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# THE CANADA LANCET.

A MONTHLY JOURNAL OF

MEDICAL AND SURGICAL SCIENCE,  
CRITICISM AND NEWS.

## Original Communications.

### FREE INCISION OF ABSCESS OF OSTI- TIS OF HIP; AND CLOSURE WITHOUT DRAINAGE.

BY H. AUGUSTUS WILSON, M.D.,

Clinical Professor of Orthopedic Surgery in the Jefferson  
Medical College; Professor of Orthopedic Surgery  
in the Philadelphia Polyclinic, etc.

I will in this paper refer only to cases in my private practice in preference to my hospital experience, because these cases were in a more favorable condition for operation, and because it was possible to keep them under control in a more satisfactory manner, and I was less likely to lose sight of them. My hospital experience in similar cases is far less satisfactory, and I regret that I cannot at this time give the statistics in addition to those contained in this paper.

I am convinced that the occurrence of an abscess of any considerable size is generally evidence of neglect, and that its growth to a size to raise the question of the advisability of its evacuation is a still further error. The neglect of early recognition of the malady and the enforced postponement of rigid immobilization render necessary the consideration of the question now under discussion.

In view of the well-recognized facts that spontaneous resolution by absorption does take place in favorable cases, and that even after spontaneous rupture of an abscess the resultant sinus sometimes does ultimately close, it might appear to be adding an unwarranted risk to operate at all. But on the other hand, the occurrence of the abscess being often caused by neglect, and the doubt that must exist as to the possibility of obtaining a final favorable result, even with the employment of the desirable forms of mechanical rigidity of the joint, favors the application of remedial measures of an operative nature which are based upon sound surgical principles. The great diver-

sity of opinions, even among orthopedic surgeons, as to the expediency of operative interference in hip abscess is evidence, first, that operative procedures alone never cure in this condition, and, secondly, that the scientific use of mechanical principles alone frequently accomplishes that which can be obtained in no other way. Until the recent introduction of asepsis and antisepsis the evacuation of hip abscess was followed by no better results, and not infrequently by not as good results as those obtained by spontaneous rupture. In those cases that did not succumb by amyloid degeneration or fatal tubercular disease elsewhere, there was almost invariably a sinus of nearly a lifetime's duration. At the present day the successful accomplishment of a cure of hip abscess, by free incision, depends upon the thoroughness with which aseptic precautions are observed. I am convinced that where failure has occurred it has been largely due to incompleteness in anti-septic precautions, and I believe that it would be far better not to open such an abscess when for any reason the most strict asepsis and antisepsis could not be obtained and maintained. I can see no good reason for waiting for an abscess of the hip to reach the point of rupture before resorting to surgical interference, because at that time there is not only a natural increase in the size of the abscess accumulation, but the original site of the osseous origin has had everything to favor an increased destruction. The abscess wall has become thin, and tends to a non-union at that point, leaving the much-to-be-dreaded sinus; the constitution will have become depraved from the presence and attempt at absorption of so great a quantity of deleterious material and it is not at all unlikely that bone excision is so frequently indicated because of the great extent of erosion produced by the delay in evacuation. The proportion of cases of hip disease that have abscesses is variously stated as being from 50 to 75 per cent.

The London Clinical Society's committee in 1880 reported 401 cases of hip disease, of which 69 per cent. developed abscesses in the course of a few years.

Cazin\* reports 80 suppurative cases treated in a hospital at Berck. Fifty-five per cent. were cured; 12½ per cent. died; 25 per cent. were not cured; 7½ per cent. were improved. In Alexandra

\*Bradford and Lovett: Orthopedic Surgery, p. 294.

Hospital, London, in 260 suppurating cases, 33½ per cent. died; 42 per cent. were cured. Hebern\* classifies results obtained in his hands. Of those not operated upon in three years, 19 per cent. recovered, and 15 per cent. died; 66 of the remainder were not well in four years; 26 per cent. had recovered; 17 had died; 57 were not well. In five years 24 per cent. had recovered; 21 died; 55 not well.

Taking all the cases, those operated upon and those not, at the end of five years, 13 per cent. were without operation; 37 cases were resected, with a mortality of 51 per cent.; 11 per cent. had been amputated, with a mortality of 60 per cent., and 29 per cent. had remained not well.

Senn, in his work on "Tuberculosis of the Bones and Joints" (page 448), says: "A suppurating hip-joint in the adult warrants a grave prognosis. Anæmic patients and patients suffering tuberculosis of other organs, or from other serious complicating disease, are bad subjects for operative interference." And again (page 449): "The more conservative operations on the hip-joint, in the operative treatment of tubercular affection, that are now gradually displacing typical resections, will yield more satisfactory functional results, while the thoroughness with which osseous foci, the disease capsule, and infected para-articular tissue are now being removed, will be less frequently followed by local recidivation."

Lovett and Goldthwait† say that in every case of abscess of the hip treated in the Children's Hospital of Boston, from 1883 to 1887, that had been subjected to aspiration, whether followed by injection of iodoform or not, subsequent free incision became necessary. In the same hospital from 1884 to 1888 inclusive, there were 370 cases of hip disease, of which number 70 were suppurating.

Dr. R. H. Sayre‡ says: "It seems to me that the cases reported as dying of amyloid disease and general tuberculosis are an additional argument in favor of more thorough removal of diseased tissue before the general system has become exhausted beyond hope of recovery."

The procedures that I have found to give the most satisfactory results are those by free incision,

extending the entire length of the abscess, evacuation of the contents, and sealing of the wound. The day prior to the operation the field is as scrupulously prepared as is customary in surgical procedures. The incision is made at first only large enough to permit the contained pus to slowly escape; as soon as it has ceased to flow, the incision is increased to the full extent of the cavity. Peroxide of hydrogen (medicinal) is now thrown in in a small stream until ebullition almost ceases, and the accumulation of detritus is then thoroughly washed out by means of a stream of warm 1 to 1000 bichloride of mercury solution, from a fountain syringe. By the use of the Barker-Willard irrigating curette, the entire pyogenic membrane is carefully and thoroughly scraped, and any shreds of fibrous tissue remaining are removed by scissors. It is now possible to trace the site of the original osteitis, and when found, if not too extensive, its removal is frequently easily accomplished with a gouge.

The difficulty experienced in obtaining a sterile, and at the same time an efficient emulsion of iodoform in olive oil, has induced me to dust powdered iodoform over the entire surface after it has been carefully dried with gauze sponges. The edges of the wound are brought in contact and so held by silkworm-gut sutures, and the entire surface is covered with a thick fold of aseptic gauze, the incision having been covered with protective.

Enforced immobilization is secured with a long, padded splint reaching from the axilla to the malleolus, and retained in position with plaster-of-Paris bandages applied to the leg and the trunk, or by some form of portable bed or fixation apparatus. At the expiration of one week to ten days the stitches are usually removed, if primary union has been obtained. The external dressings and fixation apparatus are re-adjusted and maintained for a period of three weeks more. The subsequent procedure is enforced mechanical immobilization of the joint, either in bed or by apparatus, as the individual requirements of the case may indicate.

While the statistics I have to offer cover a comparatively small number of cases, they may be of use when added to others, and I therefore give them. The cases operated upon by me by the method described number 24. There were 16 girls and 8 boys. Eighteen were upon the left side and 6 were upon the right. The abscesses had been

\*Bradford & Lovett: Orthopedic Surgery, p. 325.

†Transactions of American Orthopedic Association, vol. ii., p. 83.

‡Op. cit.

observed by the patient, parent, or attending physicians as follows: "For three months in 5 cases; seven months in 3 cases; eight months in 4 cases; ten months in 6 cases; one year in 4 cases; two years in 2 cases.

In 5 cases re-accumulation occurred, and subsequent evacuation was required. In 3 of these there has been no re-accumulation, although several months have elapsed. In 1 case a persistent sinus exists. In 1 case infection took place from a stitch-wound abscess, when catgut sutures were employed. In 14 cases more than one year had elapsed, and in 11 of this number the original cicatrices have remained firm and unbroken; 3 were re-opened for re-accumulation, and the second cicatrices have not yielded six months after the second operations. In 10 cases, less than a year has elapsed since the operation, of which number 9 have remained closed, and in 1 a persistent sinus is now present. In 16 cases the bone origin was not found. In 3 it was found to be of an extensive character, involving the head of the femur and acetabulum. In 3 cases the deposits were found to exist in the femur, and were of small size. In 2 cases the site was found in the rim of the acetabulum and quite small in extent. In addition to the above there were a number of suppurating cases upon which I did not consider operation advisable. Some of them were upon the point of spontaneous rupture, the overlying skin was thin, very tense, and the abscesses of large size. In other cases recourse was had to mechanical fixation without operation. In contrast to the distressing persistent sinuses that have so frequently followed attempts to avoid the radical procedure here described, I have felt that in future I should be inclined to extend the range of cases upon which I would consider the operation advisable.

I have frequently observed spontaneous resolution without rupture of an abscess of considerable size, and have seen many cases where the spontaneous closure of a long-standing sinus has occurred after a prolonged period of time; but these were under the most favorable circumstances, and I can but doubt that they would have obtained a more speedy cure if these abscess-accumulations had not been left so largely to themselves. Upon the other hand, the presence of persistent and often multiple sinuses is of

entirely too frequent occurrence, and would tend to favor the employment of measures that, while apparently of a serious nature, certainly offer prospects of the avoidance of sinuses—relief from which can often be obtained only by recourse to operative procedures very similar to that employed in their prevention. The unsatisfactory results obtained in the treatment of hip abscess may be traced to—

- a, delayed operation;
- b, imperfect measures of operating;
- c, squeezing the abscess to evacuate the contents;
- d, the employment of the drainage-tube;
- e, and most important of all, the failure to employ prolonged and absolute fixation of the hip-joint.

(a) In delayed recourse to operative procedures the extensive destruction of bone tissue prevents the closure of an abscess cavity by a constantly renewing accumulation. (b) The imperfect operative measures are those which remove but a part of the sac contents or wall, or where the cavity to be closed is too large to permit a thorough cleansing of the parts, or where the cavity about to be closed is filled with some fluid which, in escaping through the incision, tends toward the production of a sinus. (c) In squeezing the parts surrounding an abscess to assist in more rapid evacuation, the already inflamed tissues are bruised, and upon this point I can cordially endorse every word that Phelps\* said when discussing this same subject in 1889. He deprecates the squeezing out of the pus, and says that "if the abscess is properly opened at first there will be no necessity for doing this." (d) With reference to the employment of the drainage-tube, I cannot agree with Dr. DeForest Willard† with reference to the necessity for its use. Dr. Willard advocated gradual withdrawal of the rubber drainage-tube, believing that it assisted in effecting a thorough cure, and that this was of far more importance than obtaining primary skin union. My own experience is that the employment of the drainage-tube is invariably followed by a sinus which but rarely closes spontaneously. R. W. Lovett, in his classic prize essay, entitled "The Etiology, Pathology, and

\*Transactions of American Orthopedic Association, Vol. ii., p. 92.

†Ibid., p. 146.

Treatment of Diseases of the Hip-Joint," 1891, p. 120, says: "The experience with regard to the drainage-tube at the Boston Children's Hospital is of interest. Of forty-three cases of abscess of the hip operated on between 1884 and 1888, one is recorded as having healed within six months, and about half of the sinuses healed within periods varying from one to two years, the rest remaining open almost indefinitely. These cases were all thoroughly cleansed after free incision, and were either packed with gauze, or, more commonly, drainage-tubes were inserted and antiseptic dressings employed. The site of the drainage-tube was almost always the site of a sinus, which persisted for a varying period of time." (e) In the failure to employ prolonged and absolute fixation after the evacuation of an abscess there is an entire disregard of the fact that by this means alone abscesses have been arrested in their growth, and that absorption has thereby been induced. If these are facts—and no one can doubt the statements made by Shaffer, Judson, and other orthopedists who deprecate the resort to surgical measures—then the employment of immobilization will materially assist in the recovery after the evacuation of an abscess, and in the prevention of re-accumulation.

#### PROGNOSIS IN PNEUMONIA IN CHILDREN.\*

BY A. M. BAINES, M.D., C.M., L.R.C.P.L., TORONTO.

To make my part of the symposium of great interest I find somewhat difficult, and I fear it will be looked upon, to a great degree, as a statistical comparison.

It is necessary to plunge at once into a few figures to convey a proper idea of the terrible mortality in pneumonia generally. In England, in 1876, Dr. West says there were from pneumonia of all ages 24,492 deaths, of which 12,878 were in children under five years of age. Dr. Lewis Smith gives nearly the same figures.

Why this great mortality in young children? The anatomical peculiarities of the child's and infant's lungs have already been fully discussed, but possibly a short *resumé* may not be out of place and may fully emphasize the points.

