necessary, twenty are absolutely inadmissible, and the remaining sixty may be performed or not according to circumstances, and surgeons may and do err in each of these classes of cases."

The death of Dr. Arthur Farre, F.R.S., London, Eng., at the age of 75 years, is announced in our exchanges.

ONTARIO MEDICAL ACT AMENDMENTS.

The Committee of the Medical Council has at length succeeded in carrying through the House certain much needed amendments to the Ontario Medical Act. We congratulate the Council and the profession of Ontario upon the fact that power and authority have been given to deal with those registered practitioners who disgrace the profession of medicine by unseemly advertisements, and the most flagrant quackery. It was certainly not asking too much from the legislature to give power to the Council to exercise some wholesome discipline upon members who are "guilty of infamous or disgraceful conduct in a professional respect." The Law Society has had for years a somewhat similar provision on the statute book, and has acted upon it from time to time when necessity arose, and no injustice can be shown to have been done to the humblest member in consequence. So we trust it will be with regard to the power given to the Ontario Medical Council. We have not the slightest reason to fear that this power will ever be abused, but rather that it may become a dead letter, owing to the difficulty of defining what shall and what shall not constitute "infamous and disgraceful conduct." The penalty to be inflicted upon any licensed practitioner found guilty of the above charge shall be the erasure of his name from the Register of the College. For the purpose of exercising this power, the Council shall appoint a Committee of their own body, consisting of five members, three to constitute a quorum. Power is given the Committee to call witnesses, examine the same under oath, to cross-examine and otherwise to constitute itself a court of competent jurisdiction for the purposes of the Act. The right of appeal to any judge of the High Court of Justice, for Ontario, within six months from the date of erasure of his name from the Register, is given the defendant.

Clause I. of the Act, in reference to College representation, has been amended by enacting that only those colleges which shall establish and maintain a Medical Faculty in connection therewith, shall be represented in the Council. Another important clause has been added, viz.: that no registered medical practitioner shall be liable in any action for malpractice unless such action be commenced within *one year* from the date of such

professional services. The clause of the Bill relating to the payment of medical witness' fees at the rate of \$5 per day and mileage was struck out on the third reading. It was objected to on the ground that it was class legislature.

TRINITY UNIVERSITY, TORONTO.—M.D., C.M., Jas. McLurg, *Gold Medal*; J. B. Reid, *Silver Medal*; A. Bradford, A. E. Yelland, H. C. Phillips, O. G. Niemeier, J. M. Thompson, W. J. Stevenson, B. Hawke, H. R. McCullough, A. Lawson (*Honors*). A. D. Graham, A. J. Stevenson, W. A. Fish, W. A. Shannon, eq.; C. H. McLean, C. R. Staples, J. H. Hoover, M. J. Keane, D. Mitchell; W. Newell, R. R. Hopkins, W. D. Scott, eq.; R. McLennan; L. P. Booth, S. H. Quance, eq.; A. Y. Scott, 70 per cent. W. Babbitt, J. C. C. Grasett; F. O. Lawrence, M. J. Glass, eq.; T. A. Amos, U. N. Thornton, D. P. McPhail, A. Thompson, R. R. Ross, J. A. Phillips, J. W. Shillington, A. E. Mackay, J. W. Ross, Mrs. A. L. Pickering, A. B. Foster, E. Clouse, F. L. Shaffner, E. Spencer, W. B. Nesbitt, 60 per cent. A. Myers, T. S. Phelps, W. H. Clarke, Miss A. McLaughlin, D. Bechard, P. J. McDonald, D. W. Kester, 50 per cent.

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TRINITY MEDICAL SCHOOL.—*Fellowship Degree*: A. E. Yelland, *Gold Medal*; Jas. McLurg, 1st *Silver Medal*; W. C. Scott, 2nd *Silver Medal*; J. M. Thompson, A. Bradford, W. Newell, C. R. Staples, A. Lawson, D. P. McPhail, M. J. Stevenson, O. G. Niemeier, A. Thompson, *Certificates of Honor*. T. A. Ames, W. Babbitt, E. Clouse, W.

