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THE ETIOLOGY AND TREATMENT
OF ECZEMA.*

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Toronto.

When your secretary honored me by the request to read a paper before this Association, I thought I would be able to present one of some little originality, at least from a clinical standpoint. Owing, however, to a variety of engagements, I could not find time to prepare such a paper, and concluded instead to give a plain talk on the etiology and treatment of eczema. Many of you will, no doubt, be quite familiar with the methods of treatment which will be given; but it may be of service to us all thus to review our knowledge of this very practical subject.

Eczema is a catarrhal inflammation of the skin, which, like other inflammatory processes, is due to some form of irritation. This irritation may be either of internal or external character, and it may be here stated that the internal are usually the predisposing and the external the exciting causes of the disease. An abnormal condition of the digestive and assimilative functions is one of the most frequent causes. Dyspepsia and constipation are often found in eczematous cases. In these conditions toxic products are, in all probability, reabsorbed and

produce a poisoned state of the blood. Mal-assimilation is also a frequent condition. Products not sufficiently oxidized circulate in the blood, probably as uric and oxalic acid, which, with other less known bodies, act as irritants in the causation of eczema. Faulty excretion, by the retention of toxic agents, acts in the same way. From these considerations it will not be surprising to find eczema present in cases of glycosuria and albuminuria. Some years ago I had under observation a case of almost universal eczema in a child which demonstrated the connection which often exists between this disease and the formation of uric acid. The child was strong and healthy until two years and a half old, when symptoms of indigestion appeared; these were soon followed by a rash upon the skin, accompanied by severe itching; then the kidneys exhibited signs of irritation, as shown by pains in the back and frequent desire to micturate. The child remained in a wretched condition for many months. The irritation of the skin was extreme; in fact, an almost universal eczema. Symptoms of dyspepsia were present. The urine was at times albuminous, and always contained an excess of uric acid. It was noticed on several occasions that when an exacerbation of the skin affection occurred, the irritability of the bladder increased and an immense amount of uric acid was discharged. Crystals in large quantities would form as soon as the urine cooled. Another curious fact was also noticed, viz., when soothing applications succeeded in lessening the irritation the quantity

* A paper read before the Huron Medical Association, Oct., 1891.

of uric acid diminished. It would thus appear that a very close relationship existed between the condition of the skin and the formation and excretion of uric acid. After about a year's treatment the patient became perfectly well, and is now a strong and healthy girl.

A class of cases in which we find eczema frequently is made up of those who eat and drink too much and who take too little exercise. They are plethoric and have a tendency to the formation of fat, and present frequently a more or less sallow appearance. If such persons are in the habit of drinking beer, the digestive function will be much impaired; foul tongue, occasional attacks of mild catarrh of the stomach, and more or less jaundice are very frequent symptoms. In such cases there exists constantly a great strain on the excretory organs to rid the system of excess of sub-oxidized substances; and if those organs become deranged, this excess in the blood is still greater. Neurasthenia is frequently the cause of attacks of eczema. Owing to a depressed state of the nervous system, the functions of digestion and assimilation are improperly performed, and we have as a result a poisoned state of the blood. In this class of cases, although the result, so far as the blood is concerned, may be similar to that of the plethoric conditions, the cause is very different, and the treatment must, therefore, be different also. It is very probable that the oxidation of food products in the blood is largely accomplished in the liver, and that, therefore, this organ is frequently deranged in case of eczema. I am quite conscious of the fact that in thus speaking of the internal causes of eczema a good many indefinite terms have been used, but we cannot help using them until we obtain more accurate knowledge of the physiological and pathological processes connected with digestion and assimilation. We must also remember that the careful observations of the clinicians have usually led the way to the discovery of great pathological facts. The view that eczema is ever hereditary is now somewhat questioned. I am positive that I have seen many cases of a hereditary character, notably in one family, where I know it to have existed in four generations. In gout and rheumatism eczema is often present as well as that condition which Dr. Murchison called lithæ-

mia, a condition which I have to some extent already described. Bulkley states that eczema and asthma often exist together. I have frequently seen asthma and ichthyosis in the same patient; and as the latter condition predisposes to eczema, this may account to some extent for the concurrence of the two diseases. Very often when an eczema has arisen from purely local causes the skin takes on a diseased habit, and the abnormal condition will continue long after the local cause has been removed. This will often account for the continuance of an eczema in a patient whose functions are quite healthy. Dentition, although rarely the cause of an eczema, frequently precedes an exacerbation of the disease and assists in prolonging it. A reflex irritation of the nerve centres is frequently the immediate cause of an eczema. This may come from the intestinal tract, uterus, or, as Crocker says, from the skin itself. Dr. Jamieson thinks that the abuse of tea is a fruitful cause of eczema. The ingestion of such indigestible food as cheese, salt meat, etc., acts as cause by reflex influence. Vaccination may be the cause of eczema.

The local or external causes of eczema may briefly be stated to consist of sudden changes of temperature, exposure to cold and dampness, chilling of the surface, chemical and mechanical irritants, including parasites. It has, of course, been long recognized that such parasites as pediculi, acari, etc., are frequent causes of eczema. More recently it has been shown that the vegetable growths are a frequent cause of the prolongation of an eczema, and sometimes of the origin also. That form described by Unna as seborrhœic eczema is always parasitic. The parasitic element in the local causation of eczema must always be taken into consideration in the treatment. An eczematous surface is, without doubt, a good soil for the growth of various forms of bacteria. Unna, however, in my opinion, goes too far when he makes the statement that eczema is always of parasitic origin. Various trades and occupations are often the cause of eczema, and, although we know this to be a fact, we sometimes omit to make enquiries upon the point. Articles of domestic use, such as soaps, are often a cause of this disease. I remember the case of a family of children who suffered from eczema,

where I found they used a coarse form of hard soap. When they ceased using this the disease disappeared. In undertaking the treatment of an obstinate case of eczema, it is absolutely necessary that a careful study of it should be made in all its aspects. The various organs of the body should be examined to find out if there is either organic or functional disease. The habits of the patient as to eating, drinking, and the amount of exercise, should be inquired into. As a general rule, facts will be brought out by such an examination which will be of great importance in the management of the case. Indigestion, a condition so often found, must be carefully treated. The regulation of the diet, excluding such articles of food as are known to disagree, is in all cases necessary. In such plethoric patients as I have described, a complete change in the methods of living may require to be enjoined. Less food, and that of a plainer character, with increased exercise, may be advised. In cases of flatulent dyspepsia it may be necessary to exclude starchy food, and to place the patient upon the scraped beef and hot water diet. In this way fermentation is prevented. Nearly all of these cases are complicated by constipation, and remedies for the latter have an excellent effect upon the dyspepsia. The most frequent aperient I use is from that simple formula which is associated with Starin's name: *R. Magnes. sulph. ʒi., ferri sulph. grs. iii., acid sulph. dil. mx*, in combination with a simple bitter infusion. This taken half an hour before breakfast in a half tumbler of hot water has an excellent effect. In place of this other aperients may be used, such as Carlsbad salts, Hunjadi Janos water, cascara, or the pulv. glycyrrhizæ co. Calomel in $\frac{1}{4}$ gr. tablets, one given at night two or three times a week, has a favorable action on the liver. Bulkley's prescription of potas. acetate. and tr. nux vomica is a very useful one. In those neurasthenic cases a similar condition of the bowels may be found, which must be treated in the same way. It will be found necessary in such cases to find the cause of the neurasthenic condition and remove it. At the same time measures must be adopted for building up the system, such as massage, rest, and the internal administration of the phosphates and arsenic. The pure phosphorus is an invaluable remedy

in such cases if the stomach will bear it. In gouty cases pot. iod. and lithia may be given in addition to other remedies indicated. As to the question of diet in the treatment of eczema, much difference of opinion has arisen. It may be stated, as a general rule, that such articles of diet as are known to derange the stomach, such as pickles, pork, and pastry, must be interdicted, and that such as are known to build up the system enjoined. No rule can be laid down. One patient may take too much meat, and this must be either lessened or excluded. On the other hand, another may take too much starchy food, and it may be necessary to exclude this. We can only come to correct conclusions by carefully studying each case.

In infantile eczema the management of the diet is the principal part of the treatment of the case. I may safely say that I have seldom met with eczema in children where I have not, upon enquiry, found grave errors in diet. It would be impossible for me to go into the subject at present, any more than to say that such general rules must be followed as will support the child, and at the same time avoid irritation of the digestive tract. As a remedy for such irritation, Dr. Crocker recommends the following mixture: *R. Sodæ bicarb. grs. v.; spts. chloroform, m. i.; aq. anetni ʒi.* For a child a year old, hydrar. creta may be given in one grain doses three times a week.

It is impossible in a paper such as this to go into a description of the many forms of treatment necessary in such a variety of cases. I have, however, said enough to indicate that abnormal conditions of the internal organs must be sought for, and if possible remedied. Now, as to specific remedies, arsenic has had the greatest reputation. Not so many years ago it was used altogether too freely, and it is now a question if the pendulum does not swing too far in the opposite direction. In the dry and scaly form of this disease, arsenic is certainly beneficial, and in some of the moist forms, when the disease depends on malaria, this remedy has also a good effect. It is certainly safe to say that in proper cases arsenic has a positive effect in the cure of eczema. It should, of course, not be given in acute inflammatory conditions.

In the eczema of children, particularly in those of an anæmic character, cod liver oil is almost

a specific, and it is sometimes surprising that so nauseous a remedy is so well borne by the stomach. Antimony has been recommended by Malcolm Morris, and Dr. Piffard speaks highly of the use of the viola tricolor. Spts. terebinthum in from ten to fifteen minim doses has been strongly recommended by Dr. Crocker. The latter authority recommends counter irritation over the spine in cases in which the vasomotor system appears to play an important part.

In the local treatment of eczema, care must be taken to fully appreciate the abnormal condition present and to suit the remedy to each case. If there is excessive irritability, soothing applications and protection from the air may be indispensable. If, on the other hand, a low, indolent process is present, stimulation may be necessary.

Again, if there is much induration, due to the organization of inflammatory products, remedies to remove this may be required.

The external remedies may therefore be divided into sedative astringents, protectives, alteratives, absorbents, and anti-pruritics. In many cases the same remedy may be sedative and protective, thus belonging to more than one class.

A preparatory treatment is necessary in those cases where the surface is covered by scabs or scales. These may be best removed by the plentiful use of oil and a poultice, or by the application of a saturated solution of boracic acid. In the most irritable forms of acute eczema, powders are preferable to any other form of application. They may be applied by dusting the surface or by means of powder bags. The use of the latter was suggested by Unna. They are made of fine cambric, and of a shape and size suitable to the part to which they are to be applied. They are filled with fine powder and quilted across so that the contents will not be easily moved from one part to another. They are of most service in cases where it is necessary to keep two raw surfaces apart; for instance, under the breast or in the folds of the groin. A constant powder application is thus made. The powders used most frequently are: Pulv. amyli, pulv. talci, acid boracic, zinci oxidi kaolin, oleate of zinc, and acid salicylic. By using various combinations

of these a drying, protective, or astringent and antiseptic effect may be produced. It is absolutely necessary that the powder should be very fine and should not contain any coarse particles.

A combination recommended by Martindale is as follows:

| | | | | |
|-------------------|---|---|---|------|
| R.—Acid salicylic | - | - | - | 3.0 |
| Talci | - | - | - | 87.0 |
| Pulv. amyli | - | - | - | 10.0 |

Another, recommended by Jamieson:

| | | | | |
|--------------------|---|---|---|-----|
| R.—Cerasini | - | - | - | 1.0 |
| Kaolin | - | - | - | 2.5 |
| Pulv. acid borac'c | - | - | - | 1.0 |
| Zinci oxidi | - | - | - | .5 |

Lotions are also used in acute eczema. They are protectives, sedatives, and astringents, and of stimulating character. To the former belong the simple lead lotion, the black wash, lead and opium wash, etc. The following is a sedative and protective lotion of general utility:

| | | | | |
|-------------|---|---|---|------|
| R.—Calamine | - | - | - | ʒj. |
| Zinci ox. | - | - | - | ʒii. |
| Glycerini | - | - | - | ʒij. |
| Aq. ad. | - | - | - | ʒvi. |

Apply with a large soft brush.