The respiratory epithelium lining the air cells is in the infant in a condition of extreme delicacy. Physiologists point out that there is not an increase in the number of the flat nucleated epithelia lining the alveoli, but that they simply increase in size, thickness and strength of adherence; thereby adding to the power of resistance of inflammation, and are not so easily detached as they are in infancy, when, as in broncho-pneumonia, we find them filling the air cells. A second consideration is that of the manner of the disposition of the blood vessels and their behavior in contradistinction to those in the adult. They are held together very loosely, and being but little restrained can therefore become speedily tortuous and congested and easily press upon the small alveoli.

With small alveoli, thick walls and abundant distribution of vessels, we can see from these anatomical peculiarities that, as Northrup says, "It is easy to understand how by hypostasis, distension of the vessels may be an important factor in displacing the air in feeble subjects with weakened respiratory vigor and partially obstructed bronchi. Proportionately the extent of the bronchi is greater than that of the air spaces." One more point is that regarding the bronchial glands, the readiness with which they take on inflammation and the frequency with which they become tuberculous.

This embryonal condition of the lung may be said to continue with children, advancing certainly toward perfection, until the child arrives at the age of five years, when the lung assumes the condition of the adult lung.

Thus referring very superficially and briefly to these important points we see how they modify our prognosis, and to some extent account for the great mortality in the pneumonias of children.

Recent authorities point out the fact that all cases of pneumonia have a certain amount of broncho pneumonia in connection with the inflammation. Therefore there are but two varieties to consider,—lobar pneumonia and broncho-pneumonia—known by many synonyms, namely, catarrhal pneumonia, lobular pneumonia, capillary bronchitis, inflammation of the lungs, catarrhal fever, and many other terms now obsolete. We will consider first lobar, or croupous, pneumonia. This variety is certainly met with in children but is much less common than broncho-pneumonia. If

\*Read before the Ont. Med. Association, June, 1892.

a primary attack, it is rarely fatal, and seldom leaves behind it any disagreeable sequelæ. The mass of authority is certain of this fact, and it is probably deemed so fatal by many because they have overlooked the fact that it is generally accompanied by broncho pneumonia, which is indeed always to be dreaded.

Before giving a decided prognosis, the previous general health of a child must be considered, and the hygienic surroundings also; for we all know and have personally seen the almost miraculous change occur in a child taken from the midst of squalor, filth, ill-feeding and no nursing, to the clean, bright wards of the Children's Hospital, and good nursing. Baginsky states that out of sixty cases of croupous pneumonia he had but four deaths, and that nearly half of these little ones were under two years of age. The later authors contradict the statements made by authors of a few years since that the younger the child the more fatal the disease. Baginsky's cases contradict this, and he has been corroborated by many others. It has been also stated that if the disease attack the upper lobes there is much more likelihood of cerebral symptoms and fatal result than if in the lower. Eustace Smith, Emmett, Holt, Gorden Morrill and others say, however, that they have noted no difference in this respect.

The pulse and respirations become rapid in pneumonia but neither of these symptoms must be looked upon as necessarily severe, it not being such an unfavorable symptom as in other diseases. We frequently see the pulse 140-150 and recovery take place—of course when there be no other symptom of intercurrent trouble adding to the flame. Respiration is frequently observed to be between 40 and 50 with no great danger imminent; but should it get over 50, a most thorough examination of the chest should be made to ascertain the amount of lung implicated, which, if it be great, necessarily adds much to the gravity of the prognosis. Rapid breathing may mean more than hepatization, it may mean septic absorption. A temperature of 105 continued for some days is a serious symptom, but should this be for but one day it is not serious—in fact many cases show this high temperature just before crisis. Irregularity of temperature is a bad precursor, pointing at times to septic influence at work. "According to Thomas," says Morrill, "a want of correspondence

between range of temperature and that of the pulse is unfavorable; though high temperature with moderate pulse is less so than the opposite condition." Irregularity of respiration as well as pulse is an indication of exhaustion, therefore most unfavorable. Termination by lysis is not more unfavorable than that of crisis, although it is uncommon. Delicate, cachectic children have but little power of resistance to a disease which cripples the function of respiration, and almost all the fatal cases of pneumonia are amongst this class of patients.

Again, when pneumonia complicates such diseases as scarlet fever, whooping-cough, measles, diphtheria, tuberculosis and bronchitis, the prognosis is rendered more doubtful and generally grave. Should pleuritic effusion, be evolved it would form a most unfavorable complication, for then the already embarrassed lung would have a greater load to carry.

Regarding cerebral symptoms, when active delirium or mania be present, they are always most alarming but not necessarily fatal, except when pointing to the presence of meningitis, which is always grave. Meningitis is, fortunately, a rare complication of pneumonia.

#### BRONCHO OR LOBULAR PNEUMONIA.

As already stated, this variety is much more common and fatal than the foregoing. There can be no doubt but what many cases of death from so-called bronchitis would be found, should an autopsy be made, to have been broncho-pneumonia. In fact, it is doubtful if a fatal case of bronchitis could be verified—that is pure, simple bronchitis without broncho-pneumonia.

The Boston Board of Health published a schedule of deaths from all causes in childhood, from 1879 to 1886, being 1203 deaths, of which 2050, more than one-sixth of the total, were from pneumonia and bronchitis; which showing gives this dread disease a terribly high mortality, so high that it is equal to diphtheria, and second only to cholera infantum. It seems also to be the cause of many cases of phthisis. This, however, is a doubtful starting point, unless there be a favorable tuberculous nidus present. Regarding the time of year—the months of December, January and March seem to have the highest mortality, and August, September and July the lowest as in order named.

When a case of broncho-pneumonia complicates measles, it should always be looked upon as grave, for it seemingly involves a larger amount of lung tissue proper, and the death rate in this class is very high.

The prognosis in any case of broncho-pneumonia cannot possibly be given at first with any degree of confidence, for it may be that primarily a small amount of lung tissue is involved, and at times it will go on by continuity of tissue so that the child we leave with light symptoms one day, we may find the next day as bad as bad can be. Again, it is not uncommon for some lobules to clear up to a certain extent and the inflammation to go to other parts of the lung. So that the temperature may have uneven and eccentric flights and remissions according to the invasion and remission. As before mentioned, should it follow measles, or pertussis or other diseases accompanied by high temperature, the prognosis is far graver. Morrill gives his mortality percentage in broncho-pneumonia as 48.3-10 under ten years of age. The extent of lung tissue involved makes the case favorable or not so. The greater the amount, the graver the prognosis, the physical signs being much altered according to the amount of lung involved. Take the temperature; should it keep persistently up to say 105 for any length of time, it is a bad omen. Again, do you find a pulse respiration ratio of 1-1 or even 1-1½, death is probably imminent. A decline of temperature accompanied by pallor and collapse is the gravest symptom and marks a probable rapid ending.

A child whose health is impaired by any former illness or heredity must always be looked upon as an unfavorable subject. The presence of diarrhoea, vomiting, inability to take nourishment or stimulants, delirium, flagging pulse and continued fever, all form symptoms which render prognosis grave. The possibility of atelectasis, emphysema, carnified lung, phthisis and pleuro-pneumonia cannot be discussed in this paper as too much time has already been taken. I will give, therefore, the summing up of Dr. Northrup in his classical paper in *The Reference Handbook of Medical Science*, which paper I have freely used:

"Broncho-pneumonia in infancy is an exceedingly fatal disease. The gravity of the prognosis varies, however, in the following particulars:—

It is most grave after whooping-cough in infants,

and the younger the child the more fatal the disease. Next in gravity is the pneumonia after measles, in which Ziemssen gives fifty per cent. of deaths. Close upon this comes the pneumonia with diphtheria. It is not easy to say which is the cause of death in this combination. Patients recover after having had both; in case of death diphtheria seems to be an efficient cause. Age is important before other considerations. Ziemssen lost half of his pneumonia patients under one year of age. Two-fifths of those from one to three, one-fourth of those above three.

Pneumonia which develops quickly tends to a speedier resolution and affords a favorable prognosis.

Previous existence of rachitis, tuberculosis, feeble constitution and surroundings of poverty allow the resolution to become prolonged and the patient to die of exhaustion. The conditions of crowded hospitals may be classed as unfavorable surroundings.

It is believed that fat children have less resistance to broncho-pneumonia, not having so much blood in proportion to their weight as well nourished children having less adipose tissue.

The prognosis is unfavorable where early suffocative symptoms are prominent.

Further unfavorable symptoms are, a sudden fall of temperature, with rapid and feeble pulse, irregularity of pulse, slowing of respiration, Cheyne-Stokes respiration, sudden disappearance of cough and restlessness giving place to stupor and delirium. These mark the last stage of a fatal case."

#### TURPENTINE POISONING WITH AN UNUSUAL SKIN LESION.\*

BY GEO. H. CARVETH, B.A., M.D.

Physician to Toronto Dispensary and Toronto Home for Incurables.

Miss A. B., a young woman of nervous temperament, as a result of over study and overwork, had become somewhat run down in health, shown by attacks of atonic dyspepsia, constipation, etc. In the early part of January, 1893, she determined to take a dose of castor oil to relieve the constipation. In mistake about one half ounce of old

\*Read before the Toronto Medical Society, May 18th, 1893.

spirits of turpentine was given to her mixed with an ounce of whiskey. The mistake was noticed only after the turpentine had been swallowed, but nothing was then done except to take a dose of castor oil. The turpentine was given at 11 o'clock in the evening. A short time after the patient fell asleep and awoke at 4 a.m. complaining of sickness at the stomach. She vomited soon afterwards and was then restless till about 8 a.m., when a convulsion came on followed by a state of unconsciousness. I saw her a few minutes after the onset of the convulsion, and found the following condition present. Pulse weak, feeble and rapid, face and lips pale, patient restless, delirious at times, talking incoherently, but could be partly roused.



Urine had been passed in quite a quantity since last evening, no irritation of the urinary organs at any time.

Whiskey, sweet spirits of nitre, milk, and sweet oil were given, and warmth applied to the body; vomiting was induced by irritating the fauces. The vomited matters had a strong odor of turpentine, ten hours after the turpentine had been taken. The bowels were moved by magnesium sulphate and injections. After vomiting severely a number of times she regained consciousness, and immediately complained of a burning pain in the right leg, saying that erysipelas was coming on, as

she could feel the leg hot and painful. On examination the back part of the leg and thigh was found to be red, swollen and covered for a space of five inches by thirteen by a bulla or blister exactly resembling a burn. On pricking the blister the contents were watery with a strong odor of turpentine, and in quantity about ten ounces.

The position of this blister was behind the knee, and reaching from one inch above the fold of the ham to eleven or twelve inches down upon the calf of the leg, in width from three to five and one half inches. At 11 o'clock in the morning the temperature of the patient was 100, pulse 100.

By evening of this day temperature and pulse were normal.

Next day the skin beneath this blister looked dark in color, and on the 3rd day it became quite black, and it was evident that death of the skin had taken place.

About the 6th day the line of demarcation appeared between this dead skin and the surrounding healthy parts, but the sloughs were not completely separated till the 21st day, leaving a cavity four inches by twelve, and in depth, down to the muscles, the skin and sub-cutaneous tissue dying and coming away.

On the 27th day the cavity was filled to the level of the surrounding skin, and skin grafting was done by means of small sized pieces of skin laid on the now healthy looking granulations. The grafts took well, and the ulcer was healing rapidly, when the time for the ordinary monthly sickness approached. At once the ulcer began to look unhealthy, and a few granulations in the centre of the sore died. On the 36th day this small dark spot appeared, and on the 43rd day *all* the granulations had died and come away, carrying all the new skin grafts except two, which had been near enough to the edge to receive nourishment from this source.

On the 47th day new granulations began to form all over the floor of the ulcer, and the edges were growing in rapidly. On the 48th day the accompanying photograph was taken.

On the 50th day the ulcer was healing in all parts and looking well, new skin grafts taking rapidly. About this time the general health began to improve, the patient being able to be driven out, with the limb elevated.



On the 70th day the ulcer measured one inch by three inches, and was looking well. As the time for the next monthly sickness came near, healing stopped, and the ulcer remained stationery for a week, but no granulations of any account died, and after this time the healing was rapid. At the time of the next monthly sickness, healing had almost taken place; a spot  $\frac{1}{4}$  inch in diameter only being left, and no special effect was seen in the sore except that the scar looked dark and congested for two or three days. On the 106th day the ulcer was all healed, and the patient able to go about.

### Selected Articles.

#### ON LUPUS.

(Continued from July No.)

Arsenic is the next remedy, and is, according to my judgment, best given at the beginning of the course in the shape of the solutio solvens mineralis, a far superior preparation to Fowler's sickly-tasting, irritating solution; the dose four or five minims, gradually increased to six, eight, or ten times as much. Perhaps a mixture of dilute nitrohydrochloric acid and some mild, bitter infusion, like that of snake-root, is as good a vehicle as we have. The preparation should be continued so long as it seems to be doing good, and when such amendment as it is thought to be affecting comes to a standstill, then the arsenic is to be given in the form of a pill, at first in small quantities, such as the fiftieth of a grain three times a day, gradually increased.

