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*A Monthly Journal of Medicine,
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 Scientific News.*

WINNIPEG, NOVEMBER, 1887.

MANITOBA AND ITS CLIMATE.

CONSIDERED AS A HEALTH RESORT.

The pictorial papers have ever illustrated Canada by winter sketches, ice palaces, snow shoe exhibitions and other like scenes, making very charming pictures, but all suggestive of arctic regions and an intense degree of cold, so that Canada, particularly Manitoba and the Northwest, is ever associated with frost and snow and rigorous winter. Whereas, for six months in the year along the chain of the Canadian Pacific Railway, from the Atlantic to the Pacific oceans, the boundaries of this vast dominion, stretch millions of acres where the artist's pencil can find innumerable scenes of sylvan beauty, wood and waterfall, which faithfully portrayed would give a more correct idea of Canada when limned in a temperature of semi-tropical warmth. Two months of what in England would be denominated bracing weather, when the whole face of nature presents a phantasmagoria of bewildering beauty, when the woods and prairies are gorgeous with the varying hues of nature's decay—a scene which sight can alone realize, for the words of the poet, the pen of the traveller, or the brush of the artist, must fall short in depicting, describing and portraying the glorious beauty, the innumerable

blended tints of vegetable decay presents. Then come four months of undoubted winter, no rain, snow falling principally at night, days of bright sunshine, particularly in Manitoba and the Northwest, when the warm rays of "old sol" make themselves gratefully felt through an atmosphere commonly registering thirty and reaching fifty below zero, and then during the mid-day hours not unpleasantly cold, for this low temperature is attended by almost perfect aereal stillness and the absence of all superfluous moisture in the surrounding atmosphere renders the cold far less penetrating than that of a foggy November day in England. This is no exaggerated sketch of Manitoba's climate. There are no doubt, days in winter when the elements are masters of the situation and to defy them is to court destruction, but where is the climate and where is the country to be found entirely enjoyable throughout the year, free from all drawbacks. We know of the scorching rays of the sun in Hindostan and the monsoon; the hot winds of Australia; the sand storms of Africa, and the simoon of Arabia. All countries have some points unfavorable, there is no perfect climate under the sun. But the climate of Manitoba and Northwestern Canada places this portion of the Dominion above all other countries as the most favorable for transplanting the Saxon race and perpetuating that stalwart physique which is characteristic of the inhabitants of the British Isles. It is, however, in an hygienic aspect we desire to draw attention to the climate of Manitoba, feeling sure that if the advantages to be derived by a residence here were better understood that the physicians of Europe would gladly avail themselves of adding another field to those already known where climatic influence is chiefly depended

upon for the arrest of disease and the repairment of its ravages. That the climate of Manitoba exercises a most salutary effect in the incipient stage of chest trouble is a well established fact demonstrable by hundreds of cases. There are numerous young women who have come to this country from the eastern provinces of the Dominion suffering from symptoms of impending lung disease sufficiently urgent to require medical care, which a short residence in the dry atmosphere of Manitoba has completely arrested, and, as Betty soon finds a willing Barkis here, they are to be found settled all over the province keeping up the reputation for fecundity the female sex of Manitoba have acquired such a record for, all declaring that until they came to this province they suffered from more or less chest affection. The pine forests of the Engadine have been for a long time a favorite resort for the phthisical patient and the mild climate of Algeria, which as winter quarters must always hold its own. But it is probable that in no part of the world will climatic influence do more for the arrest and removal of lung trouble in its early stages than this climate for at least five months, viz: from the middle of April to the middle of September. Scattered throughout the Northwest are groves and belts of gigantic conifers in comparison with which the Engadine fir would sink into insignificance so that if the vicinity of this timber exercises a prophylactic influence, one's tent may be pitched in pine groves overhanging magnificent lakes abounding in fish and amidst scenery of sylvan beauty, on ground rarely trodden by the foot of man. Through such a country the tourist may wander for hundreds of miles and for the first time realize the feeling of absolute freedom. Let physicians try the

experiment, and those who travel over the world in search of that without which all else is valueless, make up a party, arriving in Manitoba at the time mentioned and spend the five following months in wandering from spot to spot as fancy dictates and the result will be that thousands will follow the example, and many a disease stricken frame will with renovated health have reason to rejoice in having visited the land of the Hill and Cree Indian, which is now pictured to their mind as an inhospitable region of perpetual ice and snow.

OTOLOGY.

The recognition that the profession has extended to aural specialism has no doubt been productive of much good in rescuing this part of the human organism from the preserves of empirics. The frequent unsatisfactory results in the treatment of ear disease, or more properly expressed, for the loss of hearing power, led students for a long period to content themselves with a knowledge of the anatomy and mechanism of the auditory apparatus. While the diseases and their treatment incidental to these structures had scant attention in the curriculum of a medical student's education, yet a student of ordinary ability can without any great mental labor become as capable of treating all known aural affections possible of alleviation or cure as a specialist in this special branch. True that constant manual practice in particular operations leads to manipulative perfection, and a surgeon who is in the constant habit of syringing the meatus auditorius for impacted wax or for the dislodgement of a foreign body, or catheterising the eustachian tube, will do his work more gently and harmlessly than a tyro who works with the force of a

hydropult, aggravating what he attempted to relieve. This hitherto existing unskilfulness in the use of the syringe and eustachian catheter arose from the fact that in the days of medical pupilage no instructions were given and no opportunity afforded for the practice of these simple and frequently necessary operations. As aural surgeons are now attached to the various hospitals, the performance of these minor operations form part of the student's education. With the appearance of the membrana tympani in health and disease he becomes familiarized, and by ocular means he readily detects any abnormality of it. This is the unfailing index to the condition of the auditory apparatus. Any unhealthy condition of any standing in connection with the auditory structures except that arising in the nerve of audition, affects this membrane and its implication in but a trifling degree, exercises a sensible effect on the hearing power. When we remember that imbedded in the membrane of the tympanum, between its internal and middle layers, is the head of the malleus, influenced by the slightest vibration of this membrane and transmitting this influence through the os incus and orbiculari to the stapes, which, united to the fenestra ovalis membrane, continues the agitation to the sacculi and tubes in the labyrinth, awaking the sensibility of the filaments of the portio mollis. By calling to mind the anatomy of this delicate structure, we can readily understand that any morbid condition of the membrana tympani, must influence the measurement of auditory power. For the perfection of hearing, its condition must be that of perfect health. With Brunton's instrument the student, with a little care and practice, can gain a thorough knowledge of the appearances of this membrane—a know-

ledge which can only be acquired by one's eyesight, and which no literature on the subject can teach.