Ointments are not to be recommended in the acute stage of an eczema, but are of great service after the irritable condition has passed off, or in the subacute forms. Of these the old ung zinci ox., either alone or with vaseline, still holds its place.

When a cooling effect is desired, an ointment made up with cold cream or a similar substance as a base has an excellent effect. The following has been recommended by Dr. Jamieson as a substitute for cold cream:

| | | | |
|--------------------------|---|----|-------|
| R.—Aq. rosæ ol. amygdala | - | aa | ʒx. |
| Cera alb. cetacei | - | - | aaʒi. |

An ointment made up as follows can be used on almost any form of eczema:

| | | | |
|--------------------|---|---|---------|
| R.—Zinci carbonate | - | - | ʒi. |
| Acid salicylic | - | - | grs. x. |
| Vaseline | - | - | ʒi. |
| Cerat galeni ad | - | - | ʒi. |

It is especially useful in eczema of the face or lips.

Some ointments are applied in order to have a continuous effect. They prevent exposure to the air and act also as astringents and sedatives. The most useful of this class is the

drachylon ointment, which was so much used by Hebra. It should be made in the following way :

"The oil is to be mixed with a pint of water and heated by means of a steam bath to boiling, the finely-powdered litharge being sifted in and stirred continually ; the boiling is to be kept up until the minute particles of litharge have entirely disappeared. During the cooking process a few ounces more of water are to be added from time to time, so that when completed water still remains in the vessel. The mixture is to be stirred until cool." The olive oil and litharge should be of the best quality.

Diachylon ointment, as used here, is usually made by melting together equal parts of olive oil and lead plaster. I have found that made according to Hebra's formula to be the best. It is first spread over strips of old cotton and applied over the diseased surface. It is probably one of the best and most generally used ointments, and can be applied in a large class of cases.

Similar continuous applications may be made by the salve muslins of Unna. That one containing zinc ichthyolate is especially useful.* I have also used, particularly for eczema of the palms of the hands, the salve muslin containing salicylic acid.

In the chronic and indolent form of eczema, stimulating and alterative preparations are indicated. The mercurial ointments produce their beneficial effects largely on account of their character as parasitocides.

The tar preparations are specially useful in dry, scaly eczemas. The oil of Cade is most frequently used, and may be combined with the simple drachylon ointment. *Ol. rusci* is much more expensive, and is not any better than the oil of Cade. Salicylic acid is an excellent agent, particularly if there is much scaling and thickening of the skin.

As permanent dressings the pastes are very useful, particularly in the case of children, where it is almost impossible to prevent the ointment from being rubbed off.

Lassar's paste is the most generally used :

| | | | |
|--------------------|---|---|---------|
| Rx.—Acid salicylic | - | - | grs. x. |
| Vaseline | - | - | ʒss. |
| Zinci oxid. | - | - | ʒi. |
| Pulv. amyli | - | - | aaʒii. |

This may be applied to any part of the body except the palms of the hands, the soles of the feet, and the eyelids. It acts as an astringent and protective.

The formula of Ihle's paste is as follows :

| | | | |
|--------------|---|---|---------|
| Rx.—Resorcin | - | - | grs. x. |
| Lanolin | - | - | |
| Vaseline | - | - | |
| Zinci oxidi | - | - | |
| Pulv. amyli | - | - | aaʒii. |

This, similarly to Lassar's, is first spread on fine old cotton and applied.

Some years ago a number of permanent dressings were introduced by Prof. Pick, of Prague. They have since been improved by Unna. The basis is a mixture of glycerine and gelatine in various proportions. They require to be heated in a water bath before application. They are in this way liquefied, and when they come in contact with the skin they form a thin elastic covering. They act as protectives, astringents, and sedatives. They need not be changed oftener than twice a week. Care should be taken not to use them where there is much exudation, as the latter collects under the dressing and produces irritation.

The following formula I have most frequently employed :

| | | | |
|--------------|---|---|----------|
| Rx.—Gelatine | - | - | 15 parts |
| Zinci ox. | - | - | 10 " |
| Glycerini | - | - | 30 " |
| Aq. | - | - | 40 " |

This preparation is easily made by gradually heating together the ingredients in the proportions given above.

Another formula is given by Jamieson :

| | | | |
|--------------|---|---|----------|
| Rx.—Gelatine | - | - | 15 parts |
| Zinci ox. | - | - | 10 " |
| Adipis | - | - | 10 " |
| Glycerini | - | - | 65 " |

These are heated together over a water bath, and two per cent. of salicylic acid added. These preparations are especially useful when protection is needed. I have seen some of the most irritable itching forms of eczema wonderfully improved by these applications.

Another protective application is that made by dissolving rubber in chloroform. This was introduced by Auspitz, of Vienna, under the name of traumaticin. It was used, however, by Dr. Bethune, of this city, and by myself at his suggestion, some years before Auspitz's publication.

Many agents, such as zinci, oxide, etc., may be applied mixed with traumaticin in the same proportions as in the ordinary ointments. After its application to the skin the chloroform evaporates, leaving a thin covering of rubber, which adheres closely to the surface and is with difficulty removed. It is especially useful in eczema of the hands and feet.

Soaps are of great use in the old and indolent eczemas. The two most frequently used by me are the *sapo viridis* of Hebra, and the overfatty soap of Unna. The latter is used in the more irritable conditions. Many indolent eczemas of the legs may be successfully treated by Hebra's method of using *sapo viridis* and drachylon ointment. The ointment is first spread on strips of cotton ready for use. The green soap is then applied to the parts, washed off with hot water, and the limb is thoroughly and quickly dried, when the ointment is applied and the leg bandaged.

In all the acute forms of eczema water must be excluded. In chronic eczema of the legs, accompanied by great thickening of the skin, the application of very hot water by means of a sponge has an excellent effect, and will aid in reducing the induration. In varicose eczemas the passive congestion is remedied by the application of the rubber bandage.

In conclusion, I will repeat my first statement. It is necessary to know, in the first place, the pathological process which is going on, and, in the second place, the nature of the agents you use, in order to successfully treat eczema by external applications. Each case must be carefully studied, and the effects of the application closely observed.

ACUTE PANCREATITIS, WITH HEMORRHAGE AND FAT NECROSIS.

BY JOHN CAVEN, B.A., M.D., L.R.C.P. LOND., AND WM. OLDRIGHT, M.A., M.D.

So little, comparatively speaking, is generally known, as yet, of the morbid conditions occurring in the pancreas that no excuse seems necessary when recording cases observed.

Amongst the recognized diseases of the pancreas, apart from neoplasms, hemorrhage and inflammation are perhaps the most important.

Hemorrhage into the pancreas is, on all hands, admitted to be the cause of death in a series of cases, in some of which the end of life comes suddenly, almost instantly, whilst in others the patient succumbs after an illness of at longest a few hours' duration. A satisfactory explanation of the occurrence of pancreatic hemorrhage, unaccompanied by inflammation, has not yet been brought forward. Vascular changes have been spoken of, but not proven; aneurysm, whilst naturally suggesting itself, has not been shown to exist. Fatty changes in the gland itself and a nervous origin have also been suggested.

Pancreatitis may be primary or secondary, the latter variety occurring in the course of pyæmia when it is suppurative, or as the result of a new growth, carcinoma most commonly, or calculus.

Instances of primary pancreatitis are so rare, or, at any rate, so infrequently recognized during life and proven by *post mortem* examination, that the number of them throws but little obstacle in the path of the student; on the other hand, the paucity of reliable and complete records renders accurate study and classification a matter of considerable difficulty.

The most exhaustive analysis of such cases that has yet been brought before the medical profession is to be found in the monograph on acute pancreatitis by Dr. Fitz, of Harvard University, being the Middleton-Goldsmith lecture for 1889.

Dr. Fitz, as a result of his investigations, not only of all recorded cases which he has been able to find, but of a relatively large number which he has been fortunate enough to have seen, classifies those showing inflammation under the heads: hemorrhagic pancreatitis, suppurative pancreatitis, and gangrenous pancreatitis. Any one of these forms may be accompanied by fat necrosis, in which disseminated nodules of necrosed fat, varying in size, are to be found scattered through the fatty deposits in the omentum, mesentery, subperitoneal tissue, and around and within the pancreas itself.

Acute pancreatitis is to be described anatomically as consisting in "degenerative changes in the parenchymatous cells, or exudation in the interstitial issue, or both these factors" (Fitz).

In all acute infectious diseases the parenchyma-

ma of the pancreas, as of other glands, may be more or less affected by changes embraced under the name of cloudy swelling, which are supposed to be the initial stages of parenchymatous inflammation. In the class of cases under consideration at present, however, the changes are much more marked, and the interstitial processes are, no doubt, a large part of all instances of "genuine acute pancreatitis."

With regard to causation, acute pancreatitis is said to result in many cases from an "extension of a gastro-duodenal inflammation along the pancreatic duct." It may also depend upon hemorrhage, or be the cause of hemorrhage. In the following case the hemorrhage evidently accompanied or resulted from the inflammation, and did not cause it. No inflammatory process could be traced from the duodenum.

One of the most interesting, and at the same time difficult, problems in these cases is that of the causation of the accompanying fat necroses. Bacteria have been found in and around the necrotic patches by Chiari, and, as will be seen further on, the reporters of this case have also to speak of micro-organisms seen; but it is extremely doubtful whether these are more than accidental contaminations of the tissue. No proof can be offered of a causal relationship.

Balser concluded from examination of several cases of various diseases in which fat necroses existed along with other morbid conditions that an *excessive growth* of fat cells may cause death of fat and be associated with hemorrhage, either the necrosis or hemorrhage causing the death of the patient. Such an explanation can be of no effect in the case we are to report, since the amount of fat present was by no means excessive in any part of the body, and, moreover, Virchow thought that the changes spoken of by Balser as fat necroses were merely cadaveric, as proven by the absence of any vital reaction in their neighborhood.

Robert Langshans, of Berlin, in a contribution to the "Festschrift," dedicated to Virchow in honor of his seventieth birthday, describes a series of experiments made by him upon dogs and rabbits with the object of determining whether or not ferments derived from the pancreas itself could give rise to fat necroses. His procedure in conducting these experiments

was quite simple, consisting in the injection into adipose tissue in the animals used of a watery solution of pancreas rubbed up in a mortar with fine glass. The results of twelve such experiments are tabulated, and in one only (a rabbit being the animal used) was any satisfactory conclusion reached. In this case fat necrosis, similar to that seen in cases of pancreatitis, was observed and fully described. Langshans has since undertaken a new series of experiments in the hope of confirming and concluding what has already been done; but meanwhile we are justified in considering his single successful result as at least very suggestive.

The following case is one of pancreatitis, with hemorrhage and fat necrosis:

Dr. Oldright was called to see Miss H. during the forenoon of Monday, October 5th, 1891, the message indicating that she was in severe pain, afterwards found to be referred to epigastrium. The intensity of the pain may be inferred from the fact that two messages were sent within fifteen minutes. On questioning it was found that the patient, in addition to an ordinary breakfast, had eaten a number of grapes, swallowing the skins. A diagnosis of acute dyspepsia was made and treatment to suit ordered, a small dose of morphine being given with other remedies. Within an hour and a half the physician was summoned again, the epigastric pain having become very intense, and being described now as passing through the back and up under the shoulder blades; vomiting had occurred, a quantity of grape skins constituting part of the vomited matter. A hypodermic of morphia was given to relieve urgent symptoms, and purgatives prescribed in order to clear the alimentary canal; at this time also a purgative enema was administered, with little result. During the next twenty-four hours opiates and carminatives were exhibited, and counter-irritants and fomentations applied externally. On Tuesday afternoon the patient appeared much better, and so far no rise of either pulse or temperature had been observed, but towards the evening the temperature rose to 101° F., and the radial pulse beat 100 to the minute; continued pressure over the lower part of the abdomen disclosed tenderness; treatment, opium in large doses and hot fomenta-

tions. On Wednesday morning the pain had subsided to a great extent, but nausea was marked. Opiates were now omitted and purgatives again administered—calomel, Seidlitz powder, and enemata. Bowels were moved thrice between 12 o'clock a.m. and 3 o'clock p.m., many grape seeds and skins passing. Shortly before 3 p.m. the physician was sent for, the report being that the patient had lost the use of her limbs. This motor paralysis was found to be complete in the arms and partial in the legs. Sensation also was impaired, more noticeably in the right arm than elsewhere. Hysteria from exhaustion was suspected, and a consultation asked for. About 8 o'clock p.m. Dr. J. E. Graham saw the patient with Dr. Oldright. The condition then was about the same as before: pupils, normal; pulse, 50 beats to the minute; muscles of neck paralyzed; sphincters, all right; patellar reflex was not obtained, but the test could not be made satisfactorily; no reflex gagging occurred on tickling the fauces; no paralysis of muscles of face or tongue; voice like that of a person with swollen tonsils; no albuminuria. The patient was then moved into a larger room, and was immediately seized with a severe epileptiform attack, which threatened suffocation, there being much spasm of the facial muscles. This convulsion was limited to the face and neck. Soon afterwards she seemed more comfortable. Pot. brom. and assafoetida were given by the mouth and rectum. At the request of her friends, Dr. A. J. Johnson was now called in consultation, meeting Drs. Graham and Oldright about 11 o'clock p.m. Dr. Graham and Johnson left about midnight. Shortly afterwards Dr. Oldright left the sickroom, going downstairs; he had been seated but a few minutes when the nurse came down to ask a question, received her answer, went upstairs and immediately called the doctor, who, on reaching the bedroom, found the patient dead. A friend in the room said she had been seized with a convulsive attack similar to the one described above and died in it.