This part of the treatment, if not so indispensable as was taught by Mr. Hunt, is at any rate of great importance; it multiplies the chances of doing good, and therefore should always be included in the programme. Mr. Hunt effected some wonderful cures with arsenic alone, imposing no restrictions as to diet, and having a perfect horror of all strong local applications. Among other instances he showed at the London Medical Society a bad case of lupus of the face cured in this way. Some of those present suggested that it was only an instance of arrest of the disease, which would be sure to return, and then Mr. Hunt was merciless enough to show the patient at the Society, a year later, still cured, no relapse having occurred.

I never could understand how it was that Mr. Hunt managed so well, as I certainly was not so successful, though I tried four different preparations of arsenic most perseveringly, and as I thought carefully enough, I constantly found that the patients could not continue to take the

medicine for anything like the time necessary to effect a cure. The eyes became red, tender, and weeping, the tongue coated, the appetite impaired or lost; diarrhoea, nausea, and vomiting set in even when a strong stomachic-like essence of ginger or peppered brandy was given after each dose. Under such circumstances it is of no use to persevere in the administration of the medicine, the question being, what is the best *temporary* substitute, for it is always desirable to return to the solution. I have myself for long turned to the phosphoric acid, and have found nothing equal to it in its power of setting right a disordered stomach and coated tongue. I have usually given from fifteen to thirty drops in some mild bitter, like that of Seville orange or calumbia, three times a day, continuing this till the symptoms have quite passed away, for it would serve no useful purpose to revert to the arsenic before the system has been restored to its normal state.

At one time I used iodide of potassium as a substitute for arsenic. Having seen reports of cases in some of the medical journals, showing that lupus had been cured with large doses of this salt, I gave it a good trial, beginning with moderate amounts and continuing these as high as the stomach would bear; but in no single instance did I notice the slightest good result in lupus of the face, head, or neck. Some of the patients were speedily made so ill that they could not continue the iodide, and I was obliged to admit that, if others could cure lupus of these parts with it, the task was beyond my powers. This admission, however, I have had to make with regard to so many remedies, that I have grown case-hardened. In lupus of the limbs, especially when seated on the lower parts of the legs, I have sometimes found the iodide very useful. Sooner or later the necessity for any measure of the kind passes away, and then the arsenic should at once be resumed, and sedulously continued, unless some further disturbance should again require the suspension of it, as may easily happen. I have had to interrupt the use of it four or five times before proper toleration was established.

The nature of the local means employed must vary according to the extent of the ulcerated surface and the avocations of the patient, for in many cases it is most imperative, and particularly when the disease is seated on the face, not to add to existing disfigurement, and some of our best means do add to it; consequently they must be reserved for patients in the wards, or for young persons who are not compelled to go out to work. Carbolic acid, 95 p. c., is an excellent application, inasmuch as the stain caused by it speedily passes off, while any slight pain it may occasion is still more speedily relieved by the free application of hot water. The patient should be supplied with the acid and taught how to use it, attacking daily

as much of the lupoid surface as can be done without much pain being caused. At night some mild ointment, like spermaceti or zinc thinned down with liquor plumbi and sweet almond oil, may be applied, the part being covered with Irish linen to prevent the ointment from being rubbed off and the sheets from being greased. When ointments are objected to, the part can be bathed with hot undiluted liquor plumbi. As far as practical all discharge should be removed before applying the acid, and sometimes nothing, not even the most sedulous bathing, effects this so thoroughly as a hot turnip poultice, which offers a convenient medium for keeping heat and moisture a long time in contact with the part without much trouble to the patient. Besides, it is possible that the turnip possesses some slight degree of healing power, because patients frequently remark that the part feels much soothed by the use of the poultice, and the disagreeable smell often noticed in children suffering from clipping ringworm or eczema of the head is at once removed by this remedy, while in them the irritation of the scalp is often visibly removed. The poulticing is repeated every day until the crusts and discharge are completely got rid of.

But when the hands of the medical attendant are not tied, the permanganate of potass should be turned to as offering greater advantages. The solution I employ is one of a drachm to the ounce, and the diseased surface is mopped with this daily till a dark, glossy, hard, adherent film has formed, when it may be discontinued until the lupoid surface is again laid bare by the peeling of the scale. The operation of this remedy is often excellent, especially in the erythematous variety. Any tendency in old papules to rise and enlarge suddenly should at once be checked by rubbing with the solid nitrate of silver, the surface being merely damped; when it proves too painful, iodized glycerine may be substituted. Sometimes, when all appears to be doing well, a small painful sore will form quite suddenly in one of the nostrils, or a few papillæ will all at once break down, and an ulcer take their place with such rapidity as to remind one of sloughing. In such emergencies I think pure chian turpentine is by far the best dressing, the discharge being carefully removed and the powder well dusted on the place. Treated in this way I have seen not only such a lesion close up, but the cicatricial tissue which formed over it take on a much healthier look than other healed parts. The application of calamine lotion to protect the surface from the air is often a source of comfort which patients appreciate highly; it offers also the advantage that it hides much of the disfigurement, especially that caused by erythematous lupus. The rabid irritation sometimes seen in sycosiform lupus, particularly when seated below the chin, is often materially alleviated by scalding with hot water, which, indeed, can be beneficially

resorted to in all forms of the disease, followed up by the free use of Duhring's sulphide of potass lotion, or solution of carbolic acid, in rectified spirit, three or four grains to the ounce.

Beyond these I know of no local remedies likely to be of service in lupus. I have not tried many, but those which I have tried completely failed in my hands. Nitric acid, acid nitrate of mercury, chloride of zinc, caustic soda, and caustic potass, have been exceptionally recommended. I used them, as I thought, with all needful care, and did little but mischief with them, causing severe pain to far less purpose than might have been attained to by milder means, and not unfrequently with acids injuring the surrounding sound tissue. Nor do I see how it is possible that anything useful in this direction could be extracted from those authors who have touched upon the subject, inasmuch as it would require many years of unremitting labor to select the local application for trial. The reader may think this exaggeration; if so, he has only to observe for himself. Of the caustics alone twenty-three have been recommended, and I need hardly point out that an almost endless series of experiments and researches would be required to determine which was the best of any half-dozen submitted to examination. Indeed, if I had said that half a lifetime would be needed to decide, with scientific precision, such a point with regard to the whole number, I should hardly have overshot the mark.

Besides, there is one very serious objection to the use of caustics which has not met with the attention it deserves, and that is, that if the remedy fail to overpower the disease, it sometimes rapidly and seriously aggravates it. This was particularly the case with a girl admitted into St. John's Hospital suffering under lupus of the nose, cheeks, and back of left jaw. She had, after nearly seven years' attendance at different institutions, been thoroughly cauterized under chloroform in a provincial hospital. Shortly after this the disease began to spread, whereupon the surgeon, apparently thinking he had not done enough, again took her into the hospital and cauterized the places most severely with chloride of zinc. But the operation only had the effect of increasing the extent and rapidity of the destructive process, and when, sometime afterwards, she put herself under my care, there was evidently no attempt at repair. Moreover, the fact that any kind of operation is so dreaded by many timid persons as to make cauterizing prohibitory in their cases should always be kept in view. So far, then, as concerns treatment generally, but there are certain hindrances and complications which demand special attention, and which I now proceed to take up.

Thus close, thundery weather often brings on a relapse almost as unpleasant for the medical attendant as for the patient. Papules, which had

been diminishing in size and fading in colour, suddenly enlarge and become reddened or pink, while a serous or purulent discharge, which had perhaps been absent for weeks or even months, speedily reappears, accompanied by stiffness, burning and itching, particularly in the sycosiform variety. In such emergencies I have seen nothing answer like the tartrate of antimony. The doses of it ordinarily prescribed are of no use here,—supposing, indeed, they are of use anywhere, which I rather doubt. At least thirty to forty minims of the wine should be taken three or four times a day, and I constantly increase the amount to three, four, or even six drachms daily; I never hear of sickness or even nausea being caused by such quantities, and believe the fears about the over free use of antimony to be entirely unfounded. To prevent, however, any feeling of depression being set up, the acetate of ammonia is added, as is, for no particular reason I can offer, unless it be habit, spirit of nitric ether in small quantities. The use of the calomel is kept up, and rather pushed at such times, and followed on each occasion by a full dose of the senna draught next morning. The local treatment should be of the most soothing kind. A hot fomentation or hot turnip poultice, at least once daily, followed by free use of a weak bicarbonate of soda lotion, a drachm to the eight ounces, with half an ounce or more of cherry-laurel water; at night spermaceti ointment is laid rather thickly on the part, being then covered with a single thickness of Irish linen. When an ointment is objected to, as is sometimes the case, the part can be well mopped with hot liquor plumbi.

The diet should at all times be light, but on these occasions meat should be interdicted, the nearest approach to it being a little weak veal or mutton broth; weak tea and dry toast, milk puddings, white fish, vegetables, supply all that is useful. That general refuge, beef-tea, should be utterly avoided, being as heating, irritating, and generally mischievous as anything can well be. No beer should be allowed on any pretence whatever, and if the use of wine be permitted at all, then only some very light kind, such as hock or sauterne. Perhaps it may be as well to say here, that it is much better to adhere to this diet throughout; meat, especially the heavier and more stimulating kinds, strong soups, jellies, meat juices, stout, and brandied wines, being especially injurious, and only permissible when the patient seems to be suffering severely from exhaustion, which, though a very rare, is yet a possible occurrence. In a few extreme cases of this nature I have given rum and milk freely, and a liberal allowance of it certainly seemed to save the life of one woman, sinking to all appearance under the ravages of the disease.

Every now and then, without any manifest

cause whatever, the patient complains of utter loss of appetite and distaste for food; of weakness, languor, and weariness; of backache, and a feeling of being equally indisposed for work or rest. When such symptoms prevail, lime often relieves the patient more quickly than any tonic I have seen tried, and perhaps of all the preparations of it the lacto-phosphate—first recommended, I believe, by M. Dusart—is the best, two or three teaspoonfuls five minutes before breakfast and dinner having often an excellent effect. The phosphate is not prescribed because lime is considered useful in strumous affections, but because under the influence of it the patient recovers appetite and strength, and the depressing symptoms just mentioned pass away. I therefore presume that it acts here as a kind of tonic, just as in other phases of the disease the saline and mercury do, patients getting fat and strong under the use of them.

I have seen no reason to believe that any mineral water or bath is of the slightest use in this disease. It is well known that the power of relieving, if not of curing, lupus has been claimed for some of them, particularly the waters of Louèche, which, in addition, render the same invaluable service to seventeen other diseases of the skin, as also to “secondar syphilis” and “inveterated states such as scrofula;” it is also well known that only too many medical men fall in with the morbid fancies of their patients, and sanction their going to places celebrated for the curative qualities of their waters, the accounts of which are often an insult to common sense. Supposing them to possess only a moderate share of the qualities claimed for them, there ought to be no dearth of cures to trumpet forth to the world, yet I have vainly searched far and wide for one authentic case. The vapour bath often affords these patients much relief, apparently because it promotes improvement of the health and a more comfortable state of the skin.

There are three varieties of weather which seem never to agree with lupus patients—raw, cold east winds; east winds in summer, accompanied by much light; and close, thundery weather. The two first can, of course, be avoided by patients in the wards and those who can remain at home; no precautions avail against the last, and there is sometimes no alternative but to expect a relapse, and deal with it as promptly as may be. Those whose work compels them to be a great deal out of doors should protect the part as well as they can from winds and sun; but they have a hard and sometimes an impossible task before them, for exposure to such agencies is often inseparable from the work by which they live.

It has several times been noticed that an attack of erysipelas has materially influenced lupus for the better, setting up a healthy reaction when

nothing ~~else~~ has availed, just as it does when it fastens on a sluggish ulcer. I have never seen this myself, and, indeed, we have never had any erysipelas since the hospital was opened; but a girl, suffering from intractable lupus, which had extensively ulcerated the lips and cheek at the left side of the face, was sent for change of air to the convalescent home, and while there was attacked with erysipelas. Some weeks after this I had an opportunity of examining her, and found that a great improvement had certainly taken place; the ulceration on the oral surface of the lips was nearly healed, and a great deal of the adjacent skin was beginning to show the bleached, scarred surface seen after lupus has been cured. Looking to such facts, the question naturally arises as to whether it would be legitimate practice to place a lupus patient in a ward where erysipelas had broken out, and thus invite an attack of this disease; for my part, if suffering from such a loathsome, disfiguring complaint as lupus, I should certainly ask that this might be done for me. Anyhow, the suggestion, if acted upon, would open up a wide field for experiment, and in due time a vivid description might appear of the struggle for mastery between the bacillus of lupus and the micro-organisms of erysipelas—a conflict even more desperate than that of the microbe and phagocyte, of which we had such interesting narratives, peculiarly redolent of imagination, coolly avowed, indeed, to have been engendered by it, and lamentably wanting in evidence.