Otology still occupies the position of a subsection at the meetings of the British Medical Association and we think deservedly so. Throat, nose and ear are inseparably connected; disease of one soon implicates the other. Aural surgeons almost invariably tack on some other organs to their specialty, recognizing the fact that the large proportion of ear diseases or loss of auditory power are due to a process of implication and are rarely an affection *per se* set up primarily in the ear. The recent essays on this subject by aural surgeons are on catarrhal affections of the nose and throat, diagnosing as they must that ear disease and diminution of hearing power is generally to be traced to the extension of morbid conditions from other parts. There are, of course, diseases arising in the organ, but they are rare in comparison with those implicating the ear from adjacent structures. The true advance in the practice of otology for the last quarter of a century is due to this recognition, notwithstanding all that has been recently written on the subject, singularly little originality of treatment has been propounded. Old methods rechaufféd under a different name have marked the advance (?) for the cure of "deafness," but now that it has become a part of the student's general education, coming years will probably prove less barren.

We are told of operations on the bones composing the chain of ossicles, but who that has worked at this subject believes them, and if he did, could believe in any good results by the practice.

Aural surgery is still in the lowest ranks of specialism, and it still remains a fallow field for professional cultivation.

ENTERIC FEVER AS SEEN IN INDIA AND IN OTHER TROPICAL AND SUB-TROPICAL COUNTRIES.

BY JAMES M' CARTNEY, M.D.

Since the comparatively recent general recognition of enteric fever in India, and in other countries where malaria is prevalent, a constant disposition has been evinced on the part of individual observers to describe it as something different from that fever as it occurs in Europe. There are some who go the length of naming it typho-malarial fever, and others again who, even when ulceration of Peyer's patches is found on *post-mortem* examination, still believe, from the peculiar course of the fever, that the disease is of the climatic remittent type.

Having seen enteric fever myself in climates so dissimilar as those of England, South Africa, Mauritius, and India, both in the hills and plains, I have gradually come to believe that a difference does exist, though probably one of degree only, between the home and the foreign variety; between enteric fever as seen in cool, temperate, and non-malarious countries, and that of hot, moist, malarious regions. Moreover, these differences appear to me to manifest themselves *pari passu*, as we pass from temperate zones towards the tropics.

Is it possible that these very peculiarities of enteric fever have themselves been the cause of the true nature of the disease having remained unrecognized in India for so long after it had been fully differentiated from other forms of fever in Europe?

Budd's opinion, accepted by so many, that enteric fever must be propagated from the dejecta of persons

affected with the disease, has led those who hold such doctrine to look for other causes for the fevers they meet with, knowing the improbability of such infection, and to regard them as climatic remittent fever. While it must be admitted that in many instances in England outbreaks of enteric fever have been traced to specific infection from individuals primarily affected, in India such can hardly be the case, unless, indeed, it were admitted that infection came from a masked and unrecognized type of the disease existing amongst the native population, and classed as remittent fever.

1. As showing its widespread existence in India, independent of epidemic influence, Sir Anthony Home pointed out, in his inspection report for 1883, that no station hospital for British troops was without a case when he visited, and it is the experience of most Indian observers that cases of enteric fever continue to crop up, one after another, with longer or shorter intervals between them, but without the least apparent individual connection. This would negative the specific infection theory in India, and suggests some peculiarity of etiology.

Taking it for granted then that there are certain peculiarities attaching to the disease as seen in India, and in other tropical and subtropical countries, notwithstanding the opinion of some authorities to the contrary, the pointing out and establishing, if possible, of these differences, might lead to a better understanding of the whole subject of the continued, pseudo-continued, and remittent fevers of hot countries. Having mentioned the first peculiarity of the disease—namely, its tendency to occur in a widespread manner, but without connection between individual cases as in Europe, I will pass on to the next.

2. This is its tendency to occur in many gradations of intensity. Thus,

while in England a medical man is able to pronounce with tolerable certainty that his patient is "in for typhoid," experience teaches us in India to be more guarded, for although to have the courage of our opinions is a good thing, it will not improve our reputation with our patients to declare at the outset a case to be "typhoid" which may recover within a week.

And we may here discuss the point—Are these transient febrile complaints, lasting a week or ten days, which are so common in India, allied to enteric fever? They appear to be so for the following reasons: 1, They occur at the same time as acknowledged cases of that disease; 2, they are most prevalent in the hot and dry months, April, May and June, at a time when ague is at its minimum; 3, they are readily distinguishable from ague, and are usually called remittent fever; 4, they are frequently associated with the recognized concomitants of enteric fever, such as sore throat, etc.; 5, they do not present the complications of ague, such as hepatitis, jaundice, dysentery, or melæna; 6, they may develop all the pathognomonic symptoms of enteric fever, or they may run on for months without doing so, or without developing any complication to account for their continuance; 7, quinine does not check their progress; 8, they attack young soldiers in particular, like enteric fever; 9, they are indistinguishable from the commencement of enteric fever; 10, relapse is infrequent.

3. The next peculiarity of foreign enteric fever is the frequent existence of constipation, or of alternate constipation and looseness of the bowels.

4. Often associated with this peculiarity is faintness and fewness of the characteristic lenticular rose spots.

5. The abdominal lesions are less marked, Peyer's patches less inflected, ulcerations are less numerous and smaller. In India we often find that perfora-

tion takes place in the most unexpected manner when all abdominal symptoms were absent, and we find, on *post-mortem* examination, merely a small punched-out aperture, with finely eroded edges, whereas, in England the ulcer is commonly large, and has eaten through a thick mass of infiltrated glands, and presents a soft, shreddy appearance.

6. Another marked peculiarity of foreign enteric fever is its great tendency to relapse or to be followed by secondary fever. In nine cases out of ten this has occurred in my experience; the reverse is the case in Europe. Moreover, when relapse does take place in Europe, the symptoms of enteric fever are all repeated over again. In India relapse is usually a nondescript secondary fever, of a remittent type, with a tendency to run on indefinitely, the temperature falling in the morning to near, and sometimes even below, the normal point. In some cases distinct intervals of apyrexia occur, and in those cases, if closely looked for, an allied condition may be observable about mid-day. The patient becomes restless, his face paler, and he draws the bedclothes round him. To what extent this secondary fever is really agucish, that is, malarious, appears to me uncertain, for it is not accompanied by the complications of ague and persists unchecked by quinine. It is as common among those who have not previously suffered from malaria as in those who have. I have found it persistent in the hills, where there was not a case of disease due to malaria in the station. Whether this frequent relapse, or secondary fever, as I prefer to call it, be due to malaria or to other causes, this peculiarity must have gone far in the past, and still goes far, to satisfy the minds of those who believe in the existence of a specific bilious remittent fever in India, and that they have had to do with a malarious re-

mittent and not an enteric fever from the beginning in such a case.

7. Perhaps of all the differences between home and foreign enteric fever, the most apparent and the one longest observed in India is the marked departure from the typical temperature chart of the home variety. In India we do not find that gradual elevation of the temperature so common at home in the commencement of the attack, but on the contrary the thermometer registers 102° in the morning or 104° in the evening when first used. As the case progresses, too, we have peculiar upward starts of the temperature, often followed by corresponding depressions, and later on in the disease periods of apyrexia, or even of subnormal temperature, these again being followed by sudden exacerbations. In fact, the temperature chart of Indian enteric fever indicates it as a disease of sudden accession, irregular in its course and liable to change its character before its termination.