The family history in this case is good in all respects, and throws no light upon it.

Post mortem examination of the body was made next morning about twelve hours after death.

Report: Inspection shows the body of a female of apparently about thirty years of age; nutrition very good; *rigor mortis* well marked; *post mortem* staining well marked in usual positions; external orifices all right.

Section: Shows a large amount of subcutaneous and subperitoneal fat; muscle in good condition; omentum presents numerous yellowish white nodules, varying in size from that of an ordinary bean downwards, in which, on cutting them open, whitish spots like caseous matter are found—these were at first supposed to be tubercles; mesenteric glands are enlarged and some show central opaque whitish areas as from necrosis; all the abdominal viscera exhibit marked venous congestion, but, with the exception of the pancreas, appear otherwise healthy; the thoracic viscera are in very good condition; heart contains fluid blood and no clots.

Pancreas: Much larger than usual in cross measurement and also thickened; the capsule is tense and distended over the parenchyma by a reddish fluid, and here and there upon the surface yellowish spots similar to those in the omentum are to be seen; similar spots are noticed in the peripancreatic tissue. On cutting into the organ a quantity of blood at once oozes from its surface, the whole tissue seeming to be soaked with it. Closer inspection shows that the blood is diffused through the interstitial tissue and underneath the capsule, but does not apparently invade the parenchyma. At no point is a clot visible. No ruptured vessels can be found, nor are there macroscopic changes noticeable in the vessels anywhere in the body. The brain and spinal cord also were carefully examined, and appeared to be in a perfectly sound condition.

Microscopic Examination: Parts of the pancreas, mesenteric glands, and omental nodules were submitted to microscopic examination, with the following results:

(a) *Pancreas:* The interstitial structures show considerable infiltration with blood, the capsule, subcapsular tissue, and interlobular bands near the surface being by far most affected. No changes can be made out in the vessel walls, but they are crammed with blood corpuscles; the stripping off of the endothelium of the arteries is very remarkable, the cells being mixed through the clotted blood in the vessels. The

capsule is also in places considerably infiltrated with inflammatory cells. In the fat tissue in the neighborhood of the capsule and adherent to it are necrosed patches similar to those described below, and even the fat which is not otherwise affected shows marked small cell infiltration. In the interlobular tissue, acute inflammation is in process, as indicated by round cell infiltration, but this is patchy. The parenchyma of the organ in parts presents areas of cell necrosis without definite signs of inflammation; in others merely cloudy swelling; whilst in others round cell infiltration is so dense as to completely destroy lobular structure. At no place can abnormal collections of fat be seen in the pancreas. The condition, then, is one of acute interstitial and parenchymatous pancreatitis, with hemorrhage and necrosis. No blood appears *within* the lobules.

(b) *Mesenteric glands*: Swollen; dense small cell infiltration of periphery, with central, necrosis, the necrotic areas being quite soft in the gross specimen.

(c) *Omental nodules*: These are seen on examination to consist of greatly modified fat tissue. A division into two zones, and in some cases three, can readily be made out. In the central and middle zones the cells retain their outline fairly well, and can generally be accurately delimited with the eye; in the outermost zone, in parts, only granular debris infiltrated with inflammatory corpuscles can be recognized. In many of the fat cells of both inner zones the cell contents are collected into a large globule located centrally in the cell, with either clear areas or granular matter surrounding; in many instances these globules are of a marked bright yellow color. The cells of the central area, as a whole, stain with carmine much more feebly than those of the middle zone, although both stain markedly enough. Taken from centre to circumference the cell contents can be better described as finely granular than otherwise, some being completely filled out, others only partially so. Fat crystals are to be seen in a few of the mid-zone cells, but not generally. The zone of the inflammatory reaction is narrow, as compared with the size of the whole nodule, and composed in large part of granular debris, leucocytes, and proliferated, connective tissue cells. In a few spots fat cells

have broken down and collections of free oil globules are visible. This has happened near the outer zone. Staining for the bacillus tuberculosis gives a negative result, but treatment of sections, with methyl blue only shows numerous small rods, occurring singly or in pairs, scattered through the inflammatory zone, but very few being seen in the central areas. These rods vary considerably in length (4 to 10 *m.*), free individuals being longer than the articles of a pair. In single rods the ends are rounded. Spore formation is noticed in the longer rods. No micro-organisms have been seen in the pancreatic sections. Attempts at cultivation have failed.

Selections.

THE REACTION OF URINE WITH ETHER.

BY ANDREW H. SMITH, M.D.,

Professor of Clinical Medicine at the New York Post-Graduate Medical School; Physician to the Presbyterian Hospital.

If a specimen of urine, taken promiscuously, be thoroughly agitated in a test-tube with half its bulk of pure sulphuric ether, there will result, in most instances, an abundant white foam. If now the tube be corked and set aside, this foam rises to the surface and gradually condenses into a greyish gelatinous plug, so firm, it may be, that the tube can be turned upside down without disturbing its contents. In another smaller proportion of cases no foam will result from the agitation, and the ether will immediately separate from the urine and form a clear layer above it. In some instances a second prolonged agitation after the elapse of a few moments will produce the reaction described. In other cases it may be obtained by adding a few drops of acetic acid and shaking the tube again very thoroughly. It will always be noticed that when the reaction occurs the fluid begins to clear first at the bottom, and the clearing progresses upward. When the reaction does not take place the order is reversed, a clear layer of ether appearing first at the top. Pending a thorough chemical investigation as to the nature of the substance thus separated from the urine, I find that the reaction occurs in urine which does not respond to any of the

tests for albumen or for peptones. It occurs also in urine from which the phosphates have been removed, and it cannot be obtained with simple solutions of urea or of the urates. It is most abundant in the urine of those who have a good appetite and good digestion, and is usually absent after long fasting, or when the diet is greatly restricted. From these facts it seems probable that it represents an excess of nutritive material taken into the blood and thrown off by the kidneys, and not a product of disassimilation. Albuminous urine responds to the test in the same way and under the same conditions as normal urine; but if the patient is on restricted diet and the urine does not react to the test, it can be made to do so by adding nitric acid and filtering out the resulting precipitate. A portion of the albumen is redissolved by the acid, and at the time so modified that it is acted upon by the ether. This is shown by the fact that if the albumen be removed by heat and filtration before the acid is added, the reaction cannot be produced; but if a drop or two of acid be placed upon the filter, the filtrate immediately responds to the test. The same effect may be produced by acid spontaneously generated in the urine, so that a specimen of albuminous urine which will not show the reaction while fresh may do so after the acid fermentation has progressed for twenty-four or forty-eight hours.

It is possible that the presence of this material in the urine, and its peculiar reaction with ether, may explain some cases of anuria after prolonged etherisation. The ether being eliminated by the kidneys and mixing intimately with the urine in the tubules affords all the necessary conditions for plugging the latter with gelatinous material, too firm to be displaced, suspension of function necessarily following. Until we know more of the possible reactions of this substance, it will be well to receive with caution the results of some of the more "delicate" tests supposed to detect the presence of minute proportions of albumen.—*Lancet*.

THE MORALITY OF VIVISECTION. — The article on "Vivisection," by the Rev. L. J. Wallace, published in the March issue of the *Westminster Review*, is a significant indication of

what the verdict of any dispassionate and rightly-informed layman must ultimately become. The question, Is vivisection useful? is one that hardly needs discussion in the *British Medical Journal*. The antivivisectionists themselves have for the most part ceased to seriously rely upon ignorant denials of the utility of physiological experiment to medical knowledge, and therefore to remedial power. Consciously or unconsciously, the knowledge acquired by the more thoughtful antivivisectionists in the course of controversy has led them to give more prominence to the broader issue summed up in a negative answer to the question, Is it moral?

Mr. Wallace, after discussing the utilitarian aspect, approaches the broad ethical issue in a dispassionate and judicial spirit. Reviewing the evidence on both sides, he recognizes that the antivivisection propaganda has been the outcome of emotions, misled by "descriptions" of a very partial and very exaggerated character, and he warns those who so recklessly impute evil that it may be immoral for the man of science to *abstain* from vivisection.

"A great moral force is working on behalf of the physiologists. Suffering and death are on every side of them, and, if by any fair means they can alleviate one and retard the other, they have no right to neglect these means. They are, so far as their power extends, debtors to humanity, and they would act an immoral part if they declined to make any legitimate effort to discharge this debt." This is the language of a man who, in presence of an ethical problem which has forced itself upon his conscience, has felt it his first duty to acquaint himself with the conditions and circumstances of that problem.

We most heartily welcome examination of this character; the bare details of vivisection are repugnant to every healthy mind; they are repugnant to the mind of the physiologist himself if he imagines them as dissociated from their motive. Vivisection is employed thoughtfully, reluctantly, and sparingly, but it is employed of imperious necessity. We wish that those impulsive antivivisectionists whose feelings have been outraged by the horrible imaginings to which they have given themselves up could have seen it to be their duty to search the springs of their own convictions, and to

admit as possible that the convictions of physiologists might be entitled to their respect. Upon no other condition than that of mutual respect can that corrective modification of mind by mind be secured which is essential to moral development. The motive of science and the instinct of mercy may and should exist in the same mind; the domination of one mind by one tendency, with a contempt or a hatred of another mind, is hurtful to both. We believe that at present the moral defect is greater on the side of the mercy-mongers than on that of the secret-searchers. But we also believe that the best men of both tendencies feel that mutual respect which is the condition of mental and moral commerce. It would hardly be possible to-day, for any man to avow a total disregard for the sufferings of the animals he experimented upon; nor could an educated thinker write to-day, as was written from the Athenæum Club by Mr. Lilly, that "the results obtained by researches in the latrine and brothel are of precisely the same value as those which the vivisector derives from the torture trough." We would advise the conscientious antivivisectionist to read Mr. Wallace's article. It may lead him to distrust the leadings of "moralists" of the type of Mr. Lilly, who writes on two successive pages (one of them headed with the attractive title, "Artists in Filth and in Torture"): "I regard it (that is, vivisection) as absolutely unethical, and should condemn it unhesitatingly, however great the advantage resulting from it might be." . . . "I should be glad to see legislative sanction given to the proposal that vivisectors should make experiments on themselves and on one another."—*British Medical Journal*.

