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THE

Canadian Practitioner

FORMERLY "THE CANADIAN JOURNAL OF MEDICAL SCIENCE."

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SUBSCRIPTION, \$3 PER ANNUM.

Literary Communications may be addressed to any of the Editors. All Exchanges and Business Communications should be addressed to DR. ADAM WRIGHT, 20 Gerrard Street East.

TORONTO, AUGUST, 1886.

Original Communications.

THE INFLUENCE OF MALARIA AND QUININE UPON PREGNANCY AND PARTURITION.

BY GEORGE T. M'KEOUGH, M.B., CHATHAM, ONT.

In the western peninsula of Ontario, notwithstanding extensive drainage, the erection of dikes, and other sanitary improvements, the various forms of morbid phenomena induced by malaria are still largely prevalent, and constitute probably the largest class of disease that medical practitioners have to contend with in that district, in consequence of which quinine is freely prescribed. To a medical man practising in such a locality there constantly arises some very important and unfortunately moot questions concerning the effect of both malaria and quinine upon the pregnant and parturient state. Of the few published observations on these points no two reporters apparently agree. In the hope of being able to come to some definite conclusions concerning these disputed questions, I have endeavoured, for some time past, to interrogate with reference to this particular subject all cases of pregnancy coming under my notice. Although my experience has necessarily been limited, I have thought it sufficient to arrive at certain deductions.

In the first place, are pregnant women liable to suffer from intermittent fever, or other manifestation of malarial toxæmia, or does the state of pregnancy confer upon them a condition of immunity from the action of this poison?

Crédé (Monatsch. fur Geburtsh., Band xv, S. 1, 1886)* states that in Leipsic during the years 1856 to 1859 there was almost absolutely no case of ague in a pregnant woman. Griesinger (Virchow's Handb. der Spec. Path. and Ther. Infectious Krankh, 1856)† found that during the prevalence of a quartan fever in Prague only two out of 8,639 pregnant and parturient women were attacked. On the other hand, Loov‡ states that it is very common for pregnant women to have intermittent fever. Playfair§ says that the occurrence of hypertrophied spleens in infants has been often observed in malarious districts, and consequently believes that the disease must frequently occur in intra-uterine life. Goth, of Klanisburgh (Zeitsch fur Geb. und Gyn. Band vj. s. 17, 1881)* asserts that in a severe outbreak of malarial fever, 46 out of 881 pregnant women were affected. My own notes agree more nearly with the latter observers referred to. Of two hundred and twenty-eight (228) cases of pregnancy investigated by me, thirty-six, or 15·8 per cent., exhibited some form of malarial poisoning.

These investigations were made among women chiefly in the lower walks of life, who consequently were exposed to the various vicissitudes of the laboring classes, together with unsanitary surroundings—conditions that probably would render them more or less predisposed to those pathogenic organisms which there is much evi-

* Quoted in *Brit. Med. Jour.*, July 18th, 1885.

† Ibid.

‡ Quoted in *Am. Jour. Med. Sc.*, Jan., 1886

§ System of Midwifery, p. 224.

dence for supposing are connected with the malarial phenomena. Several of the observed cases, also, occurred during the months of the past winter and spring, when the omnipresent poison was more prevalent and virulent than usual. These statistics, however, show decidedly that gestation confers no exemption whatever from attacks of malaria, but that the pregnant woman is probably more likely to suffer from it, if exposed to its influence, than if she were not in that condition.

Why I should have found a larger percentage of pregnant women suffering from malarial manifestations than other observers I cannot say, unless, with the reasons previously alluded to, the district in which my records were made is one in which ague and its congeners are more prevalent than in those localities in which other statistics were collated.

Secondly. When malaria attacks a pregnant woman does it exert any remarkable effect upon the course of pregnancy? To this query my observations give a very decided affirmative answer. Of the thirty-six women who contracted malaria during their period of gestation, all of whom received treatment, some however in a later stage than others, seventeen either aborted or were delivered prematurely. Malaria may not have been the sole cause of the miscarriage in each case, but as they all suffered from this toxic condition at the time of the accident, I believe it to have been a prominent factor in the etiology. Although women with a history of previous abortions, especially those who suffer from lacerations of the cervix, or other morbid state of the uterus giving rise to the various hystero-neuroses, are probably more apt to miscarry if afflicted with malaria than women comparatively healthy, still many of those women who suffer from pathological conditions of the uterus, rendering them prone to miscarry, I am convinced would have gone to their full term if malaria had not attacked them. These figures agree approximately with Goth's. Of his forty-six cases, previously referred to, nineteen labors were premature. Bourpane (*Centraibl. fur Gyn.*, 1884, s. 821)* affirms that malaria causes more abortions than syphilis. This, of course, can only refer to malarious localities, which for obvious reasons may be

*Quoted in *British Med. Jour.*, July 18th, 1885.

correct. Grauden* believes that a woman, the victim of malarial fever, is apt to miscarry. Lusk † writes that malarial fever does not produce abortions except in rare instances. Boufils (*Goz. Med. de Paris*, Jan 2, 1886) ‡ records that whilst abortions are far from being the rule in women attacked with paludism, premature labor is frequent. Of the seventeen cases occurring in my series, two happened in the second month of gestation, three during the third, three in the fifth, two in the sixth, five in the seventh, and two in the eighth. That is five in the first half and twelve during the second half of pregnancy. Whilst, of the nineteen victims who had malaria, but did not miscarry, only three were attacked during the first half, and fifteen during the last half, and of these fifteen seven were afflicted during the last month of their pregnancy. This statement coincides with some observations recently made by Loov,§ that intermittent fever occurs more frequently in the second half of pregnancy than in the first. The prognosis of an abortion or premature labor occurring during an attack of intermittent or remittent fever is not more fatal than such accidents from other causes. The seventeen cases under my care all made good recoveries. The treatment adopted was the syringing out of the uterus with an antiseptic solution in those cases in which the fingers or hand had been introduced into that organ for the purpose of extracting the placenta or membranes—the immediate delivery of the placenta and membranes being my practice in almost all cases; the use of antiseptic vaginal injections subsequently, and the liberal administration of quinine, much more of the antiperiodic being required to cut short the fever and prevent other paroxysms than in ordinary cases of these fevers. As to the direct cause of the expulsion of the products of conception during an attack of malaria opinions also vary. Oazeau|| considers that the fever is the cause. Grauden* that the infection of the fœtus by the increased temperature may result in its expulsion, by first causing its death. Boufils, already referred

**Am. Jour. of Obstet.*, Dec., 1883.

†*System of Midwifery*, p. 254.

‡Quoted in *Med. News*, Feb. 6th, 1886.

§*Am. Jour. Med. Sc.*, Jan., 1886.

||*System of Midwifery*, p. 445.

to, believes that these accidents are owing to congestion of the uterus, and its lining membrane produced in the first or chill stage. In two of my cases, however, there was no elevation of temperature, intermittent neuralgia with other malarial phenomena being alone present. In other cases in which a miscarriage took place, the temperature never rose higher than 100°F., and the paroxysms were not ushered in with a perceptible chill. In a few instances I have attended women in premature labor while suffering from a severe attack of intermittent fever, and yet the child was born alive. Consequently the hypotheses advanced above would not explain the cause of the accident in these cases. I am inclined to think the cause is a neurotic one, and independent of temperature. When the organism is under the toxic influence of malaria, the nervous system is always in a condition of high tension, and it is not unreasonable to suppose that the explosion, which in one gives rise to a rigor or pyrexial attack, in another to neuralgia, in a child may be to an eclamptic seizure, might in a sympathetic organ like the uterus, inaugurate pain and contractions.

While authorities differ so widely on the last two questions, these discordant opinions extend equally to the action of the remedy upon which all depend in the treatment of malaria of pregnancy. Shröder and others maintain that it is extremely problematical whether quinine has an oxytocic action or not. Cazeau § considers it a certain preventative against premature labor, whilst many others † assert that it has a decided ecbohic action. Hausman (*Berliner Klensche Wochenschrift*, Sept. 11th, 1882) records a case of well-marked uterine contractions following the administration of quinine in a case two months advanced in pregnancy.

I have given quinine both in large and small doses in many cases for the purpose of quickening or rendering more efficient labor pains in cases of inertia of the uterus, or for stimulating the uterus to contraction when the escape of

the amniotic fluid has not been followed by pains. I have also frequently administered it for intermittent fever, neuralgia, and other malarial phenomena during the course of pregnancy, and in only the two following cases have I ever seen any perceptible ecbohic action follow its use:

Mrs. R. M., aged 30—3 para. I saw her on the third day following her parturition, she having been attended by a midwife, who, it was stated, assisted the expulsion of the placenta by pulling on the cord. Her labor was not tedious, and she was in perfect health at the time. For the first forty-eight hours after the birth of her child she suffered severely from "after-pains," but for the twelve hours previous to my visit they had not been nearly as severe. A few hours before I saw her she had had a slight chill, and her temperature at the time of my visit was 103.5°F. I left her 40 grs. of quinine, ten grs. to be given at once, to be followed by four grains every two hours. I was informed the next morning that about two hours after she took her first dose of medicine the "after-pains" returned with redoubled vigor, and continued, at short intervals, for about half an hour, when a "large bloody mass" was expelled from the vagina, after which the pains entirely ceased, and her condition rapidly improved. Her subsequent convalescence was uninterrupted.

Case No. 2.—Aug. 8th, 1885. Mrs. H., mother of two children, informs me that she has been troubled with "falling of the womb." She is pregnant about five months. Yesterday she felt bearing down sensations, intermittent in character, but has had no pain or hemorrhage. This morning, while micturating, a sudden profuse gush of water escaped from the vagina. A digital examination revealed the vagina moist, the finger passing readily into the external os, but not through the internal. She was ordered to bed, and $\frac{1}{4}$ gr. of morphia given.

I saw the patient again the following evening (Aug. 9th), about six o'clock, when I found her suffering from the usual symptoms of an acute paroxysm of ague. Her temperature was 101.5°F., and she was sweating, the fever evidently abating. No symptoms of labor had

* System of Midwifery, p. 445.

† *Am. Jour. of Obstet.*, Dec., 1883.

§ *British Med. Journal*, July 18th, 1885.

‡ *Ibid.*

appeared. Five grains of quinine were ordered every two hours. I was again called about midnight, shortly after which the fœtus was expelled. She informed me that about an hour after she had taken the second dose of her medicine (quinine), and almost coincident with symptoms of cinchonism, labor pains set in, and continued to gradually increase in severity up to the time of my visit, the medicine being taken at the regular times.

From the action of quinine in these two cases, which I think is sufficiently definite, I infer that in certain rare instances quinine overlaps its ordinary physiological area, so to speak, and, as is well known, it exceptionally produces an erythematous eruption on the skin, commonly called the "quinine rash," so it will exceptionally produce uterine contractions. When this does occur, its action seems to conform more to the natural rhythmical intermittent contractions of that organ than to the tonic ecboic action of ergot. But this action of quinine is certainly an unusual one, and the premature expulsion of the embryo or fœtus occurring after the administration of this drug is not due, in the great majority of cases, to the remedy, but to the poison for which it has been administered. Therefore, I believe, quinine should be administered freely in malaria-complicating pregnancy, with the precaution, however, of either administering a preliminary dose of opium, or of giving the patient a dose to be kept conveniently by and taken at the first indication of pain referable to the uterus; not so much on account of the occasional undesirable action of quinine upon the womb, but more particularly to assist its action in preventing premature labor, which is so likely to occur during an attack of malaria.

The fourth and last controversial point upon this subject which I desire to refer to, is the effect of labor upon a malarious attack. Ritter believes that the tendency of parturition is to arrest a malarious attack, in explanation of which he suggests that the hemorrhage may be the cause of the arrest, whilst Goth, on the other hand, states that an attack will be prolonged by child-birth. My own cases induce me to concur with the last-named observer, the following history, which I transcribe from

my case-book, being one of several bearing out this opinion:

Feb. 14th, 1886. Mrs D., aged 37, seven and a half months pregnant. Every afternoon during the past week she has felt feverish, her bones ached, she had a general feeling of malaria, and her urine was highly colored. About two months ago she was treated for intermittent fever. She was taken in labor during the past night. I saw her about eleven o'clock this morning, when pains were quite strong, and coming regularly about every five minutes. The os uteri was not dilated, and there had been no discharge either of blood or water. Temperature 100°F., pulse 104. I injected hypodermically $\frac{1}{4}$ gr. of morphia, and ordered a 3-grain capsule of quinine every two hours. Shortly after the morphia was used the pains subsided, and she slept for a couple of hours. She had a slight chill about four o'clock, and about five labor pains again came on more severe than before, terminating the second stage of labor about half-past six: When I reached the patient about seven o'clock, being absent from home when sent for during the afternoon, I found labor completed, the child, still attached to the placenta, lying on the bed. A careful examination of the placenta revealed it to be perfectly intact. There was very slight hemorrhage accompanying delivery. The uterus was hard and well contracted. Her temperature was 102°F., but otherwise she felt comparatively comfortable. About half-past eight o'clock she had a very severe rigor, and shortly afterwards became maniacal, requiring several persons to maintain her in bed. When I saw her again, about half an hour afterwards, she was more tranquil and rational, but her temperature was 105.5°F. The quantity of quinine she had been taking was doubled, six grains being ordered every two hours, and twenty grains of antipyrine administered at once, ten grains to be repeated every four hours until her temperature fell. Vaginal lotions of carbolic acid (1 in 30) were also ordered every four hours.

Feb. 15th, 8 a.m. Axillary temperature normal. After the second dose of antipyrine, the fever rapidly subsided, and she sweat profusely. The quinine to be continued, the dose reduced to 4 grs. every second hour.