8. As an eighth peculiarity it may be stated that in India there is not that long apparent stage of incubation which occurs in Europe, during which the patient is said to "sicken for fever" for many days before he is attacked. In India I have rarely been able to make a soldier admit feeling ill or "off his feed" for more than two or three days before coming to hospital.

Now, if we admit all these peculiarities and divergences between home and foreign enteric fever, may not this lead to a correct recognition of that large group of febrile diseases now appearing in our returns as remittent fever, febricula, and many cases of the so-called simple continued fever? May it not become possible to relegate these complaints to their proper position in the nomenclature of diseases, remittent fever being merged in *ague plus* some complication, such as hepatitis, hepatic abscess,

dysentery, head affection, splenitis or phthisis pulmonalis, etc.? Then we could restrict simple continued to thermic fever, the initial stage of heat apoplexy. With regard to febricula it might also be possible to differentiate between its various forms, whether these be due to exposure to heat and fatigue (thermic febricula), abuse of alcohol (drink febricula), error in diet (food febricula), or enteroid fever.

Supposing it be true that foreign enteric fever manifests itself in every gradation of severity, from slight indisposition and febricula to the most severe type met with in Europe, and supposing this to be the rule and not the exception in India, we must then, I think, look for some explanation of this peculiarity to the etiology of the disease. The theory I would suggest to account for this is that the *materia morbi* of enteric fever exists in India in many gradations of intensity, and that the severity of any given case is in proportion rather to the strength and maturity of the poison entering the system than to the quantity.

Whilst in cold countries the poison appears to come to maturity more slowly, but more certainly capable of producing the disease in a virulent form with all its characteristic symptoms, in India this does not appear to hold good.

The explanation I would offer is that the source of enteric fever poison, fœcally contaminated water, undergoes the process of zymosis or fermentation more rapidly under the favouring influences of open drains, heat, and moisture in India; but that the microbe outruns its own growth as it were, and less often, in proportion to its immature production in India, attains the full degree of elaboration which a longer period, under less favouring influences, enables it to arrive at in the dark, cold, underground sewers of Europe.

THERAPEUTICAL VALUE OF THE MORE RECENT ADDITIONS TO THE GENITO-URINARY PHARMACOPŒIA.

BY E. HURRY FENWICK, F.R.C.S.
Assistant Surgeon to the London Hospital, etc., etc.

Three years ago the Drug Committee of St. Peter's Hospital recast the hospital pharmacopœia. It would have been obviously unwise to have included any of the newer remedies without good evidences as to their real value. It would have been still more unwise to have rejected them altogether. I undertook, therefore, to investigate these "new drugs" systematically in the out-patient department, and to report subsequently upon them. To make the inquiry thorough a large outlay of money would have been needed. This initial difficulty was overcome by the prompt generosity of Thos. Christy and Co., Lime street, London. Those well-known drug importers placed at my command for three years an unlimited supply of the new remedies which have been advocated for the treatment of genito-urinary disease. The following few grains of wheat remain after much winnowing.

Kola (*Sterculia acuminata*).—A powerful stimulant; contains 2·3 per cent. of caffeine, also theobromine. In the form of chocolate I found this drug to be of great value in tertiary syphilis, where large doses of potassium iodide have to be administered. The cases of syphilis in which the chocolate was first tried were often of the worst and most neglected type, being drawn from the neighbourhood of the London Docks. Later work has proved its value in the well-fed. Patients were able to take doses of 30 gr. to 60 gr. of the iodide without inconvenience as long as the kola was administered with it. It is now prepared in the form of a paste—"kola-tina"—like cocoa paste, as it is found

more effective in the liquid form. From 1 dr. to 2 dr. makes a breakfast cupful; where this is inconvenient, the stick kola-chocolate is eaten. Dose, 1 dr. to 2 dr.

Salix Niger (Black Willow).—A sexual sedative of decided value; useful in ovarian hyperæsthesia, also in prostaticorrhœa, spermatorrhœa, excessive seminal emissions, and enforced continence. In the latter disorders its action is good, but inferior to potassium bromide, this is, however, somewhat counterbalanced by its non-depressant qualities. Dose, $\frac{1}{2}$ dr. to 1 dr. Finding it of value in those wearisome cases of urethral neuralgias following gonorrhœa, I began to substitute soda salicylate for it. I was impressed by the relief this latter afforded. In cases of urethral pain in the adult, I first eliminate stone, stricture, urethral granulations, and over-acid urine, and then prescribe soda salicylate (5 gr. to 8 gr.), with a gratifying result.

Lycopodium clavatum.—The tincture is of real value in frequent micturition, irritable bladder, and cystospasmus, where such is not dependent upon actual disease or foreign body. It has been found useful in spasmodic retention of children. Dose 15 m. to 1 dr. Note: White lycopodium is an inferior substitute, but still of some value. Dose, $\frac{1}{2}$ dr. to 1 dr., between bread-and-butter. Yellow lycopodium is useless.

Kava Kava (*Piper methycticum*). This drug is of benefit in pyelitis, cystitis (acute or chronic), and urethritis. It is inferior to copaiba, and sandal oil, but much more pleasant to take. It is of value when the oils are not tolerated. The inflammation seems to be increased at first. Fluid extract, $\frac{1}{2}$ dr. to 1 dr. on a full stomach.

Stigmata Maidis (Corn Silk).—Difficult to obtain at certain seasons, but of great value in pyelitis and renal colic. One case is especially worthy

of notice. A patient who had suffered from renal colic and pyelitis for seventeen years was admitted into the hospital for exploration of the kidney. The patient was so relieved with corn silk that he refused operative interference. It is also of value in chronic or subacute cystitis, but in my hands it has failed in acute cystitis. Note: The fresh infusion is the best; dose, a wineglassful. Failing this, use the extract; dose, $\frac{1}{2}$ dr. to 1 dr.

Papaw, Papyotin, Papaine (*Carica papaya*)—Of marked benefit in syphilitic ulcers of the tongue and throat, especially when mixed with cocaine. The surface of the ulcers and the white patches (secondary syphilis) rapidly clean and begin to skin over. Lozenges have been made by Messrs. Christy, which are most useful (papaine, $\frac{1}{2}$ gr.; cocaine, $\frac{1}{4}$ gr.; potass bicarb., $\frac{1}{4}$ gr.). In a girl of seven with severe syphilis in the mouth (after direct inoculation), the ulceration had resisted all applications for eight or nine months, and the child had wasted considerably. A few of these lozenges produced a marked effect, the ulcers healed and the child rapidly fattened. Mix papaine with a small quantity of glycerine and water, so as to form a thin paste, add a little bicarbonate of potash, and brush ulcers with the same thrice daily. Whatever its position may be, as a digestive ferment papaine is worthy of trial as a preventive and reducer (?) of renal calculi. Dose for renal stone, 1 gr. to 3 gr., or more, in pill or powder; to be taken with meals.