A. Fish, J. C. C. Grasett, A. D. Graham, R. R. Hopkins, S. H. Hoover, B. Hawke, D. A. Kidd, F. O. Lawrence, H. R. McCullough, A. Myers, R. McLennan, D. Mitchell, T. S. Philp, H. C. Philips, J. B. Reid, J. W. Ross, A. J. Stevenson, F. L. Schaffner, W. A. Shannon, W. N. Thornton.

Primary. J. M. McFarlane, J. Crawford, H. W. Armstrong, H. Becker, H. C. Elliott, J. H. C. Fisher, G. K. Mark, W. J. Milne, H. D. Quarry, W. R. Wade, J. G. Wiley (*Honors*). W. E. Harding, J. R. McCabe, J. P. Ogden, H. A. Turner, 70 per cent. U. E. Bateson, W. W. Birdsall, John Brown, P. Brown, H. Chapple, D. K. Crossthwaite, A. T. Emerson, F. F. Ferguson, J. M. Henwood, W. Kerr, D. McLeod, T. J. McNally, J. M. G. Millman, T. J. Moher, H. J. Mullen, W. W. Nasmyth, T. C. Patterson, J. T. Rogers, D. A. Rose, F. G. Saulter, R. J. Wade, H. W. Wilson, 50 per cent. J. C. Auld, T. G. Batemau, O. M. Berdan, M. C. Dewar, H. C. S. Elliott, T. A. Fitzgerald, F. H. Johnston, A. J. Macaulan, H. Mason, J. H. McFaul, jun., T. C. Patterson, A. E. Wills, R. J. McDonald, W. L. Bain, E. R. Bishop, J. Cowan, J. D. Deacon, A. E. Edgar, C. H. Hamilton, E. S. Jackson, H. W. Jeffs, J. H. O. Marling, P. J. McDonald, J. H. McFaul, sen., A. McMeans, B. Z. R. Milner, 50 per cent.

Scholarships.—*First Year*: F. C. Clarke, 1st *Scholarship*, \$50; C. B. Carveth, 2nd *Scholarship*, \$30; J. N. Sifton, 3rd *Scholarship*, \$20. *Physiology Prize*: C. B. Carveth, \$25. *Second Year*: J. M. McFarlane, 1st *Scholarship*, \$50; J. Crawford, 2nd *Scholarship*, \$30.

MCGILL UNIVERSITY, MONTREAL.—M.D., C.M., E. Evans, *Holmes Gold Medalist*; H. A. Lafleur, *Prizeman*; J. Creasor, *Sutherland Gold Medalist*; A. F. Garrow, *Prizeman in the Primary*; W. H. Abern, J. A. Berry, E. H. Blackader, S. W. Boone, W. Bowen, Jay Boyd, K. Cameron, W. Christie, A. M. Cowie, J. A. Dickson, C. L. Easton, C. J. Edgar, W. E. Ellis, E. J. Evans, J. D. Flagg, E. W. Fillmore, J. M. Fraser, A. W. Gardner, A. G. Hall, W. Hall, A. L. Hamer, J. W. Johnson, J. A. A. Kelly, A. M. Lafferty, H. A. Lafleur, W. F. Loucks, A. D. Macdonald, A. L. McDonald, D. D. McDonald, H. McKinnon, V. H. Morgan, T. J. Norman, J. A. Porter, J. C. Potheir, E. Reavely, G. C. Richardson, D. L. Ross, J. M. Scott, D. J. Scully, G. C. Stephen, H. E. Trapnell, P. H. Warneford, H. P. Wilkins, E. P. Williams, A. A. Young.

VICTORIA UNIVERSITY.—M.D., C.M., O.R. Avison, J. Appelbee, J. J. Brown, J. M. Cameron, D. A. Dobie, H. P. Galloway, T. H. Halstead, J. A. Palmer, W. R. Shaw (*Honors*). W. Armstrong, S. G. Barton, J. Bell, A. E. Collins, C. R. Charteris, E. Campbell, W. H. Clapp, E. J. Free, W. R.

W. J. Glassford, O. Groves, A. J. Hunter, H. R. Hay, M. J. Mullock, J. H. McCahey, A. M. McFaul, C. F. Moore, A. H. Perfect, P. J. Rice, D. Sinclair, G. H. Shaver, G. R. Stockton, J. C. Smith, G. Stewart, M. Tovell, W. J. Walsh.