OPERATION FOR SPASMODIC TORTICOLLIS.—Some advance appears to have been made in the surgical treatment of this most distressing affection; but until its pathology is more clearly ascertained, we cannot hope that the results of treatment will be anything like uniformly successful. One point that lies on the surface is the variations met with in different cases. In one patient the sterno-mastoid muscle may be the only one affected, in another it will not be implicated at all, and similar variations are met with in the case of the other muscles which

rotate the head. It is, therefore, difficult in some cases to determine exactly what muscles are implicated and to what nerves treatment must be directed. Difficulty also arises from the depth at which some of the muscles and the nerves supplying them are placed, so that any operation on these nerves involves a very deep dissection. Nerve-stretching, even when very thoroughly carried out, has not been attended with success, and simple division of the nerves has not given better results. Surgeons are now dealing with these cases by the free excision of the nerves supplying the affected muscles, removing the nerves as near to their central ends as possible. Last year M. Petit recorded twenty-six cases in which he had excised the spinal accessory nerve. Of these, in thirteen a successful result was obtained, seven were much improved, two were slightly better, and three enjoyed temporary benefit only, while one patient died from phlegmonous erysipelas. The operation in question is a comparatively simple measure. The more difficult cases are those in which the posterior muscles are involved. Early last year Dr. W. W. Keen recorded a case in which he had excised muscular branches of the posterior divisions of the first, second, and third cervical nerves with marked benefit, but not complete success. Soon after, Mr. Noble Smith recorded a case in which he had performed the same operation on the second, third, and fourth cervical nerves. Dr. Powers has now related a third instance of this operation, in which he exactly followed Dr. Keen's procedure. The last two patients were greatly benefited by the operation. Dr. Keen makes a transverse incision carried down through the complexus. Mr. Smith employed a vertical incision. The results thus obtained are well worthy the attention of surgeons, although the treatment is only empirical.—*Lancet*.

TOBACCO AND DEPOPULATION.—Thoughtful Frenchmen, it is well known, are coming to regard with some uneasiness the signs of stagnation, if not of actual decrease, in the population of their country. Malthusian doctrines, however attractive in point of economy, do not now appear to exercise that fascination which once was theirs, and which we cannot doubt has much to do with the reduction of reproductive.

energy. We are reminded, however, by the author of a paper on this subject recently published, that other causes may have contributed somewhat to the same result. Under the heading of "Le Tabac et la Depopulation de la France" M. E. Decroix, who is the founder of a society intended to check the abuse of tobacco, assures us that, among such, a prominent place must be assigned to the influence of tobacco. The arguments by which he seeks to fortify this opinion are by no means void of ingenuity, and are supported by the evidence of investigations and information contributed by various medical men, and of the vital statistics afforded by different departments of the country. Among the former there seems to be a consensus of opinion that tobacco consumed in excess exhibits in various degrees a constant sedative influence upon the reproductive system. A series of experiments by Dr. Depierras are quoted in order to show that the same rule holds good among the lower animals. In this case the offspring of cock and male rabbits exposed to the fumes of tobacco are said to have proved feebler and shorter-lived than those born under natural conditions. The conclusions founded upon statistical testimony are very emphatic, more so, indeed, than we should consider to be justified by the accuracy of the method pursued in this enquiry. After comparing ten departments in which a greater, with ten others in which a less, amount of tobacco is consumed, M. Decroix, by summing up their collective disparities, has no difficulty in showing that in the former there is a marked excess of deaths, of stillbirths, of divorces, of illegitimacy, which he takes to be a mark of morbid vitality, and a falling off in the size of families. When, however, we compare the departments with each other separately, we frequently miss that evident connection between cause and effect which the author's views on tobacco would lead us to expect, and it is clear that we must in many cases allow for the action of other influences in producing the result for which it is blamed. Under the circumstances we cannot agree with all the propositions advanced in this paper. At the same time it cannot be denied that the excessive use of "the fragrant weed" is to be numbered among the forces opposed to a continuance of healthy life.—*Lancet*.

THE
Canadian Practitioner

A SEMI-MONTHLY REVIEW OF THE PROGRESS
OF THE MEDICAL SCIENCES.

Contributions of various descriptions are invited. We shall be glad to receive from our friends everywhere current medical news of general interest.

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TORONTO, MAY 2, 1892.

PUBLIC HEALTH ACT AND INFECTIOUS DISEASES.

We think it very important that reports of contagious diseases should be sent to the proper authorities, in accordance with section 80 of the Public Health Act. Although the proper observance of this regulation involves a certain amount of labor on the part of the physician, for which he receives no remuneration, we believe the profession of Toronto, as a whole, have shown a commendable desire to conform with the requirements respecting such reports.

Section 86 of the Act provides that any one neglecting his duties in such matters shall become liable to a penalty of \$20. Many have objected to such a provision; but we believe that past experience has shown that, without the penal clause, the Act would be to a large extent useless.

While, however, we are willing to support the observance of the laws, we must appreciate the fact that it is no trifling matter to have a respectable and reputable physician dragged into the police court, as Dr. Baines was, and subjected to the humiliation of the imposition of a fine for the violation of a law. The court, showing more sense than the accuser, recognized the fact that the doctor had shown no desire to evade the law, had actually reported the case, had been in the habit of reporting his cases, but in this instance had not done so within 24 hours after a diagnosis had been made, and imposed only a nominal fine. As we understand it, the case was one of naso-pharyngeal diphtheria in a young man, æt. 24, which terminated fatally in three days. Every pre-

caution was taken in the way of disinfection and isolation. Two trained nurses were obtained. Doctor Baines spent a large portion of his time, day and night, endeavoring both to save his patient's life, and to prevent the spread of the disease. The tremendous worry and anxiety to which he was subjected can well be understood and appreciated by all medical practitioners; and we think that the additional burden of his police court humiliation was, under the circumstances, quite uncalled for. Dr. Baines' friends were extremely pleased to learn that he was able to pay his fine—of one dollar—and thereby escape imprisonment; while the Medical Health officer has the proud satisfaction of knowing that he "won his suit."

THE WINNIPEG GENERAL HOSPITAL AND DR. FERGUSON.

We regret to learn from the *Northern Lancet and Pharmacist*, that Dr. A. H. Ferguson has been dismissed from the staff of the Winnipeg General Hospital by the authorities of that institution. The *Lancet* says that this action was "without shadow of cause or justification," and goes on to comment as follows: "Had Dr. Ferguson committed a grave crime, scander courtesy could not have been extended to him. No intimation of his dismissal had, or has been given to him even up to the present, his first appraisal of it being a paragraph in the *Free Press* newspaper giving the names of the professional staff appointed for the ensuing year, Dr. Gray's name being substituted for his. . . ."

"The students regard Dr. Ferguson as their teacher in surgery, and have entered a public and indignantly worded protest at this action of the hospital authorities, which they have sent to the public papers. They have very fairly pointed out that the fees they pay to the hospital for the instruction they receive within its walls form a considerable item of revenue, and that the dismissal of Dr. Ferguson deprives them of the instruction for which their fees were paid, and that perseverance in the course the governors have adopted will necessitate their going elsewhere for their surgical education."

Dr. Ferguson's career is well known to many in Toronto. He took his degree in Trinity Medical College, and graduated in the Univer-

sities of Toronto and Trinity College in 1881. He has been practising several years in Winnipeg, and has been highly successful. He was one of the promoters and strong workers in the Manitoba Medical College, in which he was Registrar and Professor of Surgery. We know nothing about the merits of the trouble between Dr. Ferguson and the hospital authorities beyond what we have learned from the editorial of the *Lancet*, from which we have taken a few extracts; but we feel very sorry that an act which must affect seriously the relationship existing between the medical college and the hospital should have been considered necessary by the governors of the latter institution.

THE MEDICAL ALUMNI ASSOCIATION OF THE UNIVERSITY OF TORONTO.

The annual meeting of this Association will be held in the Convocation Hall of the University on the afternoon of May 6th, immediately after the special convocation of the Medical Faculty. At a meeting of the Council held April 19th, it was decided to have a dinner on the same evening at Mr. Harry Webb's restaurant. A strong committee was appointed to make arrangements, and we understand that they are working with great enthusiasm, being determined to make it the most successful dinner in the history of the Association up to the present time. If they make it equal to the pleasant entertainment of last year, it will be quite satisfactory to all parties. There will be no official invited guests, but members will be allowed to bring friends on payment of one dollar and fifty cents for each. The charge for members will be two dollars each. This will include the annual fee for membership.

We have been requested to state that as some matters of considerable importance will be brought before the Association at the annual meeting, it is very desirable that there be a large attendance. The President and members of the Council would like especially to see the cities and towns outside of Toronto well represented.

CREDE, the distinguished obstetrician, died at Leipzig, March 14th.

ONTARIO MEDICAL ASSOCIATION.

The twelfth annual meeting of the Association will be held in Toronto on the 1st and 2nd of June. The topics for discussion will include "Diphtheria," "Antiseptics in Surgery," "Hay Fever," "The Third Stage of Labor," and "The Therapeutics of Constipation." Addresses are expected from some prominent American physicians.

A feature of this meeting will be two symposias of four papers each upon "Hip-Joint Disease—its early diagnosis; expectant, operative, and mechanical treatment"; "The Pneumonia of Children—differential diagnosis: from tuberculosis; from pleural effusion; general prognosis."

Papers of interest have been promised by various members.

The names of readers and subjects of papers should be sent to the Secretary by the 10th of May. Forms of application for membership may be obtained from the Secretary. Return tickets will be issued at one fare and one-third.

Meeting of Medical Societies.

CLINICAL SOCIETY OF MARYLAND.

WM. T. WATSON, M.D., *Secretary.*

Baltimore, Feb. 19th, 1892. The 262nd regular meeting of the society was called to order by President Robert W. Johnson.

Dr. Hiram Woods read a paper on

THE TREATMENT OF GRANULAR CONJUNCTIVITIS,

and exhibited patients treated by the method he now uses, viz., that of Dr. Knapp, which is the squeezing out of the spawn-like lymph follicles by means of forceps specially adapted to the purpose.

Case 1.—A man with pannus of three months' duration. Had been treated all this time with bluestone, with no improvement. Forceps were used very gently; some granulations pressed out. Considerable pain and much bleeding from conjunctiva ensued. Following day the man's eyes were wide open and photophobia completely relieved. Squeezed out some more granulations. He came back next day with conjunctiva quite clear. Has not returned since.

Case 2.—Girl with so-called diffused trachoma of two years' duration. Was treated all last summer with bluestone. In November was suffering intensely; the entire upper lid of right eye covered with spawn-like soft follicular granulations extending over on to the ocular conjunctiva. Two operations performed. At the first nearly all the granulations of the palpebral conjunctiva were squeezed out; at the second all those that had escaped in

the first operation were destroyed. There was swelling and pain for a couple of days; these symptoms disappeared and photophobia also. There are still a few granulations in the retrotarsal fold, which will be removed. The palpebral surface is quite smooth.

Case 3.—Follicular trachoma of long duration. Granulations of connective tissue variety buried deep in conjunctiva. Dense, heavy pannus along upper part of cornea, and whole cornea vascular. Follicles pressed out with exercise of considerable force. Conjunctiva became perfectly smooth. After a month inflammation was set up by small amount of jequirity, with the view of clearing up the pannus. The pannus cleared up, the photophobia has entirely disappeared, and the eye is almost well.

Case 4.—Man troubled with trachoma for four years. Came to hospital early in January and was operated on without previous treatment. Granulations were of connective tissue kind. A great deal of thick, heavy pannus. Photophobia considerable, lachrymation much, and whole eye congested. Granulations squeezed out by using considerable force. There was a good deal of pain and considerable reaction, and after two weeks the eye was watery and somewhat painful. There is now no watering, the eye is clearing up, the lid is smooth, and he is in a fair way to get well of his pannus.

Two other cases, both in young Jewish women, were in the atrophic stage, and very little could be done except to relieve irritative symptoms. Both suffered intensely from photophobia and lachrymation. One operated on a week ago, and is almost entirely relieved of photophobia. The other, operated on yesterday, feels better to-day than before the operation. Two cases operated on at the hospital never returned.

His experience with these cases, together with the experience of Dr. Knapp in his 114 published cases, leads Dr. Woods to the conclusion that this is the best method ever devised for the relief of granular conjunctivitis.

Dr. J. E. Michael: I was for a number of years Dr. Chisholm's first assistant in the Presbyterian Eye and Ear Hospital, and I remember very vividly the many cases of trachoma that came to us day after day and month after month and year after year to have nitrate of silver or bluestone applied, and it was our habit to regard these cases as almost hopeless. I have noticed, of course, a gradual improvement in some of them, which would go to a certain point and then stop. I have never seen any cases which have shown anything like the improvement seen in these cases exhibited by Dr. Woods. I want to express my satisfaction that so important an advance has been made in treating such an obstinate and troublesome pathological condition.