It is now so much the fashion in speaking of lupus, and, indeed, of many other maladies, simply to bring forward a case in which some new remedy is effecting a cure or materially relieving the symptoms, and there to leave the subject, that I feel doubtful whether the reader will care to go into the question of what are the chances of cure under the system recommended. The possibility of comparing these with the success affected by other methods is negated by the scantiness of authentic records on this head—at least I have found little in the shape of an endeavor to grapple with the problem. Lugol's cases were too few to admit of any inference being drawn from them. Dr. Piffard's experience affords us some most valuable information. In 1887 he published an account of twenty-five cases, sixteen of which were successes. Out of eight of these, treated by excision only, six were successful, two failures; while of five treated by excision or scraping, both followed by the actual cautery—the method which he prefers—all were successful. Again, in 1879, he communicated the particulars of nine more cases. One, treated by excision only, was a cure; of the remaining eight, six were successful, one a case of improvement, one was a failure. Quite recently, Mr. Harrison of Clifton, in a paper read before the British Medical Association, gave the particulars

of ten cases treated locally with hyposulphite of soda solution, forty grains to the ounce, followed by dilute muriatic acid, five minims to the ounce, with the object of setting free "nascent sulphur and sulphurous acid deep down in the skin structures." Of these ten, one seems to have been absolutely cured, one nearly so.

Such are the few facts which I have been able to glean. On the information conveyed by textbooks on diseases of the skin I do not propose to touch. It is generally restricted to the recommendation of the stereotyped remedies, from which we cannot always gather whether any of them, or any combination of them, has ever been successful; what the relation is of cures to failures in the hands of the various authors; to what particular forms and stages of the disease the different remedies are applicable; and, lastly, whether, when all the steps required by an author as necessary for success have been taken, we can rely on curing any individual case of lupus by the most persevering use of them. I presume a certain value attaches to this mode of writing, because the system is so persistently maintained, but I have not myself been able to discover it. As to my own success or insuccess I have no statistics to offer, having so often found it impossible to trace the cases to the end. I can, therefore, only say that the treatment recommended has answered infinitely better in my hands than tonics and caustics ever did, and that by means of it the majority of those patients, who give treatment a fair trial, are either relieved or cured, equally whether suffering from the affection on the head, face, or limbs; lupus of the hand presenting, perhaps, the greatest difficulties of all, and twice in my experience defying treatment so long that the patients left off attending—one only partially, the other scarcely at all relieved. Multiple lupus, too, affecting the limbs, hands, and feet, I have sometimes found refractory to it in the case of out-patients, and only to be satisfactorily treated in the wards. I may here add one thing which has surprised me very much, and that is the slight amount of deformity often left after a lupoid patch, treated in this way, had healed up, the cicatrix becoming peculiarly vascular in some cases.

But only too often treatment never has a fair trial; there are always plenty of people who never have observed, and never mean to observe, the measures necessary for cure. Foremost among these are the incurably perverse patients, who contrive to misunderstand every direction given them, and who, whether they deceive themselves or not, seem always bent on deceiving the medical attendant; affirming that they have sedulously followed up treatment when it is clear that they have done nothing of the kind, and justifying themselves with such pertinacity that I have often thought such people must labor under some affection of

the brain. Next we have the incorrigibly lazy, whom neither the ravages of the disease nor the entreaties of relatives can induce to make one rational effort for the purpose of being freed from such a misery as lupus. One might think that the first encroachments of a disfiguring affection of the skin would impel any person attacked by it, especially when that person was a woman, to seek relief at any sacrifice of time and trouble, to submit to any restraint requisite for cure. But it is not so. A girl with a large patch of lupus on the left jaw and neck, allowed it to go its way for more than two years without doing anything for it, though she was living in the immediate vicinity of a hospital devoted to diseases of the skin, and not a quarter of a mile from a general hospital. One young man, fearfully disfigured and just beginning to mend, left the hospital because he was not allowed to go out as much as he liked in raw, cold weather, which always aggravated the disease; and I am frequently obliged to threaten with immediate dismissal patients who seek to excuse their irregular attendance by the most frivolous pretext.

Next, come the helpless, born in poverty or doomed to sink under it, with whom the wolf is always at the door, and life such a hopeless struggle that they have little time and little heart to attend to anything beyond its daily wants; with whom the question is not to ward off disfigurement, but to keep cold and hunger from the hearth. With these medicine will never be able to deal. The philanthropist may strive to better their lot; the pedant, who affects to believe that education is the panacea for all social ills, may proclaim that by elevating the minds of these outcasts through the medium of his nostrum, he will rouse them to shake off the apathy which stands in the way of cure. It is all vain. When the philanthropist and pedant can infuse reason into a brain pre-occupied with sordid cares, then, indeed, they may persuade such patients to attend to their maladies, but till then they will continue to suffer. But, apart from the helpless, there are numbers of struggling but right-meaning persons who are constantly shifting their quarters because they must go whither their work calls them. Others, too, there are whom daily toil chains fast to the spot all day long, with whom to leave work means to want food later on; some too poor to bear the petty cost of travelling to the hospitals, and others too weakly to support the fatigue of coming frequently to allow of any good being done. The upshot of all this is, that I never feel confident about a lupus patient attending regularly till experience has shown that this is likely to be the case.

A distinguished physician, attached to one of the largest London hospitals, not very long ago asked, in the course of a lecture, whether any man

could say that he "ever got lupus out of the system." This is a fair instance of the way in which the subject is so often dealt with. The question seems legitimate enough when levelled at the incomplete accounts so often met with of the real and ultimate effects of treatment; and, duly weighed, might serve as a warning to men to tell us definitely what can be done in the way of cure in lupus and what cannot be done, where the most hopeful must cease to hope, and where our knowledge of its pathology ends. But in itself the question is not legitimate; it would never have been put in such terms had our knowledge of the disease and its therapeutics been reduced to precise form and established on a lasting base. I doubt if the lecturer himself could have described with exactness what he meant by getting lupus out of the system, or under what form he supposed it to exist while in the system. The issue raised, however, even in this crude shape; is of great importance to the subject, for it reflects the widespread belief in the incurability of lupus which I have so often heard expressed; as it must mean either that the disease cannot be cured even in appearance—a belief for which there is, as regards many cases at least, no justification—or that if apparently cured, the unhealthy disposition to it is never overcome, and the disease infallibly returns; to which the rejoinder must be, that time is needed to decide whether such cures as those mentioned in the foregoing pages are lasting or not, and that, even if a relapse has to be counted on, still immunity from suffering for years, or even for months, is a priceless boon to those labouring under lupus.—J. L. Milton, in *Ed. Med. Jour.*

#### ELECTRICITY IN HERNIA.

One would suppose that there would be very little "new under the sun" in reference to the management of hernia. I should hesitate to add to the volumes written on that subject during the past half dozen years, were it not for the fact that I believe I have something both new and important to offer. It is to the management of recent strangulated and old irreducible herniæ, that I desire to direct attention. I shall confine myself strictly and briefly to my own method of procedure, one which has given me considerable satisfaction, and which in strangulated cases has saved me much trouble, and the patient all risk of injury from taxis or operation. Many a case of strangulated hernia has been sacrificed, either because of the inability or the disinclination of the physician in attendance to operate, or because no competent help was within reach. This, in my opinion, need not be, since the "operation" which I propose is simple and open to all. All that is necessary for the successful treatment of recent

strangulated hernia, is the possession of a fairly powerful (20 30 cell) battery of low tension. The patient is first placed in the most convenient position for reduction, such as is generally advised in the employment of taxis, and medium size fine sponge electrodes, moistened in warm saline solution, are used. The anode is placed directly over the tumor, the cathode within a couple of inches, when the current is turned on, gradually increasing its strength until as much as can be borne is passing. To measure the current is not necessary, although advisable. This should be passed steadily for from two to five minutes, or as long as the patient (in the absence of an anæsthetic) can bear it. On the removal of the electrodes, very gentle attempts at reduction should be made. If these are not almost immediately successful, re apply the sponges, and allow the current to pass as before. This should be repeated until reduction is easily effected. Taxis should be the most gentle; no prolonged or rough handling is necessary. The following cases of mine will give an idea of the obtaining conditions and the results secured. I will state right here that in every case taxis was tried, both by myself and others, and proved totally ineffective. The cases would have been given over to the surgeon's knife.

Mrs. A. B.—, aged fifty-two, umbilical entero-epiplocele, size of a hen's egg, and existing for ten years, came to my office December 10th, 1888, suffering from strangulation. Constriction, moderately tight; tumor, bluish: twenty-four hours' duration. Repeated attempts at reduction by taxis, failed. Anode, over tumor; cathode, two inches to the left of umbilicus, when three applications were made, lasting in all about fifteen minutes, and on removal of electrodes for the third time, the hernia was reduced almost by a touch.

R. H. W.—, aged thirty-five, railroad official, complete oblique inguinal enterocele, six months' duration, came to me the evening of April 5, 1892. The constriction was very tight; duration of strangulation, five or six hours; attempts at reduction by myself and others failed, the general opinion being that there was nothing left but to operate. Galvanism applied as described during five or six minutes, with three or four slight intermissions, was followed by reduction with very little effort.

J. Z.—, aged twenty-seven, car carpenter, large scrotal enterocele of ten or more years' duration. Strangulated for about four hours; resisted all efforts at reduction by taxis, position, etc. In this case it was found necessary to continue the current, with numerous intermissions and constantly increasing strength, for fully half an hour. At each intermission gentle attempts at reduction were made, but half an hour elapsed before any apparent impression was made. Reduction was finally accomplished easily.

One more case, and I am done with (his subject, George L.—, two and a half years of ago, neglected scrotal enterocele of two years' duration, was brought to my office, May 15, 1892, with strangulated hernia. Duration of strangulation about ten hours; constriction, very snug; tumor very tense. After etherization, efforts were made by myself and others to effect reduction. Our efforts proved unavailing. One physician, Dr. Ewing, remarked that he had assisted at an operation a few days before, in a case identical, and expressed himself to the effect that an operation would be absolutely necessary. Anæsthesia was most profound; an extremely powerful current was run for (with intermissions) twelve to fifteen minutes, reduction than being fairly easy.

When the patients is very sensitive, or in the case of children, an anæsthetic is necessary.

My cases now number upward of twenty, and in none have I failed to reduce the hernia within from five to thirty minutes. Of course, it is understood that complicated cases may be met in which this treatment would not be successful, but, fortunately, they are very rare and need not be taken into account, as in the event of failure the operation may be done, no harm having resulted from treatment, and no material delay occasioned.

*Irreducible Hernia.*—In the treatment of old irreducible herniæ, the usual conditions to be overcome are from the formation of adhesions, and, in entero-epiploceles, and epiploceles, thickening and induration of the omentum. There are other rare causes for this irreducibility, as in a case upon which I recently operated, a congenital complete oblique inguinal. Patient, thirty-five years of age; tumor composed entirely of omentum, which was spread out fan-shape, base measuring six inches; apex at external ring, one inch, which small portion completely filled both rings and canal, plugging them so well that, although the patient had never worn a truss, at no time had the intestines escaped, the rupture causing him no trouble or inconvenience, except through the large size of the scrotum. The irreducibility here was due to the disparity between the part to be returned and the openings through which it should pass, a condition that was unusual, as in most old irreducible herniæ of any size the canal is obliterated, or nearly so, the ring being approximated (the hernia direct) and widely dilated. It is to the ordinary forms of irreducible herniæ that my method is applicable, and in which it has been successful in nearly half a hundred cases. In fact, unsuccessful in only three—one an enormous scrotal entero-epiplocele, scrotum measuring twenty-six inches at the junction with the body, and twenty-eight inches from side to side in line of raphe, irreducible over twenty years. Before reduction had been accomplished a violent effort on the part of the patient caused strangulation. The surgeon who saw him,

and who operated, informed me that he found no adhesions, nor any other apparent cause for irreducibility. The other cases were quite similar, both becoming strangulated. An operation was deemed necessary, and as the patients lived at a distance, I did not see them, nor did I operate. The time usually necessary, according to my experience, to effect reduction, is from one week to one month. In one case over two months was occupied; this was an enormous scrotal entero-epiplocele, irreducible for twenty years. As in this case, it is often impossible to reduce the sac—but that is of small account—as a truss can be worn just as well, though the sac remain permanently down. The after-treatment of such cases will be reserved for a future article. The time required to effect reduction depends somewhat upon the nature of the case. Enterocoeles yield quite quickly, as a rule; entero-epiploceles and epiploceles require much longer time.

