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FLATFOOT: ITS DIAGNOSIS AND TREATMENT.

BY W. W. BREMNER, M.D.,

Late Assistant Surgeon to New York Hospital for Ruptured and Crippled. Orthopedic Surgeon to the Toronto Infants' Home.

Flatfoot is a breaking down of the normal arch of the foot, more or less pronounced according to the severity of the case. It may be either congenital or acquired.

The acquired form is that which is most frequently seen; it may be caused by rickets, prolonged standing (static), paralysis or injury.

This affection is much more common than is usually supposed, about two hundred cases are seen annually at the New York Hospital for the Ruptured and Crippled, and is often diagnosed as rheumatism or chronic sprain, and treated with various liniments and lotions, of course, without beneficial effect. Anatomically it is a dislocation outward, more or less pronounced, of the anterior part of the foot at the medio-tarsal joint.

In a normal foot, a line drawn down the front of the tibia falls on the second toe. In flatfoot, this line falls within the great toe. The ligaments connecting the os calcis, astragalus and scaphoid are put on the stretch, also the tendons of the tibialis anticus and posticus. In very severe cases the scaphoid is almost completely dislocated outward.

Symptoms.—There are certain symptoms common to almost every case of flatfoot. The patient complains of weakness and discomfort in walking, of great fatigue, and often intense pain in the foot after prolonged standing. The gait is awkward, and often there is a limp. The feet are generally everted in walking and standing. On examination, we find that the front of the foot is

turned out in relation to the leg. There is often swelling of the dorsum of the foot, and in severe cases great resistance to abduction and extension; (this symptom may be absent in commencing cases, and yet there may be very great pain), in fact, all the motions of the foot and ankle are often more or less restricted. The average amount of flexion present in the ankle-joint is about 70°, and of extension 140°. Adduction can usually be made until the sole of the foot makes an angle with the floor of from 40° to 50°.

Patients should be examined carefully as to these motions. It will usually be found that they are unable to raise the inner border of the foot at all, while the adductors, the peronei, and extensor longus digitorum are in a state of chronic spasm.

These patent signs are only present in the more severe cases, but in every case there are points of tenderness, which are characteristic of this disease. There is one over the astragalo-scapoid articulation at the inner border of the foot. One in front of the internal malleolus, and also at the base of the first and fifth metatarsal bones. The one at the astragalo-scapoid is always present. There are other painful points not so constantly present; one is in front of the external malleolus. These points are often extremely sensitive to either pressure or weight bearing. In some acute cases there is heat, redness and swelling, closely simulating rheumatism; the pain is often most severe in cases where there is very little actual flattening of the arch, while in some advanced cases of long standing pain may be almost absent. It will be seen from the foregoing description, that the muscular balance of the foot is lost. The adductor muscles on which the strength and elasticity of the foot chiefly depend, being strained and their power lost.

Treatment.—The treatment must be directed to overcome the state of affairs we find present. When there is not much deformity and spasm present, it is often sufficient to bandage the foot well, and to use a light steel foot plate, made from a plaster cast, taken while the foot is held in as nearly a correct position as possible. This is the method recommended by Dr. Whitman, of New York, whom I had the pleasure of assisting in many of these cases. Where there is considerable deformity and spasm it is necessary to etherize the patient and replace the bones in

*Read before the Brant County Medical Association.

their proper position. This is best done by forcibly extending and adducting the foot. The heel and toes are both turned inward the foot forced into a position of extreme equino-varus. There is often a great deal of crackling of adhesions during the operation. At times it requires much force to place the foot in its new position, and this is best obtained by placing the patient on a couch and bringing the affected foot between the operator's legs and using the knee as a fulcrum over which to press the foot. By this means the foot is over-corrected, the contracted muscles and ligaments are put on the stretch, and those that have been strained and weakened given complete rest and an opportunity of regaining their lost power and tone.

After the operation the foot should be put up in this over-corrected position in a well-fitting plaster case, and retained there from one to three weeks, the patient being allowed to walk about with a cane. At the end of one week the bandages should be removed and plaster casts taken of the foot, the bandages should then be reapplied while the necessary plates are being made. These are made from thin hammered steel, and extend from the ball of the great toe to the inner tuberosity of the os calcis in the sole of the foot, and from half an inch above the outer border of the foot to the tuberosity of the scaphoid.

At the end of two or three weeks the plaster is removed, then careful massage and bandaging employed for a few days and the plate applied. It is worn in an ordinary shoe, but it is better to get some common sense boot with the natural inward curve of the foot preserved. In addition, the inner side of the shoe may be built up $\frac{1}{4}$ inch after the method of Thomas of Liverpool. In the after treatment it is well to see the patient every day for a considerable time, and to gently but firmly put the foot into the portion of adduction so as to fully stretch the abductor muscles. This should be continued until all stiffness and spasm are gone.

The patient should be instructed to take the following exercises every night and morning:

1. To adduct and invert the feet several times—assisting those motions with the hands if necessary.

2. To raise the body on the bare toes twenty to thirty times with the feet parallel to one another. Lastly, and perhaps most important of all, he

should be taught to walk correctly, that is with the feet parallel to one another, so that the weight of the body is lifted over the toes at every step; in this way the weak muscles are exercised and strengthened.

In very severe cases it may be necessary to use an upright leg support in addition to the steel sole plate with a leather belt to support the inner malleolus.

THE FAILURES AND SUCCESSES OF BROMOFORM IN THE TREATMENT OF WHOOPING-COUGH.

BY J. T. DUNCAN, M.D., TORONTO.

Mr. President and Gentlemen,—In estimating the value of any new theory, and especially any new drug, full weight must be given to those cases in which it may be said to be a failure, as well as those in which it is a success.

Now, although bromoform in one sense may not be really "new," (for it has been before the profession for at least two years), still it is not improper to use that term in reference to it, for it has not yet come into general use.

In discussing it, then, we shall first carefully examine its reported failures, then look briefly at its successes, afterwards endeavoring to sum up the evidence, and decide whether it is a genuine addition to the armamentarium of the physician—especially with reference to the treatment of whooping-cough—or not.

Advocates claim that it lessens paroxysms in number and severity, relieves or abolishes vomiting, promotes sleep, increases the appetite, reduces the danger of complications, cuts short the disease, and, is indeed, according to some, a specific.

I. Unfavorable reports.—Dr. J. Cassel (*Medical Annual*, 1893), has treated 40 cases. He says there is not much to claim for it as shortening the duration of the disease, but it lessens the number of paroxysms in the day. It will not take the place of other drugs. Large doses are poisonous.

Dr. Ullmann states that the cases which improved under treatment by bromoform showed themselves equally amenable to other and different remedies, and the cases of a worse type were not checked by either drug. The length of the illness was as little shortened as ever. Complications of every sort occurred, and the course of the disease

was not influenced. The mortality was not increased. Bromoform, perhaps, as a narcotic, somewhat unfavorably influenced the general condition of the younger children.

The above reports are those found in the *Medical Annual* for 1893.

In Sajous' *Annual of Medical Sciences* I have found only one unfavorable reference in regard to the use of this drug.

I come now to the personal experience of some members of this Association in regard to it.

Dr. Burns, of College Street, who tried it in one case, stated that he did not consider it superior in its effects to a mixture which he had been in the habit of using, consisting principally of bromide and chloroform; and Dr. Clelland, of Queen Street, who, last summer, treated one case by this drug, had rather discouraging results. In my own experience I have had what may be spoken of as initial failures, that is to say, the drug has done no apparent good at first. These will be referred to later on.

In speaking of the failures or disadvantages of the drug, cases of poisoning must be referred to. Of these I have only found the following recorded:—

CASE I—Boy æt. 7 years. This boy was under treatment for pertussis by bromoform, the following being the mixture:—

R.—Bromoform, ʒi.
Aqua, ʒiv.

S.—Shake well, and take ʒi. every two hours.

The last dose in the bottle was the poisonous one, and was stated to contain x. to xv. mins. of bromoform. He recovered by hypodermic injections of digitaline and ether sulph. The disease was not shortened, nor the severity of the attack lessened.

CASE II—Girl, æt. 2½ years. She took at least ʒjss. of pure bromoform. She also recovered under similar treatment. (The above cases are reported in the *Ontario Medical Journal* for April, 1893.)

E. Sachs (*Sajous' Annual*) reports child, æt. 4, took 23 grains (minims?) Collapse took place. She recovered by means of hypodermics of ether and tepid baths.

These are the unfavorable reports in regard to this drug.

II. *Successes*.—The last *Annual of the Medical Sciences* (*Sajous'*), contains a report from Dr.

Krieger, who treated nine cases with, he says, "great success."

The same publication refers to Nauwelaer's experience, who regards it as a specific, but considers it dangerous. Dr. Earle, of Chicago, has treated eight or ten cases with good results.

Schippers says he has had good results with proper doses.

Squibbs' *Ephemeris of Materia Medica* (quoted in the *Canadian Practitioner*), says, "It still has an increasing use in the treatment of pertussis, with comparatively few failures. It apparently simply aborts the paroxysms, and probably reduces the number somewhat, but has little other effect on the regular course and duration of the disease."

Stapp has treated 100 cases, Lowenthal 100, Newmann 25, and Schippers 250, all with great success. These latter cases were, however, referred to last year.

Dr. Forfar, of this city, reports great success with bromoform in the treatment of pertussis, but, as he combined this treatment with the administration of phenacetine, the record is not directly to the point.

Dr. Clelland, also of this city, reports this year, "I used bromoform in seven cases of pertussis during the past winter. I was surprised and pleased at its effects. The change and improvement, in most of the cases, was very rapid. I would use it now in every case. It is in advance of any treatment I had previously used."

Dr. Gilpin, of Brechin, Ont., had a good opportunity of observing the effects of this drug last winter. The epidemic which occurred in his practice was a severe one. As to the results, I quote from a letter received May 22nd. He says, "I have had at least 25 cases. I found 'bromoform' to benefit in every case.

I don't think it cut short the disease to any marked extent, but where I had the patient under treatment from the first, it cut short the paroxysms in a marked degree; in every case they slept better right from the first dose. I had no bad symptoms in any of my cases." The letter concludes with the statement: "I found bromoform a great boon."

My own experience this summer has been limited to a few cases, only two of which were severe. And as these cases throw light, in my opinion, on

some reported cases of failure, I will speak of one of them in some detail.

Boy, æt. 5 years, had been coughing a week before I saw him. I ordered three drops of bromoform, three times a day. This was April 13th.

April 15th. No improvement. Gave chloral and bromide mixture.

April 19th. A diagnosis of whooping-cough was now definitely made. The mixture of chloral and bromide had not done any good. Therefore I again ordered bromoform, increasing the dose to ℥ vj., three times a day.

April 23rd. Little improvement. Ordered ℥ x., or even xij.

From the time of getting the larger dose, the boy improved. Up to the 25th April the case was a severe one. Hourly paroxysms at night, vomiting distressing; no appetite, the child evidently failing; the mother anxious and alarmed.

But on calling, the second day after he began with the larger dose, the mother expressed herself as delighted. The whole aspect of the case had changed. Paroxysms were reduced in number, less severe in character; vomiting much lessened, appetite getting really good. All the mother's anxiety had disappeared. Ordered to continue ℥ xij.

May 17th. Patient has no cough during the day now, coughs about twice at night; does not vomit at all, is very hearty. Mother wants to know if he may go to school, as he is so well.

The other case, being very similar both in severity and course, need not be particularly referred to. He made no improvement until the proper dose was given.

In order to decide the question intelligently, Mr. President, I have thus placed before you all the evidence, both for and against, which I have been able to obtain.

Anyone dispassionately perusing that evidence, would say that the testimony is largely in favor of this drug as a most important assistant in the treatment of pertussis.

While so many practitioners have been successful with the drug, however, it undoubtedly has failed in the hands of a few. Granting that its use, by some practitioners, has been void of benefit, these negative results cannot be held to invalidate so many positive successes. But can even these negative results be reasonably accounted

for? Some of them probably can be by the insufficiency of dose.

I will ask you to look for a moment again at the case I have just reported. That patient, beginning with a three minim dose, as I supposed, did not improve till it was increased to xij., apparently. I say apparently, for the patient, although getting x. to xij. drops, only was really receiving about ℥ iv., the explanation of this anomaly being, that the medicine had been given by the dropper, and the drops were so small that it took from two to three drops to make one minim.

As the original method of giving this drug was simply to drop the dose into a teaspoonful of water, no doubt some have failed to give a sufficient dose, from overlooking the fact that a drop does not by any means represent a minim.

As further proof that insufficiency of dose accounts for the failure of the drug, other records might be given if time allowed.

On discovering, in my own case, the possible error of the older method of administration, I adopted and modified a formula which was published in the *Canadian Practitioner*, of which glycerine is the basis, as follows:—

R—Bromoform, fl. ʒ j.
Alcohol,
Tr. card. co., āā " ʒ ij.
Glycerine, " ʒ xij.

Given thus, I found minims iv. equal in effect to the 12 drops previously administered. Although we can thus be sure of the proper dose being given, there is the disadvantage that children do not take it as readily as when dropped into water.

Dosage.—Schippers gives the standard doses, thus:—

Six to twelve months . . minims ij.
One to two years " iij.
Two to three years " iv.
Three to four years " v.
Four to seven years " vj. to vij.
Three times a day.

These doses may be more easily remembered by using minim j. for each year of the child's age, cautiously increasing if not at first successful.

Dangers.—The method of administration must be mentioned. In one case of poisoning, the drug had been ordered simply with water. Bromoform is not soluble in water, and sinks to the bottom almost "like quicksilver," as stated by a corres-

pendent. Now, no matter how well such a mixture is shaken, the bulk of the bromoform would remain till the last dose. In the case referred to, the results which might have been anticipated did actually occur, viz.: no improvement in the disease, and a poisonous last dose. If given in water, the safer way is to drop the dose into a teaspoonful at the time of administration.

Glycerine is a much better solvent, but even some glycerine mixtures require thorough shaking before using.

Poisoning.—The fatal dose has not yet, so far as I know, been determined. Poisonous symptoms have, however, been observed after doses of 23 grains (minims?), and a drachm and a-half. The latter dose was taken by a girl of 2½ years. She, as well as all the others, recovered, and, apparently, without any unfortunate sequelæ.

In endeavoring to arrive at the truth of this question, Mr. President, I shall simply sum up briefly, and without recapitulating the evidence, by stating that bromoform—

(a) Reduces the number, and lessens the severity of the paroxysms.

(b) Rapidly relieves the vomiting.

(c) By thus quieting the stomach, it increases the digestive powers.

(d) Gives comfortable rest, and, in the doses stated, appears to be a perfectly harmless drug.

On the other hand, I do not think it is yet proved to be able to shorten the duration of an attack, and, as it acts only as an antispasmodic, not as an antiseptic, it cannot properly be spoken of as a specific for pertussis.

CEREBELLAR HEREDO-ATAXIA.

BY DOCTOR PIERRE MARIE.

Translated from the French by D. Campbell Meyers, M.D., Toronto.

(Concluded from January No.)

In regard to the muscular sense (we have already seen that Romberg's sign was usually but little marked or absent) opinions differ somewhat; the majority of authors consider it if not intact at least scarcely altered; but Klippel and Durante state that in their three cases it was very notably deranged. The same difficulty of interpretation is met with when one seeks to explain

the mechanism of the motor troubles in typical Friedreich's disease.

The plantar reflexes are generally preserved, rarely exaggerated, sometimes abolished.

As for the organs of the special senses, apart from the eye, I have nothing notable to add, except in the three cases of Klippel and Durante, a diminution in the acuteness of the hearing, in one case of the same authors an impairment of the olfactory sense on the left side; in another case some slight changes in the taste.

In regard to the vision it is quite different. We must here consider in detail the muscular apparatus, the movements of the pupils and the vision properly so-called.