Dr. Wilmer Brinton read a paper on

PHLEGMASIA ALBA DOLENS, WITH REPORTS OF THREE CASES.

In about 1100 cases of obstetrics Dr. Brinton has seen three cases of phlegmasia alba dolens, or the so-called "milk-leg." The various views as to its causation were given. It is now generally held that it is caused by phlebitis, that phlebitis being an extension of the disease from the vessels

of the uterus. Virchow claims it to be due to a physiological thrombosis.

Case 1.—Mrs. D. Confined in November, 1884. Second child. Labor rapid. Lying-in period uneventful until eleventh day. Temperature and pulse normal for 7 days; the record no longer kept. On eleventh day patient was found in bed crying with pain in left leg. Pulse, 120; temperature, 101½. Had had a chill in the morning, followed by feeling of *malaise* and intense pain in left leg. Leg was swollen and hot to the touch. Swelling much greater next day. Pulse and temperature became normal in a few days. Swelling gradually disappeared, first from the foot, then from the calf, and then from the fleshy part of leg. It was three months before she ceased to complain of stiffness and soreness.

Case 2.—Mrs. S., confined by a midwife, Oct. 8th, 1888. No trouble or complications. Remained in bed till tenth day, and then resumed her domestic duties. On the night of fourteenth day after confinement had a chill, followed by pain through body and intense headache. Next morning was somewhat better, but could not move left leg without pain and it was rapidly swelling. Dr. Brinton was called in next day and found patient in bed. Pulse, 120; temperature, 101½. Complained of a general feeling of *malaise*, severe headache, and very severe pains in left leg. Leg much swollen and oedematous, especially in calf and about the ankle; especially tender to touch on inner side of popliteal space. In two days swelling about ankle began to disappear. In 17 days got out of bed, and soon began to move about and attend to household duties.

Case 3.—Mrs. T., delivered Sept. 1st, 1891, of twins. It was a case of placenta prævia centralis, with much loss of blood, from which the patient rapidly recovered. Lying-in period uneventful, although pulse and temperature slightly above normal. Pulse 85 to 100, and temperature 99½ to 101. On the 10th day sat up for a short time. On the evening of the 11th day temperature rose to 104 and pulse to 126. Had had decided rigor about midday. Next morning, pulse 100; temperature 101. Examination revealed a case of septic endometritis, due, doubtless, to lacerated cervix. The "skilled" nurse had given the injections in such an imperfect manner that no benefit had been derived. On the 4th day from the beginning of the attack the left leg showed marked signs of phlebitis. Pain first felt below Poupart's ligament, and extending down the thigh to the leg. The leg became greatly swollen. In ten days painful symptoms subsided and patient moved the leg without much pain, when suddenly pulse became rapid, temperature 104, and right leg became involved more extensively than the left. About seven weeks from time of delivery she was able to be removed to Washington. She is now enjoying the best of health.

The treatment of these cases was by internal administration of quinine, opium, aconite, and phenacetine, and, locally, absolute rest of limb, application of flaxseed poultices to certain parts of limb for a few days, and later the limb was rubbed from time to time with camphorated oil and a flannel bandage applied daily from toes upward. In Case 3 the uterus was washed out daily for some time with bichloride solution.

Dr. W. S. Gardner: I would like to ask Dr. Brinton if he kept the temperature record of that first case up to the time she was attacked.

Dr. Brinton: I did not. It is now several years since, but I am satisfied that the pulse and temperature were practically normal; if not, I would have made a record of the case.

Dr. Gardner: There is quite a difference between a "practically" normal temperature and an actually normal temperature. I believe that if the temperature records of all these cases are kept accurately you will find that few, if any, will have a normal temperature from the time of confinement till the time that phlegmasia alba dolens comes on. I think it is a fact that is about as well established as anything connected with septic troubles of the puerperal state that this is one of the conditions that we have as the result of septic infection, that it is nothing more than a connective tissue inflammation in the leg due to sepsis. The clot in the veins is entirely a secondary affair and has nothing materially to do with the condition. There are many *post mortems* reported in which there were no clot and no phlebitis. Even if this were not the case, the retarding of the return flow of blood would not give the condition found in phlegmasia alba dolens. Retarding would give you a simple oedema. In phlegmasia you have, in addition to oedema, what seems to be more of an inflammatory condition, although it is not associated with the redness of ordinary inflammation; it is an infiltration into the tissues instead of a pouring out of serous fluid into spaces beneath the skin, so that the limb becomes practically solid and does not pit readily on pressure.

So far as the treatment of these cases is concerned, it is just the treatment of all our infectious diseases except syphilis and malarial fever. You cannot do anything with them; they either get well or they die. You cannot cure typhoid fever, nor scarlet fever, nor phlegmasia alba dolens, nor troubles where there are micro-organisms developing in the tissues. You can only treat the symptoms as they arise.

Dr. J. E. Michael: The question as to the necessarily septic nature of phlegmasia alba dolens is not by any means settled, and Dr. Gardner's statement that a careful record would in all cases show a rise of temperature or other conditions indicating a septic state of the patient is not carried out by the facts in many instances. I am convinced that Dr. Brinton's cases are as he stated them to be. He took the temperature for a certain number of days, and, finding no rise, did not take it again. I have seen one case of phlegmasia. The woman was dropsical, badly nourished, and badly cared for. She had general oedema and oedema of the lungs, and every evidence of advanced kidney disease. She was confined successfully. For several days her temperature was normal, that is, under 100; for we regard, in such cases, anything under 100 as normal. On the 12th day there was the sudden occurrence of pain and the other symptoms which Dr. Brinton has given as indicative of beginning phlegmasia alba dolens, and the case turned out to be so and had a fatal issue. The uterus, vagina, and everything connected with the generative organs were absolutely free from any evidence of previously existing inflammation. There was a clot in the femoral

iliac vein which had undergone softening, and was described by the pathologist as the "puriform softening of Virchow." I think there is a question if there was anything which comes under the description of puerperal septicæmia and its various manifestations. What adds to the interest of this discussion is the statement made by Dr. Brinton, which is in accordance with our histories and experience, that cases of phlegmasia alba dolens occur, as a rule, in patients having a normal puerperium. The condition of the blood or whatever it may be which predisposes it to easy clotting is undoubtedly, according to the views of Virchow, responsible for its clotting under these circumstances. I am convinced that at least a portion of these cases are not associated with distinct phlebitis, but are the result of primary clot formation, and do not begin till the clot is formed.

The other side of the case, and one that is taken by a good many, including Dr. Gardner, is that phlegmasia alba dolens always indicates a septic condition. I am inclined to think that there is a septic condition which produces, clinically speaking, the same condition which we find in phlegmasia alba dolens. We have the occurrence of phlebitis in the neighborhood of the generative tract and in the adnexa, and we may have a phlebitis which would involve the femoral vein and would produce the clot and the general train of symptoms following. I do not think we have grounds for sepsis in all the cases. I believe the only satisfactory solution can be arrived at by gathering together all possible information about the occurrence of this disease in lying-in hospitals now and comparing it with its occurrence in years gone by, when septic conditions prevailed to such an extent. Virchow says that in the examination of these clots in cases that terminate fatally we have an appearance of pus surrounding the vessel and which would on careless examination be taken for pus, but in which the most scrutinizing examination reveals no pus and no bacteria; so I am inclined to think that we can have phlegmasia alba dolens with no septic infection whatever. I am inclined to think that two of the cases spoken of by Dr. Brinton were of this kind.

Another point bearing on this subject in a most practical way is that in by far the great majority of cases where we do have positive puerperal septicæmia, we do not have phlegmasia alba dolens.

Dr. J. H. Brarham: As Dr. Michael has said, it is difficult to decide whether all cases of this disease have the same cause. Where there is a clot in the vein, if the trouble begins as an infection, the organisms enter some of the uterine vessels and gradually extend to the larger vessels; this is the theory maintained by many good observers. If it is simply clotting of blood extending from the smaller veins into the larger ones, this can occur without sepsis. Some cases are not accompanied by these clots at all; in these cases the swelling is due, I think, to stoppage of the lymph vessels.

The occurrence of chill and the rise of temperature and pulse in these cases look as though there was some form of septic infection. I do not believe that simple stoppage of circulation without some infection in addition causes these symptoms. As to how the infection gets there, there is some doubt. It is well known that we may have a very late form of sepsis in obstetrical cases. Without

any previous rise of temperature, decided septic trouble may come on ten to eleven days after labor. Either there was a late infection or there was at first a very slight infection and then it took time for sufficient development of the organisms to produce decided septic symptoms.

Dr. W. S. Gardner: With reference to the history of these cases, we know that it is an extremely rare disease. Tyler Smith gives us a history of one man having three successive cases of labor in which phlegmasia alba dolens occurred. There was another series of three successive cases in this town a few years ago. While these series of cases are very short and might be considered as coincidences in any ordinary disease, considering the extreme rarity of phlegmasia alba dolens, I think a series of even three cases is strong presumptive evidence that it must be due to something which can be communicated by some one to the patients.

If the remarkable degree of disorganization which is found in these cases is not due to micro-organisms, how then are you going to account for it?

Dr. Brinton: I am inclined to think that sepsis is the cause in a certain number, but not in all cases.

As to normal temperature, in the vast majority of cases I think that the temperature will be 98° to 99°, and that in many cases there is a normal temperature of 100.5°. In some cases where the temperature has been 100°, the lying-in period has been as uneventful as where the temperature was 98.5°.

March 4th, 1892. The 263rd regular meeting was called to order by the president, Dr. Robt. W. Johnson.

Dr. J. M. T. Finney read an exhaustive paper on

APPENDICITIS.

D. W. S. Thayer: A number of men in Munich have collected one thousand cases of appendicitis in the Munich hospitals. A German doctor has analyzed these cases, and arrives at the conclusion that appendicitis is fully as common in females as in males, if, indeed, it is not more common. As to age, he finds the proportion almost exactly the same in old age as in youth.

Operation must be governed by surroundings. In a large city where we have good surgical skill, I believe that where the symptoms progress twenty-four hours the case should be handed over to the surgeon. I believe that the majority of these cases belong to the surgeon.

Dr. J. D. Blake: There is no doubt but that under proper conditions an early operation is advisable. To induce the patient's family to permit the operation to be done at his home or at a hospital is often impossible.

I was rather struck with Dr. Finney's idea of combining all these conditions—typhlitis, perityphlitis, and appendicitis—under the same head, because it is a difficult thing to know just which you have.

I remember that Dr. Chew once said that at a meeting of the American Medical Association the physicians were discussing appendicitis on the medical side and concluded that at a very early day such cases should be handed over to the surgeon for operation; at the same time the surgical

section were discussing the same thing, and concluded that an operation should not be performed too early, that it was better to wait.

I have seen two cases where an early operation showed that the trouble was located in the appendix; which was removed. In two other cases that I have seen there was so much adhesion that it was difficult to determine where the trouble began.

I remember one case in a young man where the aspirator was used to determine the presence of pus. Three and one-half ounces of pus, with distinct odor, were drawn. It was thought better not to withdraw it all, as the walls of the abscess might collapse and there would be a tear in the abdominal cavity. The patient has since had no further trouble.

Eight months ago I was called to a young man with appendicitis. I advised operation, which was declined. Five days later I aspirated him and drew away nearly four ounces of pus. The next day I drew away a little over two ounces of pus. On the tenth day I removed about an ounce of very thick tenaceous pus. This patient has never had any trouble since. I had a similar case six months ago in which I aspirated twice. He has since complained of pain about that region, and I have recommended an operation. Certainly, where the diagnosis is not plain, an aspirator rarely jeopardizes the case, and very often throws some light upon the trouble. In another case, in which I used an aspirator, I got about three ounces of blood, and the symptoms all disappeared.

Dr. J. F. Martenet: I am distinctly a medical man, but have been converted through personal experience to the belief that appendicitis is distinctly a surgical trouble. The cases which I have attended have come on abruptly, with acute pain. I have had four cases in my practice within twelve months. Two of the cases Dr. Chambers saw with me. An operation was advised, but in neither of the cases would the family consent. My habit at present, in every case I meet with, is to state that it is a distinctly surgical trouble, and refer it to the surgeon. One of my cases who refused operation secured relief by suppuration through the bowel. This was a year ago. In July last she passed through another attack safely. Lately she was operated upon by Prof. Kelly and is now well.