Piche (*Fabiana imbricata*).—Of undoubted value in lithiasis and renal stone. One patient obtained so much relief from the hæmaturia and pain that he obtained the plant direct from Peru every mail, and made the infusion himself. In my hands it has failed in chronic cystitis. Dose, fluid extract, $\frac{1}{2}$ dr. to 1 dr.; infusion, a wineglassful.

Cocaine—The fresh work with this drug is to be brought before the Medical Society. Routine work: Lithotrity in the feeble was performed with a 4 per cent. solution; small stones in the adult with a 20 per cent. solution. Internal urethrotomy needs a solution of 20 per cent., and any vesico-urethral instrumentation one of from 4 to 20 per cent.

Naphthaline ($C_{10}H_8$).—A derivative of benzol and allied to phenol. Given with benefit in fetid urine. The micrococci speedily disappear, and the urine becomes sweet. The large doses recommended (15 gr.) are unnecessary, and produce vomiting and abdominal pain. Dose, 3 gr., cautiously increased. Note: Urine of patients taking naphthaline smells of phenol, and may remain exposed for some days without change.

Pine or Spruce Extract (*Abies excelsa*).—Has a slight diuretic action, and relieves renal pain unconnected with calculus. It is of use also in a bath, and as a liniment in gonorrhœal rheumatism. It is a pleasant vehicle for drugs in pyelitis and cystitis. Has proved of benefit in gleet. Dose, 1 dr. in water.

Ulexine (*Ulex Europæus*).—“A more powerful diuretic than sparteine or preparations of *sarothamnus scoparius*” (Gerrard). This is to be employed with caution in stricture. One patient with stricture of old standing, after taking a pill containing $\frac{1}{2}$ gr., had temporary suppression of urine, vomiting and fever.

Strophanthus (*Kombé*).—I believe there is a distinct future before caffeine, digitaline, and strophanthus as adjuvants to operations upon the vesico-urethral tract. We have sometimes to deal with partial or complete temporary suppression, and sometimes with rigors after operative interference or even instrumentation. Caffeine seems indicated to avert the former; strophanthus the latter. Again,

if we have reason to anticipate sudden flooding of the renal vessels and consequent urinary fever as the result of an operation, then digitaline, from its power of controlling the renal circulation, is indicated. Our treatment, however, on these lines must go *pari passu* with our oncometric knowledge of drugs which effect the kidney circulation or the abdominal blood pressure. I believe strophanthus has power, worthy of further investigation, in controlling rigors. I employed it on the theoretical grounds that it increases cardiac power and general blood pressure. Five in-patients suffering from violent rigors after instrumentation, were treated with the tincture in doses of 5 m. after catheterisation. In no instance were rigors induced.

Chaulmug-z Oil (Oleum gynocardiæ).—Of value as a liniment in gonorrhoeal rheumatism, osteocopic pain of syphilis. Its power is increased if it is mixed with lanoline. It has great influence upon some forms of adenitis, also in secondary syphilis. Dose 5 m. to 10 m. on a full stomach.

Hydrastis Canadensis (Golden Seal).—Of some use as an astringent vesico-urethral injection, checking mucous discharge; worthy of trial in some forms of prostatic engorgement and enlargement. Dose 10 m.

Damiana (Turnera aphrodisiaca). Good in some cases of diminished sexual power, where such does not depend upon organic disease. Often in use in melancholia and depression, if of genito-urinary origin.

Caroba (Jacaranda tomentosa).—Of some value in secondary and tertiary stages of syphilis. Dose, 1 dr.

Naphthalin is said to have been used successfully by Rossbach ("Jour. de Phar. d'Alc-Lor."), in chronic diarrhoea. Bouchard considers it valuable for obtaining antiseptics in cholera and typhoid fever. It is serviceable in vesical affections when the urine is

to be disinfected, In the form of pomade it is used for eczema and psoriasis.

Digitalin.—Ph. Lafon, reaches the following conclusions, as a result of his study of this substance: 1, Digitalin is absorbed slowly. 2, It is not eliminated by the kidneys. It could not be detected in the urine. 3, It does not appear to localize itself, at least, in the form of digitalin, in any particular organ, either in acute or slow poisoning. It is not cumulative. (4) It is not sensibly modified in the digestive apparatus. It appears to undergo a complete transformation in the circulation. This change is probably effected by some oxidizing agent. (5) Digitalin offers a relatively great resistance to both physical and chemical agencies, to various ferments, and to putrefaction.—Boston Med. Surg. Jour., April 7, 1887; Jour. Phar. Chim., Jan. 1887.

Iodol in ear diseases.—Dr. Stretter, who has used iodol, the new inodorously substitute for iodoform, in a number of cases of ear disease, finds that in acute purulent inflammatory affections iodol applications rapidly produce marked benefit, but that in chronic inflammations of the middle ear it is generally quite useless, or at best, no better than other more common methods of treatment.—Am. Pract. and News.

Use of salol.—Kleefeld, of Gorlitz, reports from his clinic the following results obtained by the use of this drug: His use extended over a period of three months, and in thirty-five cases of rheumatism and varying forms of neuralgia he obtained the best results. There followed no ill after-effects from its administration; ringing in the ears occurred infrequently and was not severe.—Med. News, Feb. 19, 1887: See also Amer. Jour. Phar., 1886, pp. 380, 521, 552.

Peroxide of hydrogen has been used by Dr. B. W. Richardson; (Accele-

piad No. 13), in whooping cough with favorable results, the disease being cut short quickly and determinately. It was prescribed as follows :

Hydrogen peroxide (10 vols. strength), 6 drms. ; Glycerin, 4 drms.; distilled water sufficient for 3 oz. Dose half a fluidounce to be taken in a wine glass full of water.

Phosphate of calcium in the night sweats of phthisis.—According to Dr. Reborn, there can be no doubt that this salt has a special effect on the secretions, although the mode of its action is obscure. It has the advantage of not being at all poisonous, is easily administered, is well borne by the stomach, stimulates nutrition, and prevents diarrhoea.—Brit. Med. Jour.

DISLOCATION OF THE SCAPULA

BY W. E. HOME, M.B. EDIN., B.S.C.,

Surgeon R.N. H.M.S. Alexandra.

As dislocations of the scapula are not very common, it may be worth while to put the following case on record.