In two cases of Sanger Brown (IX and XVIII) there existed a quite pronounced *ptosis*, which, however, was incomplete, because, by an effort, at least in the second of these cases, the patient was still able to raise the eyelids, and uncover the sclerotic above the cornea when the eyes were directed horizontally. This incomplete *ptosis* gave to the patient a singular expression quite analogous to that induced by an intense emotion. In the cases of Klippel and Durante there was no question of *ptosis*, the eyes are described as wide open, but they note "the astonished appearance" of the facies.

In the greater number of cases one observes, not a true nystagmus such as is frequently seen in disseminated sclerosis, but *nystagmiform jerkings* which are present when the eyes are moved to an unusual degree in any direction. This is, however, a symptom which belongs equally to typical Friedreich's disease. A large number of cases have presented, in a more or less pronounced manner, a *paralysis of the right external rectus muscle*. Sometimes this is observed only by the tendency which certain patients have of moving their eyes in the same direction (above and to the left—Fraser) sometimes one notices a certain degree of internal strabismus, sometimes even a true *diplopia* which, however, is only transitory. It is further necessary to mention here, as quite frequent, a *difficulty in convergence*.

The pupils are usually equal without mydriasis or myosis, but their reactions are often defective. The light reflex is slow or even abolished (Sanger Brown), the accommodation reflex being preserved; there is then in these cases, as in ordinary tabes,

the sign of Argyll-Robertson. Lastly, in two of their patients (Louis H—, Francois H—,) Klippel and Durante noticed a diminution or even the absence of the *accommodation reflex*; there was total reflex immobility of the pupils.

As to vision itself, I must insist particularly on the troubles which it presents, because, as I have said, these troubles are very important in diagnosis.

The visual field has been found contracted in a large number of cases; we must note that this contraction of the field of vision was always bilateral; very pronounced in certain subjects, less so in others.

Somewhat less frequently, but in several cases, however, *dyschromatopsia* has been noted, and this has been ordinarily more marked for green than for the other colors which are better recognized.

The acuteness of vision is not always, but quite frequently, diminished, and this in a variable degree. In one of Nonne's patients (Fritz) it was $\frac{1}{2}$ in the right and $\frac{1}{4}$ in the left eye; in another patient (Hemrich), $\frac{1}{8}$ in both eyes. In cases XVIII. and X. of Sanger Brown, the acuteness was $\frac{2}{300}$ on both sides; these patients could read No. 5 of Snellen, although with difficulty, at a distance of eight inches, with an ordinary light. In case XIX. of the same author, No. 3 of Snellen was read quite well at a distance of ten inches. The diminution in the acuteness of vision may, however, be much more pronounced. Klippel and Durante speak of amaurosis in two of their cases. In that of Botkine there was blindness of the left eye. We must also remember the fact pointed out by this last author that several of his patients, in whom the acuteness of vision was only moderately diminished, were able to read by a dim light much more easily than by an ordinary one. In regard to the onset of this diminution of acuteness of vision, it does not seem possible at present to form any precise rules; certain points are, however, to be noted. This phenomenon is not initial; it is seen usually several years after the commencement of the disease, and when the motor troubles of the legs are already very marked. In case IX. of Sanger Brown, the weakness of vision appeared only twenty years after the disease began. One must not suppose, however, that it is always thus, because in case VII. of the same author, the diminution supervened eight years

after the commencement of the disease, and at the end of only four years in one of the cases of Klippel and Durante (Louis H—). Another fact to be noted is that the troubles of vision seem to begin most frequently in one eye only, then one, two, three years later the other eye is invaded. These troubles progress more or less slowly.

There now remains the fundus of the eye to be considered in those patients which present troubles of the vision. Klippel and Durante say they have found nothing abnormal, but Fraser, Sanger Brown and Nonne have observed in it some manifest alterations. These latter changes consist especially in a *whitish decoloration of the papillæ*, with very distinct preservation of their contour, and in the *diminution of the calibre of the capillary vessels*; atrophic lesions of the *choroid and retina* are also present.

If now we compare the condition of the visual organs in hereditary cerebellar ataxia, with that seen in typical Friedreich's disease we find some important differences. It is true that in the latter affection, the nystagmiform jerkings are quite analogous to those we have just described, but except this, all the remainder differ; in Friedreich's disease ocular paralysis are wanting or are extremely rare; the pupils have always a normal reaction, there is no contraction of the field of vision (except in cases accompanied by hysteria—Charcot,) there is no dyschromatopsia, the acuteness of vision and the fundus of the eye present nothing abnormal.

Let us continue this comparative study, and examine the peculiarities of speech in these different patients. Here the analogy again becomes complete. In cerebellar heredo-ataxia, just as in Friedreich's disease, speech is slow, guttural, hesitating, explosive-like, resembling closely that of individuals suffering from disseminated sclerosis, only less scanning. As Klippel and Durante have remarked, it is in polysyllabic words that pronunciation offers the greatest difficulty, but not because the patient skips a single syllable; during the efforts that he makes to speak, the tongue, the muscles of the lips, the other muscles of the face execute movements of an exaggerated extent, which contributes to give to these individuals a very singular appearance which might lead one to doubt the integrity of their intelligence.

We will presently see that in many cases this would be incorrect.

The *psychical faculties* are in fact, speaking generally, unaltered; at most it is only a question in the greater number of cases of some *diminution of memory* or of a *melancholy turn* of the mind. Sometimes, however, there exists some more marked mental troubles; in case XII of Sanger Brown, there was *hebetude*; in the same manner the patients of Nonne showed a simplicity, a carelessness really morbid; this latter author further remarks that in these latter cases the *cranium* was of particularly small dimensions.

In regard to the digestive apparatus I have nothing abnormal to discuss, at most in the cases of Sanger Brown (cases V, XV, XXII), some disturbance of deglutition, the patients having a tendency to choke when they drank hastily. In the case of Botkine there was an excessive secretion of saliva.

The only notable modification in the genito-urinary functions seems to consist in the fact that in the greater number of women attacked with cerebellar heredo-ataxia menstruation appears late (in general at about 18 years of age), a phenomenon which is also met with in typical Friedreich's disease. Excepting this the periods are normal both as regards regularity and quantity. The genital power in the male sex is not sensibly altered.

In case X. of Sanger Brown, the urine was retained only with difficulty; as soon as the desire to micturate arose the patient was obliged to satisfy it without delay, for fear of accidents. Otherwise the sphincters performed their functions normally.

The absence of trophic troubles in cerebellar heredo-ataxia merits recognition because it is only from pure exception, that the nails became detached in a case of Klippel and Durante (Francois H—). A certain degree of amyotrophy in case V. of Sanger Brown, or a diminution of body weight in some of the other cases. The important point is that in cerebellar heredo-ataxia one does not find (except perhaps, in the case of Botkine, in which a slight degree of cypho-scoliosis is noted) any trace of the scoliosis so frequent in typical Friedreich's disease, nor yet of the talipes, special to this latter affection, and which is seen in it at

so early a date that it constitutes, in certain families, one of the best initiatory signs.

We have now reached the end of the clinical study of this affection. I have taken care in describing it to you, to insist on those symptoms by which it differed from typical Friedreich's disease. It is not necessary to return to this point, and I will limit myself now to a rapid enumeration of the distinctive characters which belong to cerebellar heredo-ataxia; the more advanced age at which the disease appears, preservation or even exaggeration of the patellar reflexes, frequency of the spasmodic phenomena, visual troubles (contraction of the field of vision, dyachromatopsia, diminution of acuteness of vision), absence of cypho-scoliosis, absence of talipes.

By the comparison of the symptoms in either affection one can, I think, conclude that there is a necessity for distinguishing one from the other, from a nosological point of view.

There now remains for us to decide whether, from an anatomico-pathological point of view, the same separation is not necessary.

The descriptions which we possess on the pathological anatomy of cerebellar heredo-ataxia are unfortunately not numerous, since in reality only two autopsies are at our disposal: one of Fraser, the other of Nonne; but the descriptions of these two autopsies have much in common. In both, one fact is striking, the *atrophy of the cerebellum*. This organ weighed in Fraser's case 81 grammes, in that of Nonne 120 grammes, the normal weight being from 150 to 170 grammes; hence there is a diminution of one fourth their normal weight. The cerebrum, on the contrary, seemed normal in Fraser's case, and in that of Nonne had lost only one-ninth of its normal weight. The latter of these authors found no microscopic changes in the cerebellum, whilst Fraser states that it is especially the grey cortical substance of the cerebellum which is reduced in volume, the white matter being nearly normal in amount; he even proved the disappearance of a large number of the cells of Purkinje and an alteration in those which remained. Hence a fact seems to be well established, the atrophy of the cerebellum. Another very important fact is shown by these autopsies, viz.: that the cord examined by the microscope presented no alteration whatever, the only modi-

fication which could be discovered being a simple diminution of volume (Nonne).

Let us now compare these anatomo-pathological reports with those we possess on typical Friedreich's disease. We observe that if there exists a certain analogy in the symptoms and pathological anatomy of these two affections, that there are differences in this latter which are much more marked. In Friedreich's disease, in fact, one finds, also, a notable diminution of the volume of the cord, the microscopic examination of which shows, in all the autopsies, the existence of very extensive degenerative lesions, implicating the column of Burdach, the column of Goll, the direct cerebellar tract, the crossed pyramidal tract, the cells of Clark's column. One notices how very great is the difference in regard to cerebellar heredo-ataxia which is not accompanied by any degenerative lesion of the cord whatever.

Such are the facts which appeared to me worthy of the creation of the group cerebellar heredo-ataxia. In this rapid sketch, in order to make the facts more clear to you, I have spoken intentionally, only of the cases in which the anatomical or clinical characters were well marked, in order to present to you a sufficiently striking picture of this affection. I must not terminate, however, without speaking to you of certain reservations which the study of this question suggests.

There exists in fact several cases which from their less well-defined symptoms and even from the more complex lesions discovered at the autopsy, cannot be easily placed in this new morbid group, nor yet will they enter distinctly into that of typical Friedreich's disease. But, by the fact itself, that they share each of these affections, they form so to speak between the two, transitional forms, which it is extremely difficult to class in a rational manner.

I will speak to you at first of the two cases of Seeligmüller, in which we note indeed the commencement after puberty, the exaggeration of the patellar reflexes, a general appearance different from that of typical Friedreich's disease; but the troubles of vision are absent or seem to be so, and such being the case it is impossible to affirm that they belong to cerebellar heredo-ataxia.

In the first case of Rouffinet the age of the patient, the existence of visual troubles lead one

to suppose that we are dealing with the affection now under consideration; but the report is so abbreviated on all the other points that sufficient evidence is lacking to come to any definite conclusion.

Lastly, the most interesting case of all, from this point of view, is certainly that of Menzel, in which we find, along with nearly all the classical symptoms of typical Friedreich's disease, the exaggeration of the tendon reflexes and the existence of other spasmodic phenomena (the claw hand, legs contracted in flexion). The absence of visual troubles alone prevents the classification of this case in cerebellar heredo-ataxia. One would think that the autopsy on a case of this kind would easily permit of a solution for the difficulty, but in this instance we find that the lesions not less than the symptoms participate as well in cerebellar heredo-ataxia as in typical Friedreich's disease.

In fact, the autopsy of the case proved that as in the latter of these affections, the cord presented very pronounced and multiple degenerative changes (posterior columns, crossed pyramidal tracts, direct cerebellar tracts, columns of Clarke, etc.), and, as in the former, there existed a manifest atrophy of the cerebellum with a disappearance of the cells and fibres of Purkinje.

Such a case may well inspire the reservation of which I have just spoken. On account of the scanty information we at present possess, we must, until further advanced, ask ourselves if cerebellar heredo-ataxia and typical Friedreich's disease are not, from the point of view of general pathology, more closely related to one another than might be at first supposed from the differences which they present, either in regard to their symptoms or anatomically. It is possible in a word that both affections may be only different forms of the same morbid conditions, a same initial process, hereditary degeneration, attacking in the nervous centres analogous but distinct organic systems, or indeed implicating in Friedreich's disease a number of systems other than those involved in cerebellar heredo-ataxia.

Selected Articles.

THE GREAT MEDICAL ERROR OF THE DAY.

In the treatment of the diseases of women at the present time, there seems to me to be a tendency to lay too much stress upon lesions of the reproductive organs. Too little heed is, therefore, given to the nerve-element of woman's diseases, and as a natural sequence, the surgical feelers and antennæ of the medical profession, always too keenly sensitive, vibrate vehemently at the approach of an ailing woman. This trend of the profession, to appeal to the knife as the great panacea for woman's diseases, is seen everywhere. It prevails alike in city, town, village and hamlet. It asserts itself in every medical discussion, and stands out in bold relief upon the pages of every medical journal. It has caused many needless sexual mutilations and unnecessary operations, and it is, in my opinion, the great medical error of the day.

It comes, not so much from the glamour surrounding surgery, nor from the greed of gold, but from errors of judgment, and from mistaken diagnosis. These arise from the fact that woman, through her sensitive and emotional organization, is a bundle of contradictions. More pitiful than man, and more long-suffering, her anger is more cruel, and her jealousy more relentless. Feebler than man, an appeal to her affection will make her surpass him in sheer muscular endurance. Who can nurse her kin so untiringly, and with so little rest, as even a frail woman can? What father can equal a mother in fondling and soothing a sick and fretful child through the weary night watches? What man can undergo the sheer fatigue, the strain and stress that a woman will for those she loves? Even in her pleasures, her physical amusements, she will, through keen enjoyment, often out-tire the strongest man. In one word she is a creature of impulse and of emotion. But all nerve-strains, whether arising from the emotions, from the affections, or from the passions, have their reactions, and very strange and very misleading reflexes come from the loss of brain-control over insubordinate lower nerve-centres. For what is hysteria but nerve misrule, and the panic of the brain at incompetent control. The secret and sanctity of woman's inner life lies in her affections, and what disturbs them disturbs the nerves, and through them their environment of flesh and blood. These unruly nerve lights flashing and fading at their own will, and without control, in the different organs of the body, the most careless observer may sometimes plainly see, for the clue is then as secure as the steps of a geometrical problem. But then again the symptoms are more

frequently obscure. Often they are as misleading as the lapwing's flight. To construe such symptoms, to unfold their sense, and to paraphrase them, so as to gain a true conception of their character, often demands a deep acquaintance with human life, and a keen insight into the most secret springs of its action.

Again, what is very perplexing, uterine symptoms are by no means always present in cases of uterine disease; and, what is still more bewildering, when so-called uterine symptoms are then present, they need not necessarily come from the uterine disease. The nerves are mighty mimics, the greatest of mimics, and they cheat us by their realistic personations of organic disease, and especially by their life-like imitations of uterine disease. Hence it is that even seemingly urgent uterine symptoms may be merely nerve counterfeits of uterine disease. In fact, the time has come when we must give up the belief, which with many amounts to a creed, that woman is woman because she has a womb, and that the womb is at the bottom of nearly every female ailment.

Nerve-strain, or nerve exhaustion, comes largely from the frets, the griefs, the jealousies, the worries, the bustles, the cares and cares of life. Yet, strangely enough, the most common symptoms of this form of nerve-disorder in women are the very ones which lay tradition and dogmatic empiricism attribute to ailments of the womb. They are, in the usual order of their frequency, *great weariness*, and more or less of *nervousness*, and of *wakefulness*; inability to walk any distance, and a bearing-down feeling; then headache, napeache and backache. Next come scant, or painful, or delayed, or suppressed menstruation; cold feet, and an irritable bladder; general spinal and pelvic soreness, and *pain in one ovary*, usually the left, or in both ovaries. The sense of exhaustion is a remarkable one; the woman is always tired; she spends the day tired, she goes to bed tired, and she wakes up tired; often, indeed, more tired than when she fell asleep. She sighs a great deal, she has low spirits, and she often fancies that she will lose her mind. Her arms and legs become numb so frequently that she fears palsy or paralysis. Nor does the skin escape the general sympathy. It becomes dry, harsh and scurfy, and pigmentary deposits appear under the eyes, around the nipples, and on the chin and forehead. Blondes are likely to get a mottled complexion, and brunettes to be disfigured by brown patches, or by general bronzing. Sometimes the whole complexion changes to a darker hue, and an abnormal and a disfiguring growth of hair appears on the face. There are many other symptoms of nerve-strain, but since they are not so distinctly uterine in expression, and, therefore, not so misleading, I shall not enumerate them.