Dr. J. W. Chambers: The statistics from the medical side seem to be faulty. A person may have had three or four attacks, and they are reported as three or four cases cured. A surgeon operates on a case, and reports one case cured.

As to women having it as frequently as men, I have under my own observation known of three women upon whom the gynecologists had diagnosed pelvic cellulitis and salpingitis, and removed the "tube," which proved to be the appendix. In a large number of cases the appendix is really a pelvic organ, and if inflamed it will certainly be a case of salpingitis with some gynecologists. Such errors may have something to do with statistics. There is no reason in the world why women should escape more than men; certainly they are just as liable to catarrhal affections.

Referring to aspiration, I think Dr. Blake's patients are relieved rather than cured. I should hesitate to use the needle. If I should find pus with the aspirator, I should never feel that I had

done my duty unless I had cut down and removed all the pus. It would not be good treatment to aspirate an abscess of the thigh, and it is also not good treatment for an abscess in the iliac region.

Dr. Ingle: I believe the sooner we place these cases in the hands of the surgeon the better. When the family would not consent to an operation, I have treated these cases with salines and enemata, without any relief whatever.

Dr. Thayer: In the Munich statistics it was said that undoubtedly cases of appendicitis had been called salpingitis and pelvic cellulitis, and many cases in the female were doubtless missed in this way.

Dr. Martenet: Two of my cases occurred in females, one of five years and the other of ten years of age.

Dr. Blake: There are certain cases where I can find no distinct indication of what my patient has, whether it is typhlitis, perityphlitis, or appendicitis, and when I have waited long enough I put in an aspirator to find out if there is pus, and in no case have I seen bad symptoms follow, and in some there was distinct benefit. I think we are thoroughly justified in using an aspirator to make a diagnosis.

Dr. Finney: As these are pus cases, the operation can be done as well at the patient's home as in a hospital.

As to aspiration, I agree entirely with Dr. Chambers. Where there are sufficient indications for aspiration, there are still more indications for the use of the knife.

Clinical Notes.

A CASE OF NEURITIS.

G.F., janitor, Englishman, æt. 52, married.

Family history: Unimportant. Father and mother were of rural laborer class; both died about the age of sixty-four. No history of cause, except that the father had for some time before death suffered from shortness of breath (asthma?) and rheumatism, not apparently very severely.

Personal history: Enlisted at the age of eighteen years in the British army, artillery service, and served till the age of twenty-nine, when he got his discharge, the regiment being then in Toronto. He acted for the most of his period of service as officer's valet, and so escaped the ordinary hardships of service. His habits having always been temperate and careful, he left the service in sound health; no trace of venereal or syphilitic disease. Since leaving the army he has acted as janitor of a college in Toronto.

History of present attack: During November, 1891, he found his legs becoming weak and

painful from the knees down, especially on making any muscular effort, such as lifting, and finally even standing. This condition came on gradually, and led to his having to give up work.

On examination I found, in addition to slight general disturbance and *malaise*, largely mental in origin and owing mainly to family matters, the following conditions :

Digestive system : Normal.

Circulatory system : Normal.

Respiratory system : Normal.

Emunctories : Acting very well on the whole.

Nervous system : In addition to general *malaise* referred to above, the pain and tenderness complained of was found to be very definitely confined to the lines of the external and internal popliteal nerves. The least pressure on the median lateral lines of the leg elicited great pain, which was deep-seated. Pressure on the posterior line of the leg was not nearly so painful. The pain thus elicited lanced up into the thigh and down to the toes. The point where the external popliteal nerve rounds the head of the fibula was excessively tender. The extent of the tender area was from the upper end of the popliteal space to the lower third of the leg. This condition was exactly symmetrical in both legs.

Accompanying the tenderness were other nervous disturbances, both motor and sensory.

(1) *Motor disturbances* : Tremulous spastic contractions of the muscles of the legs occurred every few moments, causing sharp pain; they occurred in spite of any effort of the patient's will to stop them. The knee jerk in both legs was decidedly exaggerated, particularly the left. The muscles were so "weak," responded so ill to volitional impulses, as to cause an incoordinate and tottering gait.

(2) *Sensory disturbances* : These were interesting. On each side of the leg, in the median line and occupying about the middle five or six inches of the length of the leg, was an area, three-fourths of an inch or so wide, of anæsthetic skin, pressure upon which elicited deep-seated pain; below this, above each malleolus, was an area, one and a half inches wide and two or three inches long, of hyperæsthetic skin, slightly tumefied, but not appreciably pitting on pressure; the slightest brushing of which with

the finger-nail caused sharp pains in the nerve tracks in the back of the leg. During recovery the anæsthetic portions of the skin seemed to recover their normal condition first.

In a few days similar pain and tenderness appeared in the arms, the brachial nerves being involved for three or four inches along the inner border of the biceps. Motor and sensory disturbances did not occur in the arms, beyond an occasional irritable twitching.

Dr. J. E. Graham saw the patient with me and drew my attention to the defined anæsthetic and hyperæsthetic skin areas. His diagnosis was like mine—multiple neuritis—and he suggested the cause, which I believe to be the correct one, that the neuritis was rheumatic. Careful enquiry led me to exclude nicotine, alcoholic, and metallic poisoning as the cause. The patient himself ascribed it immediately, and I think correctly, to the fact that after spending the greater part of the day, and all the night, in a very warm, dry room over the boilers of the engine room, he had to walk half a mile or more to the post office night and morning. He noticed for some time that the cold "struck in," from the knees down, very sharply, then the legs ached all day, and, latterly, were sore all the time, except when he was out in the cold, which seemed to relieve them. The temperature of the room in which he slept, though he kept the window and fanlight open, was at least 75° F. all the time. During the day he was constantly on his feet and running up and down stairs.

Treatment—Medicinal : Regard had to the excretory system. Alkalies and potassium iodide administered. Locally, the pain was controlled very partially by poultices and glycerinum belladonnæ. Rest was enjoined in bed, and later on a sofa, though splints were not applied.

Dietetic : Nourishing food such as patient fancied.

Duration of attack : Five weeks elapsed before he could return to work.

Second attack : Began in a similar way about the middle of February, and ran a similar course, except that arms were unaffected. Nerves of legs involved no higher than knee. Marked by same symmetry of distribution as before. This time the left leg was rather the worse, and the sense of weakness from the

knees down more marked, with appreciable atrophy of peronei muscles, especially of left leg.

Treatment: Anti-rheumatic remedies and rest, followed on subsidence of active symptoms by a mixture containing strychnine, hydrochloric acid, and calumbo. At the end of March, 1892, after five weeks' absence, he returned to work, pain all gone, very little tenderness persisting, no sensory disturbances, but slight weakness still felt, the peronei of the left leg being still distinctly atrophied, and tremulousness of both hands, suggesting incipient *paralysis agitans*.

I shall keep this patient under observation and report further anything worthy of record. F.

Correspondence.

Editor of THE CANADIAN PRACTITIONER :

Your issue of March 16th contains some remarks by Dr. Seibert, of New York, intended, I presume, as a reply to an article of mine published Feb. 1st; but really I fail to see in what manner he has answered my questions, but one, viz., that the corpses of the bacilli slaughtered by chlorine are the guardians of the living tissue.

Now I do not presume to be so thoroughly versed in pathology as such men as Loeffler, Klebs, or even Dr. Seibert, all of whom I acknowledge to be vastly my superiors in that respect, they having infinitely superior advantages and facilities for obtaining pathological knowledge than I could possibly attain in a comparatively small country town, and it is to this superiority I appeal for certain explanations asked for. Still, to my mind, my queries relative to the local origin of diphtheria remain unanswered, and, until some further proof of the correctness of local origin views appears, I shall hold fast my own ideas of constitutional origin. Dr. Seibert states that "true diphtheria is caused by the Loeffler bacillus (usually associated with streptococci) entering the mucous membrane of the pharynx, and there causing that local inflammation known as diphtheria." Now did I not say in my article that diphtheria was the result of a bacillus? Is that remark of Dr. Seibert's any answer to my first question: What produces the symptoms during the period

of inoculation? (And I think all will acknowledge that there *is* a period of incubation.) This exists for some days previous to the local manifestation in the throat. If the bacilli merely produce a specific local inflammatory process, and this local inflammation produces the constitutional symptoms, how is it that the latter precede the former?

I perfectly agree with Dr. Seibert that the exudation is the *result* of the disease, but my contention is, this exudation is the mode by which the poison is eliminated from the blood, and is harmless if it can be kept aseptic, or unless it becomes so abundant as to interfere with respiration or deglutition. The crisis arrives and it is cast off. How is it that the (sometimes severe) constitutional symptoms which *precede* the appearance of the pseudo-membrane subside so visibly when the exudation takes place? Is it not because the blood, which has been so charged with the poison, has succeeded in obtaining a spot for elimination, the tonsils, this acting as a safety-valve, which prevents an explosion that might kill the patient in a very short space of time, so overwhelmed would he be by the accumulation of the poison?

Dr. Seibert's theory is that there is, first, an inflammation, and, secondly, an exudation, so that the disease actually existed before the exudation appears by which the disease is recognized. During, and prior to, this inflammatory pre-exudate stage certain symptoms manifest themselves, constituting the period of incubation. I want to know what produces these symptoms. Are they to be accounted for by a reflex action produced by local irritation and infection? Or is it by the action of a certain poison contained in the blood?

If the disease is of local origin, why does the bacillus select the mucous membrane covering the tonsils? Is it different in any way from that covering the palate and uvula? And why is it that in case of one tonsil being attacked, the other will take on the same form without involving the intervening soft palate and spread by direct extension?

Dr. Seibert has cleverly avoided replying to my questions by asking others relative to erysipelas, phlegmon, carbuncle, and abscess, in which I cannot observe the least resemblance or even comparison to the question at issue.

I can assure you I am not directing my remarks to Dr. Seibert personally; but, as I cannot possibly harmonize the local origin theory with the order in which the symptoms, during a case of diphtheria, occur, I should like some explanation as to the reason of this. After receiving a fair and common sense cause for this reverse order of things, I shall enrol my name as a convert, and not until then.

I hope you forgive me for occupying so much space, and trust that this may be the means of obtaining some further explanation and more satisfactory reply to my questions.

J. S. BENSON, M.R.C.S. Eng.

Chatham, N.B., March 28th, 1892.

Book Notices.

A Practical Manual of Diseases of the Skin.

By G. H. Rohe, M.D., Prof. of Mat. Med., Therapeutics, and Hygiene, and formerly Prof. of Dermatology in the Coll. of Physicians and Surgeons, Baltimore, etc., etc., assisted by J. W. Lord, A.B., M.D., Lecturer on Dermatology and Bandaging in the Coll. of Physicians and Surgeons; Asst. Physician to the Skin Department in the Dispensary of Johns Hopkins Hospital. *No 13 in the Physicians and Students' Ready Reference Series.* 12mo., 303 pages. Extra cloth; price, \$1.25, net. Philadelphia: The F. A. Davis Co., Publishers, 1231 Filbert Street.

Book Reviews.

Treatise on Gynecology, Medical and Surgical.

By S. Pozzi, M.D., Professor Agrégé à la Faculté de Médecine; Chirurgien de l'Hôpital Lourcine-Pascal, Paris; Honorary Fellow of the American Gynecological Society. Translated from the French edition under the supervision of and with additions by Brooks H. Wells, M.D., Lecturer on Gynecology of the New York Polyclinic; Fellow of the New York Obstetrical Society, and the New York Academy of Medicine. Vol. I., with 305 wood engravings and 6 full-page plates in color. New York: William Wood & Co., 1891.