For the successful treatment of irreducible hernia, a very low tension, galvanic battery of considerable power, medium size and small sponge electrodes are required. A milliamperemeter is not absolutely necessary, though for many reasons advisable, the gauge for current strength being what the patient can possibly bear. If scrotal, the current is passed directly through the hernial tumor. When this becomes too painful, anode is used on scrotum, moving it about from place to place; cathode, at junction of scrotum with body. In incomplete inguinal, femoral or umbilical, the anode is placed directly over tumor; cathode, very near by, the object being to get the polar effect as much as possible. The time occupied in a single sitting should not exceed fifteen minutes, interrupting frequently, care being taken to have the current traverse every portion of the tumor. After each treatment, attempts at reduction should be made, the tumor being not too forcibly kneaded and manipulated, in order to assist in breaking up any adhesions that may have been weakened or partially destroyed by the current. The following will illustrate the average run of cases, as I have found them:

Lewis P.—, aged fifty-six, undertaker, large scrotal entero-epiplocele, irreducible ten years, in size as he expressed it, "as large as the hub of a lumber wagon, nearly as hard and tense." Numerous attempts at reduction had been made by different surgeons. I first saw him in January 16, 1888, when treatment was begun. He was a good soldier, and stood an exceedingly hot current without complaint. January 21, 1888, after the fourth treatment, reduction was accomplished with the greatest ease, the necessary manipulations taking not over a minute or two.

J. W. S.—, aged sixty-five, merchant, complete oblique inguinal enterocele, size of hen's egg, irreducible ten years; has suffered very much,

being obliged to wear a hard, slightly convex truss-pad, with considerable pressure over the tumor to prevent strangulation, which had occurred several times when attempting the use of a concave pad, or to go without any. Being a gentleman of wealth, he had consulted many prominent surgeons. No hope of relief was offered except through an operation. He consulted me June 2, 1889. Treatment was at once begun and repeated every other day. On July 1, 1889, reduction was accomplished, and a truss applied, which is worn with comfort.

John W.—, aged twenty-six, railroad engineer, scrotal entero-epiplocele, irreducible three years. Tumor, the size of a goose egg. Began treatment March 1, 1891; daily applications. March 16, 1891, reduction effected. Mr. W.— had consulted several physicians before coming to me, among them an emeritus professor of surgery, the unanimous opinion that an operation was demanded, on account of the liability of strangulation, owing to the nature of his occupation, and to the fact that he was on his engine away from home, out of the reach of aid most of the time, and could wear nothing in the way of protection.

L. W. M.—, aged thirty-two, bookkeeper, very large scrotal entero-epiplocele, scrotum measuring fourteen inches in circumference, irreducible 20 years. Many attempts at reduction had been made. Consulted me January 10, 1892. Treatment began and repeated every second to third day. In about four weeks the intestine was reduced, the large mass of omentum going slowly. There is a question in this case—if there is not still some omentum down, the scrotal tissues are very much thickened, the sac is surely down and thickened—but I can not satisfactorily determine the presence of omentum. If there is any, it is very little. One reason for feeling that there is no omentum left, is that he has worn a truss with convex pad, continually for several months without discomfort, which would not likely be the case were omentum present and pressed upon by the truss-pad.

John S.—, aged fifty-eight, brewer, large scrotal entero-epiplocele, fifteen years' duration, irreducible eight years. Began treatment August 1, 1889; treated every second to third day; reduction accomplished, September 3, 1889, and a truss applied which was worn with comfort till his death, which occurred from Bright's Disease, about one year later. As to the rationale of my treatment, I shall have the pleasure of explaining my theory in a future article. I shall then also have something to say in reference to the treatment for the "radical cure" of ordinary reducible hernia, taking advantage of the cataphoric action of the galvanic current.—Jas. J. Marcey, M.D., New York, in *Med. Rec.*

## THE OPIUM AND SALINE TREATMENT OF PERITONITIS.

To an article upon this subject by Dr. H. M. Russell, in the *Therapeutic Gazette*, we would make the following suggestions: We agree with the author that each individual case requires treatment adapted to its own peculiarities. The opium treatment is indicated, we think, without exception, as long as the peritonitis is localized. If we give purgatives before a general peritonitis has taken place we run a great risk of converting a local into a general peritonitis by the production of peristalsis. In these cases purgatives can only do harm, while opium, stopping peristalsis, will give the lymphatics a chance to absorb the infectious material, so that it may be made innocuous by the blood serum. On the other hand, if we have to deal with a general peritonitis, the indication to stop peristalsis is no longer imperative; on the contrary, we now find ourselves in harmony with the science of physiology and pathology if we give purgatives. By doing this we unload the lymphatics and blood-vessels and thereby place them in a condition to absorb larger quantities of the infectious material, bacteria and ptomaines. If it is necessary to give opiates in order to relieve pain we try to use as little of it as possible in order not to interfere with the physiological action upon which we place the most reliance; because it seems, with our present knowledge of pathology, the most rational thing to do.

In addition to the remedies mentioned in the article we have in some cases found very great relief by the application of cold in some form, preferably the rubber water coil. This we think, is more in harmony with scientific facts, than the application of heat, but here too, we must individualize and cannot put down a general rule that we could apply to any case. It is also our opinion that local peritonitis is often mistaken for general peritonitis and that, where we have to deal with the latter, we are always justified in performing laparotomy, look for the cause of the peritonitis and remove it. Idiopathic peritonitis, we think, is simply a name by which we cover up our ignorance. Having formulated our ideas as short and concise as possible we reproduce the author's very able article:

All authors of to-day agree that idiopathic peritonitis is rare. A few contend that it does not exist, but that general peritonitis is always a symptom. In my experience I have not met with a case which could not be traced to some previous lesion. Since peritonitis is usually a symptom of some previous disease, no set treatment will answer for all cases. To give salines to a patient who is suffering from a peritonitis

caused by an incarcerated hernia would be as wide of the mark as to benumb a patient with opium who has a peritonitis from impaction of the bowels. It is necessary that a diagnosis of the cause be made before the case can be rationally treated. With that phase of the question I do not propose to deal. The great number of cases of peritonitis presenting themselves to the general practitioner, however, have as their cause some lesion insignificant in itself and entirely unaffected by medicinal treatment, and the disease presents itself simply as a case of peritonitis. The inflammation must be controlled before the cause can be reached. How best to gain that end is the question which confronts us all, and which I approach with becoming humility. When I left the halls of the University of Pennsylvania he who suggested any but the opium treatment was sneered at. Since that time the saline treatment has arisen, and has followers who declare that to give opium is death to the patient, and to omit purgation with salines is equally reprehensible. Both these treatments have able supporters, who give no quarter and desire none. I suffered from a severe attack of peritonitis, and recovered under strict opium treatment. Moreover, as a student, I was thoroughly imbued with the belief that this was the only rational treatment for peritonitis, hence I feel much like a deserter in suggesting any other method of treatment. My first cases of peritonitis were given opium until they were narcotized, were passably comfortable, and generally died. Nevertheless, I could never bring myself to the state of mind in which I could omit opium. Hence, in my later cases, I have constantly used a combination of salines and opium, and with the happiest results.

The following cases, taken at random from my notes, will illustrate what has been by far the most satisfactory method of dealing with the cases of which I speak. They all corresponded to the type of a general peritonitis, the cause of which could not be found at the time, or, if detected, could not be remedied.

CASE I.—Mrs. N., aged fifty-two, was attacked with symptoms of dysentery. She had frequent stools, and passed some blood and mucus. These symptoms were controlled by small doses of opium. Suddenly, on the evening of July 19, 1891, the patient was seized with excruciating pain in the ileo cecal region. This was controlled by a hypodermic injection of morphine. The next morning the pain was still severe, and the whole belly was tense and exquisitely tender; the pulse was quick and hard; the woman was suffering much pain. She was ordered one half ounce of Epsom salts dissolved in a half-glass of water, and a tablespoonful of this was given every half hour. A hypodermic injection of morphine was administered to relieve the pain. The general condition



of the patient was bad. There was considerable tenderness over the ileo-cecal region, with resistance, while the whole belly was tense and tender. The patient lay on her back, with her thighs flexed. By the time the last of the half-ounce of saline was administered there had been two profuse watery stools. The belly became less tense and markedly less tender. The treatment after this was morphine hypodermically sufficient to keep the patient quiet, and salines sufficient to cause daily a large watery stool. Gradually the general inflammation decreased. The cause of peritonitis was demonstrated in a palpable, tender tumor in the ileo-cecal region. The woman made a complete recovery.

CASE II.—Mrs R., was seen in consultation. Her records had been missed for two months. Three days before she came under my observation she was seized with severe pain in the abdomen, simulating labor-pains. Shortly the whole belly became tense and very tender. On my visit a tumor was found, involving the right Fallopian tube. This was probably the cause of the trouble. The whole abdomen was distended and exquisitely tender, the patient screaming at the slightest touch. The bowels were constipated. As there was a specific history, and as the woman was pregnant and in fairly good condition, the treatment by hypodermic injections of morphine sufficient to control pain, and salines to cause large watery stools, was advised as the best means of combating the trouble. Laparotomy was decided against because of pregnancy and a specific history. This patient was afterwards seen by Professor B. C. Hirst, and the treatment continued. The woman made an excellent recovery.

CASE III.—Harry R., was seized with severe "cramps" while at work in a mill. On examination, a tender swelling was found in the ileo-cecal region. The patient lay with the knees drawn up and the whole belly tense and sensitive. A hypodermic injection of morphine was given and salines ordered. On the first movement of the bowels, which was profuse and watery, there was great relief. The general tenderness speedily disappeared, but there remained in the ileo-cecal region a decided tumor, which was demonstrable for two weeks. The patient has since gone through a similar attack, and is at present suffering from a third. It is probably a case of recurrent appendicitis, complicated, on at least two occasions, by a general peritonitis. A laparotomy will probably be required before definite cure.

These three cases—taken at random from a number of records which I have—well illustrate the set of cases to which I refer. Two were probably appendicitis, the third was certainly Fallopian disease, but in all three the one condition threatening life was the general peritonitis.

I would repeat that this method of treatment will no more than any other supplant a rational operative treatment, but it is superior in my hands to the opium treatment alone. I have had no experience with a pure saline treatment, but to my mind the intense pain always demands an opiate. A combination of the two methods secures comfort to the patient from the opiate and depletion of the inflamed peritoneum from the saline. The opium is best administered hypodermically, since thus less of the drug is used. The saline I have always administered in a saturated solution, a half ounce of this being given half-hourly. Strict rest, of course, must be ordered, and a liquid diet prescribed.

These means may be supplemented by leeching when the case is seen early, and by application of a light poultice to the abdomen, or a cloth wrung out of hot water and covered with oiled silk.

In conclusion, I would state that the means best suited in my hands to the treatment of peritonitis are:

1. Diagnosis as to the cause.
2. Removal of the cause where practicable.
3. Hypodermic injections of morphine sufficient to control pain.
4. Administration of a concentrated saline solution until free watery stools are produced.
5. Leeching and poulticing.—*Med. Rev.*

#### STRONTIUM BROMIDE IN THE TREATMENT OF CHRONIC EPILEPSY.

The constantly increasing number of incurable epileptics, both in asylums and at large, occasions an ever-growing demand for new drugs, from which we may at least hope to effect some improvement, in either their physical condition, or a diminution of the number of seizures.

Among the recent applicants for medical favor in this line has been the bromide of strontium (Paraf-Javal), purporting to be a salt, free from the impurities of the ordinary commercial article which render it unfit for continued use, or even poisonous in moderate doses. This statement as to its non-toxic action we have found to be well founded, no evil result having followed 30 grain doses repeated thrice daily, and no case that has been treated with the salt has shown other than beneficial results. Above all, we have to note continued absence of a bromide acne (even disappearance of the rash, though it was present when the use of the strontium was commenced), a very much lessened somnolent effect, the patients without exception appearing brighter and more cheerful under its use than with the sodium salt, and finally certain excitable cases were less quarrelsome after a seizure, than under the every-

day treatment; points all of very considerable value, both in private and asylum practice.

We have not been able to determine that the actual character of the seizures, when they do occur, is altered to any extent by the strontium salt, though some of the attendants were of the opinion that the convulsions were lighter in character than before the treatment was inaugurated, but it remains an uncertain point, the opinions being too much at variance to be of value.