Now, let a nervous woman, with some of the

foregoing symptoms, recount them to a female friend, and she will be told she has "womb-disease." Let her consult a physician, and he, especially if she has backache, bearing-down feelings, an irritable bladder, and pain in the ovaries, will assert the same thing, and will diligently hunt for some uterine lesion. If one be found, no matter how trifling, he will attach to it undue importance, and treat it heroically as an erring organ. If no visible or tangible disease of the sexual organs be discoverable, he will lay the blame on the invisible endometrium, or on the unseeable ovaries, and continue the local treatment. In any event, whatever the inlook or the outlook, a local treatment more or less severe, is bound to be the issue.

Yet, these very exacting symptoms may be due wholly to nerve-strain, or (what is synonymous) to loss of brain control over the lower nerve centres, and not to direct or to reflect action, from some supposed uterine disorder. Neither, for the matter of that, may it come from some real, tangible, and visible uterine lesion which positively exists. Thus it happens that a harmless anteflexion, a trifling leucorrhœa, a slight displacement of the womb, a small tear of the cervix, an insignificant rent of the perineum, or, what is almost always present, an ovarian ache, each plays the part of the will-o'-the-wisp to allure the physician from the bottom factor. To these paltry lesions—because they are visible, palpable and ponderable, and because he has, by education and by tradition, a uterine bias—he attributes all his patient's troubles; whereas a greater and subtler force, the invisible, the impalpable and the imponderable nervous system, may be the sole delinquent. The sufferer may be a jilted maiden, a bereaved mother, a grieving widow, or an neglected wife, and all her uterine symptoms—yes, every one of them—may be the outcome of her sorrows, and not the outcome of her local lesions. She is suffering from a sore brain, and not from a sore womb.

Fortunately for my own reputation and for that of my medical brothers who have thus erred, this grave error of diagnosis is not without excuse. For, as has been shown, the symptoms of nerve-strain—the reflexes of grief, of love, of neglect, of remorse, of jealousy and of unrest—so closely simulate those of even coarse uterine lesions that the nerve mimicries very readily may be mistaken for the symptoms of actual organic disease. Nor, indeed, are they always distinguishable the one from the other, for the marvellous kinship between mind and matter is a tangled skein unraveled yet by dead-house or by laboratory.

Let me illustrate this: Some years ago a healthy lady, aged 23, was engaged to a gentleman whom she tenderly loved. The wedding day was named, the clergyman was notified and the invitations were sent out. Three days before the one fixed

upon for the marriage there came a letter from the man breaking off the engagement. The blow to her love and to her pride was, of course, great. She secluded herself in her room, and in a few days took to her bed with many symptoms of nerve prostration, of which dysuria and an irritable bladder were the most prominent. For these vesical symptoms she was treated by the family physician with external and internal electricity and with repeated flushings out of the bladder. Getting no better, but steadily worse, the next year she fell into the hands of a specialist who diagnosed anteflexion of the womb, cervical erosion and fissure at the neck of the bladder. He dilated the urethra, washed out the bladder and treated the womb *secundum artem*. Still remaining an invalid, she consulted a third physician six months later. He also dilated the urethra, examined the bladder with the endoscope, washed it out repeatedly, applied electricity to it by an internal electrode, and gave cold douches. No improvement following this treatment, she called in a fourth physician. He kept her several weeks under his care, dilated her urethra, and treated her mainly with electricity if I remember correctly, but of this I am not absolutely sure. At any rate, she was not made a whit better, and a fifth physician was summoned. He without success treated her for anteversion of the womb and rectal ulcer. She now saw her sixth physician. By this time her urethra had been dilated so frequently that, in the examination, his finger entered the meatus urinarius, and, not at first recognizing his mistake, he remarked upon the extreme narrowness of the vagina. He recommended the formation of a button-hole fistula in the urethra, but this advice was rejected. Four years after the beginning of her disorder she returned to the second physician whom she had previously consulted. After treating her heroically for some time without the slightest benefit, he proposed the excision of the bladder. This operation was refused, and she, one year later, drifted back to her sixth physician. He first made a button-hole fistula in the urethra. This failing to do any good, an artificial vesico-vaginal fistula was next tried. No benefit accruing from this operation, her ovaries, as the last resort, were removed, but peritonitis set in and she died. Now, what is the true interpretation of this sad case? The terrible shock to her pride and to her affections shattered her nervous system, and she was suffering more from the reflexes of a sore brain than from a sore bladder or from sore ovaries.

One more example for illustrating the influence of the mind over the body: A lady, after receiving the sudden news of her sister's death, began at once to throw up her food. Despite all remedies prescribed by the family physician, the vomiting

persisted so stubbornly that she lost flesh, became weak and menstrual disturbance set in. A consultant, recognizing the neutoric character of the disease, wished to treat it accordingly. Yet, so impressed was she and her relatives by many so-called uterine symptoms, which they attributed to some disease of her reproductive organs, that they laughed at his diagnosis and dismissed him. Two specialists, therefore, were summoned separately, and each one independently of the other attributed the vomiting and her other symptoms to tear of the neck of the womb, and advised an immediate operation. For this purpose she went to the private hospital of one of these gentlemen. Directly after her admission she was seized with such violent and uncontrollable vomiting that in a few days her life was in danger. First one eminent physician and then another were called in by the specialist, and the three were in constant attendance until, after a desperate illness she became well enough only to be carried home. No operation whatever had been performed on her cervix, for she had been dangerously ill and was still too ill. She was now placed in the hands of her first consultant, who treated her nerves and her nerves only. Under this treatment she became well, and has continued well ever since, although the cervical tear still exists. In one word, it was the old, old story of wounded nerves counterfeiting a wounded womb.

Strange it may seem, the coccygeal joint is very liable to play the barometer to any kind of mental worry. The serious surgical blunder is, therefore, not infrequently made of extirpating for sheer hysterical coccygodynia this important bone, important for its muscular origins and insertions. I have known coccygodynia to attack a lady after the death of her mother. Every kind of treatment failed, but it was finally abruptly cured by her great resentment at the second marriage of her father.

The late Dr. Fordyce Barker told me of an analogous case caused by the sudden death of the gentleman to whom the lady was engaged. After consulting without benefit the best specialists at home and abroad, she led a sofa-ridden life, and did not stir from her house. She obstinately objected to surgical intervention, and the case seemed a hopeless one; but she was permanently cured by a lawsuit following a bitter family quarrel, on which she took a very active part. I have not in my conscience the extirpation of a nervous coccyx, but this exemption is merely a piece of good luck, and not of good sense, as the following history will show: A highly intellectual lady, among many nervous symptoms, suffered much from her coccyx. This she attributed to injuries sustained while riding a bucking horse. She was the patient of an eminent neurologist, who had cured her of all her symptoms, but the

coccygeal one. I was called in by him, and, after doing my best by topical applications, and by replacing a retroverted womb and dislocated ovaries, made up my mind that the trouble was a traumatic one needing surgical relief. The day and the hour of the operation accordingly were fixed upon; but, before they were reached, the pain mysteriously left the coccyx, never to return. A dominant mental impression—the fear of the operation—exorcised the coccygeal demon.

Once I was asked by a medical friend to see an exceedingly bad and acute case of pruritus vulvæ; the very worst that ever came under my observation. The lady was tossing about in her bed in a state bordering on frenzy from intense itching which could be allayed only by cold starch poultices applied every few minutes. Very naturally attributing it to uterine disease, my friend had discovered a small but angry-looking tear in the cervix, exuding a viscous discharge, and I was called in to the case to decide the question of an operation. I, too, was at first led astray; but the suddenness of the seizure, its vehemence, and the lack of consistency in the behavior of the symptoms put me on my guard, and we soon found out the cause to be an attack of jealousy. This was a stubborn case to manage, but she ultimately recovered under isolation, massage, and heroic doses of asafetida.

Twice I treated a highly intellectual lady for attacks of pruritus vulvæ, and of vaginismus. The itching was intolerable, and the sensitiveness of the genitalia so acute as to forbid every attempt at sexual intercourse. Each attack was brought on by mental overstrain, from exacting literary work, and much domestic unhappiness ensued. Several cases, I have personally known, of ladies who had for months been treated for supposed uterine or ovarian disease, when their whole and only trouble was remorse at having had illicit intercourse, or at having resorted to criminal abortion. I could spin out of an interminable length this list of cases illustrating the close and often very perplexing kinship between the brain and the reproductive organs, but time and space forbid, and these will suffice amply for my purpose.

For such cases as the foregoing ones moral therapeutics are needed, and we may here take a lesson from the ancients. They, recognizing the influence of the mind upon the body, successfully used incantations concurrently with medicines. Savages imitate them by their herb teas and sweat-baths, made mysterious by the pow-vows of the wizard and by the thaumaturgic pranks of the medicine-man. The incantations used by civilized nations at the present day—and I name them with all reverence—are alms, vows, spells, charms, pilgrimages, exorcisms, Christian science, the faith cure, the laying on of hands, and other like forms

of moral therapeutics, which unquestionably have cured and will cure so long as they produce dominant impression. The legitimate incantations of medical therapeutics are now pretty much limited to distractions, to diversions, to travel in foreign lands, to isolation to hypnotism, to massage, to electricity, and above all to the personal magnetism of the physician, however exerted, for this is the kernel of the treatment and the greatest of all incantations.

Sometimes in these cases an operation acts the part of an incantation. The dread of the knife, and the shock of the operation, distract the mental attitude of morbid concentration; while the enforced rest in bed gives a chance to the worn-out brain to regain strength, and to assert its supremacy over the mutinous lower nerve centres. This leads me to think that in a large majority of operations upon trifling tears of the crevix, and on incomplete lacerations of the perineum, the good which may accrue comes less from the repair of those organs, than from the mental distraction and the enforced rest. But this kind of incantation is—the surgical variety—does not always work well; indeed, it often, very often, makes matters worse. One striking example was a lady who saw her only child run over and beheaded by a locomotive. Her health began at once to fail, and she took to her back with the hackneyed symptoms of weariness, wakefulness, a bearing down, an irritable bladder, and many other canonical uterine reflexes. These were attributed by an excellent and a conscientious physician to a torn crevix, and to a torn perineum, which were accordingly repaired. But the added shock of the two operations made her very much worse. For these reasons, I must confess to becoming far less inclined than formerly to operate on trifling lesions of the reproductive organs, and especially on small tears of the perineum, the repair of which is painful, unnerving, and generally of doubtless expediency. I have become very sceptical of the influence of such lesions upon the general health, and have come to the belief that, even in bad cases, it is greatly overrated. In my experience the mistake usually made in these cases is that of attributing to the lacerations the mock uterine symptoms of nerve prostration. About this there can be no error, for I have over and over again, without any surgical treatment whatever, cured of their ailments patients, who had been sent to me for the very purpose of undergoing some operation on the womb, on the perineum, or even on the ovaries themselves.

Just as headache does not necessarily mean brain disease, so ovary-ache, groin-ache and back ache do not necessarily mean ovarian disease. Nerve-strain and these aches are, it is true, correlatives, but the middle term which connects them is merely a disturbance in the circulation. Yet, time and again—and I say this deliberately

—have ladies been sent to me to have their ovaries taken out, when the whole mischief had started from some mental worry. Their ovaries were sound, but their nerves were not, and no operation was needed for their recovery. The physician of the present day is too apt to jump from any distinctly female ache to an ovarian conclusion without the delay of any misgivings. The ache is in the back, then he argues, it probably is ovarian; it is in the groin, then, of course, it is ovarian; it is in the head, but extremes meet, and surely it comes from the ovaries. I, indeed have seen a painful nose and also a red one, attributed to the ovaries and treated canonically by the hot vaginal douch and uterine applications. From this widespread bias and pernicious haste the removal of the ovaries has degenerated into a busy industry by which, in city and in country, very many women have been and are being mutilated, both needlessly and on the slightest provocation.

So misleading, indeed, are the symptoms of a jaded brain or of other nerve-strain, under the uterine guise in which they often masquerade, that when a jilted girl, a bereaved mother, or a grieving wife, consults a physician, he, unless on his guard, will be more likely to minister to a womb diseased than to a mind diseased. Such cases, even when associated with actual uterine disease, are not bettered by a merely local treatment. Nor are medicines by themselves of much avail. What they need are the incantations of the rest cure, viz, massage, electricity and strict seclusion. Hope should be infused into every case, and above all there should be imported into it the personality of the physician. The riper my experience, the more am I convinced that, in the treatment of woman's diseases, the possibility of a nerve-origin or of a nerve-complication should be the *fore-thought* and not the *hind-thought* of the physician. —Wm. Goodell, M.D., in *Union Med. Mag.*

THE TREATMENT OF INTESTINAL OBSTRUCTION.

In introducing the discussion, Mr. Page said: it will be readily admitted that few cases give rise to more difficulty and doubt in practice than cases of acute intestinal obstruction, and by acute intestinal obstruction I mean "a total arrest of the passage of fæces and flatus." Why this is so is obvious enough, for acute intestinal obstruction is a symptom of a great variety of conditions, all of which imperil life. The difficulty in treatment arises from the doubt as to the cause of the obstruction. When a strangulated hernia exists—the commonest cause—the treatment is obvious. We attempt to liberate the imprisoned gut by taxis, first without and then with the aid of chloroform; failing, the stricture is at once cut

down upon, and the bowel liberated. Herniotomy is successful in proportion to its early performance, and it will not be denied that grave mischief is frequently done by taxis. When no hernia can be found the cause of the obstruction must be within the proper cavity of the abdomen. If it could be ascertained that a portion of gut were strangulated it could make no difference as to treatment, whether the site of strangulation were in the proper cavity of the abdomen or in a hernial sac—a diverticulum of the abdominal cavity; in both cases the treatment should be the same. Unfortunately it cannot be ascertained that the symptoms are due to strangulation. They must, however, be due to some one or other of the various mechanical conditions which are known to cause obstruction, or to an acute inflammatory process, such as a suppurating gall bladder, peritonitis, or typhlitis. I cannot think that anything but disaster is likely to arise by treating an acute inflammatory attack by abdominal taxis and repeated injections of air or fluid. Opium, bleeding, and fomentations relieve acute inflammatory symptoms, and might cure the patient were the disease not dependent upon a mechanical obstruction or upon perforation. But there is always a cause for peritonitis, and if septicæmia and external injury be excluded, in the great majority of cases, it is due either to a mechanical obstruction or to perforation, and is itself best treated by abdominal section. It is generally impossible to determine what is the cause of peritonitis, or what is the nature of the obstruction, when no peritonitis is present, without opening the belly. Why should not the belly be opened for the purpose of ascertaining the cause of the symptoms, and, if possible, removing it? It must be admitted that cases of acute intestinal obstruction (a very small proportion) recover without operation, the cause of obstruction remaining a matter of conjecture, and that the mortality in cases of abdominal section has been, and at present is, very high. The mortality from herniotomy used to be very high, and from the same cause that the mortality of abdominal section for the relief of intestinal obstruction is now high—delay. The earlier a patient is operated upon for strangulated hernia the better is his chance of recovery, and the earlier abdominal section is performed for the relief of acute intestinal obstruction, the better is the chance of success. I do not wish to convey the idea that the opening of the abdomen is a trivial matter. It is not, nor is any operation in surgery. But exploration by means of an incision cannot, at the present day, be said to add materially to the danger a patient suffering from acute intestinal obstruction is already in, and it may, and probably in most cases would, reveal the nature of the disease. It is not my purpose to discuss seriatim, the possible conditions an ex-