Judging from the first of the two volumes, we are inclined to think that the translator has some reason for his statement that this treatise is the best work on gynecology which has appeared for many years in any language. The

first chapter contains a very clear exposition of antiseptics in gynecology. We believe the author is correct in combining antiseptic with aseptic methods; and, especially in laparotomy, his statement that "rigid asepsis should be the rule for the interior of the abdomen, antiseptics being reserved for the exterior," is true. In his chapter on metritis he uses the valuable plates from the atlas of Prof. Wyder, of Zurich. We agree with him when he differs from what he considers the extreme views of Emmet, attributing so much to the effects of scar tissue in a torn cervix. He takes up the subject of infection in this chapter. We think it would be better placed with his antiseptic methods, or in a separate chapter. In places he follows the old, unproven, mysterious lines of the text-books of the past, modifying them, however, more than they have been modified in any text-book approaching completeness and giving evidence of a practical and not a theoretical grasp of the subject. He is evidently, what every modern gynecologist should be, an abdominal surgeon. Virginal metritis, found by some in every nulliparous woman with a backache, is left in the same foggy atmosphere that has always surrounded this supposed frequent but really rare disease. Is the author one of those who twice a week makes iodine or other applications to virgins with leucorrhœa and backache, or is he not? Is he a dilator of cervixes for menstrual pains and slight flexions, or is he not? If one or both, with what honest or lasting success?

In speaking of those historic relics, the intra-uterine stem pessaries, he says that they are most dangerous, but spoils the assertion by adding "unless carefully watched by the surgeon." We have no hesitation in saying that they should never be used.

We disagree with the author when he rejects diathesis as a predisposing cause of metritis. He holds that all metritis is infective. Granting that the statement may be correct, we believe that metritis occurs more frequently after labor or abortion in women of a tuberculous diathesis than in those who are free from such taint. The chapters on uterine fibroids are excellent.

We are glad to see that he gives our countryman, Trenholme, of Montreal, credit for having at least published, in 1876, the first known

case of castration for uterine myoma, although the general adoption of the operation was largely due to Hegar and his writings.

A list of Hegar's results will bear repetition here (castration for myoma):

(a) Hemorrhage. In 20 cases there was immediate cessation of the bleeding; in 4 cases cessation after irregular losses; in one case persistence of irregular metrorrhagia; in one case temporary menopause, then hemorrhage and fibro-cystic development of the tumor; in one case menopause, then hemorrhage, with beginning enucleation of the tumor.

(b) Tumor. In the same series of 28 cases, 22 diminution of tumor; 3 cases no change; 1 case, diminution doubtful; 1 case, appearance of a fibro-cystic tumor; 1 case, secondary enucleation.

He says the absolute reliance that can be placed in any report accompanied by the name of Hegar gives peculiar interest to these figures. He evidently mistrusts the statistics of some others.

We believe that before long the revived abdomino-vaginal hysterectomy will take its proper place, and that no text-book will be complete without a full description of it. We will then read less about these formidable pedicles, and operators will wonder why they kept to their pedicles at all.

A chapter is wisely given to that neglected subject, fibroid tumors complicating pregnancy. It is not as full as it might be, and leaves many important questions unanswered.

The subject of carcinoma uteri is handled in a masterly manner. In discussing the subject of uterine displacements he avoids the most important point in the discussion, namely, the results of hysteropexy, Alexander's operation, etc. The opinions of every author are much needed on this subject.

These operations, if honestly followed up, will be found, we fear, to give only a small measure of relief. The profession awaits such a critical review of the subject.

The elaboration deemed by some necessary in a text-book, and mentioned by the author in his preface as likely to be tedious, can be carried further on the groundwork now established with advantage to the work and profit to the reader. We hope this will be done in some future edition.

The anatomy of the sexual organs has been left out of the work. Many valuable plates have been added by Dr. Brooks H. Wells. The set of colored plates showing the different diseases of the cervix uteri from the catarrhal erosion of a nulliparous cervix to the papillary hyperplastic condition simulating epithelioma will be of great benefit to practitioners. The plates of the methods of suture are the best to be seen in any single work.

We heartily commend this volume to the profession, and feel assured that they cannot afford to be without it. The second volume will appear shortly.

We congratulate the author on the completion of his task. He has added a valuable volume to medical literature. The publishers are to be congratulated. They have made a wise selection from foreign medical literature.

The International Medical Annual and Practitioner's Index for 1892. Edited by P. W. Williams, M.D., Secretary of Staff, assisted by a corps of thirty-two collaborators—American and European—specialists in their several departments. 644 octavo pages. Illustrated. \$2.75 E. B. Treat, Publisher, 5 Cooper Union, New York.

The tenth yearly issue of this valuable one-volume reference work is to hand, and it richly deserves and perpetuates the enviable reputation which its predecessors have made for selection of material, accuracy of statement, and great usefulness. The corps of department editors is representative in every respect. Part 1 comprises the new remedies, together with an extended review of the therapeutic progress of the year. Part 2, comprising the major portion of the book, is given to the consideration of new treatment, and is a retrospect of the year's work, with numerous original articles by eminent authorities. The third, and last part, is made up of miscellaneous articles, such as Recent Advances in Bacteriology, Medical Photography, Sanitary Science, Use of Suppositories in the Treatment of Disease, Improvements in Pharmacy, New Inventions in Instruments and Appliances, Books of the Year, etc. The arrangement of the work is alphabetical, and with its complete Index makes it a reference book of rare worth.

First Lines in Midwifery: A Guide to Attendance on Natural Labor for Medical Students and Midwives. By G. Ernest Herman, M.B., F.R.C.P., Obstetric Physician to the London Hospital, and Lecturer on Midwifery; Examiner in Midwifery to the Royal College of Surgeons. In one 12mo. volume of 198 pages, with 80 illustrations. Cloth, \$1.25. *Students' Series of Manuals.* Philadelphia: Lea Bros. & Co., 1892.

We predict for this number of the "Students' Series of Manuals" a widespread popularity. The trained nurse, the student just commencing the study of midwifery, and even the experienced practitioner, will find in it much of value. A number of original plates, and some copied from Farabœuf, serve to elucidate points which usually puzzle the student.

The Diseases of the Mouth in Children (non-surgical). By F. Forcheimer, M.D., Prof. of Physiology and Clinical Diseases of Children, Medical College of Ohio. Philadelphia: J. B. Lippincott Company.

A series of articles originally published in the *Archives of Pediatrics* forms the basis of this book. It is the first in the English language to bring together the facts in connection with diseases of the mouth in children. Diseases of the mouth are usually so tractable that one scarcely sees the necessity for a special treatise on the subject; but, if a special treatise be needed, this certainly meets all the requirements.

A Short Manual of Analytical Chemistry. By John Muter, M.A., Ph.D., Analyst to the Metropolitan Asylum Boards, etc. Edited by C. C. Hamilton, M.D. Philadelphia: P. Blakiston, Son & Co.

This American edition differs from the English only in changes rendered necessary by the United States Pharmacopœia. Written originally for students in pharmacy, it will be found suitable for medical students as well.

Pamphlets and Reprints.

Acute Retroversion of the Virgin Uterus: Report of Cases with Remarks upon the Difficulty in their Replacement. By William A. Edwards, M.D., San Diego, Cal., Fellow of the College of Physicians of Philadelphia, and of the American Pediatric and Pathological Societies, etc. Reprinted from *The Annals of Gynecology and Pediatrics.*

Contributions to the Normal and Pathological Histology of the Fallopian Tubes; also Contributions to the Histogeneses of the Papillary Cystomata of the Ovary; also Pelvimetry for the General Practitioner; also The Premature Induction of Labor in Contracted Pelvis. By J. Whitridge Williams, M.D., of Baltimore, Assistant in Gynecology, Johns Hopkins Hospital.

Rupture of the Sac of an Extra-Uterine Pregnancy Through the Fimbriated Extremity Without Tearing the Fallopian Tube; Operation, Recovery. By Hunter Robb, M.D., Resident Gynecologist to the Johns Hopkins Hospital, Baltimore, Md. Reprinted from *The New York Journal of Gynecology and Obstetrics*, February, 1892.

Open Incision on the Concave Surface in the Treatment of Inveterate Cases of Talipes Equino-varus. By B. E. McKenzie, M.D., Toronto. Reprinted from the Transactions of the American Orthopædic Association.

Publications from the Biological Laboratory of the University of Toronto. No. II., "Peach Yellow." By W. R. Shaw, M.D., Toronto. Reprinted from the Transactions of the Canadian Institute, Vol. II., Pt. 2.

Supracotyloid Dislocation. By John Ridlon, M.D., Consulting Surgeon to the Transfiguration Clinic; Assistant Surgeon to the Vanderbilt Clinic, New York. Reprinted from *The New York Medical Journal.*

Technical Education. Address delivered by Professor Galbraith at the opening of the Engineering Laboratory of the School of Practical Science, Toronto, Feb. 24th, 1892.

On the Collection of Samples of Water for Bacteriological Analysis. By Wyatt Johnston, M.D., Montreal.

Transactions of the College of Physicians of Philadelphia. Third series. Volume the thirteenth, 1891.

Climate of Southern California in Relation to Disease. By W. A. Edwards, M.D.

Electricity in Carcinoma. By R. Newman, M.D., New York.

Trap-Siphonage and Trap-Seal Protection. By Prof. J. E. Denton.

Bald Heads. By A. E. Carrier, M.D., Detroit.

Personal.

DR. J. H. BURNS, of Toronto, after a visit of a few weeks to California, returned to Toronto, April 16th. He reports that Dr. Winstanley is enjoying fairly good health. Dr. George Wright, formerly of Toronto, is living at Redlands. He is suffering from bronchitis and asthma, and has become very thin, but is able to do a certain amount of practice. Dr. Bull, of Toronto, who spent the winter there with a portion of his family, is in good health.

DR. W. OLDRIGHT, of Toronto, went to Philadelphia, April 25, and will carefully inspect the new laboratory of Hygiene of the University of Pennsylvania, with a view of gaining information which will be of service to the University of Toronto in the establishing of the proposed course for health officers and a Museum of Hygiene.

DR. J. L. BRAY, of Chatham, was in Toronto, April 20th to 22nd. As President-elect of the Dominion Medical Association, he is trying to work up plenty of enthusiasm for the next meeting, to be held in Ottawa probably the first week in June.

DR. LAPHORN SMITH, of Montreal, has opened a private hospital for the medical and surgical treatment of diseases of women.

DR. WISHART, of London, who was seriously ill with pneumonia, is now recovering.

DR. PRICE-BROWN has removed from No. 10 to his new residence, No. 37 Carlton street.

Therapeutic Notes.

TUMENOL.—A saponated preparation of hydrocarbons is obtained near Darmstadt in the form of bitumen. The preparation can be used in three forms: (1) Tumenol itself—a dark-brown or brownish-black liquid; (2) tumenol sulphone, or oil; (3) tumenol sulphonic acid, or powder. Moist compresses, soaked with 2 to 5-per-cent. solution of the sulphonic acid, were often very successful in the treatment of acute recurrent eczema of the hands and face. In the form of a paste (5 to 10 per cent.),

tumenol oil proved more effective than the simple zinc paste to a marked degree, not only in eczema, but in superficial ulceration, impetigo, and pemphigus. An ointment of similar strength, with 5 per cent. of zinc oxide and subnitrate of bismuth, containing simple ointment as a base, was also largely used by Professor Neisser. The power of tumenol to relieve itching, not only in eczema and other forms of dermatitis, but also in prurigo and pruritus, was very marked, especially when used in the form of 10-per-cent. tinctures, with a menstruum consisting of equal parts of ether, rectified spirits, glycerine, or water. The new article is not intended or likely to compete with ichthyol.—*The Provincial Med. Jour.—Satellite.*

PETRESKO claims to have cut short croupous pneumonia by large doses of digitalis in from twenty-four to forty-eight hours, during which time he has observed an abrupt fall of temperature from 106.5° F. (the highest seen) to 98°, 96.8°, and even 95° F., together with a marked reduction of the pulse, which from as high as 140, and even higher, was brought down to 60, 40, 30, and in one remarkable instance to as low as 24. In 825 cases treated by him since 1883, exclusively by large doses of the drug, he has had a mortality of 2.06 per cent. Bennet obtained under the tonic treatment a mortality of 3 per cent. in 129 cases, and a mortality of 6.08 per cent. in 720 cases under the expectant treatment. In Edir'urgh, in a record of 698 cases treated by venesection alone, the mortality was 3.45 per cent., which speaks for itself. Petresco used 60 to 90 grains (4 to 6 grammes) a day, in infusion, for three and four days consecutively, and in these doses never noticed untoward effects, such as vomiting, diarrhoea, disturbance of the pulse, and, much less, collapse.—*Med. and Surg. Rep.*

PAPAIN.—As a digestive ferment, to be given medicinally, papain presents the following advantages over pepsin and pancreatin:

(1) It will convert or digest many more times its own weight of meat than they are able to.