Feb. 16th. After my visit last night, when her temperature was normal and pulse 80, her general condition continued favorable until five o'clock this morning, when she had another chill, and was shortly after seized with severe pain in the lower part of the abdomen. I saw her about eight o'clock, when her temperature was 102°F. She had taken 10 grains of antipyrine, and $\frac{1}{4}$ gr. of morphia shortly after the chill, the quinine having been continued, 4 grs. as usual, during the night. There was marked tenderness over the abdomen, for which turpentine stupes were ordered. There had been scarcely a trace of lochia since her confinement, the vaginal injections returning almost clear and perfectly odorless.

2 p.m. Temperature normal, and abdominal tenderness much less.

Feb. 17th, 8 a.m. Rested well all night. Temperature normal. Some abdominal tenderness and tympanites. Bowels moved naturally this morning. Quinine continued as before.

Feb. 18th. About four o'clock yesterday afternoon she had another chill, not so severe, however, as previous ones. I saw her immediately afterwards, when her temperature was 103°F. The antipyrine was again resorted to, and the quinine continued. She was again seen at 9 o'clock, when her temperature was normal. This paroxysm augmented the abdominal tenderness somewhat, but to-day it had almost entirely disappeared. This last pyrexial attack was less intense and shorter in duration than previous ones.

After the last chill Howard's quinine was substituted for a German quinine which she had been taking. The same German quinine was used, however, successfully both before and after in other cases of malaria.

The quinine (Howard's) was continued, a 3 or 4-grain capsule every two hours for the next three days. She had no more chills or elevation of temperature, and her subsequent progress toward recovery was unmarred by any further accident, except some slight uneasiness from her breasts.

This case, besides showing the marked tendency of the malarial paroxysms to persist during the puerperal state, notwithstanding the free administration of quinine, is also interest-

ing in some other respects. It presents most of the characteristics of intermittent fever following parturition, or what is often called "Puerperal malaria," a disease which is sometimes so difficult to diagnose from septicaemia following child-birth. The irregularity of the paroxysms, the tendency to inflammatory action, such as metritis or peritonitis, are features of puerperal malaria. * "Everything is prepared

* *Barnes' Obst. Med. Surg.*

for inflammation—the local injury, the hyperinotic blood charged with effete material are there; an exciting cause is alone wanting." And that exciting cause may be a malarial paroxysm, as demonstrated by the history of this case.

I think the morbid symptoms in this case were due purely to malaria unusually prolonged and modified by the puerperal state. The fact of her having had intermittent fever some months previous to her confinement, the aguish symptoms she suffered from for the week prior to her accouchement, the absence of any other source of contagia—in the one vaginal examination that was made a thoroughly disinfected finger was used,—the history of the case, and the fact that intermittent fever was rife at the time render the above conclusion highly probable.

SOME DETAILS IN OVARIOTOMY.*

BY ANGUS M'KINNON, M.B., GUELPH.

In this short paper I shall omit all reference to the diagnosis of ovarian tumors. It has been boldly asserted that the operation should be performed by *specialists only*, but I will not occupy time in discussing this point. From Lawson Tait, who has done so much to reduce the mortality in this operation, I quote these words: "A recovery after an ovariectomy is the sum of a number of *details*, all of which were efficient. A death, on the contrary, may be the failure of one only, and that may or may not be under the control of the surgeon." Since none of us need ever expect to have the large experience of Spencer Wells, the wonderful operative skill of Lawson Tait, or the per-

* Read at the meeting of the Ontario Medical Association, June 4th, 1886.

severance and sound judgment of Keith, it is clearly our duty, if we undertake the operation, to attend to every detail that may tend to improve the chance of saving the life of the patient.

In considering these details I will ask attention—

1. To the patient's general health. Unless when the operation is an immediate necessity, from peritonitis or suppuration of the cyst, some attention should be given to her general physical condition for a few weeks before the operation. Emmet advises the patient to have a sponge bath every alternate night, and a glass of hot lemonade after retiring, so that the skin may be made to act freely. The digestion may be improved by careful dieting. The bowels should be relieved by an occasional purgative. The day before the operation, a brisk cathartic may be given, followed the next morning by an enema. No food should be taken for twelve hours before the operation, *not even the time-honored brandy and water.*

2. Goodell made a valuable suggestion when he said that the operator and his assistants should have on their Sunday clothes, and not those worn in their daily routine of practice. One point of vital importance to the patient is, that no contagion should linger about the person of either the operator or his assistants. He should not therefore come to such an operation from a case of scarlet fever, diphtheria, erysipelas, puerperal fever, or after making or attending a post-mortem. Those who have unlimited faith in antiseptics may answer, "We have washed with bichloride;" "we have taken a bath," and "we have therefore no fear." Perhaps no greater evil arises from undue confidence in antiseptics than just such fool-hardiness. Indeed, it is scarcely less than criminal for any surgeon, however distinguished, to perform any abdominal section, or assist in such operation, while in daily attendance on cases like those mentioned. Then the question arises, and it is an all-important question for the general practitioner, how soon after discontinuing such attendance would it be safe to undertake this operation. In the case of attendance on diphtheria or scarlet fever at least ten days should elapse, and in erysi-

pelas and puerperal fever a much longer time, before it would be right to perform any abdominal surgery; and during that period the most potent of antiseptics should be vigorously employed, and all personal clothing changed. On the morning of operation, the operator and his assistants should take a bath, the finger-nails should be cut short and thoroughly cleansed with a stiff nail-brush, and the hands and arms washed in a sol. of bichloride (1—2000). Four surgeons are required for the proper performance of the operation: the chief operator and his first assistant, who should understand every step of the operation, a third to handle the instruments, etc., and a fourth to administer the anæsthetic. Besides these it is necessary to have a well-trained nurse, who, like the surgeons, must be free from contagion, and who must also carefully cleanse the hands. It will be her special duty to wash every sponge used, in one basin of pure water, and pass it into another basin of perfectly clean water, out of which she will wring it for use when required. These five are necessary and no more. Every additional practitioner present, even as spectator, is just an additional *possible* source of danger to the patient. Though it may be gratifying to the vanity of an operator to have a number of his fellow practitioners present, yet every consideration but the safety of the patient should be lost sight of, and it should therefore be a strict rule to have no one present that is not absolutely necessary.

3. This operation should never be performed in a general hospital, but in a private house in a healthy locality. The room should be large, with a high ceiling, and well-lighted. It should be provided with an open grate or stove, so that the temperature of the room can be kept at any required degree. The arrangements for ventilation should be perfect, and so that no drafts will blow over the bed. There should be no paper on the walls, and no carpet on the floor. In way of preparation, the walls and ceiling should be white-washed with lime, and the wood-work and floor washed with a solution of salt; after which the windows should be thrown widely open, and a fire kept on for several days, so that everything will be perfectly dry. The patient's bed should be single,

with a firm mattress which has been thoroughly dried. The operating table should be narrow and placed with the foot to the window.

4. Every instrument that may be required should be as clean and bright as it can be made. If the needles were ever used, the eyes should be cleansed by being held in the flame of a spirit lamp for a moment or two. All forceps or needle-holders require great care, particularly Koberle's scissor forceps. Simple washing, however carefully done, will not remove from the teeth of these forceps, small spots of dried blood, for removing which the point of a knife or strong needle must be used. The time is not wasted in attending to this matter. All the instruments should be placed just before the operation in a shallow tray, and covered by a weak solution of carbolic acid (1-40) or (1-60). A list of the instruments should be made, so that none may be left within the patient's body, as happened once to Spencer Wells.

The water for use during the operation should be as pure as it can be had; but, however pure, it should be boiled, allowed to cool, and then carefully strained. Abundance should be prepared the day before, ready to be used at whatever temperature may be required.

6. The ligature for the pedicle should be of the best Chinese silk. It should be well boiled in a large test tube. Several pieces of different sizes, and each about a yard long, should be prepared. After boiling, each piece should be further twisted, then stretched by attaching a weight of five or ten pounds, and allowed to dry. Immediately before the operation the ligatures thus prepared may be placed in a weak solution of carbolic acid.

7. In closing the abdominal incision, some surgeons use silk, some silver-wire, and others silk-worm gut. I think those who have once used the last-named will not return to either of the others.

8. The sponges should be of good quality, and have no ragged edges. Two of them should be flat and broad, and two or three of small size. As obtained from the dealers, sponges are very filthy and unfit for any surgical purpose. They should be soaked for twenty-four hours in a disagreeable sour solution of muriatic

acid, then washed repeatedly until no sand or other substance comes out of them. After an operation they should be soaked forty-eight hours in a strong solution of washing soda to dissolve any remaining fibrine. They are then repeatedly washed till the water comes from them clear. They are afterwards placed in a five per cent. solution of pure phenol, in which they may be kept, as Spencer Wells does; or hung up in a calico bag until quite dry, as advised by Lawson Tait.

During the operation the nurse should be held accountable for the sponges. There should be a definite number, and no one allowed to tear one in two, lest an autopsy reveal an appalling fact, as once occurred to Tait, and no doubt to others, though only he had the courage to confess it.

9. The temperature of the room should be maintained at about 80°F. during the whole time of the operation.

10. Ether is now admitted to be the only safe anæsthetic for long operations; however, frequently the state of anæsthesia is induced by chloroform and continued by ether. In this way probably less excitement and struggling may be encountered.

11. I shall omit all reference to the method of making the incision in the abdominal wall, and of conducting the main steps of the operation. Conditions may be met with in any case that will severely tax the clearest head and the most experienced hand; but to enter into a consideration of these is beyond the limits I have assigned for myself.

12. In regard to the pedicle, there is no longer any doubt that the proper way to deal with it, in every case where possible, is to apply a suitable ligature, cut it short, and allow it to drop into the pelvis. The strength and size of ligature must have some reference to the size of the pedicle. Tait insists that it should be as fine as will be judged strong enough to prevent any oozing from the stump. Emmet advises to throw a stout cord around the base of the tumor, and cut the whole mass away, for convenience. He also strongly insists that no traction should be made on any cord or ligature about the stump. It should be steadily held, not pulled forcibly, by a strong tenaculum or

forceps, and after careful examination he selects a point free from blood-vessels, and below the temporary ligature. At this point the pedicle is transfixed by a blunt needle carrying the double ligature previously prepared for the purpose. After the ligature is drawn through half its length, it is cut in two. One part is now passed around the other, and the halves of the pedicle are thus tied separately and yet held together by the interlacing of the ligatures. The ends of the ligatures are cut short, the pedicle is trimmed, leaving, according to Emmet, about an inch beyond the ligature, according to Tait only about one-quarter of an inch. As it has been shown that this stump does not slough, it is safer, whenever possible, to leave a full inch beyond the ligature. There is less risk when using the sponges in the subsequent cleansing of the pelvis that it might unfold and thus lead to hemorrhage.

13. During the operation, as soon as the tumor is removed from the abdomen it is a wise plan to place a sponge in the region of each kidney, and one or more in the pelvis, so that any oozing may not form a clot that might possibly remain behind. After the pedicle has been finally secured, the abdomen and pelvis should be thoroughly cleansed, all the sponges having been removed; any bleeding points not controlled by sponge pressure or a temporary grasp of the forceps should be tied. In addition to careful and thorough sponging of the abdomen and pelvis, Tait advises that the whole cavity be filled with pure water at a proper temperature, allowed to run from an elevated vessel, one of the operator's hands moving about among the bowels, the other closing the wound to keep the water in. The water may be allowed to run off by syphon, and the process several times repeated until the water comes away clear and clean. The cul-de-sac behind the uterus should be sponged until fairly dry and clean.

14. Having placed a sponge in the sac, and a broad flat sponge just beneath the line of incision, to take up any oozing from the needle punctures, the wound may now be closed—for this purpose, pieces of silk-worm gut with a straight needle at each end answer admirably. The

needles are introduced from within outwards, the point entering the surface of the peritoneum from half to three-quarters of an inch from the border. The stitches should be about half an inch apart, and should be carefully introduced with a view to perfect closure of the wound. Superficial stitches should complete the coaptation. The sponges having been removed, all instruments and sponges should be counted and the incision finally closed.

15. A narrow strip of oiled silk should cover the line of incision, and over this a piece of lint two inches wider, and double, saturated with a solution of bichloride. Then the whole abdomen should be padded with abundance of absorbent cotton, and a well-adjusted flannel bandage applied.

16. If the abdomen or cavity can be made clean and dry, Tait advises that no drainage tube be used, but if the adhesions were numerous, so that slight oozing occurs from vessels that cannot be tied, it is wiser to introduce a large-sized Keith's drainage tube, the inner end of which should be placed in the bottom of the cul-de-sac, the outer end projecting near the lower angle of the incision. Before introducing the tube, it should be put through a small slit in a sheet of thin rubber, about a foot in diameter. Two sponges should be fitted about the outer end, and the rubber folded up around the sponges. In this manner all the dressings about the incision can be kept clean, no discharge can return by the side of the tube, and the sponges can be changed when necessary without disturbing the dressings.

17. The dressings need not be changed till about the fourth day, and the stitches may be removed on the sixth and seventh days. By this time the wound will be found completely healed.

18. I have intentionally omitted all reference to the details of Listerism. In this operation both Keith and Tait, after a more or less thorough trial, have abandoned it, the former admitting that two deaths in his practice were caused by carbolic acid poisoning from the use of the spray, and the latter, that he witnessed one death from thymol. If we can make sure that no infection or contagion is carried to our patient, and that the room and everything

about it is perfectly clean, the sponges and instruments pure, we need not trouble our minds with the germs that float in myriads in the air.

In conclusion, I wish to relate very briefly four operations performed in Guelph recently—two by Dr. Howitt, and two by myself, in which the details referred to in this paper were attended to with considerable care.

1. *Removal of uterine appendages.*—Patient, a married woman, age 27 years; no children. For eight years she had suffered much from pelvic pain and menorrhagia; and for the past two years the pain had become almost intolerable, and the hemorrhage continuous. Dilating the cervical canal, and curetting the uterus for a few weeks diminished the loss, but the relief was only temporary. Both ovaries and fallopian tubes were removed—the former were about six times the normal size, and the latter were tortuous and enlarged, so as to resemble a coil of the bowel. There were firm and numerous pelvic adhesions that made the operation one of more than ordinary difficulty. A drainage tube was used. The patient made a good recovery. She has been permanently relieved from the hemorrhage and the relief from pain has been very satisfactory.