No. 438, aged 32, captain of the maintop, H. M. S. Alexandra, when on leave in Valletta on July 1st, 1886, slipped on a piece of orange peel and fell, striking the back of his left shoulder against the kerbstone. On arising he felt pain in and about the shoulder, so much increased by movement that he came off at once to the ship. When I saw him half an hour after the accident, he was sitting stripped to the waist, and leaning forward so as to support the left elbow on the knee. The anterior axillary fold was lower on the left side than on the right, and the girth round the shoulder through the axilla was also greater on this side than on the other

by an inch. The left clavicle was the same length as the right, and, like the left acromion, was smooth in outline and continuous with itself all round; however, between the clavicle and acromion was a deep groove in which the finger could be laid. The scapula had been displaced downwards, outwards and forwards, the tip of the coracoid being an inch and a quarter below and a little to the inner side of the outer end of the clavicle. On pressing the clavicle down and the shoulder upwards and backwards, the pain (felt along the insertion of the trapezius chiefly) was relieved, and the normal appearance of the shoulder was restored. To retain the parts in position, the outer end of the clavicle was fixed by a piece of strapping, (4 inches by 15 inches) passed over it, another strap, folded round the middle third of the arm and drawn tightly across the back, steadied the arm and shoulder, while the elbow was brought forward and pressed upward by a flannel roller, passing round the body and over the right shoulder. The patient was then laid on his back in bed. On July 9th the strapping was reapplied; and on the 17th he was allowed to get up. The strapping was removed on the 22nd (three weeks after the accident), and he was discharged to duty, well, on the 24th.

Seen again on August 21st, 1887, fourteen months after the accident, he declared that the arm was as strong as ever, and that it gave him no inconvenience. The outer end of the clavicle is somewhat thickened; but the relations of the clavicle to the coracoid, acromion, and scapula, generally, are quite normal, and are so maintained during movements, which are all perfectly performed.

The primary treatment was Sayre's for fractured clavicle; but I believe that the fortnight's rest in bed had nearly as much to do with the successful result.

EUROPEAN HOSPITAL GLEANINGS.

BY JAMES KERR, M.D.

Professor of Surgery College of Physicians and Surgeons,
Manitoba—surgeon to Winnipeg General Hospital.

While in attendance at the Royal Infirmary and Children's Hospital, Glasgow, I saw nearly all of the operations for which McEwen is specially noted—osteotomies, excisions of the hip, operations for the radical cure of hernia, and one very interesting case of brain surgery that had been operated on. McEwen still uses the spray and the very fullest and most minute antiseptic precautions; his dressings, however, are not Listerian in the recognized acceptance of that term. Instead of the gauze dressings, he uses sublimated wood wool pads, with iodoform and naphthaline combined.

The most striking feature of his operations is the discipline and perfection of organization of his operating room. His scrupulous and exacting cleanliness, the great care taken of instruments, sponges and dressings, apart from the antiseptic treatment, must of itself largely contribute to his great success; certainly I saw nothing like it anywhere else. Every instrument and sponge goes a definite circuit, immediately it leaves the operator's hand—first to its ablution, then to its antiseptic solution to remain clean and aseptic until again used. The nurses who attend, and the house surgeons that assist, work like automata. Everything is done with a precision, promptness, and watchful care that is truly admirable. They prepare their own catgut drains—bone is generally used—for dressing at the Royal Infirmary. The bone drains are easily made from chicken bones, by first depriving them of their calcareous matter by immersion for forty-eight hours in hydrochloric acid. Next the interior is filed out, and after the necessary holes are punched in

them. They are kept for use in a solution of carbolic acid and glycerine.

I saw the nurse preparing chromicised gut, and it may interest some of your readers to know exactly how it is prepared. A saturated solution of chromic acid is first made; this is mixed with glycerine (1—5), and the gut is kept in this mixture from two to five days, according to how long it is intended to remain in the tissues. It is kept ready for use in a solution of carbolic acid and glycerine (1—5). In a great many of the German clinics, they have given up chromicised gut in favor of that made by immersion in oil of juniper and kept in alcohol, as being stronger and not so liable to "snare."

Sponges used in the operating room are seen fresh, beautifully bleached and soft, after seven to ten years' use. This result is due to the fact that blood is never allowed to remain for more than a few seconds until it is washed out in the manner described above.

McEwen does not use extension in fractures of thigh, perfect coaptation and absolute immobility is secured by his splint, not according to his experience requiring it.

The operation for radical cure of hernia, performed by McEwen, is a veritable poem in surgery. It is an operation difficult to follow as described, and its author has various models and methods to illustrate it, but without which it is difficult to appreciate the various points of the procedure, especially the manner in which the layers of the abdominal wall are made to slide over each other in permanently closing the ring. In his hip cases he commences passive motion immediately. I saw 3 cases three months after operation, in both cases the knee of the operated side could be made to touch the chest, so good was the motion. He uses a very ingenious saw and osteotribe that are fixed on a movable handle

admitting of their being used at any desired angle. I saw one case where in a simple fracture of the thigh with much over-riding and deformity, he cut down and wired the fragments. A similar operation was performed the other day by Shepherd, of Montreal. I also saw one very good case of brain surgery, where he removed a rectangular section of the calvarium—about 3 inches square, scraped off some tuberculous deposits from the meninges and a segment of a convolution and replacing the bone, previously broken into small fragments, and with the result. When I saw the boy, aged about 12, sitting up and the only evidence of his having undergone this brilliant contribution to the surgery of the brain, was the cicatrix marking the outline of the scalp wound. McEwen uses, as also does Kowig, Kuster and others, metallic pins to keep the lines in close opposition in excisions of the knee. But I am afraid I am taking up too much space with this paper, and perhaps devoting too much attention to one operator. However I am but repeating the experience of nearly every other medical "tramp" that I met in my perigrinations, in giving special consideration to this truly great surgeon.

WINNIPEG GENERAL HOSPITAL.

Her Majesty's jubilee has been marked in Manitoba by the payment of the debt due on the Winnipeg General Hospital, the only institution of its kind in the province, opening its portals to all those who are suffering from disease or injury. It is deserving of all the support which can be afforded it, and unquestionably merits a much greater measure of practical sympathy with its aims and objects than it receives.

Were its usefulness more widely known, it would be more truly ap-

preciated and correspondingly supported, and time will see this accomplished. The gentlemen who devote themselves to the carrying on of the work are deserving of all praise; their greatest reward, however, must lay in the self-consciousness of the great good they have accomplished. The hospital is still in the days of its infancy, and as it matures will no doubt keep up with the go-ahead age in which we live, and not only arrive as near perfection as possible in its structural development, but also in the clinical position it aspires to, and which at present admits of such large measure of improvement.

There is a rumor that the Maternity Hospital is to be abolished, and a lying-in ward attached to the General Hospital. But in these days of septic midwifery, one can hardly give credit to such an intention. When the physician, the surgeon and obstetrician are one and the same, the perils of child-birth are not likely to be lessened by such an arrangement.

APPOINTMENTS.

WE understand that Dr. Codd, surgeon to the Mounted Infantry School, Fort Osborne, has been appointed president of the military medical board, for the investigation of claims arising from wounds received and sickness contracted while on service during the late rebellion. Extraordinary to relate, Dr. Codd is the only military surgeon on this board, which was hitherto composed of civilian medical men who could know nothing of the history of the cases coming before them. Such an anomalously constituted military medical board no war department of any country probably ever before constituted. It remained for Canada to take this initiative, but there can be no doubt that the example will not be followed by

like authorities in other places. It is not only unfair to military surgeons, but it tends, as it has done in this instance, to saddle the country with unnecessary burdens by granting pensions and gratuities to undeserving persons, while others who might fairly lay claim to them are passed over. We do not question the liberality of the Government, for they have been very generous to those cases which have been recommended.