Primary,—R. R. Anderson, J. A. Greenlaw, R. G. Howell, — Hart, A. G. Montgomery, S. T. Rutherford, H. Wallwin (*Honors*). W. Almas, J. J. Broad, W. C. Barber, J. A. Cross, J. Carruthers, W. Ogbert, W. H. Groves, W. C. Gilchrist, A. J. Harrington, A. H. Holliday, D. Henderson, S. McKibbin, J. A. Millican, D. McKay, J. C. Patton, J. H. Reid, J. A. Ross, A. J. Reynolds, F. N. Starr, P. W. Thompson, T. S. Webster, H. A. Yeomans, — Young.

**In three or more Subjects.*

ONTARIO MEDICAL ASSOCIATION.—The meeting of this Association, in June, to be held in Toronto, is expected to be more than usually interesting. In addition to the gentlemen named in our last issue, the following have signified their intention of being present and taking part in the proceedings, Dr. Lett, of Guelph, "Relation of Insanity to Masturbation; Dr. Oakley, Streetsville, "Repair of Nerves," Dr. Price Brown, Galt, "Injuries to the Elbow Joint," Dr. Ryerson, Toronto, "Ophthalmic Epilepsy," Dr. R. W. Powell, Ottawa, "Pelvic Hæmatocele, and Some Observations on Diphtheria," Dr. Packard, of Philadelphia, "on The Views of some of the Surgeons of the Last Century and our views of them," Dr. Porter, of New York, "The Etiology and Pathology of increased body heat in Relation to Disease, and the use of Antipyretics." Others have been promised, but the subjects have not yet been sent in to the Secretary. The Annual Circular Letter will be sent out with the R. R. certificates next week.

PICRATE OF AMMONIA IN MALARIAL DISEASES.—Dr. H. Martyn Clark (*Lancet*) says he has used the above remedy in India during the past four and a-half years with excellent results. He has treated over 10,000 intermittent fever cases with so much success that he has substituted it entirely for quinine and the alkaloids of cinchona. Out of 5,000 cases, of which a record was kept only nine were not cured by this remedy, which nine cases were however rapidly cured by quinine. He recommends half a grain four or five times a day in pill form as the average dose. He says: My experience leads me to the conclusion that in all varieties of intermittent fever, and in malarial

neuralgias, picrate of ammonia is a valuable anti-periodic, and it is an efficient and perfect substitute for quinia. It has the following advantages over quinine:

1. It is much less expensive. This is an important consideration where, as in Indian practice, hundreds of cases of malarial diseases have to be treated annually.

2. The dose given is very much smaller.

3. It does not produce the unpleasant effects that quinine does—headache, deafness, tinnitus, etc.; nor does it disorder the digestion or cause nausea, as quinine is apt to do in the doses in which it has to be given in India. He regards it as inert in remittent fever, as also in the enlarged spleen of ague.

UNIVERSITY COLLEGE, LONDON.—We call the attention of our readers who were educated at University College, London, to an appeal for funds to rebuild the Hospital, which appears in our advertising columns. Those who recollect the old building, will have no difficulty in understanding that it must be rebuilt, to enable it to provide for the increasing demands of the medical school. The Council of University College are resolved to build a hospital on an enlarged site, which shall be an exemplar in construction and arrangement for the treatment of the sick and the study of disease. It is in contemplation to dedicate a ward in the new building to former students of U. C. who are settled in the colonies, and to subscribe their names, in a long list it is hoped, in their memory. The number of patients treated has and is still increasing rapidly. The number of in-patients in the last fifteen years has advanced from 1,600 to 3,000 annually; the out-patients from 8,900 to 12,700, and the casualties from 7,000 to 20,000 in the like period. We trust that old University College men will assist in the education of their successors, by liberally responding to the appeal of the Council.