2. *Removal of a large parovarian cyst.*—Patient married, thirty-two years of age, and mother of two children. By the aspirator, eighteen months before the operation, I took away a gallon and a half of thin, pale fluid, spec. grav. 1010. No re-accumulation for twelve months, during which time her second child was born. Soon afterwards it rapidly returned; no adhesions were met with; no drainage tube used. Weight of tumor, including contents, about fifteen pounds. She made an excellent recovery.

3. *Removal of a large ovarian tumor by Dr. Howitt.*—Patient married, age thirty-seven; six children. A history of many attacks of inflammation. The patient's general health was in a very bad state, there being much pain, and actual peritonitis at the time of operation. Pulse 130, and tem. 102°, 103°. The adhesions were firm, the tumor being closely attached to the whole front wall of the abdomen. Some of the pelvic organs could only be separated by enucleating the external covering of the

tumor. The tumor was partially solid and weighed over thirty pounds. A drainage tube was used, also carbolic acid spray in the room, on the patient's abdomen, etc., before the operation. She recovered without a single bad symptom, being really better four hours after the operation than she had been for many weeks before.

4. *Removal of a large polycystic tumor of the right ovary.*—Patient's age about thirty: never pregnant; only four months married. The tumor was closely adherent to the abdominal wall and omentum. Used a drainage tube. The tumor contained hundreds of small cysts, one of which, near the surface, was ruptured in getting the mass out of the abdomen. The fluid was very thick. The whole weight was estimated at about twenty-eight pounds. She made an excellent recovery.

COCYODYNIA.

BY A. H. FERGUSON, M.D., C.M.,

(Professor of Physiology, Manitoba Medical College, Winnipeg.)

The coccyx naturally possesses a certain amount of motion, and when that motion produces pain, it has been called coccydynia. To the late Dr. Nott, of New York, is attributed the praise of first fully describing this affection, forty-two years ago, and of successfully extirpating the "os coccygis," as a means of radical cure. A review of the reported cases of this affection shows that the pain may be due to a variety of causes, as rheumatism, neuralgia, uterine or ovarian disease, caries, and fracture or dislocation of the coccyx.

These various pathological conditions suggest obvious causes, which are excellent guides to prognosis and treatment. It is well, however, to remember that the pains resulting from hemorrhoids, fissure of the anus, or the muscular spasms due to ascariasis in the rectum, have been confounded with coccydynia.

It is more my intention to report a case which has been relieved by excision of the coccyx, than to endeavor to produce anything elaborate or original.

Miss —, when eleven years of age, was thrown from the family carriage upon the pave-

ment, receiving so severe an injury as to be rendered unconscious, and consequently was confined to bed for six weeks. She suffered from pain in the head, along the spine, and in the region of the thorax. The coccygeal pain was excruciating, and became aggravated during defecation, and when the lower extremities were changed from one position to another. In about three months she was free from acute pain, but had a dull ache in the region of the coccyx while sitting. This ache increased year by year until it developed to a distressing pain whenever the coccyx was moved by muscular action or otherwise.

Miss ——— consulted me during January, 1885, eight years after the accident, presenting the characteristic symptoms of Coccydynia, such as pain in the coccygeal region while sitting, and increased as she attempted to stand erect, etc.

The muscular system was well developed. The appetite was capricious, the bowels constipated, and accompanied by that most distressing symptom—the frequent and rapid accumulation of gas in the rectum, and complete inability to retain it, whether in company or not. This disagreeable symptom was principally the cause of her remaining at home constantly, and no doubt had something to do with her despondent and hysterical condition. Menstruation was irregular and sometimes painful. There was neither a tendency to neuralgia nor rheumatism.

Physical examination per rectum revealed a comparatively fixed condition of the lower half of the coccyx, and a displacement forwards and inwards at right angles with the upper half. Considerable pain followed the pressure made with finger and thumb on any part of the coccyx, but upon passing the finger over the tip, and making traction as if to straighten it, the pain was much increased. In fact, my manipulations only produced an intensification of the "old pain" so familiar to her. There was no ovarian tenderness or uterine displacement. Her mother died in Boston a few days after an ovariectomy.

I learned by inquiry that her former physicians (not a few) had employed anti-spasmodics, tonics and purgatives, as well as anodynes in every form. Blisters had not been tried. I

therefore applied a fly-blister over the coccyx, which seemed only to add to her discomfort.

By the time its effects on the skin had subsided, she was anxious to carry out my proposition to operate, and remove the offending member. The sad experience of the death of her mother after an operation rendered it rather difficult to obtain her father's consent.

On the 27th of Feb., 1885, assisted by Drs. Higginson and Jones, I removed the entire coccyx.

A long incision was made, the whole length of the bone, and extending upwards for about an inch above the inferior extremity of the sacrum. Fully an inch of adipose tissue was cut through before the bone was laid bare. Considerable difficulty was encountered in liberating the tip, necessitating force sufficient to straighten it. In this attempt it broke at the angle, and was then quite easily dissected out. The upper and broader half still remained in situ, and it became a question whether to remove it or not. The offending portion was removed, and why disturb the rest? We knew that before the operation the whole coccygeal region was hyperæsthetic, and should it not be taken away *in toto* this condition might continue.

I used a strong, narrow scalpel to disarticulate it. At this stage, and while separating the attachments to the anterior surface of the bone, the danger lay in wounding the rectum, which is not far distant. The hemorrhage was insignificant, but the gap was so large as to render drainage necessary. The wound was stitched with long curved needles, and deeply set catgut sutures, which were removed on the tenth day, in a semi-absorbed state. The bowels moved that same evening, causing the wound to gape considerably. I then used straps of rubber adhesive plaster, and drew the nates well together; these kept the edges of the wound firmly approximated, and in fact in a more secure and comfortable condition than the sutures.

Should the opportunity present itself to me again of performing this operation, I should use no sutures whatever, but simply strap the buttocks together in preference, leaving sufficient space for dressing purposes.

It is now more than a year since I operated, and I am happy to report that my patient is free from pain, and able to enjoy life. A mild pil of aq. ext. aloes, podophyllin, and ext. nux vomica āā, gr. $\frac{1}{4}$, taken before breakfast, suffices to regulate the bowels, and prevents the accumulation of gas already referred to.

Selections.

[We are indebted to DR. ZIMMERMAN for the translations from the French and many of the therapeutic notes, and to DR. R. B. NEVITT for the Italian translations.]—ED.

ON THE VALUE OF BORIC ACID IN VARIOUS CONDITIONS OF THE MOUTH.

BY A. D. MACGREGOR, M.B., KIRKCALDY.

Boric acid is now officinal, and justly so. It has long been used in various metalurgical and ceramic operations, and more recently its preservative power has been abundantly demonstrated. It is this antiseptic power which gives it its great therapeutic value. It is a very stable compound—one of the most stable of the acids; it is not volatile, and only exerts its action when in solution; fortunately, however, it is soluble in more than one menstruum. Up till now, its chief application has been in connection with modern surgery, where the boric ointment, lint, and lotions all hold a prominent place. There are spheres of usefulness for it, too, in medicine; and one of these is in diseases of the mouth. It is the benefit of its local action we usually wish to gain, for, though sometimes given internally—as in irritable conditions of the bladder—its topical antiseptic effect is more often desired. In connection with its local application in various diseased conditions of the mouth, its solubility in water and glycerine, its unirritating character, its comparatively innocuous nature, and its almost tastelessness, are greatly in its favor. More particularly is this the case in treating such conditions in children, whose oral cavities cause them so much annoyance. Speaking generally, boric acid will be found useful in all conditions of the mouth, fauces, pharynx, and nose, where there

is any abrasion of the epithelium; whether it be used as a powder, gargle, mouth-wash, pigment, or confection. More definitely, I may say, it is not contra-indicated in any of the forms of *stomatitis*, though scarcely severe enough for the graver varieties.

In *simple catarrhal stomatitis*, a mouth-wash, containing from 10 to 15 grains to the fluid ounce, speedily cures the condition, and exercises the same beneficial influence in the *ulcerative* form, though there, in addition to the rinsing of the mouth, a local application in the form of the powder or pigment should be made to the individual follicular ulcers. The powder simply consists of finely powdered boric acid, mixed in various proportions with starch; the pigment is a solution of boric acid in glycerine (1 in 4 or 5). In both cases, the addition of chlorate of potassium is advantageous; indeed, I usually combine it, but it is not essential.

Nothing I know of is at once so rapid and so efficient, in the treatment of *parasitic stomatitis* or *thrush*, as this remedy. The youngest children do not object to its application, and, occasionally, you have to caution against its too frequent use. The *oidium albicans* quickly succumbs to its influence. I am well aware of the great value of nitrate of silver in many of these conditions; but, I am also alive to its extremely disagreeable and persistent taste, and the dislike which precocious children at once take to it. For thrush in children, I especially recommend boric acid, either as a mouth-pigment or as a confection. Honey and sugar have both been condemned, as being inadmissible, in combination, for the treatment of thrush; but, so far as children are concerned, I must say I consider a confection (though made with honey), which has been impregnated with boric acid, gains more by its palatableness than it loses by the tendency of the saccharine matter to further the growth of the fungus. The boric acid at once does away with this tendency. Let the pigment be frequently painted with a brush over the patches, never omitting to do it after food has been taken; or, a little of the confection, simply allowed to dissolve in the mouth; and the days of the fungus will soon be ended. I have found boric acid, combined with its salt (borax), markedly bene-

ficial. Borax alone, however, is not nearly so good.

In *pharyngitis*, and *relaxed conditions of the throat*, a gargle, containing boric acid and glycerine, with either tannic acid or alum in addition, ought not to be forgotten.

Let me allude to another condition, in which I have found combinations of this substance helpful and grateful to the patient. I refer to the condition in which we frequently find the mouth, tongue, and teeth in severe cases of typhoid fever. The mouth is hot; the lips dry, cracked, and glued to the sordes-covered teeth by inspissated mucus and saliva; the tongue dry, or even glazed and hard, brown or black, crusted with a fœtid fur. Under such circumstances, a pigment, containing boric acid (30 grains), chlorate of potassium (20 grains), lemon-juice (5 fluid drachms), and glycerine (3 fluid drachms), yields very comforting results. When the teeth are well rubbed with this, the sordes quickly and easily become detached; little harm will follow from the acid present. The boric acid attacks the masses of bacilli and bacteria; the chlorate of potassium cools and soothes the mucous membrane; the glycerine and lemon-juice moisten the parts, and aid the salivary secretion. I consider this application well worth a trial.

So much for the soft parts; a word in conclusion regarding the teeth. Few medical men, I suppose, have ever given a prescription for a tooth-powder (such a matter is beneath their notice), and the selection of the ingredients for the various powders and pastes in vogue for the purpose of beautifying and cleansing the teeth is left entirely in the hands of those who certainly should not know better than medical men. I have frequently trespassed on this debatable ground, and recommended a particular dentifrice. In view of the extremely important part the teeth play in the economy of life, I never hesitate occasionally to inquire as to the attention they receive.

A tooth-powder should possess certain characteristics; it should be antiseptic, cooling, agreeable to taste and smell, and have no injurious action on the teeth. After use, it should leave the teeth white, and a sensation of freshness and cleanliness in the mouth. As

an antiseptic in this connection nothing can displace boric acid. For years I have used the following powder, and can recommend it. Boric acid, finely powdered, 40 grs.; chlorate of potassium, ʒss; powdered guaiacum, 20 grs.; prepared chalk, ʒi; powdered carbonate of magnesia, iʒ; otto of roses, half a drop. The boric acid in solution gets between the teeth and the edges of the gums, and there it discharges its antiseptic functions; the chlorate and guaiacum contribute their quota to the benefit of the gums and mucous membrane generally; the chalk is the insoluble powder to detach the particles of tartar which may be present, and the magnesia the more soluble soft powder which cannot harm the softest enamel.

It is only right to say that loriglyceride (Barff) can replace boric acid in almost all the forms of administration I have enumerated; it is efficacious, slightly, and pleasant to the taste. —*British Medical Journal*.

FATAL RESULTS FROM "SPLITTING THE CERVIX."—Dividing the cervix at the external, or at the internal os, or in the intervening portion, though not long since a comparatively frequent operation for dysmenorrhœa or sterility, is now very rarely done. Most operators now turn to dilators for the treatment of cases where incision was formerly done; one wing of the army of gynecologists still fights under the same banner of mechanical uterine pathology, only in place of hysterotomes its enthusiastic soldiers use dilators. Possibly it is only a question of time when many of the dilators will be placed in the grave beside the hysterotomes, if the teaching of men like Duncan, Schultze, and Williams prevails, and the mechanical theory of uterine disease is cast aside.

However this may be, we have been somewhat astonished to know of the mortality which Sims had from this operation. Pajot states, in a recent lecture, that he knew of at least four deaths of women upon whom Sims had performed his operation of division of the cervix, and he believes that other similar accidents happened to him. In the light of these facts, the profession is to be congratulated upon the fact that the operation has fallen into disuse. —*Medical News*, June 12, 1886.

MASSAGE AS A THERAPEUTIC AGENT.