Dr. Sutherland has been appointed Resident physician to the Manitoba Penitentiary at Stony Mountain.

PROFESSIONAL ETIQUETTE.

To the Editor of the Lancet.

SIR: In the last edition of the LANCET, Dr. Orton comes back to the attack. After wading through his communication, I gather that he questions the reliability of the sources of my information, and indulges in an unlimited amount of abuse of my friend Mr. Droxinman. Now I consider such a course most ungenerous, and quite opposed to the spirit of British fair play. The Dr. knows perfectly well that he is writing in a journal which Mr. Droxinman is not likely to see. Were it otherwise I venture the opinion he would not have the temerity to so rudely attack that gentleman. When it becomes a question of veracity between Dr. Orton and Mr. Droxinman, those who know both gentlemen will have no difficulty in deciding who is right. A communication from Mr. Droxinman would now be in order, and it he could be accorded the privilege of making a reply to some of the doctors insinuations, I am fully persuaded that he would be found fully able to defend his position. The fact of the matter is, that Dr. Orton, in a rash moment, has made a charge which he is most anxious to sustain. I gave an unqualified denial, at the same time indulging in a little vivisection which, though apparently cruel, was not inflicted without feelings of compassion, and I indulged the hope that the Dr. would then be wise enough to quietly and gently subside. Instead of doing so, however, he with questionable taste attacks my style of writing, characterizing as "clumsy sarcasm," what I had considered a plain, unvarnished statement of unpalatable facts. That it was a clumsy statement I really do not believe, and in that opinion I am strengthened by many gentlemen in this city, about whose ability to judge of such matters, there can be little doubt. Besides I fail to see how a little clumsiness or elegance of expression can have any bearing on the case in point. I have too much respect for age to make any unpleasant allusion to the

doctor's literary style, or lucidity of diction, and I am quite willing to pay him the tribute of saying, that, in my humble opinion, they simply defy criticism. I do not pretend to be as well up in "The Talmud" as the Dr., but I do pretend to some knowledge of my native tongue.

When a medical man is summoned by telephone to see a patient, it is not customary to enquire the name of the person who sends the message. The presumption is that the message has emanated from some one in authority. Such was the case in the present instance. When I reflect that "Life is short," and "Art is long," I feel it my duty, without further delay, to settle this whole matter, and in order to do so, I submit the following declarations, from both the husband, and the uncle, the latter of whom Dr. Orton terms "a distant relative."

To certify that Mr. Droxinman, who is an uncle to my wife, employed Dr. Good, with my full knowledge and consent.

Winnipeg, Oct. 26, 1887.

J. BARRET.

I certify that I employed Dr. Good to attend my niece, Mrs. Barret, at the request of her husband, and that I left word at the house of Dr. Orton, the evening before, that he was not required to attend any longer.

MOSES DROXINMAN.

Translated the above name by A. BIEBER, witness.

These declarations speak for themselves, and so far as this controversy is concerned, I have finished.

I am, faithfully yours,
S. WILFORD GOOD.

Oct. 27, 1887.

To the Editor of the Lancet:

DEAR SIR: Kindly insert the following declaration, which speaks for itself.

Yours, etc.,

GEO. T. ORTON.

Statement of J. Barrett to Dr. Orton:—

Mr. Droxinman telegraphed for Dr. Clarke to attend my wife, though I had not requested him to do so. When Dr. Clarke came he asked me whether any other doctor was in attendance. I told him yes, Dr. Orton; when he replied, you cannot do better than continue his attendance. Mr. Droxinman, afterwards, insisted upon telephoning for Dr. Good, and I said I did not wish to pay two doctors, and was satisfied with Dr. Orton; he then said he would pay Dr. Good. I afterwards told Dr. Orton I did not wish to change my medical attendant. I do not believe any message was left at Dr. Orton's stating another medical had been called in; he was not made aware until he visited my wife, when, I think, Mr. Droxinman told him.

Witness to statement—CHARLES LOCK.

[We regret that an understanding has not been arrived at. This must end the controversy in our columns.—Ed.]

BOOKS AND PUBLICATIONS.

We have to acknowledge the receipt of "The Physician's Visiting List for 1888," published by Messrs. P. Blakiston, Son & Co., Walnut St., Philadelphia. It is in pocket book form, handsomely bound in leather, containing, besides simple, concise, and yet ample forms for keeping the accounts of fifty patients daily for twelve months, several pages of valuable matter of much use to practitioners as a table of reference. A pharmacopœia, with all the new preparations and their doses, add much value to this—the most compact visiting list we have yet seen. Price \$1.

Also, "A Year's Work in Abdominal Surgery," by William Gardner, M.D., Professor of gynecology to the Montreal General Hospital,—a pamphlet which the profession will read with much interest. The position which Dr. Gardner has attained as a gynecologist commands for all his writings on this subject, special attention.

MISCELLANEOUS.

OXALIC ACID has been found by Dr. F. Poulet (*Phil. Med. Times*) to be a valuable emmenagogue; it was employed as follows: R̄ Acidi oxalia, 1.0; aquæ, 100.0; syr. cortic. aurantii am., ʒj.0. M. Sig. A teaspoonful every hour.

COCAINE AS AN ANTIDOTE TO STRYCHNINE.—Bignon ("Genio Med. quir.") finds, as the result of experiments on dogs, that hypodermic injections of cocaine, kept up until the strychnine has been eliminated, prevent a fatal result in cases where the dose of strychnine administered is not excessive, and retard it when large doses are used.

COCAINE IN CROUP.—Labric praises cocaine as the best remedy for croup. He applies a brush dipped in a five per cent. solution of cocaine to the

throat for several seconds; a few drops are allowed to go down into the larynx. The operation is repeated two or three times a day, and nothing but a little black coffee is administered to the patient.

"DELIRIUM AFTER SALICYLATE OF SODIUM."—Schiffers *Progres Med.* records a case in which an enema containing 75 grains of salicylate of sodium was administered to a girl of seven, suffering from mitral insufficiency. Delirium supervened, with hallucinations of vision. Speech was slow and difficult, answers to questions being indistinct and confused. There were no motor disturbances. The symptoms disappeared without treatment in one day.

URETEANE.—Lagowoi finds it very useful in insomnia arising from nervous excitability, but it is less pronounced in its effects where there is local pain. It is indicated in delirium tremens, and some forms of mania and melancholia; also to combat the cerebral phenomena of typhoid. The dose varies between 1.0 and 4.0. Urethane augments the number of respirations but has no action on the pulse and temperature. The sleep produced is tranquil and is followed by no disagreeable sensations.