ploratory incision may reveal, nor how they are (when found) best to be dealt with. That would occupy more time than I think could be profitably spent over the debate. I wish to urge the necessity, after a careful examination of the abdomen under chloroform has failed to relieve the patient of at once exploring the abdomen by means of an incision. What is the alternative? Delay—opium and belladonna, copious and often repeated injections, inversion, abdominal taxis under chloroform, shaking the patient, and inflation. In how few of the known causes of acute intestinal obstruction can these means possibly be successful? What if the chance of operative interference being successful after they have failed? In how many conditions must they inevitably do harm? I do not say that in no cases of intestinal obstruction are these measures to be resorted to. In the less acute cases they are applicable, and by relieving spasm, softening and displacing fæces, are often successful, just as in cases of incarcerated hernia they suffice. Chronic intestinal obstruction generally depends upon blocking of some portion of the large intestine, and the symptoms are not nearly so urgent, but even in such cases it may be found necessary to open the abdomen. Such cases often require the large gut to be opened, and, in my opinion, this is far better done by an anterior incision, either inguinal or median, than by lumbar colotomy. There are cases—I think, the more acute—where the indication is to open the abdomen at a very early period; others more chronic where delay and other means are indicated; and there is an intermediate subacute class where it is most difficult to determine what shall be done. The best guide to treatment is, I believe, the effect the disease is having upon the patient. If the symptoms, narrowly watched, indicate that the vital powers are threatening to fail, then, though the symptoms themselves may not be very severe, I think operative interference should be resorted to, and where the question as to the propriety of opening the abdomen or waiting is pretty evenly balanced, I am of opinion it is better to operate. I know at present of no better criterion as to the necessity of operative interference in the most anxious cases than the effect the disease is producing upon the patient. It is not unreasonable, I think, to expect, with so many able men looking at this difficult problem, and from opposite points of view, that the time may come when it will be possible to make a more accurate diagnosis than we can to-day arrive at; but at present I know of no better criterion as to the necessity of operative interference, in cases of intestinal obstruction, than the effect the disease is producing upon the patient.—Fred. Page, M.A., M.D., in *Br. Med. Jour.*

MEDICAL NOTES.

Dr. Wolf says that the *Carbonated Waters* have a very favorable influence on the flow of bile.

In cases of enteric fever, Prof. Wilson says, if signs of *Peritonitis* develop, opium should be administered freely.

Prof. Montgomery says *Pain occurring at the time of or immediately after menstruation* is due to a disease of the tubes.

Prof. Wilson says during a severe epidemic of *Influenza* more lives are destroyed than during an equally severe epidemic of cholera.

According to Prof. Hare, chloral and the bromide of potassium are the best drugs that can be administered during an attack of *Tetanus*.

Prof. Keen favors the giving of *Opium* in cases of incurable disease, such as cancer, so often as the patient's painful condition calls for it.

A *Fall of Temperature* after twelve o'clock noon in a surgical case, Prof. Keen considers a good sign, showing that defervescence has set in.

Prof. Keen says in cases of *Carbuncle* the urine should always be examined for sugar, as diabetic patients are very prone to have carbuncles appear on them.

Prof. Parvin states that a cold pack applied over the region of the uterus will in many cases cause *Excessive Irritability of the Uterus* to be allayed for a time.

Prof. Keen thinks the best remedy for removal of *Proud Flesh* in a healing wound is chromic acid, ten grains to the ounce, applied about two or three times.

In cases of *Septicæmia*, Prof. Keen says, the best results will be obtained if the alcoholic stimulants be pushed to such an extent as to make the patient mildly drunk.

Prof. Hare says only cases of *Major Epilepsy* will be benefited by the use of amyl nitrite, and especially those of this form which have an aura before each epileptic attack comes on.

Children, Prof. Hare says, require a smaller amount of narcotic drugs, about one-half proportionately, than adults, but of purgatives they require proportionately more than adults, to produce desired results.

Prof. Horwitz recommends as an abortive treatment in *Acute Urethritis* the passing of water of a temperature of 120° Fahr., charged with 1-30,000 bichloride of mercury, into the urethra for the space of half an hour.

Milk given to a patient suffering from *Enteric*

Fever, Prof. Wilson says, should be diluted with lime water, in the proportion of five parts milk and one part lime water; or with an equal quantity of one of the carbonated waters.

Prof. J. Solis-Cohen says, *Loss of the Cartilage of the Septum of the Nose* will not cause deformity of the nose unless the loss extends as far back as the union of the cartilage with the vomer, or if the vomer itself be included in the degenerating process.

Prof. Hare says one of the first symptoms that presents itself on the taking of an overdose of *Acetanilide* is the appearance of a red line on the nail of the thumb, just above the matrix of the nail, and in a short time this red line will become blue in color.

Prof. Brinton says *Blood in the Urine* is generally from the kidneys, but if it clots or is bright red in color then it is not from the kidneys, but may be either due to a diseased condition of the bladder or of the prostate gland, or to a stricture, or to a urethritis.

In diagnosing a case of pregnancy, Prof. Parvin says, the question of a *Phantom Tumor* will occasionally arise, and the muscles of the abdomen will be so tense that it will be impossible to make them retract. In such cases, if an anæsthetic is administered the muscles will become relaxed and a diagnosis can then be made.

If *Gonorrhæa in a Female* involve the vulva, Prof. Horwitz recommends that she be kept perfectly quiet, that the parts be washed with a solution of boracic acid or with a 1-4000 solution of bichloride of mercury, then dusted with an antiseptic powder consisting of calomel and bismuth; and a piece of cotton is to be kept between the labia.—*Coll. and Clin. Rec.*

THE OPIUM COMMISSION.

The general effect of the evidence so far taken before the Opium Commission has served to brush away a good many cobwebs of misapprehension which existed in this country in regard to this subject, owing to an absence of definite information; and we must candidly confess that we imagined the evidence would have been far stronger than it appears to have been as to the extent of the grave evils that are commonly believed to be attendant on the habitual use of opium.

It is a common practice to pour beer into a tumbler from a good height, so as to impart a lively, frothy briskness to that beverage and to give it what is called "a head." Now, it is the misfortune of most anti-opium societies that they

adopt a somewhat similar process in pouring out their facts for public consumption. When "the head" is blown off, it is often astonishing to find how little liquor there is left at the bottom of all the froth. We trust the anti opium societies will pardon us for using this illustration in connection with their movement; but from all that we learn regarding the evidence taken before the Opium Commission the illustration is not altogether inapplicable to the subject. No one denies that the abuse of opium produces disastrous results, and it is easy to paint a picture of a debased victim of the opium habit so as to leave it to the imagination to suppose that this is the necessary and ordinary result of the use of opium—that it is a fair representation of the average everyday product of our opium trade in India and the East; whereas the result of recent investigations is to show that it is nothing of the kind, that it is quite exceptional, and that it would be a gross exaggeration to represent it as a common or frequent phenomenon.

The Indian Government, laboring as it does at present under a grave financial crisis, strongly objects to having to bear any of the expenses attending the Opium Commission; moreover, in the event of the use of opium being prohibited for other than medical purposes, this country would have to face the fact that it would have to make a large annual outlay to India to make up for an estimated annual loss to that country of some. £12,000,000 or £13,000,000, through the suppression of the opium trade. On economical and political grounds, therefore, it is incumbent on the anti opium movement to make out a very strong case why the opium traffic should be suppressed on religious, moral and physical grounds; but they have failed to do this. The reports of the proceedings of the Opium Commission have served to throw a great deal of light on the subject; the evidence, as a whole, seems to point in an entirely opposite direction, and may well make thoughtful people hesitate before they suppress the use of opium in India and encourage thereby an increased importation and consumption of alcohol, or the substitution for opium of an infuriating agent like ganja. It was a wise remark that there is a good deal of human nature in man. We are not mere mechanical automata, but sensitive, emotional organisms. So long as the causes of physical and mental depression exist, and want, hunger, sorrow and misery continue in the world, so long will human beings have recourse to agents which will either temporarily stimulate the nervous energies or dull the sensibilities. We would here call attention to a very able communication by Surgeon-Lieutenant-Colonel Crombie, Superintendent of the European General Hospital, Calcutta, which appeared in *The Lancet* of Sept. 9th, and to the testimony of numerous medical

officers and others with extended Indian experience. There seems to be altogether a large body of evidence—European and native, medical and lay—which goes to show that the moderate use of opium not only does no apparent harm, but is actually beneficial under many conditions, and that its immoderate use is very rare, and not anything like so hurtful as the immoderate use of alcohol. According to the records of the Oriental Life Assurance Company, for the last twenty years there was not a single death attributable to the use or abuse of opium of 973 death claims since 1874, and the Company has upon its books something like 20,000 native assurers. It is notorious that opium is used by some of the bravest and most energetic races of India. The Sikhs and Rajputs, for example, are fine, stalwart races, and a very considerable proportion of them take opium. We were much struck with the reported testimony of Mr. Monro, late Chief Commissioner of the Metropolitan Police, who is engaged in missionary work, and is perfectly unbiased. He condemned the anti-opium agitation as groundless, and added that the use of opium was no obstacle to missionary work. Even supposing that the opium trade was suppressed, this measure would, in all probability, be at once followed by an increased production of opium in the Native States of India and in Persia and China. It is, however, not questions of mere policy or expediency that concern us so much as the fact that a great deal of ignorant misapprehension and exaggeration exists in this country with regard to the use of opium, which the evidence given before the Commission will, we trust, remove.—*Lancet*.

PAINFUL JOINTS IN MUSCULAR RHEUMATISM.

In the *Revue Médicale de la Suisse Romande*, M. Ruel contributes an article of great practical value on the external use of the salicylates in the rheumatic affection of joints.

He says: That for more than six years in his clinic at Geneva, he has repeatedly and systematically employed external applications of salicylic acid alone, or combined internally in painful joint troubles. He first employed in poly-articular rheumatism on the integument in the *loco dolenti*, without concomitant internal medication. The effects were most rapid and happy.

Professor Revilloid in his service, says, that:

- 1st. Salicylic acid is rapidly absorbed by the skin.
- 2nd. After being so applied, it promptly appears in the urine.
- 3rd. It possesses a positive curative action in rheumatism.

He found that the best results were realized when the salt was dissolved in alcohol with about double its volume of castor oil in the form of a liniment, that has been supplied in our pharmacopæia in years.

I have had no experience with it in acute inflammatory rheumatism, but, for joint inflammations or neuralgias, or those confined to the muscles, its action is marvellous. I have found it equally efficient in plegmasia-dolens; lumbago, sciatica, blenorhagic-arthritis, or that arising from malaria or syphilis.

But, it exerts its greatest potency in the joints of children, very many of which are prematurely set down as tubercular and condemned, and shackled in braces, before rheumatic remedies are thoroughly tested.

This formula which I prescribe is better in my hands for all cases than Ruel's which is intended for rheumatic cases only. It is as follows:—

R—Acid. Salicylic, ʒ iv.
Spts. vini. rect., f ʒiv.
Chloroformi, f ʒ iv.
Tinct. opii., f ʒ v.
Olei dulcis qs. ad., f ʒ xi.—M.

Sig.—Liniment.

M. Ruel's customary formula is:

R—Acidi. salicylici, 20 grammes.
Alcohol absolute, 100 "
Ol. Ricini., 200 " —M.

This is to be applied on a flannel, which is to be covered with some impregnable material, morning and evening. In certain solutions a small quantity of chloroform may be added—say 5 per cent. This addition serves as an analgesic; besides, favors the absorption of the medicament. About twenty minutes after the salicylic acid is employed it can be found in the urine, and a few minutes after a salicylic liniment is applied pain vanishes, and it is replaced, by a sense of warmth and comfort.

Since 1887 the author has thus employed salicylic acid, in general inflammatory rheumatism, but as well, in its local phases; besides, in pericarditis and pericardo-pleuritis; in the arthroses attributable to neuralgia, gonorrhœa, etc.

My own experience with this preparation during the past six months, since I first learned of it, is that it provides us with the most valuable preparation. By this combination, employing olive oil, instead of castor, we substitute a substance more readily absorbable.

By the addition of opium the sedative properties of the mixture are enhanced so that it serves more effectually as an analgesic in painful neuralgic affections, and thus obviates the necessity of administering anodynes internally.

Linseed oil might be substituted for the olive, when economy is an item.

In all cases it should be applied fresh. Hence, should be compounded only in such quantities as are ordered, for salicylic acid decomposes very readily, and thus the valuable virtues of the remedy are lost.

It should be applied, chiefly, warm in the palm of the hand, and should be well rubbed in; not only over the affected joint, but also above to the next joint over the intersectual muscles. In most cases but a small quantity of the liniment is needed.—*Times and Reg.*

THE ROLE OF LACTIC ACID IN GASTRIC DIGESTION.

Lactic acid is present in the stomach under normal conditions from thirty to forty minutes after a test-meal composed of a roll and water or of chopped lean beef, dry bread, and water. At the expiration of that time lactic acid should entirely disappear from the stomach-contents and free hydrochloric acid alone should prevail. During the first thirty or forty minutes after meals the digestion of starches and albuminoids progresses quite rapidly, as may be proved by finding the middle-products and end-products of gastric digestion present, so that the presence of free lactic acid does not prohibit digestion.

As soon as food enters the healthy stomach the secretion of hydrochloric acid is excited and it increases in amount until the production of lactic acid is checked. The exact origin of lactic acid in the healthy stomach is still a matter of debate. It may arise wholly from fermentation, or from the combination of some food-product with a secretion from the gastric glandules, or from the gastric mucosa as a distinct secretion, although electric stimulation of the gastric glandules excites the secretion of hydrochloric acid and not of lactic acid. I think it arises largely from fermentation of the food, as its amount is usually proportionate to the amount of starchy, saccharine, and milk foods taken.

I have, however, many times found lactic acid present in the stomach-contents two, three, or more hours after the ingestion of lean meat alone, in some cases the patient having been on a meat-diet for several days; under such circumstances I have followed the usual custom of calling it sarcocactic acid.

If after a test-meal consisting of albuminoids and starches, lactic acid is found in the stomach-contents at the expiration of one hour or longer, it may be called abnormal. I have found during the past few years that lactic acid very frequently exists in large quantities in the stomach during the late hours of digestion, and that it is persistently present in some cases, without regard to the character of the food or the period of digestion. In-

deed, I have cases on record in which lactic acid was present in excess during the whole period of gastric digestion, and as many of these cases had diminished peristalsis, their stomachs were free from lactic acid only a few hours during the twenty-four.

When hydrochloric acid exists in the stomach in proportions over from 0.2 to 0.4 of 1 per cent., we dignify the defect in gastric chemistry by the name hyperchlorhydria, or an excess of hydrochloric acid. But such a state is not more definite, nor is it more susceptible of detection, study, and treatment, than lactic-acid excess; nor are the etiologic factors more definite in the former than in the latter. I therefore think it reasonable to recognize the condition as an entity, and so consider it.

Lactic acid in abnormal quantity is found in the stomach in many cases having a deficiency of hydrochloric acid. It is difficult to determine in these cases whether the lactic-acid excess is the cause or the consequence of the diminished amount of hydrochloric acid. If, however, upon the withdrawal of all starchy and milk-foods from the diet free hydrochloric acid appears in normal amount, it is probable that the excess of lactic acid depends upon improper diet rather than upon primarily diminished secretion of hydrochloric acid. If, on the other hand, free hydrochloric acid does not appear in the gastric contents after stopping starchy and milk foods, it is probable that its secretion is really deficient and therefore lactic-acid fermentation is rendered easy.