In note on this subject Dr. Wm. Murrell says : It is no easy matter to say in what class of diseases massage proves most useful. Unfortunately, its employment has been advocated in many cases for which it is essentially unsuited. Accurate diagnosis is of the utmost importance, and the sphere of usefulness of this remedy will, with increased experience, become more accurately defined. My best results have been in infantile paralysis ; and it was in consequence of the success achieved in certain obstinate cases of this disease, that my attention, as has been elsewhere stated, was directed to the subject. Progress is often slow, but the ultimate results are most satisfactory. The nutrition of the parts is maintained until new cells in the spinal cord take on the functions of those which have undergone degeneration, or have been destroyed. Massage is, undoubtedly, of much value in many cases of obstinate neuralgia, and succeeds admirably in some forms of muscular pain, such, for example, as those described by the late Dr. Inman under the term "myalgia." There is a general consensus of opinion that it is well adapted for the treatment of chronic joint-affections ; and most of those I saw treated by von Mosengeil were such as would, in this country, be considered incurable, or would drift into the hands of "bone-setters." There are some diseases of internal organs in which it is undoubtedly useful. Not long ago, a gentleman, aged 68, came to me complaining of shortness of breath, and increasing disinclination to take exercise. He had been in business, and had led a most active and energetic life. Three or four years ago he retired, and, from that time, experienced a gradual falling off in health. His appetite was poor, his bowels were obstinately confined, and he was nervous and anxious about himself. He was found to have a loud apex systolic murmur, and the heart's action was weak and irregular. I suggested massage, which was carried out systematically four days a week, for a period of six weeks. He improved from the very first, and, before the conclusion of the course, was better than he had been for many months. His appetite returned ; his hands and

feet were warmer ; the bowels became regular ; he slept well at night ; and his spirits improved in a most satisfactory manner. In other cases of obstinate constipation, especially in women, I have known massage of the abdomen do a great deal of good.

In a well-known group of symptoms from which women frequently suffer, massage is essentially useful. I recently saw a lady, aged 45, or thereabouts, a professional singer, who was laboring under the impression that she was going mad. She was so nervous that she was quite unable to accept an engagement, although she had been constantly before the public, and hardly missed a night for twenty years. She told me she felt she was not to be trusted, and that if left alone she would do herself or her children an injury. She was afraid to go near an open window, so great was the temptation to throw herself out ; and she even begged that the knives might be removed from the table at dinner. These symptoms were greatly intensified after each monthly period, and she insisted that she was suffering from cancer, or some organic disease of the stomach or womb. She was restless at night, and would often get up in the early morning, and walk for hours, until thoroughly exhausted. She was given full doses of the bromides—a drachm, or more, four times a day—but with only temporary benefit. Massage was then tried ; and it seemed, to use her own expression, to soothe her, and calm her, and make her forget her troubles. The case was a prolonged one, but now, at the expiration of three months, she is much better, and will soon be able to resume her professional duties. In several other cases of restlessness and inability to sleep, the same method of treatment has proved efficacious.

Dr. Graham, of New York, speaks highly of massage in the treatment of neurasthenia. He uses it for those "who, in spite of rest, change and medication, have become chronic neurasthenics, the result of business reverses, overwork, worry, loss of relatives, disappointed hopes, or as a sequel of some affection that has existed in some part of the system, but which has recovered or has become of secondary importance." These symptoms may be somewhat ill-defined ; but I have certainly found massage of the greatest

use in what, for want of a better name, has been called "spinal nervous weakness," or "neurasthenia spinalis."

In the treatment of corpulence associated with constipation, massage is of much value. Some months ago I saw a lady, aged 38, who, as the result of much good living and little exercise, had become inordinately stout. She was very short of breath, and was disinclined for exertion of any kind. She had been fond of literary pursuits, but even those had lost their charm, and were irksome to her. She was extremely irritable, and a source of trouble and anxiety to her friends and relatives. Massage was prescribed, and in two months she lost a stone and a half in weight, and improved notably in other respects.

For many forms of menstrual disturbance, massage may be safely prescribed. I recently saw a young lady, aged 19, who suffered intensely at each monthly period, the pain being so severe that hypodermic injections of morphia had to be resorted to. Massage of the abdomen and pelvis was prescribed, and from that time there was no return of the trouble. Cazeaux has reported several similar cases, in detail. In the convalescence from acute illnesses, this mode of treatment is a great help and comfort to the patient. There can be no doubt that massage is a very valuable therapeutic agent, and is likely to yield good results in many complaints other than those I have roughly indicated.—*British Medical Journal*, May 15, 1886.

The *St. Louis Med. and Surg. Jour.* says that for bruises there is nothing to compare with the tincture or a strong infusion of *capsicum annuum* mixed with an equal bulk of mucilage of gum-arabic and with the addition of a few drops of glycerine. This should be painted all over the bruised surface with a camel's-hair pencil and allowed to dry on, a second or third coating being applied as soon as the first is dry. If done immediately after the injury is inflicted, this treatment will almost invariably prevent the blackening of the bruised tissue. The same remedy has no equal in rheumatic, sore or stiff neck,

REPLACEMENT OF A LOST EYE.

The operation of transplanting an eye removed from a rabbit, or dog, into the human orbit, first suggested and performed by Dr. Chibret in May last year, has now been performed five times. In a recent paper (*Archives d'Ophthalmologie*, January—February, 1886), M. Terrier publishes the details of these operations, and gives the history of the only successful case down to a later date than was possible when it was first published. In Chibret's case, the patient was a girl, aged 17, and the transplanted eye was that of a rabbit. All the cellular tissue was carefully dissected off the sclerotic, and the eye was retained in the capsule of Tenon by the conjunctiva being constricted round it by a ligature. The cornea ulcerated, and gave way on the fifteenth day, when the contents of the globe escaped. The sclerotic was left, and underwent cicatricial contraction. The antiseptic used was corrosive sublimate. The second case, by Terrier, was in a man aged 30, in whom one eye had been lost by a recent injury. A rabbit's eye was used in this case also, but the cellular tissue on the sclerotic was preserved, as well as a circumcorneal ring of conjunctiva; the latter was stitched to the conjunctiva of the recipient by eight points of suture. The eye was washed in a warm solution of boracic acid, and Lister's antiseptic precautions were employed. Some entropion of the lower lid took place, and the cornea sloughed. The eye was removed on the fifth day. The third operation, by Rohmer, was on a woman aged 42, in whom there was an old adherent staphyloma, with localized iridocyclitis, and sympathetic irritation of the other eye. A dog's eye was used, the cellular tissue and conjunctiva being preserved as in the preceding case. Corrosive sublimate was used as an antiseptic. The cornea sloughed on the sixth day. Three months later, the patient returned with a fresh attack of sympathetic irritation, and the shrunken stump, which had been constantly suppurating, was removed. It was found to have contracted firm adhesions. The fourth case is the successful one already published by the operator, Bradford (*Boston Medical and Surgical Journal*, No. 12, 1885).

The patient was a man, aged 35, in whom one eye was blind and shrunken—the result of an old injury. The eye was enucleated in the ordinary manner, except that sutures were passed through the recti muscles and the optic nerve previous to their division. A rabbit's eye was then enucleated, the muscles being cut short, but about eight millimètres of the optic nerve being removed with the eye. The eye, and the orbit of the recipient, having been washed with the white of an egg, the eye was introduced, and secured, first, by a suture connecting the optic nerves; secondly, by the recti being attached to the cellular tissue on the sclerotic; thirdly, by conjunctival sutures. Iodoform was applied as a dressing, and the eye was not opened till the seventh day. There was then a superficial opacity of the cornea, and some chemosis of the conjunctiva. The suture through the optic nerve, which had been secured by a kind of slip-knot, was removed, as well as two of the sutures through the muscles; one of the latter had already given way. On the twelfth day, the remaining suture was removed; the cornea was clearer, and the conjunctiva united in its whole circumference. On the eighteenth day (the date of the previous publication of the case), the size, shape, and tension of the eye were normal, and its movement free. M. Terrier adds that, two months and twenty days after the operation, there was a cicatrix of the former ulceration, occupying about one-sixth of the cornea; that the pupil was of medium size, and inactive; and that all the movements were free. There were some opacities in the vitreous humor. The last published case is one performed by Terrier, on October 19th, last year. The patient was a man aged 66, in whom an unsuccessful cataract operation had been followed by severe ciliary neuralgia. The eye was enucleated, and a rabbit's eye introduced, and secured by sutures through the recti. Warm boracic acid solution was employed as an antiseptic. A troublesome entropion of the lower lid occurred, and caused ulceration of the cornea; the latter sloughed, and the globe was excised on the nineteenth day, when it was found to have contracted firm and vascular adhesions to the capsule of Tenon. The feasi-

bility of the operation may be considered as established, for not only was Bradford's case successful, but the fact that, in Terrier's two cases, firm and vascular adhesions had formed between the transplanted eye and the capsule of Tenon, renders it probable that a successful issue would also have been obtained in them could the ulceration of the cornea have been prevented. The latter was, probably, in a great measure, due to the entropion of the lower lid; and the occurrence of this might be prevented by modifying the details of the operation, and especially by adopting the expedient, since suggested by Terrier, of temporarily uniting the eyelids. From a physiological standpoint, the successful transplantation of so complex an organ from one animal to an individual belonging to a different species, is of the greatest interest; it may, however, well be doubted whether the operation will prove of any practical value. It is, indeed, difficult to see what advantage can be claimed for the transplanted eye over an artificial organ. The cosmetic effect of a well fitting glass-eye would probably be far better, except, perhaps, in respect to the range of movement. The vitality of the organic eye would probably be low, and it would be liable to become inflamed from slight causes. We much doubt, moreover, whether many patients would give their consent to the eye of a rabbit or a dog being constituted a part of their individuality. We should not have thought it necessary to point out the impossibility of the transplanted eye being of any functional use, had not the contrary been hinted at. Even if the retinal elements of the transplanted eye retained their power of responding to the stimulus of light, and the conductivity of the optic nerve was restored when organic union took place, still, no useful vision could result unless the retinal elements of the transplanted eye, which corresponded to any given points in the visual field, became connected with the same fibres as those connected with the corresponding retinal elements in the excised eye; this would necessitate an impossible similarity in the optical conditions, and in the number and arrangements of the retinal elements in the excised and transplanted eyes.—*British Medical Journal.*

CLINICAL REMARKS ON THE TREATMENT OF COMPOUND FRACTURES.*

BY FRANCIS J. SHEPHERD, M.D.,
Surgeon to the Hospital.

Gentlemen:—The treatment of compound fractures was, up to the period of the introduction of antiseptics, in a very unsatisfactory state. The surgeon always dreaded the occurrence of such fractures in his practice, knowing how uncertain the results of treatment were, and how often these cases died of blood-poisoning. If the external wound was small, good results frequently resulted by immediately sealing the wound with its own blood, collodion, or the compound tincture of benzoin, but not unfrequently the wound failed to close and suppuration ensued, often necessitating an amputation, which frequently ended in death. Occasionally there was not time for amputation, the patient dying rapidly of pyæmia.

Compound fractures being most common in the leg, I shall describe the treatment adapted to such a case. The method is as follows†:—

When called to treat a compound fracture of the leg, if there is severe hemorrhage and the wound is small, it would be better to enlarge it and search for the bleeding point. Having arrested all hemorrhage and placed the fragments in proper position, the wound should be thoroughly irrigated with a solution of 1-1500 of mercuric bichloride and then dusted freely with iodoform; over this, some washed gauze wrung out of bichloride solution is placed over the wound, and over this a pad of finely-carded sublimate jute, covered with bichloride gauze, and dusted with iodoform. This pad is kept in place by an antiseptic gauze bandage, and the leg placed in a McIntyre or other splint. The pad, if there be much oozing, should be removed next day and a new one applied, but the gauze over the wound had better not be disturbed. After this the dressings should not be changed unless the temperature and general condition of

* Delivered at the Montreal General Hospital, 12th May, 1886.

† In describing this method, it is, of course, understood that before treating the wound the surgeon's hands and instruments should be rendered aseptic by the usual means, a description of which is unnecessary here.

patient indicate that something has gone wrong in the wound. In my cases, as a rule, the second dressing has been left on a month, with result of finding, on its removal, the wound perfectly healed. If the wound is not of very large size, I have been in the habit of immediately putting up the leg in plaster-of-paris bandages, leaving a window opposite the wound, protecting it with an antiseptic towel whilst the plaster is being applied. The edges of the window I stuff with antiseptic jute to prevent the blood and serum getting under the plaster. After the plaster has been applied, the wound is dressed in the way I have described above. It is a very rare occurrence that the dressing has to be removed after the second day, when oozing generally ceases. In one case treated in ward 23 last summer, where there was a compound fracture of the ankle joint, with rupture of the posterior tibial artery, the wound was enlarged, the artery tied, and the parts dressed with iodoform and a large jute pad, and left undisturbed for a month, with the result of finding, at the end of that time, the wound completely healed. The temperature never rose above 99°F. In another case of compound fracture of the thigh, the same result followed the same course of treatment; and many fractures of the leg have healed in this way without the slightest febrile reaction. When the wound is large, sutures of catgut are used; but when not very large, no sutures at all are employed, the wound apparently, with the aid of iodoform, which forms a crust over it, healing as under a scab.

I take this opportunity of presenting to your notice the patient, Ed. N., aged 33, sailor, now before you, who has occupied a bed in ward No. 23 for the last nine months. His history is shortly as follows: On the 11th of August, 1885, he was brought to the hospital with severe compound fracture of both legs, consequent on falling some twenty feet into the hold of a ship. He had lost a considerable amount of blood, and there was a good deal of oozing when he was admitted. My house surgeon, Dr. Eberts, as it was near the visiting hour, merely put on an antiseptic towel and bandage. On my arrival, I found that the patient had sustained a compound comminuted fracture of the left leg, the

wound in soft parts being some two inches long, and a compound fracture of right leg, with considerable riding of bones and a large amount of laceration of soft tissues. Both legs were much swollen. After cleansing the wounds in both legs thoroughly, the left was put up in plaster-of-paris bandages, a window being arranged for opposite the wound. The right leg was so severely lacerated that it was not thought wise to put it up in plaster, so a McIntyre splint was employed. The wounds were dressed in the manner I have already described. The same night, owing to the profuse oozing of blood, the dressings had to be changed. From that time till the 9th of September (nearly a month) the dressings were not removed, and then the wounds were found completely healed, or, rather, scabbed over. After the third day, the temperature, which, on the second day, rose to 100°, was perfectly normal. The fracture of left leg, on removal of dressings, was found to be firmly united, but there was no union in the right, in which, as I said before, there was considerable riding of fragments, the bone being broken about the junction of lower and middle third. The bones were rubbed together and put up in plaster-of-paris. From time to time this was renewed, the man being allowed to go about early in November, and at present you see he has fair union in the right leg, but some shortening. He leaves the hospital during the present week to return to his occupation. I have advised him to wear for a time the plaster splint on his right leg. This case is a very good example of the happy results of this method of treating compound fractures when the wound is very extensive. Before the introduction of antiseptics the man would probably have had one leg amputated, and might possibly have lost his life by some form of blood poisoning in the effort to save the other. As it is, the man is in a fit condition to resume his ordinary work, and the accident will not in the slightest degree interfere with his future prospects.—*Can. Med. and Surg. Jour.*

The Colleges of Physicians and Surgeons of Edinburgh and Glasgow have decided to throw open to women their joint examinations for the "triple" qualification.