PRURITUS ANI.—Mr. Banks, of Liverpool, says: There is a method of treatment which I do not think is spoken of in books, but which I have tried in two or three cases with great success. This consists in anæsthetizing the patient, and then with the big bulb of a thermo-cautery, heated to a white heat, lightly running over the whole

affected surface so as to produce a superficial burn. This seems a rather severe remedy, but then the disease is sometimes a very dreadful one, and makes the lives of its victims almost intolerable. Now, the look of the cautery is much worse than the reality, and a bit of lint kept moist with a solution of carbonate of soda soon takes the smarting away. I do not know if others have tried this plan, but it is an excellent one, and may be resorted to with tolerable confidence in aggravated cases. Deep cauterization is not required; merely a superficial frizzling.

MORPHINE IN POST-PARTUM HEMORRHOIDS.—Dr. M. S. McMahan writes to the *N. Y. Med. and Sur. Jour.* that he has successfully used the following plan in post-partum hemorrhage for the last fifteen years. On finding the surface of the patient pale, the extremities cold, with profuse hemorrhage, he at once injects hypodermatically from ten to fifteen minims of Magendie's solution of sulphate of morphine. This will invariably, and within a few minutes, produce a flushed surface, warm extremities, and a stopped or much diminished flow. He adopts no other means—no styptics, no cold compresses, and no foolish plugging.

RAPID DILATATION IN DYSMENORRŒA.—Rapid dilatation of the cervix by instrumental means, in cases of dysmenorrhœa and sterility, is strongly recommended by Dr. Goodell. He finds it much more satisfactory than tents. In one case where the dysmenorrhœal pain was so severe that two physicians were in attendance giving chloroform for forty-eight hours, a single dilatation effected a cure. "No serious symptoms," he says, "have ever followed, though the dilatation is carried to the extent of an inch or an inch and a quarter. In four or five cases lacerations have resulted, but never of sufficient magnitude to require a suture."

NOCTURNAL ENURESIS.—Dr. Harkin (*Prov. Med. Jour.*) says he has given up belladonna and potash in the treatment of the above, and has adopted derivatives and revulsives, such as dry and wet cupping. He applies a blister 3 inches long by 2 wide to the neck, as close to the *foramen magnum occipitale* as possible. The application of one blister is usually sufficient. He regards the emp. lyttæ or the lin. cantharidis as the best agents to use. In obstinate cases, as in adults, and especially in females, the process requires to be repeated after a

few months, owing to a re-appearance of the trouble, and "dry or wet cupping may be requisite to complete the cure."

IMPURE ICE.—The New York State Board of Health, in a report on the dangers of contaminated ice, draws the following conclusions: Ice formed in impure water has caused sickness; it may contain from 8 to 10 per cent. of the organic matter dissolved in the water, and in addition, a very large amount of the organic matter that had been merely suspended or floating in it; it may contain living animals and plants, ranging in size from visible worms down to the minutest spores, and the vitality of these organisms may be unaffected by freezing.

EPISTAXIS.—Dr. Patrick says (*N. Y. Med. Jour.*) he has always succeeded in arresting the hemorrhage in epistaxis, by bandaging each thigh close to the body, tight enough to prevent the venous circulation, without interfering with the arterial; the arms may also be bandaged. The tension in the bleeding vessels is thus lowered by a large amount of the blood of the body being confined in the extremities, and the bleeding stops. The bandages should be left on long enough to allow pretty firm clotting to occur, and removed gradually and one at a time.

HAGER'S CATARRH REMEDY.—The *Therap. Gaz.* gives the following: The formula recommended by Dr. Herman Hager is as follows: Of carbolic acid, ten parts; alcohol, ten parts; water of ammonia, twelve parts; distilled water, twenty parts. Take two-ounce wide-mouthed bottles, fill them to one third with the above liquid; then introduce a bunch of (absorbent) cotton of sufficient size to soak up all the liquid; to be used in incipient cold in the head, coryza, chronic catarrh, etc. A stronger preparation, also recommended by Dr. Hager, is the following: Carbolic acid, ten parts; oil of turpentine, five parts; alcohol twenty parts. To be used in the same manner as the preceding Hager recommends those as prophylactic against diphtheria. He advises all those who handle and are about patients suffering from diphtheria or phthisis, to place a vial with this *olfactorium* to the nose when they approach the patient.