A very common cause of lactic-acid excess is found in impaired motility of the stomach, which allows too long retention of its contents, with the over-production of lactic acid by fermentation. With insufficient peristalsis poor absorption often exists, and it is in such conditions that I have frequently been able to demonstrate an excessive total acidity of the gastric contents, owing to the presence of both hydrochloric and lactic acids. Thus in gastrectasia of the Germain-Sée type, the stomach contains not only an excess of hydrochloric acid, but usually also an excess of lactic acid, and the gastric mucous membrane is incessantly subjected to the action of highly irritating contents. When dilatation is associated with stenosis of the pylorus from a malignant growth, hydrochloric acid is present in small amounts only, or is entirely absent. In some of these cases I have found very large quantities of lactic acid, usually with other organic acids, making a total acidity far in excess, while other cases were characterized by a very small amount of lactic acid and a faint total acidity.

Chronic catarrhal gastritis, resulting from whatever cause or causes, renders lactic-acid excess liable. In cases of atrophy of the gastric glands and a consequent absence of gastric juice we would expect to find lactic-acid fermentation at its

height, but such is not the case. In four cases of this nature that I reported the gastric contents were almost invariably neutral in reaction unless acid foods had been taken. In other cases, as yet unreported, lactic acid was found in moderate amounts, and the total acidity was always sub-normal.

Of all the factors entering into the production of lactic-acid excess, none is so potent as improper diet. The ingestion of mixed starchy milk puddings at the end of a hearty meal results in the formation of so much lactic acid that its fermentation is perpetuated throughout the entire period of digestion, to the hindrance of proper change of the albuminoids and starches. The common custom of eating pastries, sweetmeats, ice-cream, cakes and cheese after having eaten thick soups, meats, fish with various sauces, entrees made with cream, salads and salad dressings, is to blame for many digestive disorders.

Drinking milk at meals and between meals, or living on milk alone, not uncommonly lights up the lactic-acid habit in the stomach, and cases of this habit illustrate the baneful effects of persistence in a diet that is not regulated by the condition of the gastric chemistry.

I cannot emphasize sufficiently the importance of lowered general health in the establishment of a gastric state in which the over-production of lactic acid is made easy. When the blood is reduced and the nervous and muscular systems are very much enfeebled, the functions of the stomach are imperfectly performed, because the organ is supplied by impoverished blood, its innervation is disturbed, and its musculature is weak. Therefore under the many indiscretions in diet that are inevitable as the average individual lives and as the average cooking prevails, with all its death-dealing virulence, gastric chemistry is necessarily disturbed.—*Med. News.*

SURGICAL SUGGESTIONS.

Superficial Excoriations produced by braces or adhesive plaster are readily healed by the free application of the sub-iodide of bismuth. It is a fine red powder with unusual absorbent and antiseptic powers.

Potassium Permanganate solution (1 to 1000) is an excellent local antiseptic for the urinary tract. One of the advantages it has over other agents is that so long as pus or other excrementitious matter is present the fluid will be changed in color from the de-oxidation. For acute gonorrhœa it is particularly applicable, and in the preparation of cases for operation.

Multiply Operations at One Sitting.—For the past two years I have frequently done several

operations at one sitting. I have repeatedly repaired the cervix and perineum and curetted the cavity of the uterus before opening the abdomen for the removal of pus tubes, and afterward stitched the fundus of the uterus to the anterior abdominal wall with silkworm-gut, and have thus far seen no cause to regret doing so.—*Cushing*.

I Hold that to put up all injuries of the elbow at right angles is a dangerous routine practice, as is shown by the number of cases of deformity that have been recorded, and by the very grave prognosis given by all our standard text-books.—*Frere*.

A Mild Degree of albuminuria (or nephritis), especially if recent, is not a contra-indication to the use of chloroform. Even in the presence of advanced and extensive renal changes an anæsthetic may be employed, provided the patient or the family be advised of the additional risk.—*Long*.

Senile Gangrene.—So long as the gangrene be confined to one or two toes one may wait and abstain from other than general antiseptic treatment, with high position of the limb, allowing the part to be spontaneously thrown off. If the process extends, however, to the dorsum or sole of the foot we should amputate above the condyles of the femur. Amputation below the knee is almost always followed by gangrene of the flaps and brings the patient in danger.—*Powers*.

Be Prepared to go ahead the moment patient is unconscious; don't waste either the anæsthetic or the patient's forces while you are threading needles.

Find the source of hæmorrhage in gunshot wounds of the abdomen before you begin sewing up the wounds in the intestines.—*Dalton*.

Gall-stones call for operation when they cause frequent, repeated or long-continued trouble. Operation is required for empyema of gall bladder, and for hydrops too, if it causes much annoyance. If cystic duct is closed, the gall bladder inflamed, or its contents much altered, a temporary biliary fistula should be made.—*Czerny*.

Golden Rules.—Never tap a suspected renal tumor through the abdominal parietes, *i.e.*, through the peritoneum. Never think lightly of any ulcer of the tongue or lips of a patient beyond middle life. Never permit a healthy wet-nurse to suckle a syphilitic child, or child of syphilitic parents. Never neglect to warn your patient about his eyes in treating a "first" attack of gonorrhœa. Never forget many gleet are due to slight contractions of the canal and may be cured by a steel bougie.

Creosote Subcutaneously.—In a large number of cases antiseptis in tuberculous phthisis can be secured by slow injection of pure creosote in

olive oil, sterilized by exposure to a temperature of 110° F. Thirty grains of liquid can be introduced beneath the skin in an hour.—*Gimbert*.

Empyema.—In the greater number of cases the resection of a part of a rib—usually about an inch of the middle third of the sixth or seventh—is incomparably the better plan; it should not occupy more than ten minutes, the peeling off of the periosteum occupying the greater part of that time, it gives ample space for emptying and washing out the cavity, and a new lamina of bone is soon secreted by the unjured periosteum to repair the loss. But there is one precaution: keep the finger in the opening lest the pus escape too rapidly and the patient die from syncope.—*Cadogan-Masterman*.

Fractures.—The immediate application of a plaster of Paris dressing to a recent fracture is wrong, because the healing of a fracture with deformity can be prevented only by a perfect diagnosis in which the form of the fragments and their position, as well as the possibility of interposition of muscular tissue between them, must be considered in order to institute proper treatment.—*Helferich*.

Balsam of Peru ranks next to iodoform in the treatment of tubercular affections of bones and joints, and if the latter remedy for any reason cannot be employed, or has failed in effecting the desired result, it should be given a fair trial if operative treatment is not urgently indicated.—*Senn*. —*Med. Rec.*

LOCOMOTOR ATAXY TREATED BY PHOSPHATIC INJECTIONS.—James Cagney writes to *The Lancet*: At the risk of prolonging an undesirable discussion, will you permit me to say a few words on the subject of Dr. Forbes Winslow's letter in *The Lancet* of Nov. 28th? Dr. Winslow informs the profession that a cure for locomotor ataxy is to be found in the injection of phosphate of soda "in combination." He was led to adopt this unpromising expedient by the rumor of certain proceedings in Belgium, and he recommends it on the strength of his experience in a single instance. The case reported by Dr. Winslow calls for no further comment. It has been adequately dealt with by your correspondent, Dr. McNamara. Dr. Winslow's postscript adds but little difficulty. The fact that he took the unusual course of obtaining certificates of diagnosis suggests that his own mind was not made up. The certificate from the Belgian physician is applicable only to a woman—the form of the French word *atteinte* shows this—while the subject of the marvellous cure was a man. The certificate of Sir Andrew Clark deserves all respect and is very valuable, as it is probably a rare document; but it cannot be taken in lieu of the usual statement of symptoms.

There remains no room to doubt that the case was one of mistaken diagnosis; and of this, as most neurologists will agree, no better proof is needed than the result—a complete cure, as attested by the “consultation in Belgium.” It is of greater interest to inquire upon what grounds the expectation of a cure was based. I have made a diligent search for the record of these proceedings in Belgium. The most authoritative report seems to be that presented by M. Crocq, of Brussels, to the Academy of Medicine, at Paris, on Sept. 13th, 1892. It is short, and may be read with profit:

“1. The subcutaneous injection of a 1 in 50 solution of phosphate of soda in cherry laurel water produces no reaction, local or general. 2. The injection upon nervous patients produces a powerful nervine effect. 3. This agent acts only as a nerve tonic, and its effects are either curative or palliative. They are curative only in cases of functional cerebro spinal trouble; they can only be palliative in organic disease of the nerve centres. 4. The advantage of this method over those of Brown Séquard and C. Paul is in its simplicity. It is within the reach of everyone.” (*Revue Médicale* [Louvain], Nov., 1892; *Bulletin de l'Académie de Médecine*, 1882, p. 439.)

This notice proves that the ground has already been covered, and there is no need of further experiments. The first paragraph robs the “method” of its air of mystery—a very desirable thing. The third disposes of its pretensions to cure locomotor ataxy. It confirms the natural expectation that the effect of injecting phosphate of soda is that which the drug is well known to produce when administered by the mouth. Some allowance must be made for the psychical influence of the hypodermic needle, and we are too apt to assume that organic disease implies the absence of a functional element, whereas, indeed, it renders its presence more probable. The fourth paragraph is instructive, and perhaps supplies the key to the matter. The “method” is there brought in line with certain practices that have become familiar. The injection of highly complex organic substances of which we know nothing for the cure of equally inscrutable diseases is a thing intelligible if not defensible. It requires on the part of its exponent a mind of a mediæval tendency combined with therapeutic enterprize and a faculty for ignoring the acquisitions of science. Such talents are common. Working in this direction, they throw back on a species of pharmacy which only requires an incantation and the magic circle to give it the genuine impress of a very respectable antiquity. The art, however, as applied to a disease whose pathology is well known, is demonstrably out of place. But when for the mystic agent there is further substituted a simple inorganic substance, such as phosphate of soda, it is difficult to detect a spot where credulity can lurk. Meanwhile the

unfortunate subjects of locomotor ataxy are athirst for information; they will clutch at any straw. Already they are clamoring for phosphate of soda, and in many instances will have it. Under these circumstances, I trust that the information I have quoted will enable the practitioner to moderate the hopes of his patient, and in the last resort to officiate himself at the rites so vaguely sketched by Dr. Winslow. So may we pass more speedily and with least discredit through the throes of the latest discovery.

A NEW TREATMENT OF MAMMARY ABSCESS.—Tweedy (*Medical Press and Circular*) adopts Weber's method of treating mammary abscess. An early and free incision is made in the breast, radiating from the nipple, and situated at the most dependent part of the abscess. The finger is then inserted into the wound and the gland structure broken down. This manipulation, it is stated, will have no bad effect on the healthy tissue. By this process several new cavities will be found, and these, in turn, are to be opened by an incision similar to the first, and the whole thoroughly douched with some antiseptic solution.

The membrane lining the several cavities is to be curetted, and the *debris* removed by a second douching. Strips of gauze sufficient to fill every interstice of the abscess are to be steeped in a one per cent. solution of carbolic acid, and inserted by means of a long sinus forceps and probe. A large flat sponge is then placed on the breast and tightly bandaged thereto for twenty-four hours. After this period the dressings are removed, and without further irrigation the cavities are again packed, the sponge and bandage being re-applied as before.

On the third day process is repeated. In the fourth dressing the gauze packing is dispensed with and the incisions are drawn together and marked antiseptically; the sponge and bandage are re-applied. This last process is repeated every twenty-four hours until healing is complete; this usually takes place about the tenth day. In one of the author's cases the whole process was accomplished without the aid of anaesthesia. In only one of his cases was it necessary to make a second incision. The incisions are never longer than is necessary to admit a finger. Iodoform gauze should be used for packing the wounds. The author only having treated five cases, cannot say definitely what portion of the above treatment is essential, but he is strongly inclined to the opinion that curetting can be safely dispensed with.—*Therap. Gaz.*

THE MORBID ANATOMY OF AKRONEGALY.—Squance, (*British Medical Journal*) has reported a case of akromegaly in a woman, thirty-five years old, who presented intense neuralgic pains through the temples and at the top of the head, and also

shooting pains at the back of the neck, accompanied by general languor and inability to apply herself to any prolonged occupation. Her memory was defective and her articulation slow and deliberate. There was no complaint of impairment of vision. The hands, the feet, the malar bones, and the maxillæ were enlarged. Diabetes developed, and, later on, pulmonary tuberculosis, to which the woman ultimately succumbed. Only a partial post-mortem examination was permitted. The head was increased in size, the face elongated; the malar bones were enlarged and prominent; the superior and inferior maxillæ were considerably hypertrophied, though the lower jaw did not project in advance of the upper. The eyelids were thickened and the supra-orbital ridges enlarged. The nostrils were considerably increased in size and very broad, and the ears were greatly hypertrophied. The hair was scanty and coarse, and the skin harsh and rough in appearance. The hands and feet were symmetrically enlarged; the nails were broad and the big toes large in proportion. The shafts of the long bones were not only considerably thickened, but they were also roughened, approximating the male type. The thorax was considerably enlarged, especially in the upper part; the ribs were uniformly hypertrophied, as were also the clavicles. In the lower cervical and in the upper dorsal region there was a certain amount of prominence of the spine. On opening the skull, the frontal, parietal, and occipital bones were found to be thickened, the hypertrophy principally involving the diploe. The brain weighed forty-six ounces and its membranes were normal. The pituitary body was considerably enlarged, and the canal between it and the third ventricle was patent. The optic nerves immediately in front of the commissure were much flattened, especially the right, which was exceedingly soft and tearing easily. The thyroid gland was enlarged and weighed nearly two ounces. The thymus gland was persistent, the left lobe being hypertrophied and passing behind and to the left of the manubrium sterni. The gland measured nearly two inches in length and weighed one ounce. Its surface was lobulated, its consistence pulpy, almost diffuent, and its color a brightish-pink.—*Med. News.*

CARBOLIC ACID IN FULL STRENGTH IN SURGERY.—Dr. Oscar H. Allis, of Philadelphia, in a recent paper before the Philadelphia Academy of Surgery, draws attention in a suggestive way to the use of pure carbolic acid in the after-treatment of surgical wounds. He was led to investigate the effects of the application by the successful experience of Dr. B. Gardner, of Bloomsburg.

Dr. Allis thus describes the method, which had its origin in an accident: "When Lister introduced his paste Dr. Gardner used it quite extensively. After an application to quite an extensive

wound surface he was surprised to find it turn white, and that he had used pure carbolic acid. He therefore immediately washed the surface and dressed the wound, keeping it open until oozing had ceased. The case did so well that it inaugurated with him a line of treatment that he had extensively employed. As a typical application let me take an amputation of the female breast. After its removal and the ligation of the bleeding vessels carbolic-acid crystals, dissolved in sufficient water for solution, are applied with a sponge to all parts of the cut surface. Immediately upon the application of the acid the tissues turn white, which is a guarantee of its thorough action. The wound surface is then washed with water previously sterilized by boiling, and approximated with provisions for drainage. This is especially necessary, as for twenty-four hours the oozing must find ready exit. During the first few days there is slight local hyperæmia along the border of approximation, but this declines without crisis."

It is claimed for carbolic acid applied in officinal strength, 1. That no systemic absorption attends its use, and hence no danger, no shock. 2. That it is a local anæsthetic. Hence there is not as much pain after the operation. 3. That it is in a measure a hæmostatic, acting especially upon the capillary vessels. Although the use of the acid as a direct application to wound surfaces, diseased membranes, and fungoid granulations is not new, we have presented to us some thoughts on its extended employment which may perhaps be profitably directed into practical channels. The good results of its employment in the open methods of treatment of hydrocele are suggestive and instructive in this instance. In intestinal surgery it also has its given range of application. Intra-abdominal stumps are often tipped with the pure acid with good results.