In the September past, at the commencement of our experiment, we found in the City Insane Asylum thirty-six chronic epileptics, the majority being of many years' standing. At this date the whole thirty-six were treated with what is known as the "house epileptic mixture" which contains gr. xx. of sodium bromide and gr. xv. of potassium iodide to the tablespoonful, and which was given in this dose three times a day. A census of the thirty-six cases was made, and eleven of the worst and most regular epileptics were selected for the new treatment. These were, however, kept under the sodium bromide for four weeks longer, and the number of seizures that occurred daily were noted down by the attendants on charts especially prepared for the purpose. At the end of the fourth week, the treatment was changed to a solution of sodium chloride (gr. x. to  $\frac{1}{2}$  oz. water) t. i. d., upon which the eleven were kept for ten days. During this time the number of attacks increased greatly, and elicited the remark from one of the attendants that "they fall around like sheep." One curious point is to be noticed in the sodium chloride treatment, namely, that in the last two days during which it was administered, but one patient (J. P.) had a seizure. However, the very next day they began afresh, and it would therefore seem that the nervous centres had to some extent become temporarily exhausted. It is also to be noted that at the end of the ten days the eleven patients were generally in a decidedly worse mental and physical condition than under the sodium bromide.

On the first of December the selected patients were placed on a solution of strontium bromide (kindly furnished for the purpose by Messrs. Fougere, of New York), and within a few days a decided improvement became manifest in all except two cases (F. B. and M. W.). All were treated in precisely the same way, receiving 21 $\frac{1}{2}$  grs. of the salt thrice daily. The dose with F. B. was within a day or two increased to 30 grs., when he also followed in the train of the nine. On December 20th, owing to the unfortunate miscarriage of a letter, the treatment had temporarily to be discontinued, and from this date to the end of the month no medicine whatever was administered. During these ten days a gradual rise in the number of convulsions was noted. In the first seven days the rise was exceedingly slow,

in the last three days 16 seizures occurred, one patient alone having three.

On January 1st, a new supply of the bromide having been obtained, the treatment was recommenced and continued through to January 31st, 1893, without interruption. In October, under the sodium bromide, the eleven had 81 convulsions, in December there were 55 seizures, in January 65, marking a decided fall and very gradual rise for the entire number. This statement is vitiated to a degree by the non-amenability of Weinecker, Kinzer, and Schreck, and the inclusion of a case of Jacksonian epilepsy (Wasch) in the list. Excluding the cases of Weinecker and Wasch, we have the following statement: In October 76, in December 32 fits, in January 44 fits. With Weinecker the strontium treatment seemed to be of positive disadvantage. With Wasch, who has a gross lesion of the cerebrum, it seems to have had no influence either for good or evil.

With several other epileptics the strontium treatment was tried, but less systematically, partly owing to the patients at times refusing to take it; but in all to whom it was given an improvement has been noticed, both in the diminution of the number of fits, and in their increased mental brightness. One, a most unmanageable case (J. K.), with post-epileptic stupor lasting for a number of days after each attack, has improved very greatly mentally, and the number of seizures has diminished.

It is but fair to state that the *personnel* of the attendants of the Asylum is not all that could be desired, and that absolute reliance is unfortunately not to be placed on all their observations, and it is well to bear this in mind in drawing conclusions of the results of the strontium treatment. In one small ward, however, there is an exception, the attendant being very faithful and observant, and it was precisely in this same ward that the strontium salt gave its best results. In this department were the chronic epileptics, Gray, Beam, White and Chew. In October, under the sodium bromide the total number of seizures of the four numbered 37, in December 7, in January there was a rise to 18, less than one-half that of October.

An explanation may be necessary for the following histories; their indifferent character arises from the fact that up to 28 months ago no systematic histories of the patients in the Asylum were kept, and that, with two exceptions, the epileptics chosen for the experiment were admitted to the institution before that date, and no antecedent histories were obtainable.

Chas. Kinzer, aged 40, w. m. Imbecile. Parents are both dead, of unknown causes. No known heredity or neuroses in the family. Admitted Sept. 14, 1878. Cause of fits unknown. Has attacks of grand mal, averaging three weekly.

Convulsions are limited to the right side of body. The seizures average two minutes in duration, and are followed by stupor for a few minutes. There is no mark of injury to the skull. Patient had been on bromides since date of admission. There is now complete dementia. The effects from the strontium treatment have been nil.

Ed. Wasch, aged 54, w. m. Cigarmaker. No neuroses in family. Cause of epilepsy, a depressed fracture over the posterior left temporal region, caused by a fragment of shell during the civil war. Grand mal, averaging one series of attacks weekly, occurring in quick succession, sometimes as many as ten in a day. Convulsive movements begin in the muscles of the left face, then extend to the arm and leg, finally the whole body becomes convulsed. There is an aura as if a bucket of water had been poured over his head. Bromides off and on since 1863. The effect of the strontium treatment has not been marked.

C. A. Shreck, aged 33, w. m. Watchman. Cause, injury to head when a child. Has had fits since ten years of age. Petit mal and grand mal. Convulsive movements are more marked on left than on right side. Seizures occur day and night. The duration of the convulsion varies from the fraction of a minute to several minutes. Has been on bromides for a long time. Post-epileptic excitement and complete dementia. Benefit from the strontium has been slight.

Wm. Gray, aged 17, b. m. Laborer. No known heredity or neuroses, cause unknown, duration unknown. Patient is an imbecile. The convulsions are general, lasting from one to two minutes, after which he is confused and quarrelsome for several hours. Very considerable improvement under strontium treatment.

F. Beam, aged 45, b. m. Messenger. No ascertainable heredity or neuroses in family. Cause unknown, has had epilepsy since the age of 14 years. There is considerable mental deterioration. General convulsions lasting from one to two minutes, after which he is very excited and dangerous. He has an indistinct aura as if he were in the act of stepping into a carriage, the bottom of which falls through when his foot touches it. This aura apparently comes on in the form of a dream, and has been constant for a year only. Has been very greatly improved by the treatment, the attacks are greatly diminished and he is far less quarrelsome.

Isaiah White, aged 16, b. m., epileptic idiot. No history. Convulsions general and severe. Has command of only a few words. The number of seizures has been considerably diminished.

Chas. Chew, aged 32, b. m. Imbecile. Has been an inmate of the poor-house since a mere boy. No history obtainable. Has an average of two fits weekly. Convulsions general, lasting about two minutes. Is confused for an hour or more.

Has been on bromide treatment for many years. The number of convulsions has been considerably lessened by the strontium treatment.

Helen Luft, aged 45, w. f. No occupation. Father is said to have died with paralysis, the mother of cancer. Epilepsy followed measles at the age of six years. Convulsions general. Patient is considerably demented. Patient has improved considerably under the treatment.

Jennie Peterson, aged 32, w. f. No history obtainable. Has both petit and grand mal. Convulsions general. Fits since the age of seven years. Bromides since 1885. Is demented. Has not improved much under the treatment.

M. Weinecker, aged 36, w. f. No history obtainable. Has an average of one fit daily. Convulsions general, and is very quarrelsome afterwards. Is much demented. Treatment without result.

Dora Yocum, aged 40, w. f. No history. Imbecile. This case was probably the worst epileptic in the institution, having one seizure regularly every day and sometimes as many as half a dozen. Convulsions general. After an attack is obstinate and quarrelsome. Former treatment, bromides in all forms for years. Has improved greatly, attacks occur at comparatively rare intervals, and is comparatively bright.

One point is clearly seen in the tabulated statement, namely, that the strontium bromide has claims to considerably greater merit in lessening the number of epileptic seizures than its companion salt the bromide of sodium; but to me the improved mental condition, lessened somnolence and excitability, are of far greater moment than the actual diminution of the fits. The experiment shows that the salt is worthy of an extended use, and that certain cases may be greatly benefited by it.

In conclusion, I have to thank Dr. Edward Garrett, the resident physician, for his kindness in tabulating the reports, and for keeping a general supervision of the experiment while in progress.

NAME.	Oct.	Nov.	Dec.	Jan.
C. K.....	5	11	4	7
E. W. ....	0	7	5	4
C. S. ....	6	5	4	7
W. G. ....	7	3	2	4
F. B. ....	8	10	0	3
J. W. ....	11	3	3	6
C. C. ....	11	2	2	5
D. Y. ....	16	13	3	2
H., L. ....	8	9	7	4
J. P. ....	4	6	7	6
M. W. ....	5	16	18	16
Totals.....	81	85	55	64

NOTE.—From Oct. 1st to Oct. 28th sodium bromide gr. xx. and potassium iodide gr. xv. three times daily.

From Oct. 28th to Nov. 7th sodium chloride gr. x. three times daily.

From Nov. 7th to Nov. 20th strontium bromide 21½ grs. 3 times daily.

From Nov. 20th to Dec. 1st all medicine was discontinued.

From Dec. 1st, 1892, to Feb. 1st, 1893, strontium bromide grs. xxij. three times daily.—Henry J. Berkley, M.D., in *Johns Hopkins Hosp. Bull.*

### THE DRIP-SHEET.

In a recent address before the New York Academy of Medicine (*Medical Record*) Dr. Weir Mitchell gives the following directions for the use of this agent by persons needing the modified rest-cure:

What I dread most at the start, in all cases for rest, is grave insomnia. Whether it be accompanied by a state of mild mental excitement, such as we all know, or is a pure incapacity to go to sleep, or to stay asleep, or whether it be in popular medical belief a congested state, I am apt at once, in bad cases, to use twice a day lithium bromide, at first in 30-grain doses, at noon, at 6 and 9 p.m., given in the malt or not, and soon decrease grain by grain. If I want a positive aid at bedtime, I prefer sulfonal in hot water. But of greater value are some of the hydro-therapeutic devices—and best of these is what is known, or not known, as the "drip-sheet." Just how this is to be given is of the utmost importance. The following memoranda, which I shall not read to you, but shall ask you to read hereafter, must answer to show how careful one must be, in my opinion, as to these details. I give it here in brief, much as I do to the patient not under the immediate care of a nurse. I cannot help adding that several of the most useful of the water processes are neither taught in our schools, nor so accurately in hydro-therapeutic text-books as to be of much value to the general practitioner.

*Memoranda for use, at bedtime, of drip-sheet.*—Basin of water at 65° F. Lower the temperature day by day by degrees to 55° F., or to still less. Put in the basin a sheet, letting the corners hang out to be taken hold of. The patient stands in one garment in comfortably hot water. Have ready a large, soft towel and iced water. Dip the towel in this, wring it, and put it turbanwise about the head and back of the neck. Take off night-dress. Standing in front of patient—the basin and sheet behind—the maid seizes the wet sheet by two corners and throws it around the patient, who holds it at the neck. A rough, smart, rapid rub from

the outside applies the sheet *everywhere*. This takes but two minutes, or less. Drop the sheet, let the patient lie down on a lounge upon a blanket, wrap her in it, dry thoroughly and roughly with coarse towels placed at hand. Wrap in a dry blanket. Remove ice wrap; dry hair; put on night-dress. Bed, the feet covered with a flannel wrap.

If all this seems to you as you read it too absurdly minute, I shall feel some regret. Yet believe me, it is worth the trouble, and the drip-sheet is a remedy past praise. If it fail, a pack may succeed, but this is more familiar to you. I doubt if the use of the drip-sheet is as well known.—*Maryland Med. Jour.*

PEROXIDE OF HYDROGEN IN THE TREATMENT OF GONORRHOEA.—My recent experience with peroxide of hydrogen in the treatment of gonorrhœa has led me to believe that we have in this agent a most prompt and efficacious remedy. There is no doubt that peroxide of hydrogen thoroughly destroys the gonococci and promptly renders the urethral canal aseptic and free from pathogenic germs.

Acting upon the theory that antiseptics have the effect of maintaining any cavity or canal in a state of asepsis (without being deleterious to healthy tissues), which is the condition most favorable for the cure of suppuration, I have found by the use of this drug that the danger of an extension of the inflammatory process into the posterior urethra is lessened, the course of disease is decidedly shortened, and gonorrhœal complications avoided.

The following plan of treating acute gonorrhœa has proved very gratifying in my experience. I instruct the patient to use as an injection three times a day:

R.—Hydrogen peroxide, . . . . 1 oz.  
Aqua dest, . . . . . 6 oz.

Mix.

I present a brief history of two cases treated according to this method:

CASE I.—M. S., a married man, aged forty-five years, came to me in great perturbation of mind, stating that he had recently contracted gonorrhœa from a prostitute. He had all the characteristic symptoms of acute gonorrhœa. I gave him the above preparation, requesting him to use it three times a day, and told him to call again in the course of three days, which he did, when I found him completely cured.

CASE II.—The second case was that of a young man (unmarried), twenty-four years of age, who came with a gonorrhœa of six weeks' duration. He had tried a host of remedies prescribed by druggists for his trouble, but in vain. It had gone from bad to worse, and made him feel in a very despondent frame of mind. An examination

revealed the tissues of the penis to be in a very swollen and painful condition, with a profuse purulent discharge from the meatus, the lips of which were much inflamed and angry looking. He complained of great pain on urination, and was restless at night. I gave him the peroxide of hydrogen as above, directing him how to use it, and requested him to call again in the course of five or six days. When he again presented himself five days later, I found that the inflammatory process was subdued, the pain on urination had disappeared, and the patient expressed himself as feeling in every way comfortable. Ten days after this he reported himself as entirely cured.