TEREBENE.

At a meeting of the St Louis Medico-Chirurgical Society, Dr. Mulhall reported his experience with terebene. Dr. William Murrell of London, one of the great therapeutists of the age, was the first one to call attention to its virtues in what is known as winter cough, chronic bronchial catarrh. Dr. Mulhall has tried it in about thirty cases including several cases of phthisis. Dr. Murrell claims that it is one of the best medicines, perhaps the best, he has ever used to relieve chronic engorgement of the bronchial mucous membrane—loosening the mucus and making it come quite freely and easily. His own experience has been corroborative of the results reported by Dr. Murrell. In several cases it had a most astonishing result, so that in the course of four or five days the cough of a chronic bronchial catarrh was entirely relieved. One old man said that he had bought twenty bottles of medicine and none of them had had any effect in relieving his old winter cough. Dr. Mulhall ordered terebene, and he came back in the course of five days and said that it had done him more good than all the cough remedies he had used, put together. It rendered his cough perfectly loose and easy, and there was no longer any trouble with it. In several cases of phthisis it had the effect of making the secretion quite easy of expectoration, and seemed to help their condition. Dr. Murrell also claims that it is excellent for the flatulence of dyspepsia which so often complicates cases of bronchial catarrh. Another advantage which Dr. Murrell claims, is that it is administered very easily, and this certainly is true. Half an ounce can be carried in the vest pocket; and may be taken, five drops at a dose, three times a day on loaf sugar. Dr. Mulhall gives ten drops at a dose. Patients do not make any objection to taking it; it is quite agreeable to take.

Dr. Boisliniere, Jr., remarked that Professor Germain-Sée advised giving turpentine in solution containing a little alcohol in similar cases to those for which terebene has been found so useful.

Dr. Moore thought the remedy spoken of by Dr. Mulhall had a wide field. He had a chronic case of asthma which was losing its spasmodic character and assuming that of chronic bronchial

catarrh with a most viscid expectoration. He asked if Dr. Mulhall had tried this remedy in such a case.

Dr. Mulhall had not treated with terebene, any cases complicated with asthma, because he regarded the spasmodic elements as due to disturbance of the nervous system and did not suppose terebene would affect that, but the catarrhal element, it would. In cases of bronchial catarrh in which there were asthmatic seizures, he had used it with good effect. The remedy relieves the engorgement of the bronchial mucous membrane and thereby renders the patient less liable to asthmatic seizures.—*St. Louis Courier of Medicine.*

A NEW METHOD OF REDUCING HERNIA (SPONTANEOUS REPOSITION). By K. Nickolaus, (Baden).—If a loop of intestine be pushed through a small loop of rubber and injected (e. g. by a catheter in one intestinal end) the intestine will distend, but no amount of pressure can drive the water from the other end of the gut. The water will, however, easily flow out on slight traction of the free end of the intestine. It is also often found in the cadaver that a hernia, irreducible *intra vitam* by taxis, yields readily to slight pulling on the efferent end.

There are various ancient methods of reduction based on this principle—hanging the patient by the heels, suspending from the legs thrown over a nurse's shoulder, etc. These may have been more efficient by causing the subject to faint. These methods had little value, because to make traction effective, the parts must be relaxed, i. e., whatever constitutes at the time the abdominal floor must not be hard or tense.

The best conditions—relaxation of wall with greatest negative pressure—are secured by the knee-shoulder position. Renauleme once recommended taxis in the knee-shoulder position, but this was soon forgotten.

Previous emptying of the stomach, bladder and rectum favors negative pressure. This position may be rendered still more effective by placing a cushion under the knees and rotating the leg on the affected side outwards (thus,

according to Hyrtl, enlarging the external inguinal opening).

The difference in pressure between abdominal and hernial cavities aspirates the sac, leading gradually to a return of the sac contents (at first of the intestinal contents and circulatory fluids). Even a slight reduction in the quantity of the same greatly facilitates the return of the remaining parts. Some traction is at the same time exerted. These forces act primarily on the internal opening and are consequently much more effective than manipulation, which acts first on the external.

Cases 1 and 2. Incarcerated inguinal hernia. All the older methods tried in narcosis. Spontaneous reduction, in a little while, about 20 minutes, by this method. (3) Incarceration. Incomplete reduction in like manner—sufficient to leave the gut permeable. (4) A large, old scrotal hernia, not completely reducible in the dorsal position, went back readily in this way. (5) Incarcerated crural hernia in an old woman. Self reduction after twice placing in this position for three-quarters of an hour, alternating with Sim's lateral position. (6) Old man with cardiac trouble. Incarceration for 36 hours. Prolonged taxis. Knee-shoulder position repeatedly during the night although there was no change the next morning, yet manipulation now succeeded. (7) Incarcerated inguinal hernia in a young man. After he was twice in this position for three-quarters of an hour—Sim's position in the mean time—it had become so soft that the patient pushed it back himself. (8) Irreducible crural hernia (facial incarceration). After this position had been retained several hours the symptoms subsided and the gut became permeable. In three cases of internal incarceration this procedure proved of no avail.—*Cent. f. Chirg. Annals of Surgery.*

In the French Academy of Science recently, MM. Duguet and Hericourt announced that they considered the spore of pityriasis versicolor, the *microsporion furfur* as the first stage in the evolution of the bacillus of tuberculosis. When inoculated upon a rabbit this spore invariably produces an attack of tuberculosis. M. Vulpian thought the experiments of the highest interest, but that they needed to be repeated and verified with extreme care.—*L'Union Medicale.*

CASE OF RUPTURE OF OVARIAN ABSCESS WITH FATAL PERITONITIS, AND POST-MORTEM SOFTENING OF THE STOMACH. By J. J. Cox, M.D.—On the 5th of March last, I was summoned to see a female patient, who was supposed by her relatives to be at all seriously ill. On my arrival at the house at 11.30 a.m., I found a young woman, aged 25, of magnificent physique, lying in bed upon her left side with the knees slightly drawn upwards towards the abdomen. She was evidently moribund, the pulse could scarcely be felt, and her face wore the aspect of imminent dissolution. She complained of great weakness, but said she had only very little pain in the abdomen, and there was apparently not much tenderness on pressure being applied there. Her intellect was quite clear.

The history obtained was that she felt ill the previous day, but had worked at washing and ironing until seven o'clock in the evening, after which she had gone out twice to a privy in the backyard; on which occasions there was slight diarrhœa. She had only occasional slight pain during the day, which was ascribed to a probable bilious attack with slight diarrhœa. At nine p.m., she retired to bed, and had a warm poultice applied to the abdomen. Next morning she said she was not well enough to get up, but her mother had much trouble in persuading her not to attempt to arise.

A positive diagnosis could not be made. There was evidently a rapid peritonitis, but the cause could not certainly be decided upon. At first I thought there had been a rupture of a gastric or intestinal ulcer, but no history of either could be elicited. Menstruation took place normally seven days before this illness began. There were no signs of hæmatocele. I could not obtain any urine for analysis, but considered it most probable that the kidneys were healthy, as the patient showed no other evidence of acute or chronic renal disease. The circulatory and pulmonary condition was normal. I could detect no symptoms of acute poisoning nor of any ambulatory typhoid.

The diagnosis, therefore, narrowed itself down to probable acute peritonitis; cause unknown. The patient died at two p.m. the same day.

A post-mortem examination was made two

days afterwards, by Dr. Harris, in the presence of Professor Dreschfeld and myself. We found intense peritonitis in the higher part of the peritoneal cavity, with a large rupture of the stomach and escape of its contents. It seemed at first that the rupture was due to the perforation of a gastric ulcer, but closer examination showed that the injury to the walls of the stomach was owing to extensive post-mortem softening, and that the cause of death did not lie there. The intestines were removed, and carefully searched all over, but no lesion could be discovered. Dr. Dreschfeld suggested small ovarian abscess, and we found a small abscess sac, about the size of a large garden pea, which had ruptured. It still contained some pus. There were only slight evidences of peritonitis in the pelvis, the brunt of the attack having fallen upon the peritoneum around the stomach and large intestine.

This case shows that peritonitis is not necessarily most marked near the focus of injury, a fact which bears in an important manner on evidence in cases of criminal abortion.

Dr. Dreschfeld mentioned that he had known five or six cases of rapid death due to rupture of small ovarian abscess.—*Medical Chronicle*.

CLIMACTERIC DIABETES IN WOMEN.—In an article with this title Lawson Tait says: Roughly speaking, the conclusions that I have arrived at concerning this affection are that in the great majority of cases of eczema of the vulva at the climacteric period, the disease is due to the presence of sugar in the urine. I have not yet come across a case of this kind in which, having examined for sugar, I have not found it. The disease seems to begin at or near the arrest of the menstrual functions, and to extend over a period of several years, then terminating in all probability by nature's own process. The sufferings of the patient are very much diminished, and probably the duration of the disease is shortened by the liberal administration of opium, whilst the local trouble is best mitigated by ointments containing such substances as will arrest the process of fermentation change in sugar. So far, the best substance that I have found for the purpose is the old-fashioned hepar sulphuris.—*The Practitioner*.

A CASE OF CHRONIC URETHRITIS TREATED BY EMMET'S BUTTON-HOLE OPERATION.—By Virgil O. Hardon, M.D.—E. J., white, widow, aged 61, was married at 13 and has borne nineteen children. All her labors were normal, as far as she knows, and her health has always been good until twelve years ago. She then began to suffer from frequent desire for micturition, and the act was always accompanied by burning pain. These symptoms gradually increased in severity until at the present time she is obliged to urinate at intervals of from fifteen to thirty minutes throughout the day and night. The passage of urine produces intense pain in the urethra, especially at the meatus, radiating upward into the abdomen and downward into the thighs. This pain persists for some time after micturition, so that she is hardly ever free from it. In other respects her health is good, but her naturally robust constitution is breaking down under the constant pain and annoyance to which she is subjected. She is entirely unfitted for social or domestic duties, and nearly her whole time and attention are given to keeping her bladder empty.

Examination shows the meatus contracted so as to scarcely admit a No. 6 sound, and surrounded by cicatricial tissue, forming bands by which it is much distorted. Extreme tenderness exists along the urethra and in the neck of the bladder. The passage of a sound gives exquisite pain. The urethro-vaginal septum is of abnormal thickness and density. Otherwise the pelvic organs are found to be normal.

The urine, of which about an ounce is passed at a time, is straw-colored and slightly turbid. Upon standing there is formed a deposit of about one-fourth its bulk. Specific gravity, 1028. Chemical and microscopical examination shows it to be free from albumen, sugar, pus and mucus. The deposit is made up of amorphous urates.

The patient has been treated by internal medication by competent practitioners, but without receiving any apparent benefit.

January 23, 1886, with the assistance of Drs. Bizzell and Wile, she was etherized and Emmet's button-hole operation was performed. An incision was made through the urethro-vaginal septum, commencing a quarter of an inch behind

the meatus and extending to a quarter of an inch from the neck of the bladder. Through this opening the cut edge of the urethral mucous membrane was drawn and stitched on all sides to the cut edge of the vaginal mucous membrane with carbolized silk sutures. Thus no surface was left uncovered to heal by granulation. The urethral mucous membrane was found to be so intensely congested as to present a deep purple color and the capillary oozing of blood from it was very free. The parts were smeared with vaseline, and the patient was afterwards instructed to make the same application before each micturition. The wound healed satisfactorily and the sutures were removed on the eighth day, leaving a permanent urethro-vaginal fistula.

In the twenty-four hours following the operation, the patient urinated five times with only slight pain. After the second day she was entirely free from pain and has continued so ever since. She urinates sometimes twice, usually only once, and occasionally not at all during the night, and from four to six times during the day. She frequently holds her urine for six hours without any discomfort. The urine passes entirely through the artificial opening. The pain at the meatus and the tenderness along the urethra have ceased, and the congestion of the urethral mucous membrane is now very slight. —*Atlanta Med. and Surg. Jour.*

PAPAYOTIN IN DIPHTHERIA, by Guido Bell, M.D., Indianapolis, Indiana.—The idea of removing a diphtheritic membrane by dissolving it is not a new one. Pepsine has been locally applied in cases of diphtheria, notwithstanding the fact that the alkaline mucus makes it inert. Pancreatic juice has been successfully substituted.

About four years ago I reported a case of chronic ulcer in the *American Practitioner*, where every known treatment has failed. The sore was between the first and second toes, was very tender and covered with diphtheritic membrane. The local use of lactopeptine eased the pain within two days, and cleared and healed the wound within a week. I tried lactopeptine afterwards in different chronic ulcers (without those characteristic symptoms stated above) but

in vain. Lactopeptine dissolves diphtheritic membranes in acid solutions.

Papayotin acts similarly, with the condition that the solution be alkaline. Experiments with diphtheritic membranes have proven that.

For some reason I did not use papayotin in diphtheria sooner than this winter: Out of six cases I will mention only one. [History given.]