While it is not considered necessary in ordinary operative wounds, aseptically treated, it would seem to be proper in those cases in which thorough antiseptics is otherwise doubtful or impossible. Against the claim that it produces necrosis are cited numerous cases in which after the deeper tissues were whitened with the characteristic coagulation the wound was closed, healing by first intention. It may yet appear that pure carbolic acid has a rôle of its own in just those exceptional cases; at least it is deserving of a cautious trial in proper hands.—*Ed. Med. Rec.*

THE ETIOLOGY OF ACUTE ARTICULAR RHEUMATISM.—Sahli, *Deutsche Archiv für klinische Medizin*, contends that although the infectious nature of acute articular rheumatism has not yet been demonstrated, such an etiology is highly probable from the point of view of modern general pathology. In favor of such a causation are the acute

febrile course, the local involvement of the joints, and the tendency to complication by endocarditis and inflammation of serous membranes. Sahli reports the case of a girl, sixteen years old, with a second attack of acute articular rheumatism, complicated by endocarditis, pericarditis, bilateral pleurisy, and, finally, left-sided pneumonia, death suddenly taking place with cyanosis, perspiration, and heart-failure.

At the post-mortem examinations vegetations were found not only upon the leaflets of the mitral valves but also upon the aortic semilunar segments and upon the lateral leaflet of the tricuspid valve; the pulmonary leaflets were free. Inoculations were made upon agar and gelatin from the endocarditic excrescences, from the enlarged bronchial glands, the synovial membrane and the contents of an affected knee-joint, the thickened pericardium, the inflamed pleura, and from blood from the heart. In almost all instances pure cultures of a single organism developed, which corresponded in all essential characters with the staphylococcus pyogenes citreus. Animal inoculations yielded negative results. The conclusion is expressed that the organism found is to be looked upon as the cause of the disease. It remains to be determined whether this organism is a distinct one or a modified form of the staphylococcus pyogenes citreus. It seems possible (and the possibility is supported by evidence) that acute articular rheumatism may be caused by attenuated pyogenic cocci, and future investigation must determine whether a single or several species of organisms have an etiologic relation to the disease. The bacteriologic examination in the case reported indicates that the so-called complications of acute articular rheumatism (endocarditis, pericarditis, pleuritis) were etiologically related to the primary disease, of which they were thus not complications but merely localizations. In numerous other cases of acute rheumatism subsequently examined, staphylococci were also found in the contents of affected joints and in the blood.—*Am. Jour. Med. Sc.*

THE SEDATIVE ACTION OF DUBOISINE IN THE INSANE.—The following conclusions are based upon an extensive experience of this drug, given in continued doses of from 2 to 4 milligrammes:

1. Duboisine reveals itself as a marvellous sedative, capable of combating, always and in all cases, maniacal and melancholic agitation, often substituting an absolute tranquility for the most violent excitement or anxiety; its action presents itself in two degrees, the one incomplete, consisting of a simple attenuation of the exaltation, the other complete, and characterized by the total disappearance of the latter for a time more or less long.

2. The calm induced does not attain its maxi-

mum all at once; sometimes this does not occur till the second or third day.

3. Once produced, the calm is maintained very regularly so long as habituation does not manifest itself.

4. The more complete sedative action most often persists one or several days after stoppage of the drug, and often it happens that the calm is prolonged over a fairly long period.

5. In the intermittent and remittent forms of insanity, it is capable of reducing the duration of the attacks and of spacing them out.

6. The sedative action in all its degrees has been in general, particularly in the first days of treatment, in inverse proportion to the length of time that has elapsed since the administration of the remedy; hence the advantage of giving the drug in two doses daily.

7. The complete action occurs much more frequently in chronic than in acute mania, and, on the contrary, in acute than in chronic melancholia, and in a general way, in mania than in melancholia.

8. In general paralysis the complete action is less frequent than in chronic mania and acute melancholia, but more frequent than in acute mania and chronic melancholia, but, on the whole, general paralysis shows itself more sensible to the influence of the drug than the insanities.

9. Habituation occurs very promptly in the insane, is established very suddenly, and is not overcome by increasing the dose.

10. Tolerance is more frequent and more rapid in general paralysis, is more frequent in melancholia than in mania, and does not appear in the chronic forms of insanity.

11. The incomplete action is less frequent in general paralysis than in other forms of insanity.

12. In a general way it may be said that the drug is more active in general paralysis than in the insanities, in mania than in melancholia, in chronic than in acute mania, and in acute than in chronic melancholia.

13. Owing to its action on the stomach, it is well to administer the drug at times the most removed from the two principal meals.

14. It has, unfortunately, a very damaging effect upon the general nutrition, particularly when long continued.—*Glasgow Med. Jour.*

ENDOCARDITIS GONORRHOICA.—Leyden, *Deutsche med. Woch.*, relates the following case in a man, aged twenty-two. In April, he had swelling of one knee and both ankle-joints, and when admitted a month later the knee and left ankle-joints were still swollen. The clinical picture was characterized by (1) the presence of aortic and mitral disease; (2) irregular temperature with rigors; (3) repeated vomiting; (4) the development of acute nephritis; and (5) the malignant

course of the disease. The patient died in three weeks' time. One of the aortic cusps was destroyed by ulceration and covered with vegetations. There was a large mass of vegetations on one of the mitral cusps. There was only one breaking down infarct, and that in the spleen. The kidneys were swollen, hyperemic, and contained microscopic foci of softening. The myocardium also contained similar foci. From the literature of the subject here detailed it appears that (1) the relation of gonorrhœa to endocarditis is established; (2) a portion of such cases have a chronic course, and some even tend to recover; and (3) others have a malignant course. The bacteriological problem in gonorrhœal endocarditis has hitherto been unsolved. Some investigations have shown that the streptococcus was present in the valves, but generally they have been inconclusive. This case thus provided the opportunity of settling the question of the pathogeny of this endocarditis. The blood examined during life gave negative results, as also that taken from the auricle after death. The fibrinous deposits were examined bacteriologically by Michaelis. Gonococci were demonstrated (1) by their shape; (2) by their presence within the cells; and (3) by the facts that they were discolored by Gram's method, and very easily by alcohol and lavender oil. No other micro-organisms were found. That no cultivation experiments were made is not looked upon by the author as any real objection, as the above-named characteristics are sufficient. Although the settling down of the gonococci upon the endocardium is remarkable, it is not very surprising, as blood serum is a medium well suited to these micro-organisms.—*Physician and Surgeon.*

THE SURGICAL TREATMENT OF CERVICAL THORACIC AND ABDOMINAL ANEURISM.—In the *Annals of Surgery*, September, 1893, Nancrede submits the following conclusions: Cervical aneurism: (1) All methods should be supplemented by recumbency and diet. (2) Proximal compression, when feasible, should always be tried, and where the arterial coats are seriously diseased should supercede ligation. (3) "Needling" should supplement pressure when the case is progressing rapidly; possibly it is advisable in all cases suitable for compression, and is certainly to be employed where this method fails in cases with highly atheromatous vessels. (4) Proximal ligation, having been rendered much safer of late by the use of antiseptic precautions, less absorbent ligatures and the avoidance of all injury to the arterial walls by employing the "stay knot," is permissible when the walls are relatively sound until experience decides whether or not needling is superior in its results. (5) Since recurrence after proximal ligation almost certainly results from non-deposition of white thrombi, and their maintenance in con-

tact with the aneurismal wall from lack of proper changes of its lining, "needling" is then indicated. (6) Where the location prevents proximal arrest of the blood current, "needling" is the best operation; possibly distal compression—rarely feasible—might aid in the deposition of thrombi. (7) Although occasionally successful, the indications for the permanent introduction of such foreign bodies as wire, horse-hair, etc., into aneurismal sacs are so much better met by "needling" that such procedure had better not be adopted. (8) The modern revival of the older method of extirpation of aneurisms should not be attempted for spontaneous cervical aneurisms.—*Univ. Med. Mag.*

POISONING BY POTASSIUM CHLORATE.—The case of a shoemaker, aged eighteen, who died from the toxic effects of chlorate of potassium, is recorded by Dr. Ländlerer, of Berlin. The patient was ordered a gargle for tonsillitis, containing about half an ounce of the salt in a glass of warm water. He swallowed the whole in two drinks within half an hour. The first effects of the drugs were weariness, thirst, giddiness, followed rapidly by alarming symptoms, arising presumably from the action of the salt upon the blood, namely, acute anæmia, dyspnoea, cyanosis, persistent vomiting of a greenish fluid, pain in the hypochondria and around the umbilicus, with icterus. Hepatic, splenic, and renal symptoms then set in. During seven days' illness the urine eliminated did not exceed three and one-half ounces. Albumen was present from beginning to end. From the third day epithelial casts were sparingly present, while methemoglobin casts were found in great numbers from the very first day, and disappeared gradually with the clearing of the urine. The spectroscopic examination of the filtered urine gave the methemoglobin spectrum. Ländlerer considers:

1. That the poisoning is simply the action of the drug, which produces changes in the physiological condition of the blood.
2. Acute nephritis is not necessarily present in all cases; but where the illness is protracted it is seldom absent, owing to the mechanical irritation of the renal epithelium.
3. The icterus is partly hematogenous.
4. The vomiting, constipation, etc., are probably due to the fine gastric ulcers produced by capillary emboli, formed by the methemoglobin clots.
5. The cyanosis is due to the insufficient arterIALIZATION of the blood in the lung.
6. The best treatment in such cases, within twenty-four hours after swallowing the salt, would be venesection, followed by infusions of sodium chloride, or, better still, transfusions of defibrinated blood.
7. Internally potassium chlorate should not be used, more especially in children. The quantity

of the drug should be carefully limited in gargles, so that small doses may be taken in case of accident.—*Med. Press and Circular.*

INTRA-INTESTINAL INJECTIONS OF HOT WATER FOR THE RELIEF OF SHOCK, PARTICULARLY FROM HÆMORRHAGE.—Rutherford, *Rhode Island Medical Monthly*, has reported the case of a boy, nine years old, who was accidentally shot in the thigh. There was not much bleeding from the wound, but the leg soon became badly swollen and discolored. Examination showed that the swelling and discoloration arose from an extravasation of blood into the tissues, and it was decided to cut down upon and tie the bleeding vessel (the femoral artery), as the almost bloodless condition of the boy forbade the performance of amputation. In the course of the anæsthetization the pulse began to grow weaker, and doubts were felt as to the possibility of proceeding with the operation. In the hope of stimulating the patient a quart of hot water containing a small quantity of salt was pumped into the rectum by means of a catheter introduced deeply and connected with a Davidson's syringe. The pulse at once grew stronger and the skin assumed a more healthy appearance. The pulse again weakening after the lapse of fifteen minutes, two quarts of hot saline solution were injected into the rectum, the tube being introduced for a distance of seventeen inches. The presence of the fluid in the bowel caused an appreciable fulness of the abdomen, which rapidly subsided as the fluid was absorbed. Toward the completion of the operation an injection of two quarts of water had again to be made, the tube being introduced for a distance of twenty-three inches. The pulse now became strong, and the patient presented a better appearance than at the beginning of the operation. He lived for fourteen days, ultimately dying from septic infection and exhaustion consequent upon gangrene.—*Med. News.*

INTERSTITIAL NEPHRITIS.—If the kidneys are overtaxed by a highly nitrogenous diet as a man passes forty, they begin to tire and contract, and we have interstitial nephritis. They are usually people who eat meat three times a day. Nineteenths of these patients have an enlarged ventricle of the heart; but before we find any evidence of such enlargement we will find a very sharp accentuation of the second sound of the heart; the radial pulse is very hard, very tense, and very full. If a patient beyond forty years of age rises at night to pass urine more than once, or even once habitually, and there is nothing to account for in the way of irritable bladder, stricture, or cystitis, it is one of the most constant symptoms of interstitial nephritis, although it is not always present. Take the twenty-four hours' quantity to obtain the specific gravity. Place the patient upon an

ordinary mixed diet, and if the specific gravity of the urine is 1010 to 1014 go further and examine for urea. If we find, instead of ten grains of urea to the ounce, seven, eight, or six, the disease is advanced, and we have something tangible to show that the kidneys are incompetent; we have a lowered specific gravity and a lessened quantity of urea; the patient rising at night; we have an accented second sound of the heart, and we have interstitial nephritis in such cases whether there is albuminuria or not. It is very difficult to find hyaline casts by ordinary methods in interstitial nephritis. If the urine is concentrated you may find them.—*Med. Brief.*

CHEST PAINS.—These may be due to:

1. Intercostal neuralgia; tenderness at points only.
For neuralgia strap the chest and give arsenic, with an occasional mercurial purge. Quinine acts best after mercury.
2. Rheumatism of the fascia, the whole region being tender.
Chest rheumatism is connected with beer-drinking. The salicylates are useless; alkalies of doubtful utility. The best remedy is water drunk in enormous quantities.
3. Neuritis; circumscribed linear tenderness.
4. Acute pleurisy; chill, fever, friction sound.
5. Dry pleurisy; very common, relieved so surely by adhesive straps that this relief confirms the diagnosis.
6. Neuroma.
7. Aneurism; may not cause pain, even if large.
8. Cancer.
9. Ataxia.
10. Spinal disease.
11. Bronchitic pain; calls for strapping and opium.
12. Myalgia; relieved by straps.
13. Mitral disease; rarely painful.
14. Aortic disease; generally painful.
15. Dyspepsia; diffusible, radiating pains.
16. Diabetes mellitus, in later stages; pain at centre of sternum. A bad omen.
17. Zoster; pain may precede eruption for days.
18. Angina pectoris.
19. A pseudo-angina, occurring in women; not relieved by nitrites, but instantly by chloroform.
20. Phthisis.
21. Syphilis.
22. Gout.

—H. M. Brown, in *Cin. Med. Jour.*

DIAGNOSIS OF BREECH PRESENTATIONS BEFORE LABOR.—Pinard (*Rev. Médicale*) lays great stress on tenderness of the fundus. In some pregnant subjects who have passed the sixth month, pressure of the hand on the fundus causes sharp pain. Sometimes the patient feels pain without the part

being touched. In both cases the evidence of breech presentation is strong. This pain, or tenderness, is solely due to the pressure of the fetal head, which is harder and more bulky than any other part of the fetus, and distends the upper segment irregularly. That segment is not naturally designed to receive the head. Pinard especially notes that the pain disappears after version. The tenderness is influenced by the size of the head, the amount of liquor amnii, and the flaccidity of the uterine walls. This tenderness of the fundus is present in 70 per cent. of breech presentations.—*Br. Med. Jour.*

THE TREATMENT OF BLEPHARITIS MARGINALIS BY HYDROGEN DIOXID.—The treatment of blepharitis marginalis is often unsatisfactory and disappointing. Relapses frequently occur, and remedies seem to lose their effect, and at times even to act unfavorably. It is true that much of our success depends on the faithfulness of the patient or of his parents in carrying out the treatment at home. Much also depends on the physical condition of the patient, and this should always receive careful attention. Anomalies of refraction seem to play an important role in perpetuating the disease, and these also should be carefully corrected. But aside from these considerations, the treatment is often prolonged, taxing the patience of the physician as well as of the client.

The remedies prescribed for the relief of this disease are numerous, and all have met with more or less success. During the past year I have used with great satisfaction hydrogen dioxid in the treatment of this disease. I was led to its use by some experiments in cases with suppurating rings around the cilia. After removing the crusts and applying the dioxid, there was a bubbling and boiling effect for a while, which soon subsided, leaving the ulcerated surface whitened, as if a solution of silver nitrate had been used upon it. The application was almost painless, and the lid was left clean and free from pus or scales.