RADICAL CURE OF HYDROCELE.—Dr. J. K. Murray writes to the *Brit. Med. Jour.* that J. J., aged 70, had a hydrocele which had been tapped repeatedly during the last five years. On the last occasion iodine had been injected, but the fluid began to re-accumulate in less than a month. In

July, 1886, two drachms of pure carbolic acid were injected after tapping. There has been no re-accumulation yet, though four months have elapsed.

COCAINE WITH LANOLIN IN BURNS AND SCALDS IN THE SECOND DEGREE.—Dr. Ernest Wende recommends (*Buffalo Med. Press*) the following as grateful and cooling :

R. Cocaini mur. 2 parts.
 Aq. destill.
 Lanolini, āā. 17 parts.
 Cetacei, 4 parts. M.

SPECIFIC FOR DIABETES.—The Paris correspondent of the *Lancet* writes, that M. Martineau recently stated that he has cured 67 of 70 diabetic patients whom he has had occasion to treat during the past ten years, by the administration of a solution of carbonate of lithia and arseniate of soda in aerated water, to the exclusion of all other drinks. The patient uses this at meals as at all other times.

TRANSMISSION OF CHOLERA FROM MOTHER TO FÆTUS.—Lizzoni and Cattani, of Bologna, says the *Brit. Med. Jour.*, have recently demonstrated the presence of the bacillus of cholera in the blood of a five months' fœtus, the mother having aborted on the third day of an attack of cholera. They hold that the transmission of cholera from the mother to the fœtus takes place by means of the blood.

LOCAL APPLICATIONS IN ERYSIPELAS.—Dr. Archangelski says he finds the following are efficacious in this disease. The remedies are arranged in the order of merit: (1) benzoic acid; (2) tincture of iodine and turpentine as an ointment; (3) sulphate of copper; (4) sulphate of iron; (5) oxide of zinc; (6) naphthalin; (7) solution of the bi-chloride 1 to 300; (8) chloride of zinc; (9) iodoform.

AN INJECTION FOR FÆTID LEUCORRHEÆ.—The "Union Médicale" gives the following formula :

R. Potassium chlorate, . . . 13 parts;
 Wine of opium, 10 "
 Tar water, 300 "

Two or three tablespoonfuls are to be added to a quart of warm water as a vaginal injection and lotion.

A NEW PARASITE IN BEEF.—Wolf has found in the intermuscular connective tissue of the flesh of oxen a parasite which is apparently the larval form of an ascaris. It is encysted like trichinæ, but is somewhat larger, and is nearly spherical in shape

TEST FOR BILE IN URINE.—The *Med. Summary* says that a few drops of chloroform added to the suspected urine, and agitated, forms a ready, delicate, and certain test for bile. If none be present the test fluid remains limpid, but otherwise it becomes turbid, and acquires a yellowish hue, the depth of which is proportionate to the amount of bile present.

DYSMENORRHÆA.—Dr. Payne recommends (*Therap. Gaz.*) the following :

R. Pulv. camphoræ, gr. x.
 Pulv. Doveri, gr. xx.
 Ext. hyoscyami, gr. x.
 M. ft., pil. x.

SIG.—Two pills every two hours till pain ceases.

THREATENED ABORTION.—We take the following from the *Med. Reg.* :

R. Morph. sulph., gr. iss.
 Ext. viburn. prun., ʒ iss.
 Vini portense, ʒ iss.—M.

SIG.—ʒii in water every hour.

AMENORRHÆA.—Dr. Poulet says the following is a very certain emmenagogue :

R. Acidi Oxal. gr. xxx.
 Syr. Aurant. ʒ ii.
 Aquæ, ʒ vi.

S.—ʒfs ever hour.

LICENCE COMMISSIONERS.—The following gentlemen have been appointed Commissioners under the Liquor Licence Act, Ontario, in their respective districts: Drs. A. Robillard, A. McLean, P. McLaren, A. Rockwell, E. C. McNichol, J. McBain, C. M. Gould.

BISHOP'S MEDICAL COLLEGE, MONTREAL.—The following are the names of the recent graduates in medicine, W. E. Fairfield, R. Campbell, A. P. Scott, A. E. Phealan, J. M. Rœhler.