In other cases the membranes were removed within one week and a half to three days. Four applications in a day might be sufficient in milder cases. I have a glass tube, about five inches long, with a short piece of rubber tubing attached, then another glass tube, equally long, to be connected with the first one, and in cases where I have to blow into the larynx, I have a third tube whose end is closed, leaving an opening or a little canal downward and toward me. The whole apparatus can be carried in the pocket case. The doctor makes his tubes according to his case.

Papayotin affects the diphtheritic ulcer in a way very different from that of sulphur, iodine, caustic, and so on; it does not destroy the germs, but it takes the food from them. All the germ-killers are either ineffective on account of great dilution, or on the contrary dangerous to the healthy tissue. The action of papayotin is both effective and safe, and its use forms a rational treatment. Certainly its action is only local. Whatever the theoretical views of diphtheria might be, papayotin must be welcome to every practitioner.—*Indiana Med. Jour.*

Rheumatic Urethritis is what M. P. Riel (*Lyon Médicale*, March 14, 21, 1866) names a form of urethritis occurring in the course of rheumatism, accompanied by a discharge of purulent fluid and other symptoms common to gonorrhœa, but differing from it in the complete absence of gonococci. M. Riel depends upon the gonococcus for his diagnosis of specific urethritis. He reports two cases of this form of urethritis, but hesitates to ascribe them solely to the rheumatism, and assumes that there must be certain, as yet undiscovered, organisms in the secretion to render it purulent.

A PECULIAR PATHOGENIC CAUSE.—In the autumn of 1884, a coachman in Russia, who had been in the habit for years of sleeping with his horses on the straw or in the hayloft, and had occasionally been drinking with them out of the same trough, was seized with pains in the left chest. In October, several abscesses formed below the left mamma. They gradually increased in number, and changed to ulcers.

In August, 1885, he was admitted into the Jewish hospital at Berlin, and there came under charge of Dr. J. Israel, who reports the case in the *Centrbl.f.d. Med. Wissensch.*, May 1, 1886. The patient then was greatly emaciated, and his left thorax was decidedly shrunken. The latter was covered with abscesses and ulcers, whose secretion contained many stellated fungi. These are also continually present in the sputa, which, usually muco-purulent, occasionally is tinged with blood.

In March of this year the patient died, evidently of complete exhaustion, superinduced by incessant diarrhœa, which yielded to no treatment.

The autopsy revealed as the only focus in the left lung a cavity situated in the lower part of the upper lobe immediately beneath the upper surface. The process of aktinomykotic degeneration had spread from the torn and irregular anterior wall of this cavity through the thickened pleuræ to the peripleural tissues, and penetrated the wall of the thorax at numerous points. The liver, spleen, and intestinal mucous membrane were in a state of amyloid degeneration.

In the aktinomykotic cavity of the lung a foreign body was found, which was of the size of a split pea, resembled, microscopically, a piece of tooth, and was proved such by its microscopical and chemical examination!

Thus, for the first time, evidence has been adduced in favor of the hypothesis made by Israel, that the lung-aktinomykosis is caused by the aspiration of germs from the buccal cavity, and that at times carious teeth form the breeding place of these micro-organisms.

The pathological specimens were presented to the Fifteenth Congress of German Surgeons, and a detailed report of the whole will be published in the annals of the latter.—*Med. and Surg. Reporter.*

THE TREATMENT OF SYPHILIS.—We are surprised to learn from Dr. James Wilson (*Lancet*, March 27, April 3, 1866) that but indifferent success attends the treatment of syphilis in England. The doctor ascribes this to the bad methods of English surgeons in using mercury, iodide of potassium, and other good drugs. He holds that to administer mercury by the mouth is the worst way of giving it, and that the inunction plan is the best. For its best effect the skin of the part about to be anointed should be prepared by washing thoroughly with soap and water; or a general bath be taken at a temperature of 95° or 96°, which is preferable. An experienced rubber should be employed, and he will receive no bad consequences from the mercury if, previous to rubbing, he smears his hands with soap or lard. On successive days different parts of the body should be rubbed, and the sequence should be: First day, both legs; second day, both thighs; third day, abdomen and breast; fourth day, the back; fifth day, both arms; sixth day, both legs again. On each day from twenty to thirty grains of mercurial ointment are to be rubbed in on each side of the body, the inunction being preceded by a warm bath, and followed by an hour's rest. The rubbing should be continued from fifteen to twenty minutes. Follicular inflammation may be avoided by shaving the part about to be treated. [Our preference is for the bends of both elbows, the sides of the thorax and abdomen, the inner sides of both thighs, and the bends of both knees, as sites of inunction, as thus hairy parts are avoided. The skin of these parts being thin, the mercury is absorbed.] The whole palm should be used in rubbing, gloves avoided, and considerable pressure employed.

The diet and hygiene of the patient should be of the best. Salmon, eels, mackerel, Finnan haddock, salt fish, cheese, salads, and raw fruit are to be abstained from. One or two glasses of milk should be daily drank. The mouth should be frequently rinsed with the following: R. Acetate of lead, ℥iv; powdered alum, ℥vss; distilled water, ℥xvj; aromatic water, ℥viiij. Dissolve the lead and alum-salts separately in the water, then mix and stir well together; either filter or allow to settle, then decant and add aromatic water.

The author avocates putting the patient upon the use of inunctions as soon as an induration is made out. When inunctions are begun, they should be continued without a break. He has noticed that during the inunction treatment the patients are often unable to sleep at night. One of the first indications of the good effect of the mercury is an increase in body-weight, and, when the normal weight of the body is reached, or when the weight becomes stationary, there is no use in keeping up the inunctions for more than eight or ten times longer. After a course of inunctions, the potassium iodide should be given in small doses and for some time, to continue the good effect of the mercury. After a course of inunctions—say, eighty to one hundred—it is rare to have relapses, at least for a long time, or even for life.

Brief mention is made of mercurial baths, hypodermic injections of mercury, Zittmann's decoction, and the potassium iodide.—*N. Y. Med. Jour.*

THE INFLUENCE OF DIABETES ON GESTATION, PARTURITION, AND MENSTRUATION.—According to many authors, diabetes renders women sterile. Six cases studied and treated by Dr. Lecorché contradict this theory. His six diabetic patients were delivered of children at term, but they were all delicate. One child died two days after its birth; another, when 21 months old, became hydrocephalic with polydipsia. There was no sugar in its urine. A third had a double hydrocele, and was also hydrocephalic, and could not live. Dr. Lecorché concludes that diabetes does not render women sterile. When they do not conceive, it is uterine lesions, resulting from diabetes, that cause their sterility. Diabetes has direct influence on the process of gestation, impairs fetal nutrition, and is favorable to faulty development, especially hydrocephalus. Diabetes often produces dysmenorrhœa and amenorrhœa. Early menopause may result from an overlooked diabetes. The menses may reappear when the sugar disappears. According to Dr. Lecorché, metrorrhagia in a diabetic patient indicates a coexistent uterine affection, and is not the result of diabetes.—*British Medical Journal.*

REPEATED VACCINATIONS IN THE INCUBATION STAGE OF SMALL-POX.—A Russian medical student, M. Gubert, recently performed a series of experiments with calf vaccine, chiefly making use of dogs as subjects, for the purpose of deciding whether there is any use in vaccinating persons (1) who have already been infected by small-pox, (2) who are in the incubation stage, or (3) in whom the disease may have actually begun to manifest itself. This question, he says, has generally been decided in the negative, on the ground that insusceptibility to small-pox is only obtained thirteen or fourteen days after vaccination—that is, after a period at least equal to that of the incubation stage. Having somewhat modified the method of vaccinating, M. Gubert, who describes his experiments in the *Zemskaya Meditsina*, was able to obtain vaccine vesicles in a shorter time than usual. By repeating the vaccination on three successive days he was able to produce mature vesicles in four or five days. This rapid saturation of the organism with the vaccine virus enabled M. Gubert to arrest the development of the disease in twenty-seven persons, in whom, he states, he was quite certain that small-pox was incubating, while in twelve others the disease was so modified as to be considered only varioloid. The vaccination was performed in some cases when the temperature had already reached 40° C. It should be remarked that all the experiments were carried out with calf lymph, so that we are as yet without information as to whether humanised vaccine could be made to “saturate the organism” sufficiently to produce mature vesicles in four or five days. At all events, M. Gubert's observations are interesting, and worthy of repetition by other practitioners.—*The Lancet*.

IODOFORM IN ERYSIPELAS.—Dr. A. T. Selitski mentions in a Russian military medical journal the satisfactory results he has obtained by treating erysipelas, whether idiopathic or traumatic, by means of an iodoform ointment of the strength of 1 to 8 or 1 to 10. The effect of this application was seen in the reduction of the swelling, the relief of the pain, the diminution of the intensity of the erythema, and the reduction of the high temperature.—*The Lancet*.

The *Weekly Med. Review* says that favorable results from the employment of Meckes' method for the cure of angiomas are reported by Negretto. The method consists in painting the angioma with a mixture of collodion and corrosive sublimate. The whole surface affected receives four coats of the solution. The application is renewed every fourth day until the angioma is cured. Negretto reports success in two cases of vast teleangiectasis of the face. A small portion of the tumor only was painted at a time. The application is not advisable where mucous surfaces are involved. Meckes' formula is four parts of corrosive sublimate to one of collodion. Negretto finds that two parts in thirty answer. A very good cicatrix results.

Therapeutical Notes.

The addition of alcohol to Croton oil renders the latter less irritating, but none the less effective.

For the albuminuria of pregnancy Dr. Parvin, of Philadelphia, regards an absolute milk diet as the best of all therapeutic methods.

ACUTE GONORRHOEA.—M. Bedoin uses gelatine bougies, medicated with cocaine, for the treatment of the acute stage of gonorrhoea. Pain and chordee are relieved.

DR. F. N. OTIS argues that there is a positive limitation to the contagious stages of syphilis within three, or at furthest four years, with or without treatment.

HYPERIDROSIS.—For sweating of the hands a saturated solution of tartaric acid should be tried, letting it dry on the hands. Use this four or five times a day. The acid may be used dry in powder if preferred.

ERYSIPELAS.—M. Haberkorn has administered benzoate of soda, 20 grammes (300 grains) daily, in erysipelas. In most cases temperature fell to nearly normal within forty-eight hours, the general condition being much improved, and desquamation unusually rapid.

The *Pharmacist* remarks that the tincture of opium of the Br. Ph. is directed to contain about 0.75 per cent. of morphine, while the U. S. preparation contains about 1.4 per cent., if opium of mean standard strength is employed.

OLD SINUSES.—Cecchini (*Ann. Univ. de Medicina*) reports a number of cases in which he succeeded in causing the closure of old sinuous tracts, by injecting into them a few drops of oil of turpentine with a hypodermic syringe. The drug may be used pure, or mixed with oil or solution of morphia (or cocaine).

TREATMENT OF DIABETES MELLITUS.—During the past year Dr. N. S. Davis, jun., has used the arsenite of bromine in this disease in a considerable number of cases, and they have uniformly progressed favorably. Three drops were given thrice daily. The dose was sometimes as high as five drops. An anti-diabetic diet was prescribed.

Dr. Jacobi says that the tendency of cow's milk to coagulate in large and hard curds, can be overcome by adding half a teaspoonful of dilute muriatic acid to a pint of water, mixing it with a quart of milk and then boiling. The taste is pleasant, and the coagulation takes place in fine particles, as in human milk.

CHRONIC DIARRHŒA.—In the *Medical and Surgical Reporter*, Dr. S. C. Smith, of Aurora, Indiana, advises the use of a saturated solution of common salt and cider vinegar in drachm doses every three or four hours, in chronic diarrhœa of long standing. He reports cases of five and forty years duration, respectively, cured by this remedy.

COCAINE AND ITS ANTIDOTE.—Amyl nitrite is recommended by Schilling as the antidote for cocaine, as it is a vaso-dilator of the cerebrum, while cocaine contracts the vessels. A case is reported where alarming symptoms followed the injection of one grain of cocaine. Anæsthesia, analgesia, amaurosis, and deafness ensued. Inhalation of amyl nitrite gave immediate relief.—*Med. Review.*

The following application to prevent scarring after small pox, given by Reimer, *St. Petersburger Med. Woch.*, No. 20, was originally suggested by Schwimmer:

Carbolic acid 30 to 40 grains;
Olive-oil 5 drachms;
Powdered chalk 1 ounce.

Apply on a linen cloth to be renewed twice daily.

DIPHTHERIA.—M. Delthil, of Paris, has become famous for his success in the cure of this disease. Large flat dishes, filled with spirits of turpentine, are placed in different parts of the room; sponges wet with it are placed at each side of the patient's head, and it is even used to swab the throat. M. Delthil claims for this treatment sixty recoveries out of sixty-three cases, where it was instituted and carried out from the beginning of the disease.

SALICYLIC-ACID OINTMENTS FOR ECZEMA OF THE SCALP.—The *Union Médicale* for June 20th gives the following formulæ:

- | | | |
|-----|--------------------------|------------------|
| (1) | Salicylic acid | 9 grains; |
| | Tincture of benzoin .. | 20 drops; |
| | Vaseline | 1 ounce. |
| (2) | Salicylic acid | 1 part; |
| | Starch, | } each 15 parts; |
| | Oxide of zinc, | |
| | Vaseline | 30 " |

SUBNITRATE OF BISMUTH AS A DRESSING.—1. Subnitrate of bismuth possesses antiseptic properties at least equal to those of iodoform. 2. No poisonous effects are to be apprehended. 3. It is unirritating, and diminishes secretion. 4. Its action is very prolonged, though not vigorous, so that the dressings do not require to be frequently changed. 5. There is no action at a distance, nor does any specific effect attach to it. 6. It is no disinfectant, but as an antiseptic keeps the wounds pure. 7. All wounds capable of healing by first intention can do so when dressed with bismuth. 8. It also presents an excellent material for forming scabs, under which epidermis can grow over the wound. Its use on granulating surfaces has not, as yet, been sufficiently studied.—*Annals of Surgery.*

CALABAR BEAN IN EPILEPSY.—Herr Rush, of Fritzlar, recommends Calabar bean in epilepsy in cases where other drugs have failed:—

R. Ext. Calabar bean. gr. 7½
 Spirit etheris ℥ 80
 Aq. menth. pip. ℥ 300

Five to ten drops three times a day for children; eight to fifteen for adults. For children he begins with five drops, and increases the dose by one drop daily until the maximum of ten drops is reached. He then diminishes the dose by one drop daily until the initial dose is reached. He records some successful cases in the *Deutsche Med. Zeitung*.