STRYCHNINE VERSUS ALCOHOL.—The results of Jarochewsky's recent experiments on dogs, are summed up as follows: Strychnine prevents alcoholic inebriation; at the same time it enables the organism to support large doses of alcohol for a very long time; it preserves the organs (liver and vessels) from the characteristic alterations produced by alcoholism. The action of strychnine is, up to a certain limit, paralyzed by alcohol; beyond this limit, strychnine becomes poisonous to the inebriated animal. Strychnine is an excellent medicament in all kinds of alcoholism. It is also a powerful prophylactic.

BELLADONNA AGAINST IODISM.—M. Aubert, of Lyons (*F. Plan. Lyon*, 120, p. 14), finds that the coryza and other troubles which are caused by the administration of iodide of potassium to those who are intolerant of it, may be prevented by the simultaneous exhibition of belladonna. He records a case in which the iodide, both in small and large doses, caused the usual symptoms of iodism, and after long-continued administration of the drug, tolerance was in no way established. As soon as "pilules of belladonna" were given with the iodide, the unpleasant effects were no longer felt. Aubert affirms that the tolerance sometimes continues when the belladonna is omitted.

INFLUENCE OF INFUSED BEVERAGES ON DIGESTION.—Dr. James W. Fraser has studied experimentally the action of our common beverages on gastric and intestinal digestion (*Jour. Anat. and physiol.*) These are his conclusions: (1) It is better not to eat most albuminoid food-stuffs at the same time as infused beverages are taken, for it has been shown that their digestion will in most cases be retarded, though there are possibly exceptions. Absorption may be rendered more rapid, but there is a loss of nutritive substance. On the other hand, the digestion of starchy food appears to be assisted by tea and coffee; and gluten, the albuminoid of flour, is the principle least retarded in digestion by tea, and it only comes third with cacao, while coffee has a much greater retarding action on it. From this it appears that bread is the natural accompaniment of tea and cacao when used as the beverage at a meal. Perhaps the action of coffee is the reason why it is drunk alone or at breakfast—a meal which consists much of meat, and of meats (eggs and salt meats) which are not much retarded in digestion by coffee. (2) Eggs are the best form of animal food to be taken

along with infused beverages. Apparently they are the best lightly boiled if tea, and hard-boiled if coffee or cacao, is the beverage. (3) The casein of the milk and cream taken with the beverage is probably absorbed in a large degree from the stomach. (4) The butter used with bread undergoes digestion more slowly in presence of tea, but more quickly in presence of coffee or cacao; that is, if the fats of butter are influenced in a similar way to olein. (5) The use of coffee or cacao as excipients for cod-liver oil, etc., appears not only to depend on their pronounced tastes, but also on their action in assisting the digestion of fats.

HAND-GRENADES.—Some excellent suggestions concerning these high-priced appliances for extinguishing incipient fires are quoted in *Building from Chumber's Journal*. "Though undoubtedly the saline solution with which they are filled is somewhat more efficient for the purpose for which they are intended than pure water, there is no reason why a householder should not manufacture his own hand-grenades, and, by so doing, save an unnecessary outlay of money. The hand-grenade solution recommended is a mixture of 19.47 parts common salt, 8.88 parts sal ammoniac, and 71.66 parts water. It is entirely unnecessary to compound the mixture with any such exactness, as a rough approximation to the proportions given will give practically the same results. Having prepared this solution, the next thing is, to provide suitable receptacles for it, and place them about the house. Ordinary quart bottles are made of too heavy glass and do not readily break when thrown at a fire; neither are they of suitable shape for the purpose. The glass flasks used by chemists make excellent hand-grenades, for they are of thin glass, and hold just about the right amount of fluid. The principal

objection to them is their cost, but the combined cost of such flasks and the solution for filling them is much below the current price of hand-grenades. There are certain kinds of wine bottles also which might be used advantageously, as the only necessary feature is thinness of glass, so that the grenade will surely break when thrown at a fire. The bottle or flask should, of course, be stoppered; and it were well to cover the corks with sealing wax, so as to prevent any loss by evaporation.

SULPHUROUS ACID IN WHOOPING COUGH.—A Norwegian physician named Mohn, discovered, after disinfecting the bedding of one of his own children who had suffered from scarlet fever, that another child who had whooping cough and who accidentally inhaled some of the fumes of the sulphur, was suddenly cured of the disease. Acting on this suggestion, he has treated other cases of pertussis by placing the patient in a room where sulphur had been burned in the usual manner in which it is employed for disinfectant purposes. He claims that after being put to bed in such a room, the patients awake the next morning cured.

IODOFORM AND SILVER.—Poncet (*Lyon Med.*, 1886, No. 31), draws attention to the discomforts sometimes associated with the use of iodoform when articles of silver are used in eating. A peculiar nauseous taste is often present which is increased when food is taken. The tongue sometimes becomes coated. Poncet points out that articles of silver in contact with iodoform acquire a peculiar smell, and is of the opinion that patients, whose wounds are dressed with iodoform, ought not to use silver forks and spoons to eat with. According to Cazeneuve, when iodoform and silver come into contact, iodide of silver and acetylene are formed, and to this he

attributes the effects which Poncet has pointed out

THE USE OF ESERINE EYE DROPS QUICKLY FOLLOWED BY SYMPTOMS OF POISONING.—In the present month a well-grown, healthy, young lady, aged 10½, a resident and native of the Isle of Wight, was sent to me for eye troubles. In the course of the treatment, in order to neutralize the effect of atropine on the accommodation, I prescribed a solution of sulphate of eserine, of the strength of four grains of the alkaloid to the ounce of distilled water. A single application of these eye drops induced nausea, a repetition in four hours vomiting. A large experience of eserine eye drops in public and private practise has not afforded me a single illustration such as the one here recorded.—J. VOSE SOLOMON, Birmingham.

STROPHANTHUS.—"The plant is a woody climber, growing in the forest both of the valley and the hills, and found at various places between the coast and the centre of the continent above the Victoria Falls and the Zambesi. The stem is several inches in diameter and rough outside. The plant climbs up the highest trees and hangs from one tree to another like a bush-vine. The flowers are of a pale yellow, and last for but a short time during the months preceding the first rains of the season, (Oct and Nov.)" The fruit is ripe in June; the natives separate the rough epicarp and mesocarp, and dry the endocarp containing the seeds; hence the tawny appearance of the commercial follicles.

The method adopted by the natives in poisoning their arrows, is as follows: Before extracting the seed from the fruits, they dig a hole in the ground, so that they can bury the comose hair attached to the seed (for fear of its flying in their eyes), they then coarsely grind the seed, and mix

it into a paste, which latter constitutes the poison with which the arrows are smeared. Game wounded by an arrow thus poisoned dies at once, seldom being able to move a hundred yards. The flesh is eaten without any evil effect accruing. The only precaution is to squeeze the sap out of a branch of the baobab tree into the wound made by the arrow, which is said to mitigate any evil effect that might result from the poison being more plentiful in the vicinity of the wound.