These experiments were followed by a general adoption of this method in nearly all cases, but especially in those with ulcerations along the lid-margin. My experience in a large number of cases justifies me in recommending this treatment, so that others may give it a trial. The manner of its application is as follows: The larger crusts should first be removed or scraped off, after having been softened by tepid water. Then a little cotton is wrapped tightly around a Japanese tooth-pick, which is dipped into the dioxid in a little dish. The cotton is then swept over the entire edge of the lid. The characteristic bubbling will follow, and the application is repeated until the bubbling ceases. If care is taken, and the cotton is not too freely saturated, none will come in contact with the conjunctiva. In order to obviate all pain, a

few drops of a 4 per cent. solution of cocain can first be instilled into the eye. This treatment should be repeated every day. The remedy is one that any intelligent person can apply at home, and one from which there is no danger. My experience with the use of salves and ointments is somewhat disappointing. They often cause unaccountable irritation, and on this account are unreliable. In the method advised a clean remedy is used, which acts promptly and efficiently. By its chemic action it destroys the germs which cling so closely to the edges of the lids. It is not a cure all or a specific, but I certainly have had the happiest results from its use.—*Med. News.*

FISHER, of New York, in a recent article on the treatment of high temperature in pneumonia of children (the post-graduate) favors most emphatically hydrotherapy in reference to antipyretic drugs. He advises the administration of a stimulant and good whisky before each bath, and states that this stimulation is not contra-indicated, even though the child has delirium, the quantity used depending upon the condition of the heart and the age of the patient. The gist of his conclusions is as follows:

1. That cold water is the best antipyretic used to-day.
2. That it is easily obtainable, and is, therefore, adapted to all classes of cases, both rich and poor.
3. The mode of application is so simple that it adapts itself to the hospital, and equally as well to private practice; and can be applied without any distinct training.
4. Cautiously given, it stimulates.
5. Carelessly used, and longer than required, it depresses and will produce sub-normal temperature.
6. The rectal temperature should be taken, and the bath at once discontinued when temperature falls to 101°F., as it will then continue to fall.
7. That a stimulant administered before the bath may be necessary, and should be given where there is a feeble heart.
8. That the temperature indicates when to commence and when, also, to discontinue the hydro-pathic treatment.
9. Unnecessary blanketing after the bath is injurious and will produce copious perspiration which, I believe, weakens the patient.
10. The temperature of them should always be between 68° and 72°F.—*Med. Mirror.*

THERE are now fifty-five towns and cities in England which destroy their garbage and solid refuse by burning, and 570 furnaces are employed for this purpose. In many cases the heat from these furnaces is used to produce steam, and the power is employed in pumping water and running electric light and power plants, and other purposes.

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SALICYLATES IN ACUTE RHEUMATISM.

Amongst the various remedies for the treatment of acute articular rheumatism the salicylates hold their own. They have much to recommend them, notably the rapid alleviation of pain, and fall of temperature. The latter is of considerable importance to the attending physician, the former of more consequence to the sufferer.

The question as to whether they lessen the chances of cardiac complication, the most grave side of rheumatism, seems not to be definitely settled as yet, though we are inclined to think the balance of opinion is in their favor in this respect. It is generally conceded that we have considerably advanced in the therapeutics of rheumatism since the days when Sir Thomas Watson being asked, "What is good for rheumatism?" answered, "Six weeks." If then the salicylates do no more good than to shorten the period of acute disease, they must, in that proportion, at least, lessen the liability to endocarditis.

Statistics can be made to prove almost anything, and the tables, and there are not a few of them, which go to show that salicylic acid and its congeners have no influence on the cardiac lesions, are, we believe, faulty; and chiefly so for the reason that they have been all made from hospital cases, which notably show a large number of heart complications. Hospital patients are usually not put upon the treatment for several days after the accession of the disease, they are badly nourished, badly clothed, and suffer from bad environment,

previous to their removal from their poor homes to the hospital ward; all of which reasons make it pretty clear why they should suffer more than private patients placed under exactly opposite and more favorable conditions from the inception of the disease.

If, however, a physician of large experience in private practice, will look at the matter carefully, we believe he will conclude that the use of the salicylates does lessen heart complications.

Again, this group of remedies have had the onus of giving a greater number of relapses than other, and especially the alkaline plan of, treatment. The fact, we believe, is true, but the reason is obvious. Owing to the much earlier subsidence of the fever, disability and pain, under the salicylates, both patient and physician are lulled into a false sense of security, and the necessary precautions, especially *rest in bed*, are not so rigidly taken, with the natural and inevitable result of more apparent relapses. The patient who has had the agony of the old six weeks of rheumatic fever, is so terrified of a renewal of his dolors, that he is extremely careful not to take any liberties with himself in his early convalescence; besides he is so anæmic, weak and worn, that he has no inclination to get out of bed and move about. When, however, at the end of from three to five days, under the salicylates, the fever, pain and restlessness subside, the patient, not so worn and weak, is altogether prone to take liberties with himself, not looking upon his attack as being so very grave after all; while the medical attendant is, unless strictly on guard, liable to allow liberties that he would not have allowed had the patient dragged through six or eight weeks of weary and painful illness.

It may be put down as a fact, that relapses will not be more frequent than under other plans of treatment if the convalescence is properly guarded, and the salicylates continued in less quantity, for from ten to fourteen days after the subsidence of the acute attack.

To get the best results from these drugs, it is necessary to give them in large doses at first. They are very rapidly eliminated, and he who hopes to get proper results from say 30 grains sod. sal. at intervals of six hours will certainly be disappointed. It should be given in say 20 or 25 grain doses every two hours for four doses, then

every four hours for four doses, and then every six hours, till the disease yields, and then continued in quantities of from 45 to 60 grains in the day for a fortnight. Rarely, cases are found which do not yield in from three to five days. The treatment should then be discontinued as inapplicable to the particular case under observation, and some other plan, preferably the alkaline plan adopted. As to the preparation used, the sodium salt has the field. There is no evidence that any other preparation is superior to it, and no other is perhaps so universally well borne by the stomach, if the drug be pure. Many of the stomach troubles arise from impure preparations, though they unfortunately do show, along with cinchonism, dimness of vision, delirium, hæmaturia, various skin eruptions, as urticaria, petechiæ and pruritus, in a few cases notwithstanding the absolute purity of the salt. It is said that the natural sodium salicylate should be preferred to the artificial, less untoward results being observed when the former is used.

ARSENIC AS A CAUSE OF MULTIPLE NEURITIS.

Dr. Thomas Buzzard, Physician to the National Hospital for Paralytics and Epileptics, London, in a post graduate lecture on some symptoms and varieties of multiple neuritis, during a graphic lecture, reminded his hearers that alcohol, rheumatism, diabetes, septicæmia and gout were perhaps the most frequent causes of multiple neuritis, but among the exceptional causes was the administration of arsenic.

A short time before he had seen a patient, the subject of congenital chorea, who had been treated with increasing doses of arsenic for two months. The largest dose, the man said, had been seventeen drops of Fowler's solution, three times a day. While under the influence of this treatment his hands and feet became somewhat inflamed, and the soles of his feet, and especially the toes, grew red and tender. He complained of a "pricking, pins-and-needle" sensation. The cutaneous sensibility was impaired and the skin of the hands peeled. The knee jerk was abolished on both sides. His feet felt like clogs, so that he could walk but little. Six or eight months afterwards the knee-jerks were present, but "required rein-

forcement." The cutaneous sensibility was still impaired in the hands. His fingers were clumsy and when touched gave rise to prickling feelings. He was, however, gradually recovering. Alcohol and syphilis could be excluded as a cause of this polyneuritis which had developed while the patient was taking increasing doses of arsenic, and which had gradually subsided when the drug was discontinued. Such a case represented as it were, the artificial production of multiple neuritis, and might be usefully remembered, not only on account of showing the grouped symptoms of multiple neuritis, but as a warning against a certain danger belonging to the employment of too large doses of arsenic, or too long use of this drug.

USES OF THE OPHTHALMOSCOPE.—In the *Journal of the American Medical Association, Lancet*, a paper appeared recently by Mr. Edward P. Morrow which gives very practical emphasis to the plea urged by some for a routine examination of the eyes in all obscure cases. Mr. Morrow relates two cases in neither of which had diagnosis—or at least a correct diagnosis—been made until the eyes were examined with the ophthalmoscope. The first case was that of a lad aged seventeen, who had had a fall from a bicycle about six months before he came under observation. The lad struck his head and remained temporarily unconscious. He was afterwards troubled with weakness more or less general, and at intervals with dizziness when walking. He subsequently had occasional vomiting, but never sufficiently to suggest that he might be suffering from a cerebral tumor. He then began to complain of his sight and Mr. Morrow was asked to examine his eyes. He found him to be suffering from intense optic neuritis with hæmorrhage in both eyes. He died a few weeks after this without any further sign than some epileptiform convulsions. At the necropsy a large glioma was found in the temporo-sphenoidal lobe on the right side. The second case was that of a young man aged nineteen, but his symptoms were such as to suggest a diagnosis long before the eyes were examined, for he first complained of giddiness and unsteadiness in walking. Subsequently he had also the attacks of vomiting and sank into a lethargic state. The discs at the time were only hyperæmic, but a few weeks later

they were much swollen and there were numerous hæmorrhages. He wasted away gradually and at last died suddenly. At the necropsy a glioma was found on the upper surface of the cerebellum, covering the superior vermiform process and extending about equally over each lateral lobe. These cases are interesting in themselves, and they certainly point a very strong moral—viz., the duty of examining the eyes in all obscure cases, especially if there should be occasional giddiness or vomiting.

THE PATHOLOGY OF SHOCK.—M. H. Roger, in an article on Shock in the current number of Dr. Brown-Séquard's *Archives de Physiologie*; *Lancet*, sums up the results of his observations in the following terms:—"Nervous shock is the collective series of phenomena resulting from a violent excitation of the nervous system. It is characterized by a series of inhibitory acts, one only of which is constant and indispensable—namely, the arrest of metabolism. Shock is more common in proportion to the development and activity of the nervous system. Circumstances which augment the excitability of the nervous system, such as emotions, distress of mind, and the like, predispose to shock; those which diminish it, such as narcosis and hybernation, prevent its production or render it less serious and persistent. The determining causes of shock may be divided into two groups, according to whether they act like traumatism and poison directly upon the nervous centres, or whether they act indirectly through the sensory nerves, the sensorial nerves, or the visceral nerves. From the point of view of pathological physiology shock is characterized by a series of dynamic modifications (dynamogeny or inhibition) affecting all the tissues, viscera, and secretions. The capital phenomenon is the arrest of metabolism, as a consequence of which there is a diminution in the quantity of carbonic acid gas in the venous blood, and consecutively to this troubles in calorification, respiration, and circulation occur. The treatment consists in opposing hypothermy and in favoring the formation of carbonic acid gas."

VERTICAL HANDWRITING.—The relation between one's penmanship and spine does not at first appear to be very close, *Ed. Boston Med. and Surg. Jour.*; but the direct and important hygienic

effect of the position of the body required in one or another style of penmanship is well brought out by the statement and illustration of Mr. Witherbee in a recent paper. In his "Argument for Vertical Handwriting," he adds to the plea for the more legible vertical style of writing, a forcible statement of the important effect upon the child's health and figure which a more rational handwriting entails. The Vienna Commission to investigate the cause of the increase of spinal curvature and ocular trouble among school children, reported that the chief factor was sloping handwriting and the faulty positions necessitated by it. The vertical script is easier to read, easier and quicker to write, as it requires a shorter distance for the pen to travel in making each letter; for the mathematical reason that the perpendicular of a right angled triangle is shorter than the hypotenuse. There is less strain upon the eyes as the position of the body faced squarely to the desk brings both eyes at an equal distance from the paper. With the lateral position taught in most of our schools the pupil must either twist the head to one side, adding to the spinal bend, or strain the accommodation of the eyes to unequal foci. The specimens of writing and photographs which are reproduced are most telling arguments for the justice of the plea, and aside from the arguments as to ease of teaching or reading or the elegance of appearance, the simple fact that vertical writing puts the pupil in a correct position as regards the spine and the eyes is sufficient grounds for its adoption in our school systems.

TREATMENT OF CHOREA.—Eskride, *Phila. Med. News*. The medicinal treatment advocated is as follows: the patient receives as many grains of antipyrine as he is years old, and the dose is increased one grain each night until all twitching stops. At the beginning of the treatment of mild cases one drop of Fowler's solution is given after each meal, and the dose increased one drop each day until the point of tolerance is reached; then the arsenic is discontinued for two or three days, or until all unpleasant effects have passed away, when the drug is again resumed at the dose reached when it was stopped. The dose is again increased one drop each day until tolerance is reached, when it is discontinued and resumed after two or three days as before. As soon as the

twitching ceases the antipyrine at bedtime is discontinued, and the patient given the syrup of the iodide of iron in from three to ten-drop doses, depending on the age of the patient. The arsenic and the iron are continued for two or three weeks after all symptoms of the disease have disappeared and the patient has regained considerable flesh.

In all but the mildest cases absolute rest in bed day and night is insisted on from the first. In the severe cases the same treatment is employed, except the arsenic is not begun until the twitchings have stopped from administration of the antipyrine, and after the second or third day of the administration the antipyrine is given only once in each twenty-four hours, and the time for its administration is between eight and nine o'clock in the evening.

The precautions necessary in the giving of antipyrine are: to be withheld in cases where there is much rise of temperature, when there is cardiac weakness; and in cardiac dilatation, and never give it unless patient is in bed.

As a rule children bear larger doses of arsenic than adults, and its administration is not followed by ill effects if given as indicated above, stopping until all unpleasant effects have passed away. As a rule, it should be given for a month or more after all choreic symptoms has ceased.

TREATMENT OF EPILEPSY.—In the *Liverpool Medico-Chirurgical Jour.*; *Lancet*, Dr. Alexander utters a word of warning against the indiscriminate use of bromides in cases of epilepsy, a warning which, we venture to say, is not unneeded. Nevertheless in the great majority of cases no other drug is so efficacious, and it is only in rare cases that it is completely contra-indicated. Dr. Alexander has observed good results from the combination of borax with bromides, especially with bromide of sodium. In twenty-six cases in which this combination was administered the fits were arrested for several months in nine cases; in seventeen they were diminished in frequency, while in one the attacks were uninfluenced, and in another they became more frequent. But perhaps the benefits of this treatment are more uniform in regard to the mental condition of the patients. Even in those who were subject to post-epileptic mental disturbance, and in others who remained dull and stupid for several days after a

fit, the mental disturbances entirely disappeared. There are, however, certain drawbacks to the administration. The full dose sometimes produces gastric troubles, flatulence, and loss of appetite. But this inconvenience is usually got rid of by care in administering the drug after food, and by caution in increasing the dose gradually. Skin eruptions may also be produced, especially after continuous administration for some time. These may be accompanied by intolerable itching, but the eruptions are said to subside usually even without discontinuing the use of the drug. Loss of hair, which may be complete, is a much more serious inconvenience. Dr. Alexander's experience seems to confirm that of previous observers in regard to the efficacy of borax in certain cases of epilepsy.