SALICYLIC ACID IN THE TREATMENT OF GLYCOSURIA.—The *British Medical Journal* for May 1, 1886, contains an article by Dr. Holden, in which he reports six cases of "rheumatic" glycosuria in which the administration of fifteen-grain doses of salicylic acid, thrice daily, was followed by a rapid disappearance of sugar from the urine, no change being made in the patients' diet. When tried in four other cases, in which rheumatic symptoms were absent, the drug had no effect. He recommends the following combination:

Salicylic acid 2 drachms.
 Bicarbonate of sodium . . 1 drachm.
 Carbonate of Ammonium 1 "
 Water 1 ounce.

Mix thoroughly, and, after effervescence has ceased, add water up to twelve ounces. Dose, an ounce to an ounce and a half three times daily.

CAUSE OF VOMITING IN PREGNANCY.—In the *Medical Age*, June 10, Dr. C. H. Holladay, of Tina, Mo., states his belief that vomiting in pregnancy is due to the development of the corpus luteum, and the high state of irritation in the ovary during that period. In ordinary cases the development of the corpus luteum and vomiting are synchronous, commencing in the third or fourth week of pregnancy and continuing up to the fourth month, when the corpus luteum reaches its full development and the retrograde process begins. At or about the fourth month, as a rule, vomiting of preg-

nancy ceases. When it does not do so, it is claimed that retrogression is not in progress in the corpus luteum, and therefore the ovarian irritation continues and keeps up the sympathetic vomiting. Flexions, congestion or inflammation of the uterus by reflex irritation aggravate the symptom. The theory is plausible, and as likely to be true as any of the others heretofore advanced by various writers.

THE

Canadian Practitioner.

(FORMERLY JOURNAL OF MEDICAL SCIENCE.)

TO CORRESPONDENTS.—We shall be glad to receive from our friends everywhere, current medical news of general interest. Secretaries of County or Territorial Medical Associations will oblige by forwarding reports of the proceedings of their Associations.

TO SUBSCRIBERS.—Those in arrears are requested to send dues to Dr. Adam Wright, 20 Gerrard St. East.

TORONTO, AUGUST, 1886.

CANADA MEDICAL ASSOCIATION.

We have been requested to state that medical men who purpose attending the coming meeting of the Canada Medical Association can leave Toronto, by mail boat, on Monday afternoon, August 16th, and arrive in Quebec Wednesday morning following, in good time for the meeting. Those going to the Association can secure tickets, Toronto to Quebec and return, at a reduced fare, which includes meals and state-room. This reduced rate is also extended to the wives of medical men and one patient travelling to Quebec. A large and pleasant party will likely embrace this opportunity of enjoying this delightful trip. The mail boat leaves Toronto at 2 p.m. Persons wishing to reserve state-rooms for the trip can do so, without any extra expense, by writing to Mr. D. Milloy, No. 8 Front Street East, Toronto.

The following are some of the papers promised:—1. Heart Clot, Dr. Osler, Philadelphia; 2. The Medical Jurisprudence of Crime and Responsibility, Dr. D. Clarke, Toronto; 3. Diabetes Mellitus, Dr. Thos. Dupuis, Kingston;

4. Tracheotomy in Membraneous Laryngitis, Dr. Bell, Montreal; 5. The Treatment of Biliary Calculi, Dr. Ferguson, Toronto; 6. The Inhibition of the Heart in Diphtheria, Dr. J. H. Gardiner, London; 7. "Alexander's Operation" and the Treatment of Displacements of the Uterus, Dr. A. L. Smith, Montreal; 8. Excision of the Elbow Joint, Dr. Roddick, Montreal; 9. The Treatment of Tuberculous Glands of the Neck, Dr. Fenwick, Montreal; 10. Myelo-Sarcoma of the Arm—Amputation at the Shoulder Joint, Dr. Fenwick, Montreal; 11. A Case of Pelvic Abscess, Dr. Alloway, Montreal.

THE BRITISH MEDICAL ACT, 1886.

We have heard so much about the proposed amendments to the British Medical Act during the last few years, and have been so frequently disappointed about their passage through the Parliament of Great Britain, that we commenced to think that no changes would be made for some time to come. British legislators appeared to have so much to think about in connection with Home Rule and other matters that they could hardly settle down to legislate on medical matters.

To our surprise, however, a cable message informs us that Her Majesty has sanctioned the passage of the Medical Act of 1886. It becomes a question of interest to know the contents of the Act, as it is likely to affect materially the power of local authorities in the colonies, such as the Medical Council of Ontario. We are not in a position yet to give all particulars; but it appears likely that the colonies will practically have the power to control their own affairs in things medical.

We have consulted the officers of the Ontario Medical Council, and have read that portion of the Act which appeared in the *British Medical Journal*, but are unable at present to give any definite information on the subject. It appears, however, that reciprocity will be allowed with certain restrictions, and that any colonial practitioner of good standing for ten years will be entitled to registration in Great Britain. It is likely that young graduates from England, Ireland, or Scotland, on coming to Ontario to practise, will be compelled to fulfil the require-

ments of our Provincial Council, *i.e.*, they will be required to pass the examination of the Council.

If so, the Ontario Medical Council will be able to enforce the rule which requires a *bona fide* four year's course in the study of medicine in some of the recognized medical schools. The effect of this will be to give material assistance to that body in its laudable efforts to raise the standard of medical education in the Province.

NEW OPERATING THEATRE AT THE TORONTO GENERAL HOSPITAL.

This theatre, to which we made reference before, is now completed, and presents a very handsome appearance. Any person familiar with the old structure would have difficulty in realizing that it ever formed any part of the present one. It has a seating capacity for five hundred students, and in cases of emergency will contain altogether about six hundred.

The theatre is of great importance to the conjoined staff of Clinical Teachers in the Hospital, as all the operations are performed in it, and a good portion of the clinical instruction, including out-door clinics and regular clinical lectures, is given in it. Both students and teachers will highly appreciate the action of the Hospital Trustees in placing at their disposal one of the finest and best equipped operating and lecturing theatres in the world.

THE REVIVAL OF OVARIOTOMY.

Much has been recently written of a very bitter nature on this subject in Great Britain by Mr. Tait and the friends of Sir Spencer Wells. The personal part of the controversy is not edifying in any sense. We think it only fair to give great credit for the brilliant position which abdominal surgery now occupies to Sir Spencer; at the same time we must say that Mr. Tait, of Birmingham, presents a record which has never been equalled, and can hardly be surpassed, and, as a consequence, is the king of abdominal surgeons at the present time. We trust he will long be spared to pursue the great work he is doing, and hope to see an absence of offensive personalities in his writings for the future.

A MAGNIFICENT DONATION.

A gentleman, whose name has not yet been made known, has given to the University of New York the sum of one hundred thousand dollars, to be spent in the erection of a laboratory which shall be called the Loomis Laboratory. These munificent gifts to medical colleges are now becoming quite numerous. We hope that this example will soon be followed by some of our wealthy men in Canada. In these days of experimental physiology, pathology, and bacteriology it is almost impossible for a medical school to give the requisite training when it has to depend entirely on students' fees.

THE ONTARIO MEDICAL COUNCIL HALL.

We are pleased to know that the erection of a respectable hall for the Ontario Medical Council is likely soon to be an accomplished fact. The old building on the corner of Bay and Richmond Streets is now being removed and a new hall will be built at once. According to the plans, which have been carefully prepared by an efficient architect, Mr. Lennox, of Toronto, a new and handsome hall will soon be erected, which will be worthy of the profession of Ontario.

According to a report in a late number of *The Lancet* of some observations made by Dr. Joseph Coates upon a man from whom the larynx had been previously removed, it has been conclusively proved that the sounds made by the passage of air through the glottis have no share in the production of the normal pulmonary murmur as got in auscultation over the sides and base of the lungs.

DR. HOLMES ADVISES DOCTORS TO TAKE A VACATION.—Instead of a vacation editorial, which would naturally be looked for by our readers with eager interest at about this time, we venture to substitute a little verse from Dr. Holmes' poem, "City and Country":

Ye healers of men, for a moment decline
Your seats in the rhubarb and ipecac line;
While you shut up your turnpike, your neighbors
can go

The old roundabout road to the regions below.

—*N. Y. Med. Jour.*

Meetings of Medical Societies.

ONTARIO MEDICAL ASSOCIATION.

DR. MOORE ON COLLES'S FRACTURE.

(Continued from July Number.)

Dr. E. M. Moore, of Rochester, N. Y., had devoted a good deal of attention to the subject of Colles's Fracture, and a good many years ago had several opportunities of making dissections of recent cases. These had established the fact that in severe cases the ligaments on the anterior and inner surfaces of the wrist suffered disruption, the inferior radio-ulnar ligament especially being torn, the triangular cartilage commonly displaced, and the styloid process of the ulna occasionally broken off, or pushed through the annular ligament and sometimes through the skin. The displacement caused the end of the ulna to approach the pisiform bone, and measurement with a pair of calipers showed marked widening of the wrist. His present plan of treatment consisted in reduction of the displaced parts by forcible traction of the hand around the knee pressed against the ulnar border of the arm just at or above the wrist joint. Reduction of deformity having been thus effected, the parts are retained in position by the following dressing: A firmly rolled cotton bandage three inches wide, and as thick as the thumb is carefully inserted beneath the fingers (or thumb), holding the parts in position, and is placed immediately above the wrist joint in the hollow between the ulna and the flexor carpi-ulnaris (in the semiprone position of the hand). It is there retained by carefully wrapping around the roll and arm a strip of adhesive plaster, two inches wide, and then the arm is suspended by a three-inch (wide) bandage-sling from the neck, the hand depending loosely from the sling towards the ulnar side. In this way, as the patient moves about, a constant passive motion of the wrist tendons is maintained from the beginning. In six hours a narrow scissors-blade is slipped beneath the plaster on its radial border, and divides it vertically from end to end. If there be great swelling of the hand or fingers, these may then be repeatedly bandaged. This is the whole treatment, and has given him most satisfactory

results, both with regard to deformity and mobility. In compound dislocations of the lower end of the ulna, complicating the fracture, he invariably removes the projecting portion. In badly united cases, he anaesthetises the patient, interlocks his fingers with the patient's on the affected side, the palms coming in opposition, and the patient's elbow, bent to a right angle, resting on the table or other firm surface. He then presses the hand backwards with all necessary force until fracture occurs, and it is then treated as above detailed.

Correspondence.

To the Editor of the CANADIAN PRACTITIONER.

SEAFORTH, June 15th, 1886.

Mr. Editor,—I write to ask your opinion of the following conduct of a medical man in this town. The case is as follows:—

A cooper got the forefinger of one of his hands sliced—flesh, bone and all, in what is known as “the cutter”—leaving a sharp point of bone. He repaired to the office of a surgeon in town and had it amputated further up so as to secure good flaps and a bone with a proper end. A surgeon from a neighboring village happened to be visiting at the first surgeon's place and assisted at the operation. Both examined the bone, flaps, etc., and agreed that the operation was properly performed. The surgeon who took charge of the case is one of seventeen years' standing, with diploma from the Old Country as well as from Canada. They dressed the stump with iodoform and surgical cotton wool. The patient was an uneasy, fidgety man, who thought that the wound should be seen and dressed every day, and on the third day his importunities were such that the surgeon, to please him, undid the dressing and showed him that everything was doing well. From this time it was dressed every second day, or every day, and was healing nicely by granulations. The patient was impatient, and went and showed it to a young doctor who graduated a few years ago, and had come to town about a year ago. He told the patient that there was “lots of bad stuff” about it, and ordered it to be poulticed with linseed meal; and, after poulticing for some days, he discovers that there

is “dead bone” that the first surgeon “ought to have taken away.” The stump must be overhauled, the granulating flaps, which were nearly closed, must be torn open, and he must take a piece more off the end of the finger. It will then heal in four or five days. The patient, who has not a very strong mind, gets alarmed and submits to the operation. The “surgeon” in question opens the old sore, snips off a piece of bone, or rather several small pieces, gives them to the patient in a piece of paper and sends him to show them to druggists and others in town. They were small pieces nipped off for the purpose of deceiving the patient and booming himself. The pieces of bone have flesh sticking to them (granulations); the periosteum is entire. He has simply done it to raise his own reputation and injure another medical man. Let us have your opinion through your paper. Both men are members of the Huron Medical Association. This is only a sample of his conduct. Numerous instances could be cited.

In the first place, was it not unprofessional and mean for him to take the case out of the other physician's hands at all?

I remain, etc.,

SEAFORTH.

To the Editor of the CANADIAN PRACTITIONER.

LETTER FROM GERMANY.

VIENNA, JULY 5TH, 1886.

SIR,—Instead of writing a rambling letter, I have taken the liberty of reporting a clinical lecture, given by Dr. Heilter, of Vienna, to an interested class of physicians; hoping that it may not prove uninteresting to friends in Canada.