THE SPREAD OF THE TUBERCLE BACILLUS BY FLIES.—In a communication made to the Academie des Sciences by MM. Spillman and Haushalter, and recorded in *La Semaine Medicale*, the question of the spread of the tubercle bacillus by means of the common house fly is considered. The authors state that they have seen flies enter the spittoons containing the sputum of phthisical patients; they were then caught and placed in a bell jar. On the following day several of these were dead. Examination of the abdominal contents and the excrement of these flies on the inside of the jar showed the presence of many tubercle bacilli. The authors point out the wide dissemination of the disease which may take place in this way, and recommend as a preventative the employment of covers with a small opening.

EFFECT OF QUININE ON UTERINE HÆMORRHAGE.—The new Brazilian journal, *Boletim Geral de Medicina e Cirurgia*, publishes a paper by Dr. Deocleciano Ramos on the Effect of Quinine on Uterine Hæmorrhage. He cites two cases of patients who suffered, it is true, from malaria, in whom a very few full doses—fifteen grains—of quinine served to check, and indeed cure, violent and intractable uterine hæmorrhage. In one case iron and ergotin had been given internally, and cold injections administered, without

much effect, but a single dose of quinine produced a considerable diminution in the amount of blood lost, and a second similar dose completely arrested the discharge, which did not return.

LANOLIN PREPARATIONS IN SURGERY.—Dr. Guterbock has substituted lanolin for the ordinary bases employed for ointments. He has experimented with ointments containing oxide or iodoform, in the proportions of 1 to 10. He has found that, with few exceptions, those ointments made with lanolin are borne by patients in whom the same ointments made with fat or vaseline produced injurious effects. He has obtained the best results with them in cases of eczema, and in fresh burns. By the simultaneous use of disinfecting baths, along with the ointment, and by thoroughly cleansing the neighbourhood of the wound, he has succeeded in keeping large wounded surfaces in an aseptic state.

OATEN FLOUR IN THE TREATMENT OF BURNS.—The comparative success attendant on the adoption of the following line of treatment, together with the fact of my being unaware of its having been advocated before, is my reason for bringing the matter under the notice of the profession. Different treatments have been from time to time suggested with the object of favoring the healing of burns and scalds with in many instances questionable results. I have for some time been in the habit of using for all degrees of these injuries equal parts of fresh lard (that is, free from salt) and oat flour made into a paste, which, when spread on a cloth (old calico), or preferably a piece of lint, I direct to be applied or rolled round the affected part or limb, and allowed to remain on for twenty-four hours, after which a fresh application is made, and so on every twenty-four or forty-eight

hours, as the exigencies of the case demand. In every instance I was well pleased with the progress of cases subject to this treatment, several of which had been ineffectually treated by other methods.

The advantages which I claim for this application are (1) its freedom from odour, (2) its soothing properties and antiseptic action, (3) its superior healing powers, and lastly, its cheapness and the ease with which it can be procured (in most houses, on the shortest notice. This latter advantage is of no small importance, taking into consideration the sudden and frequent occurrence of injuries of this nature in everyday domestic life.

—G. GREENE, L. K. Q. C. P.

OVERFEEDING AS A RUSSIAN POPULAR TREATMENT OF PHTHISIS.—

There is decidedly nothing new under the sun. Luckily for Professor Debove, there cannot exist any reasonable suspicion that he is acquainted with the Russian tongue, otherwise it might be thought that he had derived the idea of his method of forced feeding from the Tchernigov peasantry, who treat pulmonary consumption in this way. A strong-linen bag is filled as tightly as possible with twenty pounds of barley flour, then well stitched and put into a kettle with water, and boiled for twenty-four hours. By the end of that time the flour is found to be converted into a very hard mass. The latter, after the outer moist layer has been removed by means of a knife, is thoroughly pounded and mixed with milk. To this two pounds of best butter and the yolks of ten eggs, triturated with a glassful of sugar and two teaspoonfuls of salt, are added, and the whole is baked. When cooled down, the compound is cut into thin slices, which are then well dried and converted into a very fine powder. This powder is given to the patient in whole milk, one tablespoonful to a

glassful, at first once a day, on the next day twice, and so on until the daily dose of twelve glassfuls is reached. Afterwards the dose is gradually diminished.

DR. DANDGRAF describes the case of a man who applied at Professor Gerhardt's clinic, suffering from symptoms of left-sided bronchial stenosis. He had attacks of coughing followed by dyspnoea of a severe character, and physical indications of interruption to the passage of air into the left lung. It was decided to catheterize the trachea, and, if possible, the bronchus. The larynx was anesthetized by pencilling it with a twenty per cent. solution of cocaine, and a ten per cent. solution of the same drug was sprayed into the trachea. A catheter was then passed into the windpipe with the greatest ease, for a distance of about twelve inches, where it met with resistance. At a subsequent trial it passed the obstruction, and was introduced a considerable distance farther than at first, affording immense relief. The procedure was repeated several times weekly, and suggests the wider extension of the practice of direct medication of the sub-laryngeal air-passages, preceded by local anesthesia.

ACTION OF BITTERS.—From experiments performed recently in St. Petersburg, Prof. Botkin asserts:

1. That bitters diminish the digestive power, and retard digestion; they diminish the quantity of peptones.

2. That bitters diminish the secretion of the gastric juice. If they produce a feeling of hunger, it is only by irritating the gastric mucous membrane.

3. Bitters have no influence upon the secretion of the pancreatic juice or the bile.

4. Bitters not only do not diminish but actually promote fermentation in the contents of the stomach.

Conclusion. The bitters are not of any use in the treatment of disorders of digestion.—*L'Union Medical du Canada.*

HER MAJESTY has conferred the honor of knighthood on Dr. Morell Mackenzie at Balmoral in recognition of the professional services recently rendered by him to the Crown Prince.

THE BINIODIDE TREATMENT OF SCARLET FEVER.—Having satisfied myself of the value of the biniodide of mercury in the treatment of scarlet fever, I recently tried its effect when applied locally to the inflamed throat. Taking two ounces of the bichloride of mercury solution, I carefully added a few drops of a 1 in 4 solution of the iodide of sodium or potassium, shaking the mixture after the addition of each drop, until I secured a cloudy red liquid indicative of the precipitation of the biniodide. To this I added half an ounce of glycerine for the purpose of keeping the particles of

biniodide in suspension. This mixture I applied twice a day with a straight brush in some severe cases of scarlatina anginosa, with the effect of arresting the inflammatory and ulcerative action in a very short space of time. I also injected some of it up the nostrils in one very severe case, in which the disease had extended behind the soft palate, and was causing profuse discharge from the nose, and with excellent effect. In cases where it might be thought advisable to make more frequent applications to the throat, the biniodide thus prepared might be easily applied by the nurse or mother of the patient with a little help. My practice is to introduce the handle of a tablespoon well back on the tongue, and then to apply the brush rapidly and vigorously to the affected parts of the throat. I should think that the same application would prove of great service in diphtheria also.—C. R. ILLINGWORTH, M.D., Clayton-le-Moors.

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