It will be understood, of course, that in these cases I have directed the patients to observe the usual rules for diet and internal treatment.—Dr. Sullivan in *Cincinnati Lancet-Clinic*.

A CLINICAL HISTORY.—A contemporary prints the following: Elderly spinster to doctor (who has been asked to call between eleven and a quarter past, at a distance of many miles from his house: "I thought, Dr. Corax, that perhaps I might as well see you, as I fancy I have got a cold, and I think I had better tell you how I caught it. It was last Friday—or was it Thursday? What was the day when it rained so in the afternoon and evening? You don't remember? I think it was Friday, because the *Weekly News* always comes on Friday evening, and I half remember that when I came in the paper was lying on the hall-table. I wanted to post a letter to my sister who lives in Dorsetshire, to tell her how very sorry I was to hear of the loss of so many of her best poultry—a fox had got at them, and made sad havoc in the poultry-yard—but that is neither here nor there—and Sarah being out, I slipped on my cloak and ran across to the post office. But the ground was very wet after all the rain that had fallen that afternoon, and not being able to find my goloshes—" Doctor, breaking in: "Exactly. You got your feet wet—a most common cause of a cold. I shall be able—" Patient: "Please here me out. As I could not find my goloshes, I put on a pair of thick felt boots, which could not have let any water in, so I am sure it did not arise from my getting my feet wet. But just as I got to the post office door a gust of wind blew my bonnet off." Doctor: "A perfectly clear statement. I will now—" Patient: "Will you allow me to explain myself? After all I do not believe that I got the chill in this way. Over and over again I have told Sarah by no means to allow the passage-window to be open on cold or wet nights. Only a few days ago I said to her: 'Sarah, you may be used to it, but I am not.' In this house my will is law. I desire you to pay attention to what I have said about the passage-window.' 'Yes, ma'am,' says Sarah, as upish as you please; but—" Doctor (who has

got his thermometer ready): "Ah, yes; exactly. Allow me to place my thermometer under the tongue; and will you kindly keep the mouth closed for the three minutes that are necessary for ascertaining your precise temperature. I will prescribe at once." During the three minutes the prescription is written, the doctor puts on his gloves, gathers up his hat and umbrella, and notes that there are no obstacles in the way of escape. All being prepared, he ejaculates emphatically: "Thank you. A normal temperature, I see. Good morning. You will find yourself quite well to-morrow taking what I have prescribed," and vanishes.

CERTAIN ASPECTS OF GONORRHOEA IN WOMEN.—Dr. Noble (*American Journal of Obstetrics*) says an interesting phase of gonorrhœa in women is the invasion of the womb, Fallopian tubes, ovaries and peritoneum. In the urethra, the vulvo-vaginal glands, the vagina, the uterus and the Fallopian tubes, the general facts are the same—the disease has little if any tendency to undergo a spontaneous cure. The rule is that a chronic catarrhal condition succeeds the acute inflammation—if the disease has not been chronic or "creeping" from the beginning—and that in some fold of membrane, crypt or follicle, enough of the specific poison remains to set up acute inflammation anew. The known chronicity of the disease, and its rebelliousness to treatment in accessible regions, offer but little encouragement to expect a perfect cure in an inaccessible tube from which drainage is difficult, if not impossible. Personally he knew of no case in which a gonorrhœal salpingitis had been perfectly cured. He believes that the rule of practice should be to remove all such uterine appendages when the health of the patient is compromised by their presence. There is reason to believe that gonorrhœal salpingitis invariably produces occlusion of the tube, except in those cases where the infection spreads quickly to the peritoneum and induces rapidly fatal peritonitis. In respect to the question as to removing both uterine appendages when only one is infected with gonorrhœa, he mentions the fact that when one uterine appendage has been removed for inflammation the disease is likely to attack the other tube subsequently. Therefore, in operating upon women, the mothers of families, and who are approaching the menopause, it is certainly wise surgery to remove both uterine appendages, even though one is healthy. In young women desirous of bearing children, where only one tube is infected, it should be left to them to select whether one or both tubes should be removed, as they alone must suffer the consequences of success or failure. Probably the percentage in which extension to the healthy side will occur can be materially reduced by appropriate treatment.—*Sheffield Med. Journal*.

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TORONTO, AUGUST, 1893.

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## ABSOLUTISM IN PHYSICAL DIAGNOSIS.

There is, perhaps, no examination by the physician so frequent as that of the thorax, for the various diseases of organs found in that cavity. From the day that, as a student, he enters the wards of an hospital, new stethoscope in hand, to the day he ceases practice, he is constantly percussing and auscultating, inspecting and measuring chests.

The capacity for becoming good diagnosticians of chest diseases depends upon more than the perseverance of the learner. Some seem naturally to grasp at underlying conditions, to have natural powers of combination, and to find the path to a pretty certain diagnosis in the great majority of cases quite easy, while others, apparently more persistent, at any rate during their student days, and equally, if not more careful as physicians, never seem to arrive at that stage when they can with any degree of certainty distinguish between a friction rub and a crepitant rale. To some the difference between the various heart murmurs and sounds remains, we believe, to the end of their days, rather a shadowy and indefinite thing, the result of a jumbled mass of facts learned by rote, but never understood.

To fully appreciate the above facts, one needs to have acquaintance with final students, or to have frequent opportunity of noting the ideas of practitioners. We have known a medical man of many years' standing diagnose a case of acute pneumonia as one of phthisis. Some students cannot at the end of their term tell the difference

between a high-pitched and a low-pitched note, cannot distinguish the difference in the feeling of resistance between a solid lobe of lung and one perfectly normal, or appreciate the thrill of a pre-systolic murmur. And this is true, notwithstanding that they have been quite as attentive as their more fortunate brethren who easily and rapidly learn these physical signs, and can be as certain of their existence as they can be of the meaning of an articulate word.

Do we not, however, in all candor and honesty, all sometimes meet cases that conform to no law of physical diagnosis? We believe that if the truth were known many cases of lung trouble are never clearly revealed while the patient is alive. The *post-mortem* room is an excellent institution, if for nothing else than to keep medical men modest, so far as that can be done. Of course there will always be doctors who are cock sure of their diagnosis; as there are men in all walks of life who are cock sure of whatever they profess to know. But leaving aside this fortunately small class, many of the closest observers, and best diagnosticians must often be in doubt as to the true condition of things in a patient's lung, after he has exhausted all the resources of physical diagnosis. We have been so often disappointed in our diagnosis, particularly of lung cases, that the following (*Lancet*) comes with a certain amount of balm:

A man aged thirty-eight, belonging to the Army Reserve, was admitted into the North-West London Hospital. He was severely ill, suffering from dyspnoea. He stated that a month previously he had been wet through, had a rigor and pain in the chest, and was confined to bed for nine days. Feeling better he resumed his occupation and, with the exception of a few days, had been up and about till the day of admission. The respiration was 58, temperature 102° and pulse 120°; the left chest was dull from the base to the apex, and the physical symptoms were somewhat equivocal and conflicting, the balance after very careful examination being in favor of a large effusion. The cardiac sounds were faint and almost inaudible, but the heart was apparently beating at mid-sternum. An aspirating needle was inserted in three different spots *but without obtaining any evidence of fluid*. A fourth puncture produced four ounces of clear serum. On the following day there was evidence of pleurisy on the left side, the

dyspnœa increased and the man died in the early morning of the next day.

At the *post mortem* the left pleura was found much thickened and the lung compressed, the pleural cavity being occupied by numerous loculi, separated from one another by dense fibrous bands, some of which were at least half an inch thick. These loculi were filled with clear serous fluid, the largest lying on the posterior portion of the diaphragm and containing many ounces of it. In addition there was evidence of recent pleurisy on the right side and there was a large pericardial effusion (eight ounces). The course of the needle was followed. The three first punctures had plunged into the dense fibrous septa which divided the loculi. The fourth alone reached fluid, but unfortunately penetrated one of the smallest cavities.

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#### THE USE OF CHLOROFORM IN MIDWIFERY.

It would be interesting to learn what proportion of normal labor cases in this country are facilitated, and the pangs of the acme of the second stage mitigated, by use of a small quantity of chloroform. It is safe to say that whether the practitioner has been taught in his student days to use it, or has been instructed on that other line, which has fully developed in it all the merits and demerits of conservatism, that nature is the best midwife, and should be left to take her course, he will not use it more than once or twice in practice without being converted to its use in every case, normal or other, in which it is not specially contra-indicated. The safety of the procedure depends, as is now well-known, upon two points; first, that the pain of the end of the second stage is sufficiently controlled by far less anæsthesia than would be necessary for surgical purposes, less than would be needed to stop either uterine contractions or even the contractions of the abdominal muscles. The second is that the intra-abdominal pressure, before evacuation of the uterus has occurred, is too great to make it possible for the patient to inhale too much.

As to the *modus operandi*; an assistant, other than the nurse, is not needed, as the accoucheur can superintend the first inhalation, and then let the nurse give, under his direction, after, whiffs if

necessary while he is engaged at the delivery of the head. Vomiting is not apt to follow the use of the small quantity needed. If the accoucheur choose, he may give the woman a cup or tumbler, with some absorbent cotton in it upon which he has poured a little chloroform or A. C. E. mixture, and she can use it as each pain comes on, unconsciousness causing the falling away of the cup when enough has been inhaled. The main objection to its use has been the fear of increasing the liability to *post-partum* hæmorrhage. If used for any purpose after evacuation of the uterus that fear is well founded, from the risk incurred of uterine relaxation. But that need not be feared if the chloroform is used only during the second stage.

A paper read this year by Byers, of Belfast, before the Section of Obstetrics at the sixteenth annual meeting of the British Medical Association, favors the much more frequent use of chloroform in normal labor. The author of the paper points out the fallacy in arguing that because chloroform is given and hæmorrhage follows, the one is the cause and the other the effect; the old *post hoc, ergo propter hoc*. "Dr. Byers argued that the great majority of cases of alleged flooding after delivery, occurring when the anæsthetic was used, can be explained as being due, *not* to the chloroform, but either to rapid delivery, or to a want of proper management of the third stage of labor, or to a combination of both these causes." The paper ended with the positive statement, as the result of a large experience, that "if proper care be used *post-partum* hæmorrhage will not occur more frequently when chloroform is used than when the anæsthetic is not given."

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#### OPERATIVE INTERFERENCE IN PERITONITIS.—

While laparotomy in the acute stages of peritonitis has found its advocates of late, the voice of abdominal surgeons generally is loudly against it. Dr. Eastman of Indianapolis (*Journal of American Med. Assoc.*) condemns it strongly. "In the earlier stages of septic peritonitis (and all inflammation is of septic origin), surgical interference is but adding fuel to the flames. After the patient has been tided over the acute stage of the disease, to the time when the micro-organisms have become less active, surgical efforts may be

curative by removal of the localized products of inflammation. Cases have come to my knowledge where practitioners anxious to obtain the prestige presumably gained by abdominal section, have ventured to open the swollen abdomen with no definite idea what they were going after, where they were going to locate it, what they were going to do with it, after they had found it. After opening the abdomen freely, with the hope that they might see something which the fingers had not been able to feel, they found the intestines distended with gas, piled up in formidable stacks over the abdomen and even falling down on the table. Their position was something like the man who attempted to repair the clock; he had no difficulty in taking the clock to pieces, but when he attempted to put it together again he imagined he had wheels enough for fourteen clocks."

**TREATMENT OF VESICAL CALCULUS IN BOYS.**—Pousson, in reporting, (*Gaz. des Sciences Méd.—Am. Jour. Med. Science*), a case of cystotomy for stone in a boy of eleven years, makes the following conclusions from a study of the literature:

1. The opinion of surgeons of different countries upon the comparative value of the supra-pubic operation and lithotripsy in children is not yet fixed. In France the preference is on the side of the cutting operation, and the statistics of lithotripsy, though very favorable, are perhaps misleading from the diversity of their sources.

2. The dimensions of the urethra of the child, which are still uncertainly determined, are the most serious obstacle to the generalization of lithotripsy at this age.

3. The supra-pubic operation is almost demanded in children because of the situation of the bladder and the dangers of wounding the ejaculatory ducts, to which almost all the perineal operations expose.

4. Ballooning the rectum, far from being indispensable, is sometimes troublesome and even dangerous; a simple sponge in the bowel suffices to maintain the bladder in position.

5. Union of the bladder by first intention, after suture of the wound, is possible in children. In this case the retained catheter is at least prudent, if not absolutely indispensable.

**TOTAL EXTIRPATION OF POPLITEAL ANEURISMS.**—Meinhard Schmidt advocates, in the *Archiv. für*

*klinische Chirurgie* (*Am. Jour. Med. Sciences*) the extirpation of popliteal aneurisms. The aneurism is to be removed exactly as if it were a tumor. The advantages over the Antyllan method, which is the next most radical, is that no unnecessary part of the diseased vessel is left behind, which might become the seat of suppurative processes.