(2) It can be used when pepsin and pancreatin are contra-indicated or powerless. (This latter, as known, is the case when the stomach contents are too concentrated or insufficiently

acid. Under these conditions pepsin is of little or no value, while papain acts energetically.)

(3) As regards albuminoids, it combines in itself the joint action of pepsin and pancreatin.

(4) It can be given combined with acids, alkalies, or antiseptics, as indicated by the demands of the case.

(5) It has a local action on the stomach that pepsin has not.

(6) It is not so repulsive to the mind as pepsin as it is purely vegetable.

Thus papain is indicated in deficiency of the gastric juice, excess of unhealthy mucus in the stomach, irritable condition of that viscus, and duodenal dyspepsia.—*Hershell on New Remedies*, p. 86.

MORPHINE IN CARDIAC AFFECTIONS.—The good effects of morphine, as a sedative to the dyspnoea and painful sensations in aortic affections, is to-day acknowledged by observant practitioners. In some mitral affections, morphine likewise is very useful. According to an able thesis of Dr. Hervouet, certain desperate cases of mitral affection were benefited by hypodermics of this remedy, the dyspnoea and nervous symptoms having been controlled. It seemed to strengthen the heart's action, provoking diuresis and diminishing anasarca. Through the means of morphine, patients apparently dying have been brought back to life when all other remedies of a stimulant character failed.—*Lancet-Clinic*.

INTRA-VENOUS INJECTION OF SALINE FLUID IN GRAVE HEMORRHAGE.—K. Poulsen, of Copenhagen, has been very favorably impressed with the action of the intra-venous injection of salt water (tepid distilled water, 6 per 1000 salt, and a little hydrate of soda) to the quantity of about three quarts into the veins of the arm of a woman aged thirty-six, who had complete collapse (no radial pulse), after a severe hemorrhage from the infra-orbital artery, occurring during resection of the superior maxilla for a carcinomatous growth, which had entirely involved the parts about the artery, making the arrest of the hemorrhage extremely difficult. Although the patient before the injection had been lying in a dying state, she was able a few hours later to give birth to a child safely.—*Bibliothek für Laeger*, May, 1891.—*Sattelite*.

Miscellaneous.

ONTARIO MEDICAL ASSOCIATION.

The twelfth annual meeting of the Association will take place in Toronto on Wednesday and Thursday, the 1st and 2nd of June. The session will be held each day at 9.30 a.m., 2.15 p.m., and 8.15 p.m.

The following topics have been selected by the Committee on Papers and Business for general discussion: "Diphtheria": Discussion opened by Dr. A. S. Fraser, Sarnia; followed by Dr. W. Britton, Toronto; Dr. T. S. Harrison, Seikirk; Dr. H. P. Wright, Ottawa. "The Third Stage of Labor": Discussion opened by Dr. A. H. Wright, Toronto; followed by Dr. H. S. Griffin, Hamilton; Dr. J. M. Cotton, Lambton Mills; Dr. N. W. Meldrum, Ayr. "The Present Status of Antiseptics in Surgery": Discussion opened by Dr. R. B. Nevitt, Toronto; followed by Dr. T. K. Holmes, Chatham; Dr. N. A. Powell, Toronto; Dr. Geo. A. Peters, Toronto. "The Therapeutics of Constipation": Discussion opened by Dr. J. C. Mitchell, Enniskillen; followed by Dr. A. McKinnon, Guelph; Dr. J. J. Farley, Belleville; Dr. Geo. Acheson, Toronto. "Hay Fever": Discussion opened by Dr. G. Hodge, London; followed by Dr. G. R. McDonagh, Toronto; Dr. A. B. Welford, Woodstock; Dr. W. J. Wilson, Richmond Hill. "A Symposium upon Hip Joint Disease"; (1) The Early Diagnosis; (2) Expectant Treatment; (3) Operative Treatment, by Dr. I. H. Cameron, Toronto; (4) Mechanical Treatment before and after Operation, Dr. A. McKay, Ingersoll. "A Symposium upon the Pneumonias of Children": (1) Differential Diagnosis of Lobar and Lobular Pneumonia and of Pneumonia from Bronchitis, by Dr. H. T. Machell, Toronto; (2) Diagnosis of Lobular Pneumonia, Acute and Chronic, from Tuberculosis; (3) Diagnosis of Pneumonic Consolidation from Pleural Effusion, by Dr. W. H. Henderson, Kingston; (4) Prognosis in Pneumonias Generally, by Dr. Allen Baines, Toronto. Papers will be read as follows: President's Address, Dr. R. A. Reeve, Toronto; "Chloroform Inhalation," Dr. H. A. MacCallum, London; "Acute Suppurative Pleurisy," a case, Dr. H. S. Clerke, Lucan; "Brain Injuries," Dr. J.

Olmstead, Hamilton; Ventral Hernia, Flap-splitting Operation," Dr. H. Meek, London; "Otitic Cerebral Abscess," Dr. G. Sterling Ryerson, Toronto; "Diphtheria," Dr. W. J. Wilson, Richmond Hill; "Herpes," Dr. H. J. Saunders, Kingston; "Disinfection after infectious Disease," Dr. W. J. Greig, Toronto; "Ocular Paralysis from Basal Lesion," Dr. D. J. Gibb Wishart, Toronto; "Angina Ludovici," Dr. G. A. MacKelcan, Hamilton; "Report of three cases of Congenital Malformation of the Female Sexual Organs, with Remarks," Dr. A. VanderVeer, Albany; "The Dressing of the Womb after Suprapubic Cystotomy," Dr. A. Groves, Fergus.

Additional papers have been promised by Dr. Langrill, Osheeken; Dr. A. R. Welford, Woodstock; Dr. A. R. Harvie, Orillia; Dr. W. J. Gibson, Belleville; Dr. S. Lett, Guelph; Dr. H. Howett, Guelph; Dr. C. K. Clarke, Kingston; Dr. Jas. P. Brown, Owen Sound.

The names of readers and the titles of the papers proposed should be forwarded to the Secretary not later than the 10th of May, when it is at all possible.

The officers and committee for the coming meeting are as follows: *President*, Dr. R. A. Reeve, Toronto; *Vice-Presidents*, Dr. F. L. M. Grasset, Toronto; Dr. A. Groves, Fergus; Dr. H. J. Saunders, Kingston; Dr. G. T. McKeough, Chatham; *General Secretary*, Dr. D. J. Gibb Wishart, Toronto; *Assistant Secretary*, Dr. F. P. Cowan, Toronto; *Treasurer*, Dr. E. T. Barrick, Toronto.

Credentials: Chairman, Dr. J. L. Davison, Toronto; Dr. W. H. B. Aikins, Toronto; Dr. G. M. Shaw, Hamilton; Dr. Lowry, Acton; Dr. Duncan, Chatham; Dr. Eakins, Belleville. *Public Health*: Chairman, Dr. P. H. Bryce, Toronto; Dr. S. S. Covernton, Spokane Falls; Dr. W. J. Charlton, Weston; Dr. J. J. Farley, Belleville; Dr. W. A. Ross, Barrie, Dr. Trimble, Queenston. *Legislative*: Chairman, Dr. Harrison, Selkirk; Dr. Bowlby, Berlin; Dr. Sullivan, Kingston; Dr. Waugh, London; Dr. McKay, Ingersoll; Dr. Gilmore, Toronto Junction. *Publications*: Chairman, Dr. Sheard, Toronto; Dr. A. H. Wright, Toronto; Dr. J. L. Davison, Toronto; Dr. A. Primrose, Toronto; Dr. H. J. Saunders, Kingston; Dr. W. H. B. Aikins, Toronto. *By-Laws*: Chairman, Dr. W. H. Henderson,

Kingston; Dr. R. A. Reeve, Toronto; Dr. Griffin, Hamilton; Dr. J. E. Graham, Toronto; Dr. H. A. MacCallum, London. *Ethics*: Chairman, Dr. G. R. McDonagh, Toronto; Dr. Moore, Brockville; Dr. A. R. Harvie, Orillia; Dr. J. W. F. Ross, Toronto; Dr. Moorehouse, London; Dr. H. C. Wright, Ottawa. *Papers and Business*: Chairman, Dr. A. McPhedran, Toronto; Dr. B. Spencer, Toronto; Dr. R. B. Nevitt, Toronto; Dr. J. Wishart, London; Dr. Fenwick, Kingston. *Arrangements*: Chairman, Dr. A. J. Johnston, Toronto; Dr. A. A. Macdonald, Toronto; Dr. W. Oldright, Toronto; Dr. Jas. F. W. Ross, Toronto; Dr. J. J. Davison, Toronto; Dr. G. A. Bingham, Toronto; Dr. A. Davidson, Toronto; Dr. L. M. Sweetnam, Toronto; Dr. W. J. Greig, Toronto. *Audit*: Chairman, Dr. P. Strathy, Toronto; Dr. J. Brown, Owen Sound; Dr. G. S. Cleland, Toronto; Dr. D. Hoig, Oshawa. *Necrology*: Chairman, Dr. Mullen, Hamilton; Dr. Duncan, Chatham; Dr. Lundy, Preston; Dr. Buchan, Toronto.

The chairman of the various committees are urged to convene their committees and have their reports in readiness.

Physicians who are desirous of joining the Association require to present nomination papers signed by two members in good standing. Blank forms may be obtained from the Secretary.

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

D. J. GIBB WISHART,
Toronto, April 25, 1892. *Secretary.*

TRINITY UNIVERSITY.—The following are the results of the

PRIMARY EXAMINATION.

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

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

Class III.—Miss G. W. Hulet, F. S. Nicholson and D. Thompson (equal), W. W. McQuain, T. N. Insley and Miss Pringle (equal), M. F. Lucas, F. N. Henry, J. W. White.

Passed in anatomy, general and practical chemistry, physiology, and toxicology—Rev. J. W. Dow.

Passed in anatomy, general and practical chemistry, materia medica, and physiology—R. R. MacFarlane.

Passed in general and practical chemistry, physiology, and toxicology—J. H. Hudson, J. W. McQueen.

Passed in anatomy, physiology, toxicology, and practical chemistry—E. R. Brown.

Passed in anatomy, materia medica, physiology, and toxicology—F. A. White.

Passed in materia medica, physiology, and toxicology—W. J. Bray.

FINAL EXAMINATION.

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

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

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

Passed in medicine, midwifery, surgery, clinical medicine, clinical surgery, and sanitary

science—R. E. Cooper, G. W. Davidson, A. Quackenbush.

A MILITARY MEDICAL ASSOCIATION—It is proposed to form an association of medical officers of the militia of Canada, having the following objects: (1) The bringing of medical officers in closer personal relation, and the development of a departmental *esprit de corps*. (2) For discussion of matters relating to the medical department of the militia. (3) For the discussion of military matters from a medical point of view. (4) For reading of papers on military medicine and surgery, hygiene, and equipment. A meeting for organization will be held in the Canadian Military Institute on Monday, May 9th, at 8 p.m.

NEW DOCTORS. — The following candidates have passed the final examinations in Victoria University for the degree of M.D., C.M.: A. Cleghorn, F. Forrest, F. K. Armstrong, Mrs. E. H. R. Denovan, H. Morell, G. H. Bowles, H. J. Way, J. R. Smith, J. F. Ross, W. J. Wilson, G. L. McBride, J. McFadden, L. H. Campbell, G. Clingan, F. McConaghy, A. Flatt, W. J. Smuck, J. Dargavel, J. F. Pinkham, D. A. Clark, W. C. Belt, J. A. Cowper, J. Farrow, A. Skippen, W. R. Hamilton, F. A. Rosebrugh, J. H. Towner, W. L. Holmes, F. M. Henry, F. C. Trumppour, J. J. Roach, J. A. C. Grant.

OSLER'S "PRACTICE OF MEDICINE."—The hearty reception of Osler's new book was phenomenal. The first edition of three thousand was soon exhausted, and a second is well under way. There appears to be a general consensus of opinion that our reviewer was right in designating it the best handbook on medicine extant.

THE *Northern Lancet and Pharmacist*, of Winnipeg, has been resuscitated.

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