Gentlemen,—The patient before you, as you see, is young, only twenty-four years of age; she is anæmic and rather emaciated. The lips are bluish, the veins of the neck distended with blood. The lungs we find healthy, they give a clear record. The heart-dulness is normal in size and situation; there is no evidence of valvular insufficiency or stenosis. The apex beat of the heart can neither be seen nor felt externally; the præcordia is retracted, the heart-sounds are regular but feeble. Observing the abdomen we find it enormously distended; ex-

amination gives evidence of large quantities of free fluid in the peritoneal cavity, there is no tenderness on pressure over the abdomen, and, as the intestines float readily to the upper surface in whatever position the patient is placed, we may fairly conclude that there are no important inflammatory peritoneal adhesions. The liver we find much enlarged, but with smooth uniform edge and surface. Examination of the urine gives no evidence of disease of the kidneys. The remaining abdominal organs are not seriously disturbed, but the lower limbs are œdematous and slightly livid.

Now, gentlemen, you have the picture before you, and the question may well arise, whence comes this accumulation of fluid in the abdominal cavity? It cannot be charged to the kidneys, as there is absence of general anasarca, of albumen in the urine, and of all uræmic symptoms. Can it be due to chronic peritonitis? or can peritonitis have taken part in the process? We may pretty safely answer no, first, because there is no sign of tuberculosis about the patient; second, because we have presumably absence of inflammatory abdominal adhesions; third, the abdomen is not tender to pressure, and lastly, it is rare for such distention to result from chronic peritonitis. The organ to which we look naturally, under the circumstances, for explanation of such accumulations is the liver; in this case we truly have a much-enlarged liver; but can this be the cause of the difficulty before us? The most frequent source of ascites in case of liver derangement is cirrhosis. Now, this we may safely exclude. In the first place, we know that cirrhosis is very rare at the age of twenty-four, and we also know that, in the earlier stages of cirrhosis, while the liver is enlarged, we have no great peritoneal effusion, that comes only after the liver has become contracted; while here we have a greatly enlarged one. The presence of a neoplasm in the liver can hardly be suspected on account of the uniform enlargement of the organs, and the shortness of its edge and surface. Amyloid degeneration and enlargement of the liver finds no support in the history of the case, or the condition of other organs.

There is no doubt that the liver is in an abnormal condition, but, granting that, the ques-

tion arises, would any disease of the liver explain all the conditions present? The livid lips, the distended veins of the neck, could not result from pressure on the vessels by a diseased liver. In the absence of respiratory complication we must conclude that there is some serious central derangement of the organs of circulations. Direct pressure upon the veins entering the heart we may fairly exclude, for there are evidences of impeded circulation in the terminals of both the superior and inferior cava. The heart alone, excluding the lungs, is common to both of these; so in or connected with the heart we must find the pathological spring which starts all this train of symptoms. We have already, however, excluded valvular disease; percussion shows us that neither hypertrophy nor dilatation has taken place. What, then, is the condition? There is only one possible condition that meets the requirements of this case, namely, adherent-pericardium with consequent degenerative changes in the heart-muscle itself. The symptoms present are known to be characteristic of this condition. These are, feeble heart-sound, an apex beat neither palpable nor visible and a retracted præcordia, together with the long train of congestive phenomena due to impeded venous circulation, including uniform enlargement of the liver found in this case. The cause of this condition of the pericardium is not known, the progress of the disease is insidious; its cure is impossible, and its prognosis is consequently the worst.

J. H. D.

A German linguistic purist, who objects to the name "Apotheker" as being of foreign origin, suggests that it be replaced by the following title, which expresses the functions of an apothecary in a brief and concise manner: "*Gesundheitswiederherstellungsmittelzusammenschunaskundiger*."

A Cincinnati physician's death certificate stated that the subject "died with Liver disease and New Monei." It is a little singular that this astute practitioner could not relieve his patient of at least one of these ailments. The victims of the latter are rare in these parts.—*Medical Age*.

Book Notices.

Is Pneumonia Infectious? By GEORGE WILKINS, M.D., M.R.C.S. Eng., Professor of Medical Jurisprudence, McGill University; Physician to Montreal General Hospital.

Report of a Case of Successful Transfusion in Typhoid Fever. By WM. T. WHITWELL, A.M., M.D. Reprinted from *Pacific Medical and Surgical Journal and Western Lancet*.

The Relation of the State and the Medical Profession. An address delivered June 30th, 1886, before the Alumni Association of the Department of Medicine and Surgery of the University of Michigan, by CHAS. J. LUNDY, A.M., M.D., President.

Cremation of Human Bodies not a Necessary Sanitary Measure. By FRANK H. HAMILTON, A.M., M.D., LL.D., President New York Society of Medical Jurisprudence and State Medicine. Reprinted from April number of Gailard's *Medical Journal*.

More about the Arterial Muscles.—The Stimulation (!) of Asphyxia.—Cheyne-Stokes Respiration; and *Nerve Paralysis and Contraction of Involuntary Muscles.* By THOMAS W. POOLE, M.D., Lindsay, Canada. Reprints from *The Alienist and Neurologist*.

A Manual of Dietetics. By J. MILNER FOTHERGILL, M.D. Edin., Physician to the City of London Hospital for Diseases of the Chest (Victoria Park). Hon. M.D. Rush Medical College, Chicago, Ill.; Foreign Associate Fellow of the College of Physicians, Philadelphia. Svo., extra muslin. 255 pages. Price, \$2.50. New York: William Wood & Company.

It is almost superfluous to state that the name of Milner Fothergill is a sufficient guarantee of the excellence of this work. It is well known that Dr. Fothergill has paid special attention to this subject for some years. The book is well worthy of the distinguished author, and is full of facts of great interest and utility to the general practitioner. We cannot recommend it too highly. It is written in the pleasing and practical style so peculiar to Dr. Fothergill, and will, we are sure, be highly prized by the profession.

A Manual of Midwifery. By ALFRED LEWIS GALABIN, M.A., M.D., Obstetric Physician and Lecturer on Midwifery and Diseases of Women, in Guy's Hospital, etc. Philadelphia: P. Blakiston, Son & Co.

We had supposed there was scarcely room for another work such as this, but as we have the highest respect for Dr. Galabin, we gladly commenced a perusal of this manual. The result has been satisfactory beyond our expectations. The book is marvellously complete in every respect, and is likely to become very popular among students. We have no hesitation in telling this portion of our readers that for their purposes it can scarcely be surpassed. The author has evidently studied carefully the wants of students, and in order to keep the work within the limits of a manual, has departed a little from the ordinary methods of obstetric authors by omitting any general description of the female sexual organs, or of the development of the embryo, and including only those points in the anatomy of the pelvis which have a bearing on midwifery, and that portion of the development of the ovum which refers to the formation of the placenta and foetal membranes. The book contains 753 pages and 227 illustrations. Price: cloth, \$3.00; leather, \$3.50.

Traité Élémentaire d'Anatomie Médicale du Système Nerveux. Par CH. FERÉ. Paris: Bureau du Progrès Médical, 1886.

Though the author in his preface modestly says that his work does not pretend to be a complete exposition of the knowledge attained of the anatomy of the nervous system, many will consider that a book of 495 pages on one anatomical system must be a pretty exhaustive exposition of the subject. Hitherto the literature of anatomy in this relation has been largely written for the surgeon. A more thorough teaching of medical anatomy is now a recognized desideratum in the education of the physician, and works like the one before us will be naturally in demand. For the student it is too extensive as a text-book; but as a work of reference, it will be found a reliable guide. Over two hundred illustrations, original and borrowed from well-known authors, add to the value of the work. For the satisfactory study of the difficult subject of diseases of the nervous

system, a thorough knowledge of the normal anatomy of the tissues affected is, of course, essential to the student of pathological anatomy, who will appreciate the facility afforded by the treatise of M. Fere, as it contains much information hitherto scattered through the works of various writers, and involving much time and labor to be utilized.

Bright's Disease and Allied Affections of the Kidneys. By CHARLES W. PURDY, M.D. Queen's University, Professor of Genito-Urinary and Renal Diseases in the Chicago Polyclinic, etc. 8vo., 288 pages, with 18 illustrations. Cloth, \$2. Philadelphia: Lea Brothers & Co., 1886.

We take great pleasure in referring to this work, as one of merit and originality written by a native of Canada and a graduate of a Canadian University.

The author, although well versed in the pathological anatomy of these affections, seems to have studied them principally from a clinical standpoint. For this reason his work will be of greater use to practitioners.

It is a matter of great interest, and no doubt also of importance, to thoroughly comprehend the various divisions made by pathologists in describing the morbid anatomy of the kidney, but it is impossible for the general practitioner to remember them, and impossible also for him to make so accurate a diagnosis during life. The author has, in our opinion, acted wisely in classifying the diseases of the kidneys in such a way as to be easily comprehended by the practitioner, and thus more useful at the bedside of the patient.

The book opens with two long chapters, the first on Albuminuria, and the second on Uræmia. These subjects are treated in a very exhaustive manner. In the first chapter he distinguishes renal from other forms of albuminuria, and gives the following four causes for the renal variety: (1) Alterations in the blood pressure, (2) Changes in the vascular tunics, (3) Degeneration of the renal epithelium, (4) Alteration in the composition of the blood.

He gives as the most reliable tests for albumen, the ferro-cyanic and nitric (Helliers).

Some excellent suggestions are made under

the head of Hygienic Treatment of Albuminuria.

In treating of the cause of uræmia, the author comes to the following conclusion:—"In the light of what is known, then, the only conclusions that seem justifiable are that the cause of uræmia lies in the failure of the kidneys to excrete the urine in part or in whole, or in its primary elements, and that these either act as toxic agents on the system, or generate some new and, at present, unknown agent, (through conditions resulting from their accumulation), which acts as a poison on the organism evoking the symptoms which we term uræmic."

The author in the third chapter commences the organic diseases of the kidneys by taking up acute nephritis, which is followed by chronic nephritis, cirrhosis of the kidney, scarlatinal nephritis, puerperal nephritis, lardaceous degeneration of the kidneys, and cyanotic induration of the kidney.

The book is written in an excellent style, and will be read with profit by practitioners.

Personal.

Dr. Rosebrugh, of Hamilton, has also sailed for Europe. He will attend the annual meeting of the British Medical Society, and the British Gynæcological Society, of which he was very recently elected a Fellow.

We hear that Dr. Ralph Leslie, of the University of Toronto, Canada, and St. Thomas Hospital, London, has been decorated with the Order of Leopold by the King of the Belgians, for his services on the Upper Congo.—*British Medical Journal.*

Miscellaneous.

Dr. Newman, in a paper read before the Paris Biological Society, has shown that the parasite of the Favus found on the neck and head of fowls, is the *Achorion Schönleinii*, identical with that of Favus in man.

In the children's department at the University Hospital of Berlin there is a collection of 300 nursing bottles of various sizes and shapes, each provided with an indiarubber tube, which

enclose a piece of litmus-paper colored red. It is quite clear that presence of lactic acid in the tube suffices to explain many obscure disorders of the alimentary tract for which physicians are often at a loss to find a satisfactory explanation.

Dr. O. W. Holmes: Nothing is clearer than that the Merciful Creator intends to blind most people as they pass down into the dark valley. Without very good reasons, temporal or spiritual, we should not interfere with His kind arrangements. It is the height of cruelty and the extreme of impertinence to tell your patient that he must die, except you are sure he wishes to know it, or that there is some particular cause for his knowing it.—*Medical Age*.

A TROUBLESOME PATIENT.—An incident in professional life is reported from Vienna, in which a tailor, on being told by his physician, whom he had called to consult as to a disease from which he was suffering, that recovery was impossible, forthwith shot the physician in two places, and then turned his arm—or rather arms, for there were several—against himself, with a fatal result so far as he was concerned. Nine shots in all were fired; and the number may, perhaps, be accounted for by the fact of this recalcitrant patient being a tailor; but it is to be hoped that a needless complication will not be introduced into professional life by such a practice becoming general. Medical men have already a good deal to put up with from patients; and, if further difficulties be introduced, the relations of doctor and patient may become strained. In any case, the medical man, if he must needs take lead, would probably prefer it in the shape of false coins to the more conical form of revolver-bullets. We are glad to state that the physician was not much hurt, and will shortly be able to resume what may be considered an eventful career.

According to some recent observations made by Dr. James Cameron, medical health officer for Hendon, England, and reported on by Mr. W. H. Power, Inspector for the Local Government Board, it seems to have been proved that the milk from cows suffering from a disease

characterized by the appearance of vesicles and sores on the udder, is capable of producing scarlet fever in the human subject.

In the course of its remarks upon the importance of this discovery, the *Lancet* says that "we have no hesitation in expressing our belief that we are at least brought face to face with the origin of scarlet fever. The possibility of exterminating this disease will be at once apparent, and it is satisfactory to know that Dr. Klein's services have been enlisted for the further prosecution of the inquiry on lines which the report indicates. The consideration whether these expectations will be immediately realized must be left till Dr. Klein's labors are ended and his report presented; but under any circumstances, the facts, which are already known, will give fresh impetus to the study of animal in relation to human diseases."

EXTIRPATION OF PAROTID.—J. Harry Thompson records a case of fibroid growth of the parotid in a lady 32 years of age. The tumor had been noticed five years previously, at first of slow growth, but the last six months the increase had been rapid. The visible portion was as large as an orange, and extended up behind the zygoma. A semilunar incision was made from the zygoma around the angle of the jaw and forwards, the upper part of the tumor was easily detached, the lower and posterior portions required careful and difficult dissection. The styloid muscles were preserved, the temporal, facial, occipital, internal maxillary, the lingual and external carotid arteries required ligatures. The wound left by the operation was frightful. On one side was seen the internal carotid, the internal jugular and the pneumogastric, deeper still the styloid muscles and the aperture of the pharynx. Covered by its muscles only a portion of the aponeurotic sheaths of the vessels was taken away with the tumor, the edges were brought together with sutures and carbolated compresses applied. In thirty days the wound was entirely healed and all the ligatures had come away. The facial paralysis was slight and became less.—*Giornale Internazionale delle Scienze Mediche*.

The French have taste in all they do,
While we must go without;
Nature to them has given goût!
To us she's given gout!