In the forearms and legs, where there are two main vessels of supply, and the chance for a good collateral circulation is very favorable, the radical method is the operation of choice.

The author details a case in which he excised a popliteal aneurism from each leg of a patient. The most tedious part of the operation, in nearly every case, is the separation of the vein from the artery. The integrity of the vein should be maintained if it is possible.

The author prefers packing and secondary sutures, to be tied in forty-eight hours.

In twelve cases collected by the author (including his own), the results have been very favorable. Gangrene did not occur; even an accidental cut of the vein had no unfavorable influence upon the establishment of collateral circulation.

**THE ABORTIVE TREATMENT OF ERYSIPELAS OF THE FACE.**—Dr. Talmon advises (*Internat. Jour. of Surg.*) treatment of facial erysipelas by spraying with a solution of corrosive sublimate in ether, 1 in 100, preferably by means of a hand-bulb atomizer. The more forcible the spray, the shorter the time required for atomization. Attention should be paid to the delicacy of the skin, the depth of infiltration, the presence of vesicles. The formation of vesicles in consequence of the spraying is not dangerous, and as long as the affected area is small may be beneficial. The spray should be especially applied to the periphery of the erysipelatous swelling, and the surrounding healthy skin for a distance of one or two centimetres. In erysipelas of the eyelids only the adjacent parts are subjected to the action of the atomizer. After the spraying the face should be covered with compresses frequently moistened in boric acid solution. One or two forcible atomizations are sufficient at a rule; later their force may be diminished, and only those places are to be treated where the erysipelas threatens to advance. The pain produced by the atomization is usually moderate and is due to the increased swelling and



formation of crusts This method may be employed on other parts of the body, but more force must be employed.

**MORPHINE AND GASTRIC SECRETION.**—Hitzig has noted (*Med. Centr.,—Br. Med. Jour.*) that morphine administered hypodermically to a dog is shortly afterward excreted by the stomach, and that, following upon this, there is a marked reduction in the amount of gastric juice secreted, and more especially of its acid constituent. The cessation of the action of the drug is followed by the secretion of excess of hydrochloric acid. With regard to the effect upon human gastric juice, the case is described of a patient who consumed daily two grammes each of morphine and cocaine, the latter having been resorted to in an endeavor to remove the craving for the morphine. He was treated by gradual reduction of the doses of the alkaloids, but it was not until the morphine was entirely discontinued that the presence of free hydrochloric acid was indicated.

**RECTAL FEEDING** may be carried on by means of a mixture of two eggs, twenty grains of pepsin, ten grains of chloride of sodium, and six ounces of water (*Detroit Emergency Hospital Report*). This mixture should be slightly warmed, thoroughly agitated, and then gently introduced into the bowels by means of a syringe. To facilitate the entrance of the fluid into the intestines, it is well to put the patient in a position with the hips much elevated above the head; either the knee-chest position, or with two or three pillows beneath the hips.

**ENUCLEATION OF THE TONSILS.**—Dr. Pollard, in the *Lancet*, suggests their removal as follows:—“The surgeon places the tip of his forefinger between the upper and back part of the tonsil and the posterior pillar of the fauces, tears through the mucous membrane at that spot, and then peels off the tonsil from the wall of the pharynx until it hangs loose in the throat by a short pedicle attached to its lower and anterior part. The pedicle may be either torn through by twisting or snipped across with a pair of scissors.”

**LAVAGE OF THE STOMACH.**—The comparative readiness with which the stomach may be washed out by the general practitioner, and the numerous

cases in which relief is thus afforded, leads Pick (*Centrab. f. Therap.*) to a discussion of what constitute suitable cases. His classification includes:

(1) All cases where the food remains an abnormally long time in the stomach, whether such delay is due to dilatation consequent on stricture of the pylorus or to simple stretching.

(2) Cases of carcinoma of the pylorus where the greatest relief is often given by regular siphonage and cleansing.

(3) To remove excessive mucous secretion due to gastric catarrh and as a means of testing the deficient elements of the digestive fluid.

Cholelithæmia and catarrhal icterus, to remove auto-organic poisons.

All cases where the retching might be fatal to the patient as in advanced cardiac, pulmonary or arterial disease are contra-indications.

**CALOMEL FOR CIRRHOSIS OF THE LIVER.**—Dr. L. Sior (*Hospitals-Tidende—Lancet Clinic*) had a case of cirrhosis of the liver under observation which had been treated by various methods for nine months without result. The patient, a man of thirty years, received calomel, and a striking improvement soon became manifest, as the pains and icterus disappeared. He prescribed the drug in the following manner: For three days he received five centigrammes ( $\frac{3}{4}$  gr.) of calomel six times a day with intervals of two hours. Then it is left off for three days and again resumed. This is continued for one month, and the following thirty days only four powders a day are taken.

**DANGERS OF VAGINAL PESSARIES.**—Dr. Neugebauer, of Warsaw (*Br. Med. Jour.*), has published an exhaustive analytical monograph on this question, so important in these days when gynecology is widely practiced by the surgeon and physician as well as the specialist. Two hundred and forty-two cases of injury have been collected and analyzed, five more being added in an appendix. Tabulating the results, Dr. Neugebauer presents the medical public with the following formidable statistical records. Twenty-three cases of perforation of rectum alone by the pessary; twenty cases of perforation of the bladder alone; ten cases of perforation of the bladder and rectum; one case of ureteric fistula alone; one case of ureteric and vesico-vaginal fistula; one case of

urethral-vaginal fistula; two cases of perforation of Douglas' pouch (neither fatal); three cases of perforation of the vaginal walls, the extruded portion of the pessary lying in the pelvic connective tissues; and six cases of entry of a vaginal pessary into the uterus.

RELATION OF RHEUMATISM TO CHOREA.—(*Arch. of Ped.—Arch. Gyn., Obstet., and Ped.*) Papers treating on chorea were read by the three gentlemen mentioned below, and their conclusions were as follows:

Dr. Townsend concludes—

(1) Fright, eye-strain, debility, and school-pressure, particularly the latter, which often includes some of the former, are potent, exciting causes of chorea.

(2) Rheumatism, although absent from the history of at least half the choreic patients, occurs with greater frequency among the choreic than among the non-choreic cases.

(3) There is an intimate relation between chorea and rheumatism.

(4) The heart murmur so frequently heard in chorea, sometimes associated with chorea and sometimes not, is in a considerable proportion of the cases due to endocarditis, and leads to organic valvular disease.

Dr. Crandall in his paper states that he should class rheumatism, fright, hysteria, excitement, and pregnancy, not as all powerful agents for the production of chorea, but rather as exciting agents for the production of the disease in subjects predisposed to it, the most universal and potent of which is rheumatism.

Dr. Adams concluded—

(1) That chorea is due to rheumatism in but a small percentage.

(2) That the heart murmurs are hæmic in the largest number of cases.

(3) That the successful treatment would seem to exclude latent or apparent rheumatism.

(4) That anæmia and chlorosis are well marked in nearly all cases.

(5) That severe impoverishment is by far the most potent factor.

IMPREGNATION BY A SEXUAL PERVERT FEMALE.—Duhousset, of Paris, some years ago (*Medical Standard*) reported a case of this kind, and another

has recently been reported (*N. Y. Med. Jour.*) by Dr. A. F. A. King, of Washington, in which a young unmarried woman was impregnated by her sister-in-law, who, soon after copulating with her husband, committed the simulacrum of the male act with her sister-in-law.

Prof. Hare recommends the following pill in cases suffering from chronic urethritis, anæmia, and debility:

R.—Oleo-resinæ copaibæ, . . . 3 j.  
 Oleo-resinæ cubebæ, . . . gtt. iv.  
 Ferri et ammon. citratis, . . gr. xx. M.

Ft. pil. x.

Sig.—Take one three times a day after meals.

A NEW TÆNIFUGE, proposed by Dr. Duhourcau, is the following combination in capsules:

Extract of male fern . . . 1.20 gm.  
 Chloroform, . . . . . 3.60 gm.  
 Castor-oil, . . . . . 3.60 gm.  
 Croton-oil, . . . . . gtt. ss.

To be divided into twelve doses.

NEPHRECTOMY at once is admitted by Wagner only in malignant tumor and tuberculosis of the kidney. In hydro- and pyo-nephrosis nethrotomy is better. In benign tumors and cysts partial nephrectomy may take the place of total extirpation of the organ.

PRURITUS ANI.—Dr. Wm. F. Waugh, (*Times and Reg.*)—recommends Goulard's extract diluted with four parts of water, applied constantly day and night, as an excellent application in this disease.

LOCAL ANÆSTHESIA for minor operations:

R.—Menthol, . . . . . 1 part.  
 Ether, . . . . . 15 parts.  
 Chloroform, . . . . . 100 parts.

M.—Use in spray apparatus.

A SAFE METHOD of chloroform administration Laurie says, does not exist. The all-important point is that the breathing should not be interfered with in any way.

UTERINE FIBROIDS should, in most instances, be left alone, according to Thornton's experience. He has not been favorably impressed by the Apostoli method.

A PORTER'S FOOT-RACE.—Jean Labasse, a French porter, recently carried a bag of sand weighing 220 pounds (*Med. News*) a distance of nineteen miles in fourteen hours, beating his competitors by several hours' time.

Five minims of creosote and five grains of boric acid in an ounce of the distilled extract hamamelis, is said to be a most valuable injection in gonorrhoea.

APPENDICITIS, IF SEEN EARLY.—Absolute rest, fomentations, salines every half hour until four or six fluid stools are produced.—*Jonas*.

Ten grain doses of phenacetine at bedtime is said to fully control frequent nocturnal micturitions in the aged.

### Books and Pamphlets.

A HAND-BOOK OF LOCAL THERAPEUTICS. By Allen, Harte, Harlan & Van Harlingen. Edited by Harrison Allan, M.D. Octavo, 500 pages; price, \$4. Philadelphia: P. Blackiston, Son & Co. Toronto: Carveth & Co. 1893.

The need for a book of this character has long been apparent, for there has been no text available in which the local action of drugs was not subordinated to their general actions, while the average text-book omits altogether mention of many agents, that in the hands of a specialist become valuable aids to cure.

Diseases which require chiefly local treatment are those of the respiratory passages, eye, ear and skin, together with certain general surgical affections, including the diseases of women; it is therefore to the great advantage of the work that each remedy has been thoroughly set forth by different authors who have had large practical experience in these various branches.

Each remedy has been taken up in alphabetical order, and after a description of its pharmaceutical properties, is considered in reference to its physiological effect and value in local treatment.

The demands for thorough revision of local medicaments made by the advance of theories of asepsis, have been fully considered, and a succinct account has been presented of the source and properties of the very numerous new agents which affect tissues locally.

Some drugs have been excluded which have been highly praised; on the other hand great care has been taken not to endorse imperfectly attested novelties.

This hand-book embodies the results obtained by experienced teachers, and will prove a very valuable work to the general practitioner. Two carefully made indexes make it a book of ready reference.

THE YEAR BOOK OF TREATMENT FOR 1893. Philadelphia: Lea Bros. & Co. Toronto: Carveth & Co.

In the ninth edition of the "Year Book of Treatment" there are two new articles. Dr. Dudley Buxton has a separate article on "Anæsthesia," and Prof. W. H. Corfield, M.D., on "Public Health and Hygiene," the increasing importance of which branch is evident to every one who reads even the daily papers. Among the contributors may be mentioned, J. Mitchell Bruce, Reginald Harrison, Edmund Owen, and many other men equally and favorably known. Our readers cannot go wrong in ordering a copy.

HAND BOOK OF THE DIAGNOSIS AND TREATMENT OF DISEASES OF THE SKIN. By Arthur Van Harlingen, M.D., Professor of Diseases of the Skin in the Philadelphia Polyclinic, etc. Second edition, revised and enlarged: with eight full sized plates and other illustrations. Philadelphia: P. Blackiston, Son & Co. Toronto: Carveth & Co.

The especial feature of this new edition of Van Harlingen's well known work, is the introduction of a number of illustrations, some original and others taken from special journals and monographs. The work is too well known as good, to need any further recommendation.

ANATOMY OF THE BRAIN AND SPINAL CORD. By J. Ryland Whittaker, Senior Demonstrator of Anatomy, School of Medicine, Minto House, Edinburgh. Second edition, p.p. 173. 1892. Edinburgh: E. & S. Livingstone. Toronto: Carveth & Co.

This is one of the most admirable books we have seen. It bears on every page the imprint not only of the anatomist, but what is of great importance, the teacher. It contains 40 beautifully executed plates, some colored, and all wonderfully good. We have nothing but commendation for the work, whether to physician, surgeon or student.