NITRITE OF AMYL IN AFTER-PAINS.—Mr. Kemble, writing to the *Lancet*, says he has had good results in after-pains by allowing the patient two or three

inhalations of nitrite of amyl when she felt the pain coming on. He has also used it in the sickness of pregnancy, and in obstinate cases of dysmenorrhœa, without a single failure or bad result.

WOMAN'S MEDICAL COLLEGE, TORONTO.—Dr. McPhedran has been made Dean of this faculty; Dr. Peters takes physiology, and Dr. J. Caven, pathology.

APPOINTMENT.—Dr. E. B. O'Reilly has been appointed House Surgeon to the Winnipeg General Hospital.

BRITISH DIPLOMAS.—Mr. George Snider Paterson, of Toronto, has recently passed the examination in the Science and Practice of Medicine, Surgery and Midwifery, of the Society of Apothecaries, London, and received a certificate to practise.

URTICARIA—Lassar gives 24 grain doses of salicylate of sodium every 2 hours until 3 doses have been taken, and says he thus cuts short the attack of this troublesome malady.

BUMSTEAD relates that Ricord used to say to his students: "Gentlemen, if I am to go to—well—the bad place, I know what my punishment will be. I shall have a lot of fellows with the gleet standing round me with their lamentations, their importunities, and their prayers to make them well." Bumstead adds: "This *mauvais mot* but faintly indicates the annoyance which a case of gleet often gives both to patient and surgeon."

HYOSCINE has become a prominent remedy for diseases of the nervous system, particularly acute mania. It is a hypnotic and powerful sedative. The dose should be very small at the commencement of the treatment in nervous disorders, as some persons are quite susceptible to its poisonous influences. $\frac{1}{10}$ of a grain is a fair dose of hyoscine.

AN excellent local application (*Med. & Surg. Rep.*) for "swelled testicle" is a paste formed of equal parts of bismuth and water. It removes the pain at once, and gradually reduces the swelling.

DR. MENIERE gives an enema of warm water containing 30 grains of choral, for the violent pains which in some women precede the menstrual flow.

Books and Pamphlets.

A TEXT-BOOK OF PATHOLOGICAL ANATOMY AND PATHOGENESIS. By Ernst Ziegler, of Tubingen. Translated by Donald Macalister, M.A., M.D., St. John's College, Cambridge. Three parts complete in one volume; 289 illustrations. New York: W. Wood & Co. \$5.50.

This may be said to be not only a new work, but also a modern one. A great part of the text is based upon observations made or verified by the author. Although somewhat dogmatic in style, it is upon the whole a most excellent treatise on this subject. Its value has also been greatly enhanced by the addition of references to the literature of the subjects discussed, and other addenda by the translator. The work is well illustrated, and will be found to be an admirable text-book for practitioners and students. We commend it to the favorable attention of our readers.

A COMPEND OF SURGERY FOR STUDENTS AND PHYSICIANS. By O. Horwitz, M.D., Dem. Anat., Jefferson Medical College. Third edition. Philadelphia: P. Blakiston, Son & Co.

A COMPEND OF OBSTETRICS FOR STUDENTS AND PHYSICIANS. By H. C. Landis, A.M., M.D., Prof. Obstet., Starling Medical College. Third edition. Philadelphia: P. Blakiston, Son & Co.

The above mentioned books are denominated "Quiz Compend," although the latter only is written in the style of question and answer. These works have received the most kindly criticism from the press, and the fact that they have passed through three editions within a short period, shows that there is a considerable demand for such compends. Some are utterly opposed to all compends, as tending to superficiality and cramming; and while this may be true to some extent, yet the fact remains, that much may be gleaned from small and convenient pocket companions, such as the compends before us. The work on surgery is very well illustrated for so small a work.

Births, Marriages and Deaths.

In Ingersoll, on the 20th inst., Dr. J. J. Hoyt, aged 65 years.

On the 15th February, F. D. Walker, M.D., C.M., of Cardigan Bridge, P.E.I., aged 26 years.

On the 9th ult., Dr. Benham, of Princeton, Ont., aged 50 years.