NOCTURNAL ENURESIS IN CHILDREN.—Freud *Neurol. Centrallbl.*; *Med. Summary*, states that on examining children affected with nocturnal incontinence of urine, he has discovered that about 30 per cent. of them exhibit an associated symptom that has not previously been described, namely a hypertonic condition of the crural adductors. To elicit the symptom the child is seated with its legs on a table; its feet are then grasped, and an endeavor is made to separate them as widely as possible in a horizontal direction. In a typical case the adductor spasm at first is considerable, but soon yields; on releasing the feet the legs spring back into contact. Spasticity also is found in the quadriceps extensor on attempting suddenly to flex the knee. The resistance here again is very pronounced at first, but quickly subsides. If flexion be then repeated only slight extensor-tension is observed. The deep reflexes are moderately increased in these cases; the muscles are firm and well developed; gait is natural and no other abnormality is present in the affected limbs. To a certain extent the spastic condition can be overcome by voluntary effort on the part of the patient; for instance, if the child be required to relax the adductors, rigidity temporarily disappears from them, although it continues in the extensors. As the phenomenon occurs in boys quite as frequently as in girls and very rarely exists in normal children, Freud considers that it is independent of emotion, such as fear or shame. He has been able to exclude spastic paraplegia and epilepsy from all

his cases. They have not shown any fixed relationship between the intensity of the hypertony and the degree and duration of the incontinence. Often he has seen the spasticity persist after the enuresis has been cured. He suggests that excessive spinal innervation of the detrusor and of the crural muscles may be a factor in the combinations of symptoms.

ONE CIGAR TOO MANY.—The late Sir Andrew Clark was so ardent in his crusade against over-eating and overdrinking, and so firm in his belief that in a large majority of cases diet would do far more than drugs, that he was a little too much inclined to take it for granted that his patients were self-indulgent to the ruin of their health. Among the many anecdotes to which his views gave rise, the following is one of the most amusing:—

A patient came to consult him, and was at once overwhelmed with directions on the subject of the life he should lead and the diet to which he should adhere. "Now, remember, only one glass of wine at each meal," the physician concluded, "and just one cigar after dinner won't hurt you. Good morning. Be sure you keep strictly to the one cigar."

"One cigar!" said the patient. "But——"

"My dear sir," broke in Sir Andrew, somewhat testily, "I must insist. If I am to treat you, you must follow my directions. I know quite well you will find it hard, but it is absolutely necessary for your health."

The patient heaved a deep sigh. "All right, Sir Andrew; since you insist I will do my best. Good morning."

He went his way, but his health did not improve, and at the end of a few weeks he returned to the physician's consulting room.

"No better?" said the doctor, but have you followed all my directions?"

"Absolutely," replied the visitor. "I must admit that the cigar was rather hard work at first, and in fact made me feel very ill; but I soon got used to it, and now I rather like it."

"Good heavens," said Sir Andrew, on whom the truth dawned, "do you mean to tell me——"

"Yes, I had never smoked before."—*Med. Rec.*

THE EMERGENCY TREATMENT OF A TOOTHACHE.

—Toothache, says John E. Weaver, M.D., in *Med. Rec.*, is a little thing in the books, but many physicians would rather meet a burglar at the door on a dark night than a call to cure a bad tooth ache of several days' continuance; a hypodermic of morphine only postpones the evil day, and usually the patient is respectfully referred to the dentist. The tooth should not be extracted while the jaw and gums are inflamed and the latter swollen, and it is the physician's duty to treat the case until the above conditions are removed. Always keep a small phial containing the following mixture: Chloroform, gtt. x.; glycerine, gtt. x.; sat. sol. ac. carbol., gtt. x.; morphine, gr. j., with a small wad of absorbent cotton. If the offending tooth has a cavity or decayed surface, saturate a small pellet of cotton with the above mixture and put into the cavity, or against the decayed surface, as the case may be—never pack the cotton in, or the more is the trouble—but have the pellet small enough to enter without crowding. In most cases, this will end the trouble. When the gums are swollen and tender, paint two or three times, two minutes apart, with a four per cent. solution of cocaine. This time of year, your patient may have been eating a good deal of fruit. The tongue and mucous membrane of the mouth are pale, stomach sour, and next day the toothache will return. Give ten grains of sub-carbonate of bismuth and ten grains of phenacetin at once, and a similar dose before each of the three following meals, with a laxative if needed, and stop all fruit for a few days, and it will not return. The same powder every two hours, with cessation of fruit eating, will stop the persistent, tormenting neuralgias so prevalent at this season.

REST IN THE TREATMENT OF CHLOROTIC ANÆMIA.—Dr. Frederick Taylor believes, *Pract.*, that the very important factor which has been too little regarded, or even ignored altogether, is physical or bodily rest. Arguments which are advanced are: an essential feature of the developed disease is a deficiency of the hæmoglobin in the blood. By saving the expenditure of hæmoglobin the patient may utilize what little she has to greater effect, and sooner arrive at a favorable balance than if her income in food, in oxygen, and in iron alone were cared for, while the expenditure in muscular exercise and the additional employ-

ment of the respiratory and cardiac functions were entirely neglected. If the heart is found to be dilated the argument is all the stronger, since this is a sufficient ground for requiring that physical rest shall be enjoined. It is a familiar fact that these cases improve rapidly when admitted to a hospital, although it cannot be urged that they are very much benefited by the air, food, or exercise which they get there. Iron should be given in the most suitable form, and a perfect action of the bowels should be maintained. Against fresh air nothing can be said so long as it does not involve exercise, either by walking or riding. In slighter degrees of anæmia, or in one already recovering, carriage exercise may be allowed, while in the severer forms the patient may with advantage be kept in bed entirely—the most certain means of keeping a patient most absolutely at rest. An intermediate prescription is that the patient shall get up only for three or four hours in the afternoon.

THE VALUE OF THE HANDS AND OF THE FINGERS.—Surgeons have often to estimate the chances of saving injured hands, *Med. News*, and the comparative values of hands and fingers. According to a scale of value furnished by the Miners' Union and Miners' Accident Insurance Companies of Germany, the loss of both hands is valued at 100 per cent., or the whole ability to earn a living. Losing the right hand depreciates the value of an individual as a worker 70 to 80 per cent., while the loss of the left hand represents from 60 to 70 per cent. of the earnings of both hands. The thumb is reckoned to be worth from 20 to 30 per cent. of the earnings. The first finger of the right hand is valued at from 14 to 18 per cent., that of the left hand at from 8 to 13.5 per cent. The middle finger is worth from 10 to 16 per cent. The third finger stands least of all in value; although like other useless members of the community, it is surrounded by riches, its value is only from 7 to 10 per cent. The little finger is worth from 9 to 12 per cent. The difference in the per centages is occasioned by the difference in the trade, the first finger being, for instance, more valuable to a writer than to a digger.

DEATH.—Dr. Geo. Henry Boultter, ex-M.P.P., aged 68 years, one of the oldest and most

respected of the citizens of Stirling, died at his residence on the 18th January, after a week's illness with bronchitis. The doctor graduated at McGill in 1852, and started practice in Roslin, where he remained a very short time, coming to Stirling in 1853. He started a drug store in connection with his practice. For sixteen years he was M.P.P., representing North Hastings, and for twenty-seven, was Lieutenant-Colonel in the Hastings Rifles. As a practitioner in medicine he was distinguished for his ability, and highly esteemed by his *confrères*. In every public enterprise wherein he was associated, as warden of Hastings County, as chairman of the High and Common School Board, as a prominent Freemason, as a zealous adherent of the Presbyterian church, as an honored physician, as a citizen, without reproach, he was most energetic and beneficial. He died an honor to Stirling, and Demorestville, Prince Edward County, his native village. He was buried with military honors.

CHLOROFORM AS A TAPE-WORM REMEDY.—Dr. Stephen, *Ell Raccogitore Medico*, has recently confirmed the action of the chloroform as a tenicide, he having been able to expel tape-worms with this remedy which had resisted all other measures. He employs Thompson's formula :

R Pure chloroform . . . gms. 4
Simple syrup . . . gms. 03

M. Sig.—To be taken in four doses, at seven, nine, eleven and at one in the afternoon. At noon take an ounce of castor oil.

All his patients bore the chloroform well, and it was even administered to children in proper proportions.

INCONTINENCE OF URINE.—In using belladonna for incontinence of urine in children, Watson prefers, *North-Western Lancet*, the alkaloid atropine or its sulphate. He makes a solution of one grain of the atropia in an ounce of distilled water, and gives as a daily dose as many drops of this solution as the child is years old, giving an average dose of five to eight drops. If this does not produce the well-known physiological symptoms of the drug it is necessary to push it further, as the trouble is seldom relieved unless these symptoms appear. It is well-known that atropine is well borne by children.

FERMENTATIVE DYSPEPSIA.—Dr. Austin Flint, in an article recently read before the New York State Medical Association, very highly recommends bismuth subgallate in the treatment of fermentative or functional dyspepsia. He states that nearly every case of functional dyspepsia that has come under his observation within the last year has been successfully treated by bismuth subgallate. He gives this preparation in five-grain doses, either before or after meals. Dr. Flint claims that the use of pepsin and pancreatin is of little or no use in this form of dyspepsia.

POLY-PHARMACY EXTRAORDINARY.—The following prescription has been handed to us for publication as an example of the scientific combination of drugs. The *result* of the mixture, expressed in any chemical, or physio-chemical compound is beyond us.

R—Spts. terebinth, - - - - - ʒ iv.
 Ether. sulph., - - - - - ʒ ij.
 Tinct. gent. co., - - - - - ʒ ivp.
 Mag. sulph., - - - - - ʒ j.
 Pulv. trag. co., - - - - - ʒ ij.
 Pot. nit., - - - - - ʒ iip.
 Tinct. nuc vom., - - - - - ʒ iip.
 Acid. nit. mur. dil., - - - - ʒ iip.
 Bis. trisnit., - - - - -
 Lactopep., - - - - - āā ʒ ij.
 Syr. acaciæ, - - - - - ad ʒ vi.—M.
 Sig.—ʒ js. t. i. d.

BORAX IN BLADDER TROUBLES.—There seems to be a tendency to use borax more and more internally. *The Southern Clinic*. In all bladder troubles ten grains of the powder is given several times a day. In cystitis it certainly produces good results. Torchinsky has tried it in 240 cases of typhoid fever during an epidemic, and reports 231 cases of success; 10 to 15 grains were given, and in the first three to five days the fever and diarrhoea diminished, tympanitis almost disappeared, and the stools became normal in character. As soon as this effect was produced the boric acid was discontinued and tonics given. In the later stages of the disease quinine was added to the boric acid, when there were any cerebral symptoms.

EUCALYPTUS.—I have used this drug in some two hundred cases of bronchial catarrh, and can

speak highly of its virtues. *Med. Fortnightly*. It is a stimulating expectorant, and hence only finds a proper field in cases where secretion is already established. It should not be administered when the bronchial mucous membrane is in the stage of active inflammation. Though difficult of administration, I have found very few patients who objected to its use. Three were compelled to decrease its use because it produced a curious cerebral exhilaration, not unlike alcohol intoxication. The formula I use for adults is :

R—Eucalyptol, - - - - - ʒ ss.
 Pulv. acaciæ, - - - - - ʒ j.
 Glycerine, - - - - - ʒ j.
 Syr. zingiberis, - - - - - ad ʒ vj.—M.

Sig.—A dessertspoonful three times daily after meals.

I have found it of great use in the protracted bronchial catarrh following la grippe.

TABLE GIVING THE RELATIVE FREQUENCY OF THE CONDITIONS PRODUCING HEART HYPERTROPHY.—105 cases, *Johns Hopkins Hosp. Rep.* :

	Cases.	Per cent.
Arterio-sclerosis in	62	59
Nephritis,	14	13.4
Valvular lesions,	13	12.4
Adherent pericardium,	8	7.6
Work,	4	3.8
Tumors,	2	1.9
Aneurism of heart wall,	1	0.95

TO CUT SHORT WHOOPING COUGH IN TWENTY-FOUR HOURS.—*The Illustrated Med. Jour.* says that Dr. Moncoro treats pertussis with a ten per cent. solution of resorcin, by applying the solution every two hours to the periglottal region with a throat brush. The application is made four or five times at each seance. The theory of the treatment is that the disease is due to micro-organism and affects primarily the larynx. Cultures of the micro-organisms have been destroyed by the smallest amount of resorcin.

NITRO-GLYCERIN FOR VOMITING.—A contributor to the *British Medical Journal* recommends this nitro-glycerin as the most positive remedy for controlling vomiting he has ever employed. He has found it will control all forms of vomiting, whether in adult or infant, acute or chronic. He has found it of great service in controlling vomit-

ing of gastric catarrh, and in alcohol it acted almost as a specific. Also proved useful in controlling the vomiting of pregnancy.

D. GRANVILLE L. FOX, Slate Springs, Miss., says: I have used papine in two cases of typhoid fever. In all my practice of four years I have never yet found any preparation or combination that acted so admirably as anodyne. Sometimes I combine it with bromidia and get the best of results. I expect to keep it on hand from now on, as I do not know of anything that would exactly replace it in the experience I have had with it.

URTICARIA, a disease attended by the generation of an excessive amount of acid in the alimentary tube, *Med. Summary*, is almost unfailingly cured by ten drops of nitro-muriatic acid in a wineglassful of water one hour before eating.

HALF a teaspoonful of the ammonium chloride in a goblet of water, is said to restore a drunken man to his mind and physical powers.

Books and Pamphlets.

A TREATISE ON THE SCIENCE AND PRACTICE OF MIDWIFERY. By W. S. Playfair, M.D., F.R.C.P., Professor of Obstetric Medicine in King's College, London; Examiner in Midwifery to the Universities of Cambridge and London, and to the Royal College of Physicians. Sixth American, from the eighth English, edition. Edited, with additions, by Robert P. Harris, M.D. In one octavo volume of 497 pages, with 217 engravings and 5 plates. Cloth, \$4.00; leather, \$5.00. Philadelphia: Lea Brothers & Co. Toronto: Carveth & Co. 1893.

The demand for eight English and six American editions of this standard work in seventeen years, testifies to the success with which the author has executed his original purpose. His object "has been to place in the hands of his readers an epitome of the science and practice of midwifery which embodies all recent advances." He has "endeavored to dwell especially on the practical part of the subject, so as to make the work a useful guide in this most anxious and responsible branch of the profession." The present issue is the result of a thorough revision of its predecessor

at the hands of the author. It has likewise received the benefit of careful revision by Dr. Robert P. Harris, of Philadelphia, whose annotations in this and in previous editions have covered the points wherein American practice differs from that of English obstetricians. The work will continue to be a favorite text-book for students and a trustworthy guide for the practitioner.

MINOR SURGERY AND BANDAGING. By Henry R. Wharton, M.D., Demonstrator of Surgery in the University of Pennsylvania. In one 12mo volume of 529 pages, with 416 engravings, many being photographic. Cloth, \$3. Philadelphia: Lea Bros. & Co. Toronto: Carveth & Co. 1893.

In response to the demand for a second edition, the author has revised his work to make it represent in every way the advances of the two years which have elapsed since its first appearance. The exceptionally rich and beautiful series of illustrations, in connection with a singularly clear text, afford the student and practitioner all needed instruction in the many procedures grouped under the title. The pictures of bandaging are photographically reproduced from actual life. The author has construed his title very generously, and has placed within the covers far more information than is usually accredited to minor surgery, but readers will scarcely object to such liberality. Antiseptic surgery is dealt with in accordance with the latest and most approved practice.

HEALTHY HOSPITALS. Observations on some points connected with hospital construction, by Sir Douglas Galton, Late Royal Engineer, K.C.B., Hon. D.C.L., LL.D., F.R.S., Assoc. Inst. C.E., M.I. Mech. E., etc., formerly Secretary Railway Department, Board of Trade; Assistant Inspector-General of Fortifications; Assistant Under-Secretary of State for War; Director of Public Works and Buildings. With illustrations. Oxford: Clarendon Press. London: H. K. Lewis, Gower St.

A scientific and carefully arranged work. It will be of great value to carpenters and architects.

THE PHARMACOPOEIA OF THE U. S. A. Seventh Decennial Revision. 1890. By authority of the National Convention for revising the pharmacopoeia, held at Washington, 1890. Official from Jan. 1st, 1894. Philadelphia: P. Blakiston, Son & Co. Toronto: Carveth & Co.